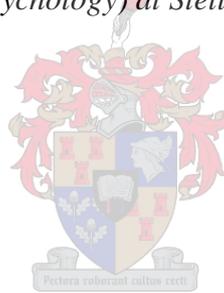


Ad hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions.

Sybrand Anthony Hagan

*Thesis presented in fulfilment of the requirements for the degree of
Master of Arts (Psychology) at Stellenbosch University*



Supervisor: Prof L. Swartz

Faculty of Arts and Social Sciences

Department of Psychology

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the authorship owner thereof and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

.....

S A Hagan

.....26 February 2015.....

Date

ABSTRACT

The provision of good quality mental health care relies heavily on effective communication. Interpreters have a profound role to play where language and cultural barriers stand in the way of effective communication. To date little is known about interpreting practices in low- and middle-income countries. This study examined ad hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions at South African psychiatric hospitals. A cross-sectional qualitative interview design was used. The research participants consisted of 13 individuals (ages 25 to 59), all who attended an in-service training course. Seven participants are male and six are female. The semi-structured interviews were transcribed verbatim. The results of the qualitative data are grouped into six themes: "Language barrier between researcher and participants", "The role of age, culture and gender", "Views on interpreting", "Willingness to act as ad hoc interpreters", "The effectiveness of the in-service training course, subsequent interpreting sessions and interest in more formal training" and "The importance of a working relationship between interpreters and clinicians". The language ability of participants is unsatisfactory to ensure the optimal delivery of mental health care, as can be seen by numerous miscommunications between researcher and participants. It is clear that interpreters can have a vital impact on the effectiveness of mental health care. There is clearly a need for trained interpreters in South Africa. The continuous use of untrained interpreters could lead to adverse health outcomes. Although participants stated that the in-service training course was helpful, it was difficult to judge the effectiveness of the course, due to various reasons. Finally, limitations and recommendations for future research are discussed.

Keywords: Interpreting, cultural diversity, South Africa, health care quality, in-service training

OPSOMMING

Die voorsiening van goeie gehalte geestesgesondheidsorg hang baie van effektiewe kommunikasie af. Vertolkers speel 'n diepgaande rol wanneer taal en kulturele hindernisse in die pad staan van effektiewe kommunikasie. Tot op datum is daar min bekend oor vertolkingspraktyke in lae- en middel inkomste lande. Hierdie studie ondersoek *ad hoc* vertolkers se ervarings van 'n indiensopleidingskursus en daaropvolgende vertolkerbemiddelde sessies by Suid-Afrikaanse psigiatriese hospitale. 'n Deursnee-kwalitatiewe onderhoud ontwerp was gebruik. Die navorsingsdeelnemers het uit 13 individue (ouderdomme 25 tot 59), wat almal 'n indiensopleidingskursus bygewoon het, bestaan. Sewe deelnemers is manlik en ses vroulik. Die semi-gestruktureerde onderhoude was verbatim vertaal. Die resultate van die kwalitatiewe data word in ses temas gegroepeer: "Taalgrens tussen navorser en deelnemers", "Die rol van ouderdom, kultuur en geslag", "Standpunte oor vertolking", "Bereidwilligheid om as *ad hoc* vertolkers op te tree", "Die effektiwiteit van die indiensopleidingskursus, daaropvolgende vertolkingsessies en belangstelling in meer formele opleiding" en "Die belangrikheid van 'n werksverhouding tussen vertolker en klinikus". Die taalvermoë van die deelnemers is onbevredigend om die optimale lewering van geestesgesondheidsorg te verseker, soos gesien kan word deur vele miskommunikasies tussen navorser en deelnemers. Dit is duidelik dat vertolkers 'n beduidende impak op die effektiwiteit van geestesgesondheidsorg kan hê. Daar is duidelik 'n behoefte vir opgeleide vertolkers in Suid-Afrika. Die deurlopende gebruik van onopgeleide vertolkers kan lei tot nadelige gesondheidsuitkomst. Alhoewel deelnemers aangedui het dat die indiensopleidingskursus nuttig was, is dit weens verskeie redes moeilik om die effektiwiteit van die kursus te beoordeel. Ten slotte word beperkings en aanbevelings vir toekomstige navorsing bespreek.

Sleutelwoorde: Vertolking, kulturele diversiteit, Suid-Afrika, gesondheidsorg gehalte, indiensopleiding

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CHAPTER 1: INTRODUCTION AND MOTIVATION

1.1 Introduction

Language and communication are central to good quality health care (Kilian, Swartz, Dowling, Dlali, & Chiliza, 2014; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014). It is important that health care workers, and mental health care workers in particular, understand what their patients are saying, and vice versa (Drennan & Swartz, 2002; Swartz et al., 2014). Language is the medium through which communication takes place, which enables clients to report symptoms to clinicians (Swartz et al., 2014; Westermeyer & Janca, 1997). There is a growing body of evidence that shows that effective communication and interaction, which happens primarily through language, is essential to addressing the concerns of a patient and ensuring that appropriate and better quality care is administered (Brach, Fraser, & Paez, 2005; Sobane & Anthonissen, 2013; Wiener & Rivera, 2004). There is evidence to suggest that there is a link between language discordance and psychopathology and treatment seeking, as the language barrier stands in the way of people seeking treatment, which could negatively affect their psychopathology. (Searight & Armock, 2013). Bischoff, Bovier, Isah, Françoise, Ariel, and Louis (2003) argue that the quality of communication can be considered as useful proxy for a global assessment of the quality of care. Westermeyer and Janca (1997) state that when patients are forced to use their second language, they tend to filter out important information. Without a common language, the task of ensuring appropriate care becomes impossible. This being said, the delivery of good quality health care and successful communication goes beyond basic conversational competence between the different parties involved. There are particular contextualised tasks which need to be undertaken in the clinical encounter (Drennan & Swartz, 2002). For example, communication is used to establish the patient-clinician relationship, which plays an important part in health care (Hsieh, Ju, & Kong, 2010). The therapeutic relationship is critical to mental health care, and without successful communication, this relationship is threatened (Doherty, MacIntyre, & Wyne, 2010).

In a world where globalisation is increasing and countries are becoming more and more multicultural and multilingual (Brisset, Leanza, & Laforest, 2013), there is increasing awareness of the gap between the quality of care provided to people who speak the language of health care, and those who do not. English is widely seen as the dominant language of health care (Karliner, Jacobs, Chen, & Mutha, 2007) in Anglophone countries, and people

with Limited English Proficiency (LEP) may not receive optimal care (Hagan et al., 2013). This language barrier that is created can cause a variety of difficulties for clinicians and patients (Bauer & Alegria, 2010; Jacobs, Diamond, & Stevak, 2010; Timmins, 2002). Solutions to this language barrier can be bridged to some extent by making use of a multilingual health care team, multilingual clinicians, ad hoc interpreters and/or trained interpreters, with various degrees of success. Having access to interpreting services in mental health care can be thought about as a human rights issue, as it would potentially offer everyone equal opportunities to access these services and foster social inclusion (Baron, Holterman, Shipster, Batson, & Alam, 2010; Kilian et al., 2014; Tribe & Keefe, 2009). Denial of health care because of a language barrier constitutes discrimination (Flores, 2006). Cultural and linguistic communication difficulties are two of the most frequent barriers to accessing health care (Pottie, Ng, Spitzer, Mohammed, & Glazier, 2008; Kilian et al., 2014), and there is commonly a link between culture and language use (Hadziabdic & Hjelm, 2013).

The present study aims to document ad hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions.

The study was conducted in the context of state psychiatric hospitals in the greater Cape Town area of South Africa. The in-service training course consisted of three interrelated activities, namely training for informal interpreters, training for clinicians and a joint workshop for interpreters and clinicians. The training for informal interpreters consisted of four sessions. The first session was an introduction and focused on the following topics: the definition and background to mental health interpreting (which includes previous research findings); the challenges regarding mental health interpreting/contextual issues; ethical issues, legal and constitutional aspects; interpreters' personal experience of fulfilling the role of interpreter in an unofficial capacity; and coping mechanisms. The second session focused on basic mental health training and involved a brief overview of common psychiatric conditions and terms. The third session was on interpreting models. During this session different interpreting models were discussed. These models include the black box model, bilingual worker model, collegial model, denotative and connotative interpreting, emergency translation, forensic evaluation and sequential versus concurrent translation (these models will be explained later). This session also included aspects that impact interpreting session (i.e., the role of gender; age; culture; power; and linguistic issues such as traditional versus modern Xhosa speakers). Role play methods were also used during this session. The fourth, and last, session focused on interpreters' needs, where interpreters were offered the

opportunity to identify their needs. A group of clinicians was trained in a similar process, and for the final session the two groups – interpreters and clinicians – were brought together. This session was used to discuss lessons learned and guidelines developed based on information that emerged during the previous two workshops.

In this chapter the key terminology that will be used, the rationale for this study, the theoretical framework and the aims and objectives of the present study will be discussed.

1.2. Key terminology

An **ad hoc or informal interpreter** is someone who is untrained in interpreting, but who has communicative competence in the two languages in question, and performs interpreting on an informal or ad hoc basis (Bauer & Alegria, 2010; Karliner et al., 2007; Timmins, 2002).

Professional or trained interpreters are trained in the art of interpreting, are paid (Karliner et al., 2007) and are tasked with the sole purpose of facilitating communication (Dysart-Gale, 2007).

Cultural competency is awareness and acceptance of cultural differences, and the ability to learn about and be able to sensitively interface with people from diverse cultures (Timmins, 2002).

People with **Limited English Proficiency (LEP)** are not able to speak, write, read or understand English at such a level that permits effective interaction (Karliner et al., 2007).

The **therapeutic relationship** refers to the cooperative working relationship that is formed between patient and clinician (VandenBos, 2007).

1.3. Rationale for the study

Language and the use thereof have an immense impact on the success of psychiatric assessment and diagnosis. For the provision of good quality health care, there needs to be successful communication between patient and health care professional. This becomes a problem in a multi-lingual country like South Africa. The dominance of Afrikaans and English, due to South Africa's political past, is still evident in our country. This has the effect that many of South Africa's health care professionals can speak only one or both of these languages; despite the fact that the Western Cape, for example, has Xhosa as an official

language (Kilian, Swartz, & Joska, 2010), and many Black South Africans that make use of mental health services are not proficient in English or Afrikaans (Kilian et al., 2014). This has the effect that Black South African's voices are being silenced (Kilian et al., 2014). It is worrying to note that problems in mental health care that were identified in South Africa 20 years ago still persist (Kilian et al., 2014). Recent studies in two psychiatric hospitals in the Western Cape, including a study which I conducted, showed that people acting as informal interpreters have a desire to be of assistance in bridging the language gap, but that they are concerned that they lack the requisite skills to work optimally (Hagan et al., 2013; Kilian et al., 2010; Smith, Swartz, Kilian, & Chiliza, 2013). It is clearly not ideal, in terms of the literature, to make use of informal interpreters (professional interpreting services are better) (Luk, 2008), but it is highly unlikely given the financial constraints on health care that professional interpreters will be employed. In this context, the question arises as to whether some training of people who currently work as ad hoc interpreters, as well as of the clinicians who work with them, may help improve services. This study forms part of a larger study led by my supervisor, Prof Leslie Swartz, on language access to mental health care in the Western Cape, and addresses the question of informal interpreters' experiences of an in-service training provided to them. My sub-study cannot answer the question of whether the training improved language access, but forms part of the formative evaluation of the action research component of the larger study. A separate study of the clinicians' responses to training has been conducted by another master's student.

1.4. Theoretical framework

Interpretative Phenomenological Analysis (IPA) is an inductive approach that aims to understand the personal accounts, or insider perspective, of an individual of a particular experience (Clarke, 2009). According to Larkin and Thompson (2012), IPA places a great deal of emphasis on how people make sense of their experience and is reliant on the researcher collecting "detailed, reflective, first-person accounts from research participants" (p.101). IPA taps into people's natural tendency to self-reflect (Smith, Flowers, & Osborn, 1997). A successful IPA study would include the capturing, analysis and reflecting upon research participants' claims, concerns, experiences, understandings, perceptions and views, and also an interpretation of these accounts (Braun & Clarke, 2006; Brocki & Wearden, 2006; Larkin & Thompson, 2012). In accordance with IPA, meaning-making is conceptualised at the level of the person-in-context (Larkin & Thompson, 2012). Thus focus will be on the meaning of an experience (e.g., a specific interpreting session) of a particular

participant (Larkin & Thompson, 2012). The degree to which each participant will self-reflect will differ, thus it is necessary for some encouragement, but it is important that participants tell their own story, in their own words (Smith et al., 1997).

The research participants in this study were chosen purposively, because they could offer a valuable point of view on the topic under discussion, which is the kind of research that suits IPA (Chapman & Smith, 2002; Larkin & Thompson, 2012). According to Larkin and Thompson (2012) the most typical data used for IPA is a semi-structured, one-to-one interview, usually in the form of a verbatim transcript. The researcher must be neutral and facilitative, giving the research participants a space where they can tell their story (Larkin & Thompson, 2012). According to Chapman and Smith (2002), it therefore requires a flexible data collection method. A semi-structured interview schedule will allow a space for the researcher and the participant to engage in dialogue, whereby the original interview schedule can be modified in light of the participant's responses (Chapman & Smith, 2002). IPA does not rely on big sample sizes. It is not the quantity of the data, but rather the quality of the data that is important to develop an insightful analysis (Larkin & Thompson, 2012). IPA is not about eliciting facts, but rather about discovering meaning (Larkin & Thompson, 2012; Smith et al, 1997) and examining in detail the understanding and perceptions of a specific group of participants, rather than making more general claims (Chapman & Smith, 2002).

Larkin and Thompson (2012) argue that when interpreting qualitative data, “you aim to develop an organized, detailed, plausible and transparent account of the meaning of the data” (p. 104). First of all you need to identify patterns of meaning, or themes, from your data. Your themes must then be able to fit into a coherent and organised thematic account or structure. From this structure you must be able to form a narrative account to serve as an analysis of your data (Larkin & Thompson, 2012). This narrative account must guide the reader through the analytic process, giving examples of what is important to the participants and highlighting your interpretations of their stories (Larkin & Thompson, 2012). IPA attempts to understand a participant's personal world, instead of simply describing their experience (Clarke, 2009). IPA focuses on the participant's subjective accounts, rather than formulating objective accounts (Brocki & Wearden, 2006). The research is dependent on the researcher's own conceptions to make sense of the research participant's perceptions (Chapman & Smith, 2002; Smith et al., 1997). The final analysis will thus be a combined product of reflection by the participant and the researcher, forming a dynamic research process (Clarke, 2009; Smith et al, 1997).

1.5. Aims and objectives of the present study

The aim of the study is:

- To assess ad hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions.

The objectives of the study are:

- To document ad hoc interpreters' experiences of an in-service training course in a mental health setting.
- To document ad hoc interpreters' experiences of interpreter-mediated sessions after receiving an in-service training course.

1.6. Outline of the thesis

Following the brief introduction, motivation and theoretical framework of the present study, Chapters 2 and 3 will expand on the literature on language and interpreter use in the mental health setting. Chapter 2 will focus on the importance of language and communication in ensuring good quality health care, providing detailed information on multicultural/multilingual societies, the language barrier, the importance of delivering culturally competent care and the role of language in South Africa. Chapter 3 looks at solutions to overcoming barriers in mental health care, with particular emphasis on the use of interpreters.

Following the literature review (Chapters 2 and 3), is a description of the research methodology (Chapter 4).

Chapter 5 is the present study's research findings, which describes the six main themes identified from the data. Following the research findings (Chapter 5), is the discussion (Chapter 6), where the six main themes are discussed.

In the final chapter, Chapter 7, conclusions are drawn, implications of the research findings are discussed, limitations of the present study are discussed and recommendations are made.

CHAPTER 2: THE IMPORTANCE OF LANGUAGE AND COMMUNICATION IN ENSURING GOOD QUALITY HEALTH CARE

2.1. Introduction

Language is the primary diagnostic tool that is used to ensure that communication can take place between patient and clinician. Without a common language, patient and clinician will have an inability to communicate effectively and this creates a barrier for mental health assessment (Anderson et al., 2003; Searight & Armock, 2013), as effective communication is crucial to health care, and particularly mental health care (Flynn et al., 2012; Kilian et al., 2014). This inability to communicate has numerous consequences for the effectiveness of health care and undermines the trust of good quality care (Anderson et al., 2003), leading to inadequate or improper care (Hadziabdic & Hjelm, 2013). It is important that people understand the purpose and nature of the services that they are receiving; better patient insight is associated with better prognosis (Kilian et al., 2014). Therefore, there is a direct link between effective communication and timely and appropriate health care (Anderson et al., 2003; Dysart-Gale, 2007). The language barrier may leave clinicians and other staff feeling defeated, helpless and vulnerable (Kale & Syed, 2010). Cross and Bloomer (2010) argue that considerable emphasis is placed on the approachability of clinicians and their ability to form a trusting and honest relationship with their patients. Forming such a relationship is difficult, or near impossible, when clinicians and patients do not share a common language. It is also important to remember that understanding a language to some extent, does not mean that you are perfectly capable of communicating in it, especially when working in an area as complex as mental health care (Anderson et al., 2003). Patients may be able to complete an intake form and indicate that they understand a language, but may still need help when it comes to understanding complex things like diagnosis or treatment options. This can also be applied to the clinician. Clinicians may have a basic vocabulary of the patient's language, but may not understand the cultural nuances that affect the behaviour or the meaning of words or phrases in that language (Anderson et al., 2003). Language is a powerful transmitter of culture (Anderson et al., 2003) and it is often difficult to separate linguistic issues from broader cultural issues (Smith et al., 2013). It is thus also important to ensure that culturally competent care is delivered, to make sure that effective communication can take place.

2.2. The effects of globalisation and multicultural/multilingual societies

The effects of globalisation and immigration to Western countries have resulted in increasingly socio-culturally and linguistically diverse societies (Anderson et al., 2003; Brisset et al., 2013; Bischoff, Kurth, & Henly, 2012; Hadziabdic & Hjelm, 2013; Swartz et al., 2014). Such richness in diversity poses a major challenge for mental health care; namely the need to provide individualised and holistic care based on everyone's needs (Hadziabdic & Hjelm, 2013). These immigrants often arrive in a country with not only limited knowledge of the dominant language of the country (John-Baptiste et al., 2004), but also in dire need of health care (Dysart-Gale, 2007; Tribe & Keefe, 2009) and a lack of knowledge of how to access and make sense of the health care system (Davidson, 2001). As a result of this, the number of people who have LEP has increased in countries where English has traditionally been seen as the lingua franca and have been used as the dominant language in health care (Karliner et al., 2007). It is important that these people are not denied the opportunity of receiving quality health care, which is both culturally and linguistically appropriate. The effect that LEP has on health care outcomes is something that has received little research attention, despite the growing number of multilingual societies (John-Baptiste et al., 2004).

One can argue that English as a lingua franca (ELF) can be seen as a variety of English on its own (Firth, 2009). ELF refers to a contact language between speakers with different first languages, who come from different national cultures or for whom English is a chosen foreign language (House, 2003; Hülmbauer, Böhringer & Seidlhofer, 2008; Seidlhofer, 2005). During an ELF encounter, speakers have to monitor each other's language proficiency and decide on various pragmatic and other conventions to ensure that there is mutual understanding, while also attending to setting-specific tasks (Firth, 2009; Hülmbauer, Böhringer & Seidlhofer, 2008). Here it is not so important to master standardised English, but rather to ensure that successful communication and the negotiation of meaning takes place (Firth, 2009; House, 2003). One can therefore define ELF functionally by its use in intercultural communication, rather than formally by its reference to standardised English norms (Hülmbauer, Böhringer & Seidlhofer, 2008). ELF emerges out of and through interactions, instead of having a standardised form (Firth, 2009; House, 2003). ELF is also hybrid in nature, in that the speakers may switch and mix languages, create nonce words, and borrow, use and re-use each other's language forms (Firth, 2009; Hülmbauer, Böhringer & Seidlhofer, 2008). Some major characteristics of ELF include the fact that it is spread across many different domains and that it has functional flexibility (House, 2003). During an ELF

encounter, speakers will thus monitor and calibrate their speech production and interpretations to fit the situation (Firth, 2009). During ELF interactions, speakers are also more likely to normalise a potential trouble source, instead of attending to it (House, 2003). They will adopt a principle of ‘Let it pass’, assuming that the trouble source will eventually become clear or end up redundant (House, 2003). Speakers of ELF will also use some non-standard forms of English to manage conversations, and despite the use of these, discussion can progress with no major communicative turbulence (Mauranen, 2009).

It is also important to remember that these multicultural societies will bring with them a diverse set of views and beliefs about wellbeing and mental health (Tribe, 2007). This complicates access to good quality health care even further, as the language and discourse of psychology was generally developed in a “Western” context (Smit, Van den Berg, Bekker, Seedat, & Stein, 2006; Tribe, 2007; Tribe & Morrissey, 2004); and even if a common language is used, the rules of communication and cultural differences can still result in miscommunication (Maltby, 1999). Western constructs may not fully apply to increasingly heterogeneous populations; it is thus important that the culture of the people that are being served is taken into consideration in mental health services (Vostanis, 2014). Mental health services must standardise data collection on the LEP status of people served and incorporate this into their records (Pérez-Stable & Karliner, 2012). In the United States of America, for example, the health care system mostly caters for English speakers (Temple & Edwards, 2002; Timmins, 2002), which is alarming, seeing as there are over a 100 languages commonly spoken (Karliner et al., 2007) with approximately 20% of the population that speak a language other than English and 8% of the population that have LEP (Searight & Armock, 2013). Communicating with patients across these language barriers is a major issue for health care in the United States (Pérez-Stable & Karliner, 2012). This lack of a common language and miscommunication may be felt by health care providers as a loss of therapeutic momentum (Bolton, 2002) and clinicians may feel detached from the therapeutic relationship (Paone & Mallot, 2008). This leads to patients who still have numerous unanswered questions after consulting with a health care professional (Anderson et al., 2003). Existing health care services must ensure that the needs of immigrant groups and patients with LEP are integrated into their services. The language barrier is one of the primary challenges for this to be realised (Flynn et al., 2012; Kale & Syed, 2010).

2.3. Limited English Proficiency (LEP) and the language barrier

Karliner et al. (2007) define individuals with LEP as not being “able to speak, read, write, or understand the English language at a level that permits them to interact effectively” (p. 728). The presence of multiple languages adds an extra challenge to mental health care (Bezuidenhout & Borry, 2009). This creates a language barrier that affects the ability of these individuals, who have different ethnicities, social class and language skills, to access health care services (Pérez-Stable & Karliner, 2012; Searight & Searight, 2009), as effective communication is difficult to accomplish (Bauer & Alegria, 2010). This can lead to multiple adverse effects on the health of patients that do not speak the language of the health practitioner (Brach, Fraser, & Paez, 2005; John-Baptiste et al., 2004; Timmins, 2002). Luk (2008) further argues that certain connections exist between a person’s thoughts and the language they speak. So even if a person can get by communicating in a language other than their first language, their thoughts and possible symptoms might be masked, as they are concentrating on communicating effectively in a language that is not their mother tongue. Patients with some level of competency in a second language might have difficulty in expressing important symptoms (Searight & Armock, 2013). It is important that access to good quality mental health services is not limited just to those people that are fluent in the dominant language (Tribe & Lane, 2009; Tribe, 2007).

Some consequences of the language barrier and LEP users of health services in English-speaking countries include a higher clinical cost, lower client retention, drug complications, lower-quality care, medical errors, misdiagnoses, longer hospitalisation, improper hospitalisation, poor compliance, underuse of services, poorer satisfaction with health care, poorer access to health care, type and compromised depth of topics expressed by patients and, in general, higher risk of health problems (Anderson et al., 2003; Bauer & Alegria, 2010; Bischoff et al., 2012; Brach et al., 2005; Brisset et al., 2013; Dysart-Gale, 2007; Flores, 2006; Flynn et al., 2012; Hadziabdic & Hjelm, 2013; Jacobs et al., 2010; John-Baptiste et al., 2004; Karliner et al., 2007; Kilian et al., 2014; Kim, AguadoLoi, Chiriboga, Jang, Parmelee, & Allen, 2011; Paone & Mallot, 2008; Sarver & Baker, 2000; Siegel et al., 2000; Sobane & Anthonissen, 2013; Timmins, 2002).

Language discordance further contributes to a minimal assessment, where the clinician pays little attention to a patient’s social and family contexts (Searight & Armock, 2013). The higher number of health care visits by patients that are faced with a language

barrier indicates that they have unaddressed issues (Flynn et al., 2012). LEP patients are also less likely to establish rapport with clinicians, receive information, empathy and encouragement to participate in decision making (Pérez-Stable & Karliner, 2012; Sobane & Anthonissen, 2013). Language barriers are often accompanied by cultural differences, which can lead to further misunderstandings and possible conflicts (Cross & Bloomer, 2010). When a language barrier exists, it is also very difficult for clinicians to judge nonverbal cues that might come up during communication (Cross & Bloomer, 2010). There is evidence to suggest that where a language barrier exists, both patients and clinicians show dissatisfaction with health care (John-Baptiste et al., 2004). This dissatisfaction with health care and general misunderstandings due to communication problems, can also lead to LEP patients not complying with referral appointments (Sarver & Baker, 2000). People that are faced with the language barrier have higher rates of disease, disability and even death; and also face a lower quality of health care (Anderson et al., 2003). Poor communication due to the language barrier also leads to fewer mental health diagnoses (Pérez-Stable & Karliner, 2012).

According to Pottie et al. (2008), poor language proficiency is also associated with poor self-reported health. Not only can existing conditions be exacerbated, but it could lead to new ones (Dysart-Gale, 2007). A lack of access to adequate health care can also result in serious legal intrusion and distrust of patients towards health care organisations (Paone & Mallot, 2008; Timmins, 2002). Patients with psychiatric conditions that are faced with a language barrier are more likely to be diagnosed with severe psychopathology, but are also more likely to not make use of health care (Flores, 2006; Kilian et al., 2014). The language barrier can also incur a substantial economic cost. There can be an increase in time spent by staff members attending to a language barrier, diagnostic tests, follow up visits, hiring or training interpreters and having to pull staff from their normal duties to help ensure communication can take place with patients (Timmins, 2002). Of central importance is also the serious threat that the language barrier places on the delivery of culturally competent health care (Timmins, 2002).

People with LEP may also miss out on a therapeutic relationship with their health care provider (Timmins, 2002), or may in general be less satisfied with this patient-clinician relationship (Sarver & Baker, 2000). Patients may find it difficult to self-disclose to a stranger that does not speak their language or understand their culture (Cross & Bloomer, 2010). The therapeutic relationship is also impacted by the fact that it is difficult for clinicians to establish credibility with their patients, as there is a lack of similarity between

their languages and cultures (Cross & Bloomer, 2010). Clinicians must take care in establishing credibility by extending their cultural boundaries to include the belief system of the patient. According to Cross and Bloomer (2010), establishing credibility might entail making certain sacrifices from the clinician, making exceptions out of respect for the patient's culture, showing a willingness to learn and apologising for ignorance about their culture. The therapeutic relationship between health care provider and patient can be a vital part of providing good quality health care. Clinicians will have to modify their communication and show cross-cultural sensitivity in order to facilitate effective communication (Cross & Bloomer, 2010). All of these factors lead to an escalated crisis in personal and community health care (Dysart-Gale, 2007).

2.4. The importance of delivering culturally competent care

A patient's cultural beliefs have a profound impact on how they perceive, respond to, and experience mental health care (Kilian et al., 2014). Cultural competence, and thus cultural understanding, in mental health care, and in basic health care training, is becoming increasingly important as societies are becoming more and more multicultural (Hayes-Bautista, 2003; Siegel et al., 2000; Swartz et al., 2014). Ensuring that patients receive culturally competent care is an essential element to delivering quality health care (Anderson et al., 2003). Although some disorders are cross-culturally consistent, there are differences with regards to the content, prevalence and severity of symptoms of certain disorders (Cross & Bloomer, 2010). Clinical issues are often viewed from the perspective of the clinician's culture, ignoring the specific ethnic or cultural views of the patient (Siegel et al., 2000). Cultural and linguistic competence by the health care team is a direct reflection of how effectively they can respond to the language and psychological needs of a multicultural and multilingual society. According to Timmins (2002), "cultural competency is an awareness and an acceptance of cultural differences, and an ability to learn about and to sensitively interface with the patients' diverse cultures" (p. 83). These cultural differences include actions, behaviours, differences in showing respect, attitudes, language, communication styles, nonverbal cues, thoughts, policies, values and beliefs that should all be taken into account by patients and the entire health care team to ensure effective health care (Anderson et al., 2003; Cross & Bloomer, 2010; Hadziabdic & Hjelm, 2013). According to Anderson et al. (2003), a culturally competent health care setting should include: a culturally specific health care setting, signage and instructional literature in the patients' language, culturally diverse staff, interpreters or staff that speak the patients' language and training for the health

care team about the language and culture of the patients they will serve (Anderson et al., 2003). Where a culturally diverse population exists, cultural competence should be an essential part of the health care setting, and should aim to provide appropriate care for everyone, while also reducing errors and misunderstandings created by the language barrier or the culture of patient or clinician (Anderson et al., 2003).

Culturally competent care will help alleviate some of the consequences created by the language barrier and will ensure more suitable diagnosis, treatment, satisfaction with services and follow-up for patients faced with the language barrier (Anderson et al., 2003; Luk, 2008). This will facilitate trust and confidence in people making use of health care services (Anderson et al., 2003), improving the rapport between patient and health care team (Siegel et al., 2000). It will also contribute to better efficiency by reducing inappropriate use of services and unnecessary diagnostic testing (Anderson et al., 2003). Cultural competence includes a variety of skills needed by the health care team, including a set of attitudes, behaviours, policies, procedures, the language that is used, sensitivity to the patients' culture, culturally sensitive bedside manners and ethnic concordance (Hayes-Bautista, 2003; Lee, Sulaiman-Hill, & Thompson, 2014; Luk, 2008; Siegel et al., 2000). All of these culturally competent skills need to come together both at an individual and systems level, to ensure effective and efficient mental health care (Siegel et al., 2000). Due to the effects of globalisation, this is a skill that many health care providers need to cultivate, as they will be working with a variety of people with cultural backgrounds different from their own (Timmins, 2002).

In order for health care providers to ensure culturally competent care, they will need standards to adhere to that clearly define and give a common understanding of what appropriate cultural and linguistic health services would entail. These standards would have the goal of eliminating racial and ethnic disparities in the health services and improving the health of the population as a whole (Anderson et al., 2003). Anderson et al. (2003) identify the criteria that would ensure cultural competence: staff members should reflect the cultural diversity of the population served; interpreter services should be provided; the health care team should receive cultural competency training; culturally and linguistically appropriate health education material should be made available; and there should be culturally specific health care settings. If the community that is served feels that their values are respected, reflected and understood, they will feel more responsive and satisfied with the quality of health care that is provided (Siegel et al., 2000).

Cultural competence in the therapeutic relationship between clinician and patient will be reflected by clinicians making an effort to understand the patient's cultural belief system about mental health and adapting their own beliefs, values and practices to better reflect those of the patient (Cross & Bloomer, 2010). Clinicians must expand their own cultural boundaries, taking into consideration patient's expectations, worldviews, and showing respect for their culture. Moreover they must take care in their explanation of the purpose of the diagnoses and treatment to avoid misunderstandings (Cross & Bloomer, 2010). Cultural awareness will be promoted if the patient and clinician work together in creating comfortable surroundings, and form a mutual understanding of issues that might arise (Cross & Bloomer, 2010). By employing a culturally diverse workforce or ensuring access to professional interpreters, health care providers would improve their services as a whole, ensuring effective care to everyone, leading to more favourable mental health and social outcomes (Hadziabdic & Hjelm, 2013; Siegel et al., 2000).

2.5. The role of language in South Africa

Due to the Apartheid years (which themselves were built on a colonial history), where mental health professionals were only required to speak Afrikaans and English, there were very few mental health professionals who could speak any of South Africa's indigenous languages apart from Afrikaans (Drennan & Swartz, 2002). Although there have been dramatic political changes in South Africa since 1994, which include the constitutional provision of equal status for 11 languages spoken in South Africa, Afrikaans and English still remain the dominant languages used in mental health care, with very few health care professionals who speak an indigenous African language (Drennan & Swartz, 2002; Levin, 2006; Penn & Watermeyer, 2012).

Even with South Africa's rich linguistic and cultural diversity, research on language issues in mental health has not enjoyed a lot of attention (Drennan & Swartz, 2002), following a similar trend to that of the United States of America and Europe and thus mirroring the international trend of neglecting language issues in mental health care (Drennan & Swartz, 2002). Deumert (2010) argues that hospitals in South Africa are ill equipped to deal with the language barrier. This results in major problems in providing good quality health care services to all South Africans (Schlemmer & Mash, 2006). In the Western Cape, for example, Afrikaans and English still enjoy the highest status (Williams & Bekker, 2008), although Xhosa is also an official language in this province (Deumert, 2010; Kilian et al.,

2010). It is expected that patients communicate in English, as it is seen as the lingua franca and acts to bridge the gap between individuals from different language groups (Williams & Bekker, 2008). These cultural and linguistic barriers are a big concern, as they limit equal access to mental health care services, and are commonplace in the South African society (Watermeyer, 2011).

2.6. Neglecting indigenous African languages

In a study by Levin (2006a), it was found that language issues constitute the biggest access barrier to good quality care for Xhosa speaking people, with failure to understand English, especially medical terminology, cited as the most common problem. Words such as depression and sickness might have a clear denotative familiarity in a different language, but might be considerably different in its connotative meaning (Bolton, 2002). Language barriers are so much part of clinical work in South Africa that they have become part of everyday life (Drennan, 1999).

2.7. Conclusion

This chapter highlights the importance of language and effective communication to mental health care and illustrates the negative impact that a language barrier can have on the delivery of these services. Patients that are not proficient in English have a severe disadvantage when it comes to receiving adequate mental health care, and are faced with numerous consequences because of the language barrier. Ensuring that culturally competent care is provided will help alleviate some of these consequences. South Africa mirrors an international trend of not providing linguistic and culturally competent care. Indigenous African languages are neglected, as Afrikaans and English still remain the dominant languages used in mental health care.

CHAPTER 3: OVERCOMING BARRIERS TO MENTAL HEALTH CARE

3.1. Introduction

Language barriers pose a serious threat to accessing mental health care, and the use of a certain language can include or exclude others. Providing mental health care in linguistically diverse societies is thus very difficult (Swartz et al., 2014). In order to address the challenges posed by the language barrier, some type of language intervention is needed to improve communication (Sobane & Anthonissen, 2013). The language barrier also compromises the clinician-patient relationship, which is vital to ensuring good quality health care (Luk, 2008; Schlemmer & Mash, 2006). Language barriers place patients at a distinct disadvantage as not being able to express oneself verbally can be disempowering and frightening (Tribe, 2007). Providing better linguistic access is vital to better access to good quality health care services (Karliner et al., 2007).

One way of bridging the language barrier between patient and clinician is by making use of bilingual/multilingual staff, but the most direct response to the language barrier is by making use of interpreters (Kilian et al., 2014). The need to ensure that effective communication can take place has led to the increasing use of interpreters (Hadziabdic & Hjelm, 2013). Mental health care services need to make language a key focus (Swartz et al., 2014) and develop a language assistance plan (Brach et al., 2005), developing the necessary knowledge and skills to cope with linguistic complexity (Swartz et al., 2014). A first step to such a plan will entail doing research on the specific language needs and local challenges of the community served (Brach et al., 2005; Swartz et al., 2014). They will also have to assess the need for bilingual staff and interpreters. Furthermore, policymakers will have to provide plans on how the language barrier will be addressed, developing national standards for health care services to adhere to (Brach et al., 2005). Where a language barrier existed, but no interpreters were used, patients reported that they were dissatisfied with the interpersonal aspects of health care, their understanding of the diagnosis and treatment were poor and they wished that the clinician had provided a better explanation (Flores, 2005). This would however be difficult, as clinician and patient do not necessarily share a common language.

Language diversity in the mental health services is a very complex issue. According to Drennan and Swartz (2002) the need for interpreters depends on the level at which these issues are considered. The interpersonal level is when there is a language gap, or absence of common language, between clinician and patient (Drennan & Swartz, 2002). On this level,

interpreters are tasked with creating meaning for both patient and clinician, ensuring that communication can take place. At the next level, the institutional level, interpreting can be seen as a linguistic resource that is made available in particular ways. This level is also influenced by the third level, the socio-political level (Drennan & Swartz, 2002). According to Drennan and Swartz (2002) the socio-political level “shapes what the prevailing attitudes to linguistic diversity will be, who has access to interpreting, under which circumstances and for which purpose” (p.1854). The fourth level, the international context, is when local practices are shaped through Western biomedical discourses (Drennan & Swartz, 2002).

3.2. The use of bilingual/multilingual staff

Bilingual staff are individuals that can communicate in the language of the clinician and the patient (Lee et al., 2014). There is evidence to suggest that using bilingual/multilingual staff can have practical and important advantages in bridging the language barrier (Flores, 2006; Hadziabdic & Hjelm, 2013; Raval, 2006; Timmins, 2002) and can facilitate better access to health care (Raval, 2006). Some of these advantages include avoidance of diagnosis errors, avoidance of treatment errors, decreased economic burden, increased patient satisfaction, knowledge of patient’s culture and increased patient understanding (Hadziabdic & Hjelm, 2013; Lee et al., 2014; Timmins, 2002). Bilingual staff will also be more likely to grasp issues like confidentiality (Lee et al., 2014). Clinicians will find it easier to trust bilingual co-worker’s knowledge and familiarity with the health care setting (Hsieh et al., 2010). Inevitably the question of their language proficiency will be raised (Hadziabdic & Hjelm, 2013; Lee et al., 2014), especially in a country like South Africa, with 11 official languages (Drennan & Swartz, 2002). Bilingual health care staff may have limited knowledge of technical terminology and lack training in interpreting (Hadziabdic & Hjelm, 2013). Lee et al. (2014) argue that the biggest disadvantage of using bilingual staff as interpreters is the time required to debrief, supervise and train them. Bilingualism is insufficient to ensure that effective communication will take place, as their language skills may be inadequate (Hadziabdic & Hjelm, 2013).

One potential solution to overcome language barriers in South Africa is for clinicians to learn an indigenous African language, but this will take time (Drennan & Swartz, 2002) and learning a language does not mean understanding the context and culture of the patient (Schlemmer & Mash, 2006). Whenever possible, clinicians that are fully fluent in the patient’s

home language should be in a position to care for these patients (Pérez-Stable & Karliner, 2012).

3.3. Interpreters

Another solution would be the use of interpreters, with ad hoc or professional interpreters being the two choices. Interpreting is a very complex process, and is valued as a relatively scarce skill (Raval, 2006; Sobane & Anthonissen, 2013), with emphasis on a wide range of issues, as will be seen throughout this chapter. Mental health interpreting is an especially complex task, as it is very challenging to interpret and make meaning of psychological functions and social behaviours (Luk, 2008). Making use of professional interpreters would be the most desirable outcome (Luk, 2008; Pérez-Stable & Karliner, 2012) and may increase access to care (Flynn et al., 2012) and increase the chances that fewer clinical errors are made (Ono, Kiuchi, & Ishikawa, 2013). Unfortunately there is evidence to suggest that there is an underuse of professional interpreters in the health services, with poor access and time constraints frequently cited as reasons (Baron et al., 2010; Kale & Syed, 2010); and a lack of interpreters in the mental health setting in general (Maltby, 1999). In a study by Kale and Syed (2010), the authors argue that the reason for using an ad hoc interpreter, especially family and friends, is because they are most easily available. These ad hoc interpreters are often used without any assessment of their skill (Hadziabdic & Hjelm, 2013). Patients often have to rely on family members or friends acting as ad hoc interpreters, or rely on their own limited language ability to bridge the language barrier and ensure that some form of clinical communication can take place (Baron et al., 2010; Pérez-Stable & Karliner, 2012). Kale and Syed (2010) suggest that one of the reasons that professional interpreters are underutilised, is because this service is not sufficiently embedded in health care as a quality assured and standardised procedure.

Working with an interpreter can be viewed from different aspects, including the views of the patient, clinician and interpreter themselves. The interpreter might be concerned with linguistic issues, technical complexities and how this will influence their workload, whereas the clinician might be more focused on what the impact of an extra person will have on the therapeutic relationship, and also how this will be managed (Tribe & Keefe, 2009). Patients on the other hand might be more concerned with the impact interpreters might have on the quality of care that they will be receiving. Of vital importance to all three parties will be the ethical implications such a relationship will inevitably bring to the table.

Interpreters give a voice to those patients who would otherwise not be understood because of the language barrier (Tribe & Morrissey, 2004), but because of a heavy workload and difficulty in managing many roles, interpreters may lose their compassionate voice for patients (McDowell, Messias, & Estrada, 2011). Interpreters do not only give a voice to patients, but simultaneously bridge the gap in the clinical setting for clinicians who do not share a common language with patients (Dysart-Gale, 2007). Where language barriers exist, interpreters are often the first point of contact for patients who can initially form a strong attachment with them (Bischoff et al., 2012; McDowell et al., 2011; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005).

Interpreting can be a very empowering experience, as interpreters may feel that they can make a difference in the lives of patients that would otherwise be hindered by the language barrier, but it is of vital importance that they receive adequate training in dealing with the difficulties and multiple roles associated with interpreting (Smith et al., 2013). It is very difficult to judge whether or not an interpreter has done a good job or not (Reithofer, 2013), as neither the patient nor the clinician can check or correct the interpreter's utterance (Davidson, 2002). Adequate training will make it easier for clinicians and patients to trust the competence of interpreters. It is important that clinicians trust interpreters to both accurately convey information and to not disclose confidential information (Baron et al., 2010). Interpreters are expected to be fluent in both languages, be able to rapidly process information, have good pronunciation and understand the predictable differences between the two languages (Bezuidenhout & Borry, 2010). When interpreting between languages, it is important that the interpretation is not too basic, as this may result in leaving out important information, but it must also not be too technical, as it must reflect the patient's story (Drennan & Swartz, 2002). Interpreters have the difficult task of translating and explaining the lay meaning of symptoms and also the more technical terminology between health care professional and patient (Westermeyer & Janca, 1997), as medical terminology may be culture specific when referring to models of disease (Levin, 2006b).

Time constraints must also be taken into account when working with interpreters (Drennan & Swartz, 2002; Kilian et al., 2014; Searight & Armock, 2013). Some psychological terms cannot be readily translated into another language and may require a paragraph or two to completely explain it to a patient (Kilian et al., 2010; Westermeyer, 2010), as different cultures and languages have various ways of expressing psychological experiences (Westermeyer & Janca, 1997). Psychological experiences can be largely defined

by the larger social context in which they are defined and given meaning. It is thus essential to remember that languages are not directly interchangeable and will rely on the particular cultural, social and political context within which it was learnt (Davidson, 2002; Hadziabdic & Hjelm, 2013; Luk, 2008; Temple & Edwards, 2002; Tribe & Keefe, 2009). Interpreters must decide what part of the message must be given primacy, negotiating meaning in the process (Davidson, 2002). Interpreters are tasked with not only negotiating meanings and words, but entire world views. Different languages might code meaning differently, be emotionally processed and internalised, where a word or phrase is not directly accessible in a different language (Luk, 2008; Temple & Edwards, 2002; Tribe & Keefe, 2009). People who speak different languages may also use different imagery and emotional content, that can be triggered pre-consciously or unconsciously (Tribe & Keefe, 2009). It is important to recognise that when making a direct translation from one language to another, that the desired or same emotional content might not be accessed. Tribe and Keefe (2009) argue that people can have specific personalities within the language they are using, and it would be difficult for interpreters to re-construct a patient's personality and memories from one language to another. As can be seen, interpreting encompasses much more than an exchange of words. There is no universally agreed method of working with interpreters that interpret between different languages, as each specific linguistic/cultural group will need the interpreter to have different skills and requirements (Tribe & Keefe, 2009).

Although there is a considerable cost involved in providing professional interpreters (Brach et al., 2005; Dysart-Gale, 2007), time spent by staff members attending to language barriers can be more expensive than hiring interpreters (Timmins, 2002). It can also be argued that improved quality of care and patient satisfaction would justify the cost involved in making use of professional interpreters (Pérez-Stable & Karliner, 2012).

As mentioned earlier, research on working with interpreters is a subject that has not enjoyed a lot of attention (Searight & Armock, 2013; Tribe & Keefe, 2009) and most research on interpreting in mental health comes from high-income countries (Kilian et al., 2014). More research is needed in low- and middle-income countries, as rather less is known about interpreting practices in these contexts (Kilian et al., 2014; Swartz et al., 2014). It is also in low- and middle-income countries that care is limited to already inadequate resources (Kleintjes, Lund, & Swartz, 2013), further reinforcing the need for more research in these countries. Swartz et al. (2014) argue that wealthier countries offer a range of interpreter services to accommodate people from linguistically diverse backgrounds and that interpreting

is recognised as an important part of accessing appropriate mental health care. Such services do not enjoy as much attention in low- and middle- income countries, like South Africa.

South Africa is a particularly interesting example, as the history of mental health in South Africa has largely been shaped by the country's intertwining of language policies and colonial and apartheid history (Kilian et al., 2014). In South Africa, there are no reports of the use of professional interpreters in mental health. However, there is evidence to suggest that ad hoc interpreters in the South African mental health services fall short in terms of ensuring effective communication, with accurate translation of key terms being a specific concern (Hagan et al., 2013; Kilian et al., 2010; Smith et al., 2013). The distribution of power within the South African context must also be taken into consideration with interpreting, as different languages have historically been associated with different levels of power (Smith et al., 2013). Afrikaans and English has historically been seen as the languages of White power, whereas indigenous African languages, like Xhosa and Zulu, have been associated with marginalised Black South Africans. This political dimension associated with interpreting is evident in the fact that the current South African government has not provided professional interpreters for mental health services (Smith et al., 2013; Swartz & Drennan, 2000), which can lead to a delay in the care of patients (Flores, 2005).

3.3.1. Defining interpreters (ad hoc/trained)

The most basic definition or function of an interpreter would be to facilitate and assist face-to-face communication between patient and clinician (Dysart-Gale, 2007; Hsieh, Ju, & Kong, 2010), operating between languages (Lee et al., 2014; Tribe & Keefe, 2009). They are speaking agents who must critically engage in a conversation, making meaning that will elicit the intended response from the hearer (Davidson, 2002). Interpreting is thus a very active process, as they must participate in the conversation and adopt purposeful strategies to manage the context (Hsieh et al., 2010). Unlike a translator who would have time to reflect and revise translations, interpreters are expected to act immediately, interpreting back and forth between two languages and have to deal with a whole host of other factors, like misunderstandings, interpersonal factors, cultural differences, errors and conflicts (Dysart-Gale, 2007; Wallin & Ahlström, 2006).

The easiest and often cheapest solution to the language barrier is the use of ad hoc interpreters. An ad hoc interpreter is someone that is untrained in interpreting, that has communicative competence in both the language of the patient and the clinician and is often

pulled away from other duties (Bauer & Alegria, 2010; Karliner et al., 2007; Timmins, 2002). The most commonly used ad hoc interpreters are family members, friends or bilingual staff (household aides, nurses and security guards) (Kilian et al., 2014; Smith et al., 2013; Timmins, 2002). Professional interpreters are people that are paid and provided by the health care system (Karliner et al., 2007), with the sole purpose of facilitating communication between clinician and patient (Dysart-Gale, 2007). Professional interpreters are trained in the type of terminology that is used in the health care setting, has a specialised set of skills and has knowledge of ethical considerations (Hadziabdic & Hjelm, 2013).

3.3.2. Tasks/Roles of interpreters

Interpreters are tasked with translating the spoken word (Bischoff et al., 2012; Paone & Malott, 2008), translating between two languages (Hadziabdic & Hjelm, 2013), and are expected to manage many different roles, going far beyond mere translation (Brisset et al., 2013). Translating the spoken word is a complex task, as interpreters must listen to the speaker, understand what is being said and convert this message into the target language (Paone & Malott, 2008). Interpreters must choose their words in order to convey the intended reaction from the hearer of the message (Davidson, 2002). The most important task of an interpreter is to bridge the language barrier that exists between patient and client that speak different languages (Paone & Malott, 2008), but they may also be expected to be a co-diagnostician, coordinator of communication, cultural and linguistic ally of the patient, institutional gatekeeper and act as an advocate for the patient (Davidson, 2001; Paone & Malott, 2008; Searight & Armock, 2013; Watermeyer, 2011).

Through language, people establish their identity (Hadziabdic & Hjelm, 2013), and an interpreter has the difficult task of producing these identities for patient and clinician (Temple & Edwards, 2002), while also maintaining their own identity. Interpreters are expected to fulfil all these roles while also mediating the contextual, social, personal and institutional expectations and goals of all parties involved in interpreter mediated sessions (Davidson, 2001, 2002). Interpretation never happens in isolation, it is always located in a specific institutional and socio-political context, where interpreters are expected to manage multiple complex contextual roles (Kilian et al., 2014). Although interpretation is always contextual, institutional interpretation is, to some extent, defined by the institutional goals and social and behavioural norms of the patient-clinician interaction (Davidson, 2001). When interpreting, interpreters also have to be aware of conceptual, functional and semantic equivalence (Luk,

2008). Conceptual equivalence refers to whether concepts used by the speaker have the same emotional impact and meaning in the language of the listener (Luk, 2008). Functional equivalence is whether behaviour from one culture is related to similar problems in another culture (Luk, 2008). Lastly, semantic equivalence refers to whether the words from one language can be translated into another language in such a manner that the interpreted text keeps the exact original meaning (Luk, 2008).

In the past, interpreters have been expected to act as a language machine that merely translates the spoken word from one language to another and have been taken for granted because of this (Drennan, 1999). It is important that interpreters are treated as part of the multidisciplinary team, as they are an invaluable source of information and act as an essential link between clinician and patient (Tribe, 2007; Tribe & Lane, 2009). Clinicians must thus work with an interpreter, rather than through an interpreter (Wallin & Ahlström, 2006). This may lead to a situation in which the interpreter feels more at ease and has the opportunity to use their cultural understanding and language skills in the treatment process (Hsieh et al., 2010; Tribe & Lane, 2009).

When working with interpreters, there is some preparatory work that could be useful before the interpreting session starts. Reflecting on cultural nuances can be beneficial to clinician and interpreter (Tribe & Lane, 2009). It would be useful to match the interpreter and client in terms of social characteristics (Temple & Edwards, 2002), like ethnicity, gender and age; and also to use the same interpreter throughout the sessions with the same patient (Lee et al., 2014; Raval, 2006; Tribe & Lane, 2009; Wallin & Ahlström, 2006). Using the same interpreter will likely improve the interpreter's knowledge and skill; and will ensure that both clinician and interpreter become more comfortable during interpreter mediated sessions (Searight & Armock, 2013). During an interpreter mediated session, it is important to remember that words do not always have a direct translation into a different language and that it might take the interpreter a while to convey the meaning to the patient (Raval, 2006; Tribe & Lane, 2009). It can also benefit both the clinician and the interpreter to discuss the session after it takes place (Searight & Searight, 2009, Tribe & Lane, 2009). The linguistic competence of interpreters, though very important, will not on its own guarantee satisfactory results (Kale & Syed, 2010). Other competencies and skills required by interpreters include interpersonal skills, expressing themselves clearly, being able to establish trust, knowledge of medical/psychological terminology, ethical expectations, knowing how to keep the patient focussed, personal qualities like empathy, being non-judgemental, respect and sensitivity and,

importantly, the ability to facilitate successful communication (Baron et al., 2010; Björn, 2005; Hsieh et al., 2010; Hadziabdic & Hjelm, 2013; Kale & Syed, 2010; McDowell et al., 2011; Raval, 2006; Searight & Searight, 2009). The characteristics of a patient's voice can have diagnostic value; therefore interpreters are also entrusted with deciphering the meaning of these characteristics (Hsieh et al., 2010).

Trust is a vital component for interpersonal relationships in mental health care. Patients and clinicians must be able to trust that the interpreter will convey their voices and messages accurately (Hsieh et al., 2010). Interpreters must master ethical principles, like confidentiality and impartiality (Kale & Syed, 2010). Interpreters must also have knowledge of the clinician and patient's culture and values, reflecting the different world views that patient and clinician might have, keeping in mind the reality that the patient might well have limited material and educational resources (Dysart-Gale, 2007). Interpreting styles are also of importance. A consecutive interpreting style is when the interpreter only speaks after the patient or clinician is finished, whereas a simultaneous or concurrent style is when the interpreter speaks at the same time as the patient or clinician (Luk, 2008; Wallin & Ahlström, 2006). The simultaneous interpreting style opens the possibility of more errors, as interpreters will be subject to fatigue and stress, therefore this style is not recommended (Wallin & Ahlström, 2006). Luk (2008) further identifies word-for-word, summary, culture-relevant and culture-expert interpreting styles. Word-for-word interpreting entails giving line-by-line translation, which minimises the interpreter's input and participation in the conversation (Luk, 2008). Summary interpreting focuses on summarising the most important points of the conversation, without necessarily using the exact same words (Luk, 2008). Culture-relevant interpreting is where the intended message is conveyed in a culturally appropriate manner, thus avoiding cultural misunderstandings (Luk, 2008). With culture-expert interpreting, the interpreter is concerned with explaining important cultural issues (Luk, 2008).

Interpreters may have the roles of conduit, clarifier, cultural broker and patient advocate (Dysart-Gale, 2007; Raval, 2006). As a conduit, the interpreter must channel information between patient and clinician neutrally, and primarily intervenes at the level of language (Bischoff et al., 2012; Dysart-Gale, 2007). The role of clarifier is concerned with clarifying messages that might be distorted due to specific cultural meaning (Dysart-Gale, 2007). As a cultural broker, the interpreter provides the clinician with a cultural framework to understand the patients world view (Bischoff et al., 2012; Dysart-Gale, 2007). In the last role, patient advocate, interpreters step outside the bounds of traditional interpreting on behalf of

patients, representing the interests of the patients, to ensure quality of care (Bischoff et al., 2012; Dysart-Gale, 2007).

Interpreters often struggle with the roles of acting as an advocate for the patient and promoting institutional goals (Kilian et al., 2014). They may also take on the role of co-therapist (Bischoff et al., 2012), as interpreters often spend a lot of time with patients and can have valuable input on patient behaviour that happens outside of the clinical interview. There is an argument to make that the role of conduit is impractical. While managing these roles, interpreters must attempt to find a balance between the voice of the professional, represented by the clinician, and the voice of the patient, or more specifically their world view (Davidson, 2001). Interpreters are often not only caught between languages, but also between patient and clinician (Tribe & Keefe, 2009), where they have to manage the therapeutic relationship. Interpreter's personal histories will influence all the roles that they occupy (Bischoff et al., 2012).

Clinicians can feel threatened by interpreters, and patients may place unrealistic expectations on them, due to linguistic and/or cultural links (Tribe & Keefe, 2009). To ensure successful collaboration between interpreter and clinician, the clinician must respect and have knowledge of the interpreter's different roles (Bischoff, 2012; Kale & Syed, 2010). Unfortunately clinicians seem to be naïve with regards to the complexities of the roles and tasks that are involved with interpreting (Smith et al., 2013).

3.3.3. Acting as a cultural broker

Language barriers do not stand on their own, as they may also involve religious and cultural differences between patient and clinician, which can also be barriers when accessing mental health services. Interpreters are thus expected to not only be bilingual, but bicultural as well, as they are not only interpreting words, but cultures. There is evidence to suggest that patients feel that it is important to have an interpreter with a cultural background similar to their own (Baron et al., 2010).

As has been mentioned, there is a strong link between culture and health care (Hayes-Bautista, 2003). Clinicians and patients are often from different cultures; therefore it is important for interpreters to not only act as a translating machine, but to also act as a cultural broker and cultural consultant (Kilian et al., 2014; Raval, 2006), to make sure that meaning is not lost through mere translation (Cross & Bloomer, 2010). A cultural interpreter is therefore

an active participant in a clinical interview (Luk, 2008). Interpreters must ensure that the clinician and patient are aware of each other's cultural beliefs, world view and ideas to ensure adequate health care (Bischoff et al., 2012; Kilian et al., 2014; Paone & Malott, 2008; Wallin & Ahlström, 2006). Interpreters can also make suggestions to clinicians on how to modify their narratives, to make them more culturally appropriate (Hsieh et al., 2010). Different cultures and ethnicities may have unique ideas, beliefs and perceptions of what health care and illness actually are (Anderson et al., 2003), and it is important that clinicians understand these differences, and similarities, where they exist. Different views of what health care is may impact how different symptoms are understood and interpreted, and how and when health care is sought (Anderson et al., 2003).

The interpreter must decipher specific cultural linguistic codes (Cross & Bloomer, 2010) and can offer extremely useful insight into the culture of a client (Paone & Malott, 2008). There is often a difference in proverbs, emotional undertones, emotional vocabularies and humour between languages (Paone & Malott, 2008; Smith et al., 2013), all of which an interpreter must take into consideration during interpreter mediated sessions. Different dialects must also be taken into consideration, where words may have different meanings in different languages (Hadziabdic & Hjelm, 2013; Paone & Malott, 2008). Different cultures have distinct norms, including greetings, displays of expressions, parenting strategies, physical contact and traditional family roles (Paone & Malott, 2008). According to Anderson et al. (2003), cultural groups that place emphasis on ethnic exclusivity, traditional family authority and a scepticism about medicine, tend to wait longer to seek out health care. For some cultures, the decision to seek and/or participate in mental health care treatment will involve the head of the family household (Cross & Bloomer, 2010). Intergenerational conflict, protecting the family from stigma and gaining respect from those that regard women as subordinate to men are also barriers that interpreters and clinicians will face when working with certain cultures (Cross & Bloomer, 2010). This will undoubtedly have an impact on how health care for these individuals will be approached and it is important that the interpreter, as a cultural broker, conveys this to clinicians.

According to Cross and Bloomer (2010) the split between body and mind is uncommon in certain cultures. There are some cultures that express mental health problems as a physical complaint, as mental health problems are not accepted as being part of their culture (Cross & Bloomer, 2010). As a cultural broker, interpreters can help clinicians understand the world of the patient and work towards a mutual understanding of

psychological problems (Cross & Bloomer, 2010). Negative social stereotypes shape how clinicians and patients behave during clinical encounters and this can lead to negative experiences with the health care system, mistrust and perceived discrimination (Anderson et al., 2003). As a cultural broker, interpreters are entrusted with the task of advocating cultural diversity, acting as an important bridge between the world of professional mental health care and local understanding, to ultimately ensure that culturally appropriate care takes place (Dysart-Gale, 2007; Swartz et al., 2014). Although interpreters can have a very influential role as a cultural broker and are often expected to be experts on the cultural and linguistic worlds of the clients, with whom they share a culture, they cannot be expected to speak on behalf of an entire culture (Swartz et al., 2014). They may come from a very different social group, even though they share a language (Swartz et al., 2014). Similarly to the fact that languages are not directly interchangeable, cultures are not mutually translatable.

3.3.4. Difficulties with the use of interpreters

As interpreters are a third party, they inherently bring complexities to clinical encounters (Flynn et al., 2012). Issues that come up when working with interpreters include conflict in managing different roles, worrying about the accuracy of interpretations, neutrality, confidentiality, building trust, positive alliance and respect in the triad (Bolton, 2002; Brisset et al., 2013; Flynn et al., 2012; Penn & Watermeyer, 2012; Raval, 2006). All these different challenges are made more difficult by the fact that interpreters have to take into account that they must manage communication in such a way that it reflects very different world views, which could also be different from their own world view (Dysart-Gale, 2007). Interpreters are often expected to be neutral and invisible, but at the same time act as a cultural broker and provide emotional support (Brisset et al., 2013; Dysart-Gale, 2007; Hsieh et al., 2010). Hsieh et al. (2010) argue that there might be serious clinical and therapeutic consequences when interpreters provide emotional support to patients. It is expected of an interpreter to be invisible, acting as a language switching operator or translating machine, taking no part in the conversation. If interpreters are expected to take no part in the conversation, they will struggle to understand what is being said, but still they must repeat this with accuracy (Davidson, 2002). Interpreters may also find it necessary to retell clinician's explanations, as they might be too restricted or scientifically expressed for patients to understand (Sobane & Anthonissen, 2013). This can create many challenges and dilemmas for interpreters (Bezuidenhout & Borry, 2010; Hsieh, 2006).

Due the complexity of patient-clinician interactions, the issue of interpreters being neutral is especially complex and not always a possibility (Dysart-Gale, 2007; Hsieh et al., 2010). For example, small talk between patient and interpreter can result in a more trusting, supportive relationship between the two, which can lead to the patient feeling more comfortable to reveal sensitive information (Brisset et al, 2013; Paone & Malott, 2008; Tribe & Morrissey, 2004). The emotional support and trusting relationship interpreters can develop with patients can be an invaluable resource for health care professionals (Hsieh & Kramer, 2012). It is unrealistic to expect interpreters to stay neutral and merely translate spoken words, as they bring with them their own set of cultural beliefs and values (McDowell et al., 2011; Penn & Watermeyer, 2012), which might in fact be useful in the interpreting session, as they can give the health care worker insight into the world of the patient. It can be argued that it is more important to ensure the delivery of good quality health care, than for interpreters to stay neutral (Hsieh & Kramer, 2012), as long as they accomplish the objectives of the team (Hsieh et al., 2010). It is not an easy task deciding how and when an interpreter must switch from being neutral and acting as a translating tool to being more active (Dysart-Gale, 2007). These interpreters would be seen as visible interpreters and are seen as active co-participants, as they help facilitate communication by processing information between language and culture (Bezuidenhout & Borry, 2010; Dysart-Gale, 2007). Being more active and acting as a co-participants does, however, introduce difficulties (Dysart-Gale, 2007). One major issue with this is what can be referred to as practising health care without proper training (Dysart-Gale, 2007).

It is also important to remember that the sometimes extra burden of interpreting has a strain on their already busy schedules, and can lead to difficulty in fulfilling their work role (Dysart-Gale, 2007). Dysart-Gale (2007) suggests that a lot of the difficulties when working with interpreters are often exacerbated by the unrealistic nature of communication in the health care setting.

Working with interpreters can also pose a threat to the therapeutic relationship between patient and clinician, as it adds an additional level to the traditional dyadic model of communication (Dysart-Gale, 2007; Luk, 2008), creating a much more complex triadic relationship. Efforts should be made to minimise the impact that this triadic relationship will have on the therapeutic relationship (Dysart-Gale, 2007), but at the same time, to realise that there may be numerous benefits of this newly formed triad. Clinicians will have to prepare for sessions with interpreters, as moving from a dyadic relationship to a triadic relationship

can be discomforting at first (Tribe & Keefe, 2009). Tribe and Keefe (2009) note that splitting and pairing can also occur, where an interpreter attempts to control the discussion, effectively creating two overlapping dyads. It is important that interpreters do not overstep their boundaries and attempt to take control of the session (Hsieh et al., 2010; Raval, 2006). The balance of power within the triad is very important and needs to be managed (Luk, 2008). The presence of an interpreter can also interfere with the establishment of rapport between patient and clinician (Luk, 2008; Searight & Armock, 2013). The presence of an interpreter can lead to feelings of detachment and inactivity from the patient, whereas clinicians can feel exposed, scrutinised and self-conscious due to the fact that someone is observing their professional work (Searight & Armock, 2013; Tribe & Keefe, 2009). Clinicians are tasked with managing complex transference and counter-transference issues that may arise inside of these triadic relationships (Luk, 2008).

The issues that arise within the therapeutic relationship can be prevented by proper planning from clinician and interpreter, where they would have to clearly define their roles within the therapeutic relationship. Patients can also find it difficult to trust interpreters, be anxious about issues of confidentiality and struggle to share personal experiences and sensitive issues with them (Flynn et al., 2012; Tribe & Keefe, 2009). Furthermore, clinicians and patients can also have a sense of vulnerability, as they have to completely rely on another person to convey their words and meanings (Tribe & Keefe, 2009). There are also certain negative emotions experienced by interpreters, including anxiety, feelings of inadequacy, sadness and intrusive thoughts (Smith et al., 2013). Interpreters, and especially ad hoc interpreters, often do not have support systems or access to professional supervision to deal with these negative emotions that they might have (Smith et al., 2013).

Apart from the difficulties associated with working with interpreters, the financial cost, additional time and infrastructure needed to accommodate interpreter services are also substantial (Hadziabdic & Hjelm, 2013; Pérez-Stable & Karliner, 2012; Raval, 2006; Swartz et al., 2014). Furthermore, professional interpreting services are generally unavailable and there is a lack of information about why the use of trained interpreters is important (Pérez-Stable & Karliner, 2012). There is also a general lack of training in the practical use of interpreters and difficulties in communicating in the presence of an interpreter (Hadziabdic & Hjelm, 2013).

3.3.5. The impact of interpreters

Studies have shown that when LEP patients make use of interpreters, there is a higher satisfaction with care, compared to when no interpreter was used (Brach et al., 2005). There is evidence to suggest that the use of interpreters can have a significant impact on mental health (Doherty et al., 2010). They can reduce medical errors, increase adherence to recommended treatments (Flynn et al., 2012; Sobane & Anthonissen, 2013) and lead to follow up visits by patients, as patients have a sense of belonging and trust in the health care system (Paone & Malott, 2008).

The impact that interpreters can have in overcoming language barriers is especially relevant in South Africa, because of the multilingual nature of the population (Drennan & Swartz, 2002). Research has shown that interpreting in health care in South Africa is usually informal and unpaid, and if paid is very poorly paid, erratic and in most cases on an ad hoc basis (Penn & Watermeyer, 2012). These ad hoc interpreters are expected to juggle their multiple roles (Penn & Watermeyer, 2012). Anyone who speaks the patient's language is often used as an interpreter, with this extra burden often falling on the shoulders of already overworked nurses (Drennan, 1999; Hadziabdic & Hjelm, 2013; Schlemmer & Mash, 2006). With the exception of nurses, the majority of mental health professionals are White and do not speak any of the indigenous languages (Drennan, 1999). In the Western Cape, Xhosa speaking staff, and especially Xhosa speaking nurses, are thought to have role overload and have difficulty managing multiple responsibilities (Drennan, 1999; Schlemmer & Mash, 2006). Taking this into consideration, it is alarming that a study by Schlemmer and Mash (2006) found that a significant number of patients at a Western Cape hospital can speak only Xhosa, yet there are no official interpreters and only a handful of the hospital staff who can speak Xhosa. There is a language policy in the Western Cape that recommends the employment of professional interpreters in hospitals, yet this has not become a reality (Schlemmer & Mash, 2006). The language barrier and dual roles also result in preconceived negative attitudes of staff and patients towards each other (Schlemmer & Mash, 2006).

3.4. Different models of interpreting

Tribe and Morrissey (2004) argue that there are four basic models of interpreting that all have a place in certain circumstances. In the linguistic model, the interpreter adopts a neutral position and tries to interpret word-for-word. With the constructionist mode, the interpreter is not so much concerned with word-for-word interpretation, but rather focuses on

conveying the correct message, meaning and emotions that are being expressed (Tribe & Keefe, 2009; Tribe & Morrissey, 2004). The community interpreter takes the role of advocate for the patient or even community on occasion and goes beyond just interpreting for them. Community interpreters can have many different roles, including a system agent, integration agent, community agent and linguistic agent (Raval, 2006). As a system agent, interpreters are tasked with facilitating access to mental health service for the patient (Raval, 2006). An integration agent has to bring together the patient and clinician's views (Raval, 2006). A linguistic agent is tasked with reproducing a meaningful translation (Raval, 2006). Community agents have to ensure that the clinician gains an understanding of the patient's community context (Raval, 2006). Lastly, the cultural broker explains contextual and cultural variables in addition to interpreting the spoken word (Tribe & Keefe, 2009; Tribe & Morrissey, 2004).

From a communicative perspective, we will look at two different models, namely the transmission model and the semiotic model (Dysart-Gale, 2007). In the transmission model, interpreters are tasked with simply conveying the message, therefore taking a neutral role in communication (Dysart-Gale, 2007). When making use of this model, interpreters act as translating machines, simply transferring information from one person to another or from a sender to a receiver (Dysart-Gale, 2007). The interpreter acts as a channel, recoding the information from the sender into the target language of the receiver (Dysart-Gale, 2007). Errors associated with this model are distortions, due to semantic or technical difficulties, conceptual incommensurability, as it is impossible for the sender to compare whether what was said is comparable in the target language; and cultural misunderstandings (Dysart-Gale, 2007). The transmission model is however favoured in many clinical settings, as there is a focus on the effective transfer of the message (Dysart-Gale, 2007). Clinicians might feel that because interpreters take a neutral role, they do not have concerns of improperly translated messages or censorship (Dysart-Gale, 2007). This model complies with traditional views of health care, the clinician speaks and the patient listens (Dysart-Gale, 2007). Although that might be true, there are questions regarding whether communication from one language to another is that straightforward, and whether the different ideological or cultural perspectives of sender and receiver might change the meaning of the message (Dysart-Gale, 2007).

The semiotic model not only views communication as conveying a message from one language to another, but rather as a process where the meaning evolves (Dysart-Gale, 2007). This model accounts for the different roles that interpreters might have to take on, namely

clarifier, cultural broker and patient advocate (Dysart-Gale, 2007). In this model, clinicians have to negotiate the meaning of their message, rather than dictating it, and in the process improve communication by developing shared meanings of health and wellbeing (Dysart-Gale, 2007). Therefore this model is sensitive to cultural barriers and how this might affect a message (Dysart-Gale, 2007). The interpreter will be allowed to explain words or phrases, like difficult terminology, to the patient (Dysart-Gale, 2007). Ethical issues might be of concern when making use of this model, as the interpreter has more freedom and there is a greater chance that they might breach ethical conduct (Dysart-Gale, 2007).

The difference between these two models is that the transmission model sees the translation of the linguistic code as the only obstacle to communication, whereas the semiotic model offers a more nuanced account of interaction, by recognising that meaning is not absolute or necessarily shared between clinician and patient (Dysart-Gale, 2007). It is difficult to argue that one model is better than the other, as both have positives and negatives. The environment, specific setting and what resources are available will have to be taken in account when deciding what interpreting model to use.

3.5. The use of ad hoc interpreters compared to trained interpreters

3.5.1. Difficulties

Searight and Armock (2013) state that errors are common with both ad hoc and professional interpreters. A study by Lee et al. (2006) found that when faced with language barriers, clinicians used ad hoc interpreters, although this resulted in medical errors and a decreased quality of care when compared with the use of professional interpreters. Even under the best circumstances, mental health interpreting is a very complex and difficult task, but when untrained interpreters are used, these difficulties are exacerbated (Kilian et al., 2014). Making use of ad hoc interpreters is often the easiest solution to the language barrier, but this should be discouraged if possible (Kale & Syed, 2010). Although the use of professional interpreters leads to fewer errors, Paone and Malott (2008) suggest that even when working with professional interpreters, errors can occur, leading to inaccurate interpretations.

Ad hoc interpreters can include a wide variety of people, including nursing staff, family members of patients, security guards and ward cleaners (Drennan & Swartz, 2002). Although using nonprofessional interpreters, like family members, friends or staff, still

occurs, many argue that it is necessary to move away from this practice, as it leads to a greatly increased number of errors that could lead to serious clinical consequences and brings with it a host of practical and ethical difficulties (Cross & Bloomer, 2010; Doherty, MacIntyre, & Wyne, 2010; Drennan & Swartz, 2002; Dysart-Gale, 2007; Flores, 2005). Difficulties associated with using family or friends as interpreters include pre-existing emotional ties that can interfere with interpretations, family dynamics, a lack of technical terminology and a breach of privacy and confidentiality (Cross & Bloomer, 2010; Doherty et al., 2010; Hsieh et al., 2010; Kale & Syed, 2010; Searight & Armock, 2013). Due to pre-existing emotional ties, family interpreters may be biased by their personal opinions and therefore lose objectivity (Luk, 2008). Studies have shown that when making use of family members or friends as interpreters, patients have often felt ashamed and not willing to convey a message (Hadziabdic & Hjelm, 2013). When family members are used as interpreters, they are also more likely to answer clinician's questions without consulting the patient and minimizing the patient's symptoms (Searight & Armock, 2013). Family members and friends are also not subject to control from the health care system (Hsieh et al., 2010).

When making a diagnosis, clinicians rely heavily on interpreters and although research has shown that many errors can occur when working with ad hoc interpreters, without them the whole process might not be possible (Drennan & Swartz, 2002). There are a number of ethical, clinical, moral and legal issues when working with ad hoc interpreters, such as patient privacy, informed consent and patient autonomy (Bauer & Alegria, 2010; Bezuidenhout & Borry, 2010; Tribe & Keefe, 2009). Errors that are associated with the use of ad hoc interpreters include content omissions, revisions, mistranslations, interviews that had to be repeated, uncertainty on fundamental issues, substitutions, additions, phrase changing, lack of medical terminology, condensations or simplification of what is being said by patient and/or clinician, turning questions into leading questions, role exchange, where the interpreter takes over the role of the patient and/or clinician, and in general, miscommunications (Baker, Hayes, & Fortier, 1998; Flores, 2005; Kilian et al., 2014; MacFarlane, Glynn, Mosinkie, & Murphy, 2008; Meeuwesen, Twilt, Thije, & Harmsen, 2009; Paone & Malott, 2008; Searight & Armock, 2013; Searight & Searight, 2009; Timmins, 2002; Tribe & Tunariu, 2009). Effective communication can also be hindered by the interpreter struggling to sufficiently engage the patient (Doherty et al., 2010). Kilian et al. (2014) state that omissions, additions and substitutions are the most commonly documented errors. Omissions are when material is not interpreted, which means that the listener is unaware that the speaker said something

(Kilian et al., 2014). Vital emotional and medical information can be omitted, purposely or unintentionally (Luk, 2008). Additions are when the speaker over-elaborates or adds additional information that the speaker did not say (Kilian et al., 2014; Luk, 2008). Substitutions are when the interpreter leaves out something that the speaker said, substituting it with different words entirely (Kilian et al., 2014). Interpreters can also normalise pathological information, not knowing the significance of what they are interpreting (Luk, 2008).

Furthermore, ad hoc interpreters are more likely to distort or exclude important clinical information (Flores, 2005). Errors when working with ad hoc or professional interpreters are increased when clinicians speak quickly or make use of an excess of medical jargon (Paone & Malott, 2008). Errors in interpreting are further compounded when there is no direct translation between languages for certain words, concepts or phrases; or when interpreters fail to take into account patients' personal reactions to sensitive information, or when they misinterpret patient affect (Paone & Malott, 2008). Paone and Malott (2008) suggest that when working with ad hoc interpreters, issues that are discussed during the session might have to be limited. Although this might be effective in reducing misinterpretations (Paone & Malott, 2008), it can make it difficult for the clinician to have a holistic view of what problems the patient is facing. Topics that should be avoided, like delusions, hallucinations, suicide, sexual dysfunction and social histories (Paone & Malott, 2008), could have a big impact on the diagnoses and could lead to misdiagnoses.

A study by Doherty et al. (2010) state that interpreters may find it difficult to establish rapport with the patients. There are professional misunderstandings of the interpreter role and that staff often have a poor communication technique when working with interpreters. When interpreters and clinicians are not properly trained with regard to interpreter mediated sessions, clinicians may also feel as if the interpreters are interfering in what was traditionally seen as "their" sessions. This can cause the clinician to feel like a bystander during the therapeutic session (Luk, 2008), therefore it is of importance that the clinician develops a rapport with the client during interpreter mediated sessions (Paone & Malott, 2008). This will be made easier by the clinician maintaining eye contact and using personal pronouns when speaking to the patient (Paone & Malott, 2008). Pérez-Stable and Karliner (2012) argue that good clinician-patient rapport is linked to positive patient outcomes. Interpreters may also find it difficult to mediate class, culture and power between clinician and patient, which could

influence clinician-patient rapport (Timmins, 2002). When interpreters are untrained, cultural references are often obscured, either ignored or over-emphasised (Kilian et al., 2014).

Ad hoc interpreters can have further negative implications on clinician-patient rapport by supporting either the patient or the clinician (Smith et al., 2013). These interpreters may also lack awareness of the clients' specific cultural or socio-political context, although they speak the same language (Paone & Malott, 2008). Ad hoc interpreters are also likely to lack knowledge with regards to the organisations' culture and policies (Paone & Malott, 2008). It is important that interpreters and clinicians are familiar with the rules when it comes to interacting within the triad (Paone & Malott, 2008). These errors are also compounded by the fact that the clinician is likely to be unaware that they are taking place (Hadziabdic & Hjelm, 2013; Timmins, 2002). Using staff members as interpreters also increases the burden on an already overburdened staff. It can lead to a loss of productivity, additional stress, role ambiguity and resentment of having additional, unpaid work (Paone & Malott, 2008; Timmins, 2002). The extra burden of interpreting can often be viewed as invisible work and regarded as a form of exploitation (Smith et al., 2013). In a study by Smith et al. (2013), it is suggested that staff members that also have to interpret, consistently bring their experience of working in the wards into the interpreting session. Due to these multiple relationships, these interpreters report on observations that were made outside of the interpreting session (Smith et al., 2013). Although this can be of some help, they are not clinically able to do so (Smith et al., 2013). Ad hoc interpreters are also uncomfortable in dealing with sensitive issues, traumatic information and relaying a patients' personal information (Flores, 2006; McDowell et al., 2011; Paone & Malott, 2008). Patients' traumatic experiences can cause interpreters to feel distressed and they can be emotionally affected by their role as interpreter (Doherty et al., 2010; Searight & Armock, 2013). Poor quality interpreting also has a negative effect on the patient-provider relationship (Baker et al., 1998). There is evidence to suggest that ad hoc interpreters, who have no training in interpreting or knowledge of key mental health concepts, are considerably more likely than professional interpreters to make errors that may have serious clinical consequences (Flores, 2006; Smith et al., 2013). Although analysis of the errors that interpreters make is important, a much more important task of interpreting is that clinical goals are achieved (Kilian et al., 2014).

3.5.2. Ethical concerns

The use of ad hoc interpreters can result in ethical issues like violating patient confidentiality, patient autonomy and role disturbance (Paone & Malott, 2008; Timmins, 2002). Issues of confidentiality are of big concern when working with interpreters, and especially ad hoc interpreters (Bezuidenhout & Borry, 2010; Searight & Armock, 2013; Smith et al., 2013; Wiener & Rivera, 2004), as they are generally not bound by a code of ethics (Smith et al., 2013,) and are one of the reasons why it is not ideal to use family and friends as interpreters (Kale & Syed, 2010; Tribe & Lane, 2009). When family members or friends are used as interpreters, they should be reminded about the importance of confidentiality. Patients should also be reminded that in situation like this, confidentiality cannot be guaranteed (Paone & Malott, 2008). Family members are also likely to withhold sensitive information, misinterpret or omit questions asked by patient or clinician, and minimise or emphasise psychopathology (Flores, 2005; Paone & Malott, 2008). The use of family members or other untrained interpreters can have serious ethical implications (Paone & Malott, 2008; Timmins, 2002). When making use of family members as interpreters, patients are less likely to be satisfied with health care services (Flores, 2005). Ad hoc interpreters generally do not have access to professional supervision and consequently use their colleagues as support, talking to them about issues that were discussed during the therapeutic encounter, which raises ethical concerns (Smith et al., 2013).

Ethical concerns are further complicated by role exchange, where a bond between ad hoc interpreter and patient might have been formed outside of the contact session (Paone & Malott, 2008). At worst, ad hoc interpreters and patients may come from the same community or share pre-existing social or kinship links (Smith et al., 2013). When interpreters and patients come from the same community, it will also be difficult to maintain clear boundaries (Doherty et al., 2010). Interpreters may then choose not to speak freely, as this may have social consequences outside of the interpreting session. Clinicians should avoid using interpreters that have multiple relationships with the patient (Searight & Armock, 2013). Where interpreters are used, the patients are often from cultures that attribute negative connotations to mental health issues (Flynn et al., 2012), which further complicates ethical concerns. Debriefing sessions between clinician and interpreter will ensure that interpreters are better able to manage the sensitive nature of contact sessions (Doherty et al., 2010; Paone & Malott, 2008). It is the responsibility of clinicians to ensure that interpreters are technically competent and adhere to ethical standards (Searight & Armock, 2013).

These ethical concerns contribute to the need for a code of ethics that should be included in training for interpreters in order to ensure that interpreters adhere to appropriate behaviour (Dysart-Gale, 2007). Areas to be covered in such a code of ethics include accuracy, completeness, confidentiality, cultural competence, impartiality, integrity, professional boundaries, professional development and respect for all parties involved (Dysart-Gale, 2007). It is important that such a code of ethics is based on solid theoretical underpinnings, but also reflects the reality of interpreter mediated sessions (Dysart-Gale, 2007).

3.5.3. Effectiveness

Although the use of interpreters in mental health services has become increasingly widespread, little is known about the impact that they have on clinical outcomes (Searight & Armock, 2013). Mental health interpreting presents multiple challenges and even under ideal circumstances, the accuracy of interpreting can be compromised (Smith et al., 2013). Tremendous strain can be placed on the quality of health care if interpreters do not receive adequate training (Drennan & Swartz, 2002), which is why the use of trained interpreters is so beneficial. Quality reassurance is one of the main advantages of making use of professional interpreters (Lee et al., 2014). When untrained interpreters are used, experience in interpreting does not necessarily translate to quality interpreting (Kilian et al., 2014; Sobane & Anthonissen, 2013). If clinicians have to resort to the use of ad hoc interpreters, they are encouraged to pay close attention to nonverbal cues, use simple brief sentence construction and work slowly (Flores, 2005; Searight & Armock, 2013).

Interpreting is a long-term learning process, as interpreters move from a mechanical understanding to more of a client orientated understanding of interpreting (Bischoff et al., 2012). Studies have shown that working with professional interpreters improves quality of interpretations and quality of care, and fosters cultural appropriateness, improved clinical outcomes and overall effectiveness (Brisset et al., 2013; Flores, 2005; Jacobs et al., 2010; Karliner et al., 2007; Ono et al., 2013, Pérez-Stable & Karliner, 2012; Sobane & Anthonissen, 2013; Timmins, 2002). There is also evidence of fewer errors in translations, improved compliance with health regimes, better adherence of follow ups, greater level of comfort, better disclosure of sensitive material and greater patient satisfaction with services when working with professional interpreters compared to ad hoc interpreters (Bauer & Alegria, 2010; Brisset et al., 2013; Hudelson & Vilpert, 2009; Karliner et al., 2007; Paone &

Malott, 2008; Searight & Searight, 2009, Timmins, 2002; Tribe & Morrissey, 2004). In a study by Baron et al. (2010), they found that patients are more likely to trust interpreters if they have been professionally trained, understand medical terminology and are accurate in their interpretations.

Professional interpreters can more easily overcome communication barriers, partly due to the fact that they have knowledge of both lay and technical terminology and can thus better explain the patient's symptoms to the clinician, but also communicate the proper use of therapy and treatment to the patient (Karliner et al., 2007). Professional interpreters go beyond the mere translation of literal words (Searight & Searight, 2009). They are able to pay attention to idiosyncratic meaning, the cultural significance of the spoken words and the importance of non-verbal communication (Rosenberg, Leanza, & Seller, 2007; Searight & Searight, 2009). The fact that professional interpreters are more accurate and complete in their interpretation is of vital importance to the health care process, as clinicians rely on interpreters to guarantee that effective communication takes place and that the meaning of their message is not distorted (Dysart-Gale, 2007). It is also important that professional interpreters develop a relationship that fosters trust with both patient and clinician, as this is vital to the therapeutic relationship (Tribe & Tunariu, 2009; Rosenberg et al., 2007). Karliner et al. (2007) argue that when interpreters are used, there is an increase in overall satisfaction with the interpersonal aspects of health care. Tribe and Lane (2009) suggest that working with trained interpreters may also be cost effective, as misdiagnoses and referrals might cost more than employing trained interpreters. There are many advantages of working with professional interpreters compared to ad hoc interpreters, but it can be argued that some communication is better than no communication (Pérez-Stable & Karliner, 2012). When interpreters are used, the utilisation rates of health care for LEP patients approached those of English speaking patients (Karliner et al., 2007). The use of interpreters has also lead to increased and better levels of patient communication, engagement in sessions, equity of service, good practise and is an empowering experience for patients (Tribe & Keefe, 2009).

Kale and Syed (2010) report that many clinicians are dissatisfied with interpreter competencies and also their own competencies in working with interpreters. Thus, it is important that health providers be trained to work with interpreters in order to form an effective and productive partnership, which will enhance the skills and confidence of all parties involved (Tribe, 2007; Tribe & Lane, 2009). Lack of training of both interpreter and clinician may lead to poorer interpreting outcomes (Kilian et al., 2014). Only a few clinicians

receive the necessary training to work with interpreters. Tribe and Tunariu (2009) argue that the training of “interpreters and of health professionals is likely to increase both confidence and efficiency in working together” (p. 76). To increase efficiency, it is essential that clinicians and interpreters receiving adequate training with regards to the challenges associated with mental health communication (Cross & Bloomer, 2010), and the possible conflicts that might arise (Bischoff et al., 2012). Health providers must also be familiar with the laws and regulations of language access in their particular setting (Timmins, 2002). There is evidence to suggest that although training is of vital importance, it is often the interpreters that have accomplished skills in both languages (the language of both the patient and clinician) that have the greatest accuracy (Paone & Malott, 2008), which is very important to the interpreting process.

Making use of interpreters is a very effective solution to overcoming language barriers (Cross & Bloomer, 2010; Tribe & Lane, 2009). To prevent potential role confusion, it is important that clinician and interpreter establish a relationship and define specific roles (Paone & Malott, 2008; Raval, 2006). Trust between clinician and interpreter will be enhanced if they believe that they have shared goals (Hsieh et al., 2010) which will lead to better quality care. It is important that interpreters understand what is being said, but also why it is said (Davidson, 2002). The use of interpreters can also enhance rapport within the triadic relationship (Smith et al., 2013).

As has been mentioned, it would be beneficial to match interpreter for gender and age (Tribe & Lane, 2009), and also as far as possible to match them for dialect and nationality as well (Tribe & Keefe, 2009). A shared common language between patient and interpreter does not guarantee that effective communication and health care will take place, as there are many other factors that can have an influence on the relationship, culture, religion and nationality to name a few (Tribe & Keefe, 2009).

It is important that clinician and interpreter are comfortable with each other, and that both parties receive training on how to handle an interpreter mediated session. Interpreters and clinicians must learn to appreciate and adapt to each other’s communication styles (Hsieh et al., 2010). It would increase the effectiveness of health care if clinician and interpreter have pre-session briefings where they verify interpreter knowledge, establish the interpreter’s role boundaries, agree on certain practises and discuss patient confidentiality (Doherty et al., 2010; Luk, 2008; Paone & Malott, 2008; Raval, 2006). Pre-sessions should also offer

interpreters and clinicians the chance to rehearse the session, allowing them to practise a neutral tone of voice, discussing possible confusing concepts, technical terms and phrasing possible difficult questions (Paone & Malott, 2008). During these sessions it is important that both parties are clear on how to work together, setting clear aims and objectives and deciding what approach to take during the clinical interview (Luk, 2008; Searight & Armock, 2013, Tribe & Keefe, 2009; Wallin & Ahlström, 2006). The clinician can also use this opportunity to find out more about certain cultural or religious views that might come into play during the session (Tribe & Keefe, 2009). Pre-session meetings would be especially useful when making use of ad hoc interpreters (Paone & Malott, 2008).

During the session, it is important to create a comfortable atmosphere, allowing the interpreter and patient to introduce themselves (Tribe & Keefe, 2009). As has been discussed earlier, languages are not directly interchangeable; therefore it is important to allow the interpreter enough time to switch from one language to another, ensuring that you establish a natural rhythm (Tribe & Keefe, 2009). Clinicians should also avoid using language that is too technical, or proverbs and idiomatic language that is culture specific (Tribe & Keefe, 2009). In order to comply with ethical standards, it is important that issues of confidentiality are discussed before and during the interpreter mediated session (Tribe & Keefe, 2009).

A debriefing session between clinician and interpreter is also recommended, where the clinician will have the opportunity to review the session, possibly gaining insight into the patients' culture and gathering the interpreter's thoughts on the patients' affect, behaviour or symptoms (Luk, 2008; Paone & Malott, 2008; Tribe & Keefe, 2009; Searight & Armock, 2013; Wallin & Ahlström, 2006). During debriefing sessions the clinician and interpreter can also discuss possible difficulties that arose during the session and will also give the clinician the opportunity to stress the importance of confidentiality (Paone & Malott, 2008; Raval, 2006). Such sessions will also help interpreter's process emotional reactions that might have come up during the interpreting session (Searight & Armock, 2013). Debriefing sessions will reduce the risk of misdiagnoses or inappropriate treatment and will ensure that culturally appropriate treatment takes place (Raval, 2006).

Although there are numerous advantages of using professional interpreters, logistical or monetary constrictions often result in the use of bilingual staff, clients, family or friends as interpreters, which is not ideal (Paone & Malott, 2008). Advantages of using family members and friends as interpreters include feelings of trust and security from patients, as they will

have more knowledge about the patient and their culture, and that they will be more involved in patient support (Hadziabdic & Hjelm, 2013; Luk, 2008). There is however a high demand for the availability of trained interpreters (Dysart-Gale, 2007; Siegel et al., 2000). Swartz et al. (2014) argue that when resources are constrained, lower level workers who deliver mental health care (if they received appropriate interpreter training) can provide better care than professionally trained interpreters. These health care workers would more likely share cultural, linguistic and social backgrounds with the clients they serve than professional interpreters (Swartz et al., 2014).

3.6 Interpreter training

To ensure accurate and effective communication, it is not sufficient for interpreters to only have knowledge of a patient's language and culture. It is imperative that both clinicians and interpreters receive the necessary training and support to ensure that the patient's mental health conditions are understood (Doherty et al., 2010; Pérez-Stable & Karliner, 2012), especially in a complex context as South Africa, and that adequate health care can take place (Kilian et al., 2014). Ad hoc interpreters play a very important role in South African mental health care services, but making use of untrained interpreters is clearly not ideal (Kilian et al., 2014). Kilian et al. (2014) argue that the provision of an in-service training course will have a positive impact on psychiatric evaluation. As making use of professional interpreters is expensive, a more feasible option could be to provide training manuals and training workshops for informal interpreters at hospitals (Kilian et al., 2014). It will then also be possible to pair interpreters and clinicians on a regular basis, establishing trust, a proper working relationship and mutual understanding (Luk, 2008).

It is especially crucial that clinicians and interpreters receive adequate training to deal with the specific communication barriers associated with working with culturally diverse patients (Cross & Bloomer, 2010; Tribe & Lane, 2009). As has been mentioned earlier, it is of vital importance that training also includes how to deal with the difficulties and multiple roles associated with interpreting (Smith et al., 2013). A code of ethics that ensures that interpreters adhere to appropriate behaviour must also be included in training (Dysart-Gale, 2007). Interpreting training must go beyond merely training an individual in interpreting and translation skills (Penn & Watermeyer, 2012; Raval, 2006). There are many skills that are required to work as or with an interpreter. Some of these include having and being able to explain cultural background (Miller et al., 2005), managing the nature and purpose of mental

health interviews (Luk, 2008), being able to build trust and working successfully in the therapeutic alliance inside the triadic relationship (Miller et al., 2005; Paone & Malott, 2008; Penn & Watermeyer, 2012; Smith et al., 2013), managing issues of power, confidentiality and other ethical considerations. Interpreters must also be equipped with some background in specialist mental health knowledge (Doherty et al., 2010; Luk, 2008) and the psychological frameworks that clinicians employ (Raval, 2006). It is of vital importance that interpreters possess these skills, as clinicians often rely on the opinion of the interpreter's to help form their clinical assessment (Searight & Armock, 2013). The success of using an interpreter does not only rely on the skill of the interpreter and overcoming the language barrier, but also the ability and skill of the clinician in working with an interpreter (Luk, 2008). Working with interpreters is very complex process that needs to be handled with sensitivity; therefore mental health care professionals also need the skill to deal with issues that might arise (Hadziabdic & Hjelm, 2013; Raval, 2006). Raval (2006) states that very few clinicians undergo specific training on how to work effectively with bilingual co-workers and interpreters. They further state that those clinicians that have received the necessary training are more likely to use interpreters. It can be argued that joint training for interpreters and clinicians will ensure effective collaboration. As mental health interpreters can be distressed by having to deal with the traumatic experiences and sensitive information of patients (Doherty et al., 2010), interpreters could benefit from gaining coping skills and mechanisms through training. Support structures are important for mental health staff (Doherty et al., 2010), and this is also something that needs to be emphasised during training. Reflective practices would benefit interpreter training. This will ensure that participants have a space where they are able to integrate what they have learned with their personal experiences and give them the opportunity to explore the emotional impact that interpreting has had on them (Raval, 2006). It would be useful if communities and the people being served be included in the development of training programmes. There is evidence to suggest that mental health interpreting can be reasonably accurate when adequate interpreting training is provided (Searight & Armock, 2013).

3.7. Conclusion

This chapter emphasises the negative consequence that the language barrier can have on mental health care and provides possible solutions to this barrier, i.e., the use bilingual staff members and/or interpreters. Particular attention is paid to the use of interpreters, as this seems to be the most viable solution. The different tasks of interpreters, the importance of

acting as a cultural broker, the difficulties of working with interpreters, the impact that interpreters can have and the different models of interpreting are discussed. Lastly, ad hoc and professional interpreters are compared, or more specifically the difficulties, ethical concerns and effectiveness of these two types of interpreters.

CHAPTER 4 RESEARCH METHODOLOGY

4.1. Introduction

As has been mentioned, the present study aims to assess ad hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions. This chapter provides an explanation of the research design, information on the participants, data collection, data analysis, ethical considerations, the researchers' reflection on the research process and limitations of the present study.

4.2. Research design

The present study utilised a cross-sectional qualitative interview design. This entails collecting all the data at a single point in time (Kilian, 2007; Bless, Higson-Smith, & Kagee, 2006).

4.3. Participants

Originally I had 19 possible participants, all who attended the in-service training course. I started by sending a short message to their cell-phones explaining exactly who I was and explaining what the purpose of me contacting them was. I also informed them that I would phone after their working hours, and that this message was a very basic introduction, so that they would know who I was when I phoned. Three of the possible participants never replied to my messages or answered their phones. One of the 19 was not working at the hospital anymore, one was on maternity leave and I was informed by a family member that one of the possible participants had passed away. These participants were excluded from the study.

Thirteen participants participated in the study. Seven of the participants are male and six are female. They are all employed at one of four hospitals in the Western Cape. Four of the participants are administrative clerks, three are enrolled nurses, one is a housekeeper, one is a housekeeping supervisor, one is an Occupational Therapy technician, one is a security guard and two are senior administrative clerks. The participants' ages vary from 25 to 59, with a mean age of 39.6. Participants were chosen on the basis that they had participated in an in-service interpreter training course in 2011. Fifteen of the participants indicated that Xhosa is their first language, with the other one being Afrikaans. Ten of the participants indicated that they had no prior experience of acting as an ad hoc interpreter before having to

perform this role at their current place of work. It must be noted that participants are not employed specifically as interpreters.

Table 1.1

Gender of Participants

Gender	n
Male	7
Female	6

Table 1.2

Job Titles of Participants

Job title	n
Administrative clerks	4
Enrolled nurses	3
Senior administrative clerks	2
Housekeeper	1
Housekeeping supervisor	1
Occupational therapy technician	1
Security guard	1

4.4. Data collection

The interviews took place at the place where participants are employed and were conducted by the researcher. After initial welcoming and thanking them for their cooperation in this study, the participants received a participant information leaflet and consent form. The

purpose and confidentiality of the interviews were verbally reiterated by the researcher. The interviews were only conducted after written consent was obtained.

Data were collected by way of semi-structured interviews. Each participant was interviewed in a relaxed and informal manner. The interviews were relaxed and informal in order for the participants to feel that they could express their opinions freely. They were made aware of the fact that I was not there to check up on them or police them. Questions were asked one by one. I made use of the interview schedule to ascertain that all the topics were covered, but the schedule was open enough to allow for the adaption of questions or new questions to be introduced. The interviews lasted between 20 and 30 minutes.

4.5. Data analysis

The audio-taped interviews were transcribed verbatim. IPA was used to analyse the transcribed data. As was mentioned before, IPA focuses on the meaning of an experience of a particular participant (e.g., a specific interview session with a participant) (Larkin & Thompson, 2012). Not only does IPA focus on the participant's subjective accounts (Brocki & Wearden, 2006), but it is also dependent on the researcher's own conceptions to make sense of the research participants' perceptions (Chapman & Smith, 2002). The aim of this is to identify certain themes within the multiple words of the text and code them accordingly. The final analysis is a combined product of reflection by the participant and the researcher, forming a dynamic research process (Clarke, 2009; Smith et al, 1997).

4.6. Ethical considerations

The participants were assured that their autonomy would be secure and that any information would be treated as confidential. The participants were informed that participation in the study was entirely voluntary and that they were free to decline to participate. They were also free to withdraw from the study at any point and they were informed that this would not affect them negatively in any way whatsoever. They were also informed that there would be no negative consequences if they should choose not to participate. Each participant was informed about their rights and a form explaining the study was given to each of them.

Ethical approval for this study, which is part of a larger study on interpreting in mental health care in Cape Town, has been obtained from the Committee for Human

Research, Faculty of Health Sciences, Stellenbosch University, Reference number N11/10/313.

4.7. Researcher's reflection on the research process

Motivation for the present study started with my honours thesis, which was on ad hoc interpreters' accuracy of interpreting key psychiatric terms at a South African psychiatric hospital. This made me aware of the need for accurate interpretations in the mental health setting to assure equal care for all people. As I was now a bit more familiar with what to expect, I was confident when I started with research and data collection.

The fact that I had sent all the participants messages before I phoned them, made the phone calls easier. It was still a bit awkward having to phone the participants after hours. I did, however, not want to phone them during working hours. Personally the most difficult phone call was when I was informed by a family member that one of the potential participants had passed away. Everybody that I did manage to make contact with and was available agreed to participate in the study. All interviews took place at one of the four hospitals in the Western Cape where the participants are employed. Once at the hospitals I was welcomed and we found a private room to conduct the interviews. All of the interviews flowed easily, with no major difficulties. All interviews were conducted in English. The difference in language between me, being Afrikaans, and the participants, being mostly Xhosa, never hindered the interviews. However, there were some miscommunications during the interviews, which was more noticeable once I had the transcribed data.

Transcribing the interviews was quite a tiresome and sometimes frustrating process. Some parts of a few interviews were difficult to hear. There was a language barrier between researcher and participants during interviews itself, where I sometimes had to go to great lengths to explaining questions to participant. These issues were compounded during the transcription process. This was due to the fact that voices were softer than in real life, which sometimes made it difficult to understand the participant's accents. I also did not have the added benefit of the participant's nonverbal communication. In one interview there was also the sound of an air-conditioner to contend with. I transcribed most of the interviews myself, but made use of a professional transcription service for the last few interviews.

I enjoyed the analysis of the data, especially when certain themes became clear. This was the point where I finally started to feel that I was getting somewhere. I was probably a bit

too excited when I realised that there were certain themes that could be identified across all of the interviews.

4.8. Conclusion

In this chapter the research design, information on the participants, data collection, data analysis and ethical considerations are considered. Furthermore, the researchers' reflection on the research process and limitations of the present study was discussed.

CHAPTER 5: RESEARCH FINDINGS

5.1. Introduction

This chapter presents the experiences of an in-service training course and subsequent interpreter-mediated sessions by 13 participants who have occasionally acted as ad hoc interpreters at the hospitals where they are employed. In accordance with IPA, I aim to understand the personal accounts of these participants' particular experiences (Clarke, 2009). Therefore, the focus will be on the meaning and perceptions of a particular experience of a certain participant (subjective accounts) (Brocki & Wearden, 2006; Larkin & Thompson, 2012), rather than focusing on more general claims (objective accounts) (Brocki & Wearden, 2006; Chapman & Smith, 2002). It is also important to note that the research findings reflect the researcher's interpretations of the participant's stories (Larkin & Thompson, 2012).

An example of a verbatim extract from the interviews is included to illustrate and substantiate research findings. This extract is presented with pseudonyms to protect the privacy and confidentiality of participants and institutions. Six main themes can be identified from the data. The six main themes are: the language barrier between researcher and participants; the role of age, culture and gender on interpreter mediated sessions; participant's views on interpreting; participant's willingness to act as ad hoc interpreters; the effectiveness of the in-service training course; subsequent interpreting sessions and interest in more formal training; and the importance of a working relationship between interpreters and clinicians.

5.2. Theme 1: Language barrier between researcher and participants

There were some instances where there was a language barrier between me and some of the participants. This is worrying, as these participants have been used as ad hoc interpreters at the hospitals where they work. Mental health interpreting is a very complex task and a sound knowledge of the two languages that are being interpreted between is the first priority. Some of the participants had difficulty understanding the questions, as illustrated below. As can be seen in the last example, when I asked the participant if they had been asked to interpret at their current place of work, the participant talked about a different hospital that they visited. *Nè* is an Afrikaans word that insinuates that something is true.

Interviewer (SH): Can you please explain the role that you fulfil at the hospital?

Participant (P6): In this hospital?

SH: So basically, what work do you do at the hospital?

P6: What I'm doing?

SH: Ja.

P6: I'm an administration clerk. Ja, I'm working with files in the office.

SH: Ok, and have you been asked to act as an unforeseen interpreter for . . . ?

P8: Sorry.

SH: Have you, have you done interpreting?

P8: Before?

SH: Ja, did the hospital ask you to be an interpreter?

P8: No the thing is, the one day I visited Hospital A hospital nè.

One of the participants also went off topic when I asked certain questions, as can be seen below.

SH: Ok, and age, do you think that has an influence? Maybe if it's a young doctor and it's an older patient or it's a young patient and an older doctor, do you think that has an influence on the session?

P8: Oh, we would say sometimes some of the doctors, they are impatient with. . . . Some are impatient. They don't give a chance for the patient to explain what is wrong and all those and say, no, no, no just like.

SH: Ok, just in general, if you can think what would make something good, an interpreting session?

P8: It's a . . . To say what . . . if you've got a complaint and all that I'll say what you complain, complaint about and then I'll try and suggest you if you can use, try this mummy then maybe it's going to help you, understand.

Another example of miscommunication is when I asked one of the participants about the role of gender in interpreting, the participant spoke about an incident outside of interpreting, as can be seen below.

P10: So there was this old man and we had to go to the bathroom that they have to undress and he said to me do you think you are going to see my - you know. Those kind of things so ja it is, it needs to be considered also.

SH: Ja, and gender you mentioned now maybe there's a gender bit as well?

P10: Gender especially the males, ja, it's also.

SH: Ok.

P10: Because the uncle that time said to me, Ek is 'n groot man [I am a grown man]. You can't stand here while I'm bathing. You must get out.

SH: Ja.

P10: And you can't look at me when I'm undressing, but in the meantime according my understanding that time was there must be supervise, he must be under supervision but he didn't understand that. So you need to make the patient understand.

In summary, there was a language barrier between researcher and participants, which is an important part of this study. I had to do quite a lot of work to try to get some of the participants to understand what I was saying in English. This language barrier illustrates the need for interpreters to be fully bilingual.

5.3. Theme 2: The role of age, culture and gender

Age, culture and gender have the potential to have a profound impact on mental health interviews. This is made much more complex when working inside the triad formed between interpreter, clinician and patient. There is now a likelihood that three people with different cultures and from three different age groups have to interact.

5.3.1. The role of age. The majority of the participants stated that age can have an impact on interpreting sessions. Most of the participants that stated that age plays a role in interpreting, discussed the link between age and culture, and how you have to be respectful towards older patients, but also that if the interpreter is older, it is easier for them to control the session (in the sense that the patient will show them respect).

It was unclear whether the majority of the participants believed that age on its own has an effect on the interpreting sessions, but rather a combination of age, culture and respect; and the role of experience, as can be seen below.

P1: [Laughter] . . . Well I don't know, but for myself, uhm, I think experience plays a role also, because look an older person has got more experience than a younger person. So that older person will know how to speak to the patient and because in our culture, younger people mos (you know) now got more respect for the older people. Now maybe if a the patient starts getting rude, I can reprimand in my language and the patient will calm down, because oh this is an old person, you know. So I think that little bit of respect also plays a role, I think in some cases, not all the cases. Older people as interpreters were nogal (rather) [. . . inaudible . . .].

P2: Ja, it also does. It also does, because sometimes a patient will, let's say it's an old patient this time, and ask Xhosa people, we we, like I said, the cultures are totally different, us Xhosa to White people. So you you you'll find that White people are, I'm sorry for saying this, [. . . inaudible . . .], so you'll find that White people are more casual and they're free, but when it comes to us, we we have to be that respecting when an old lady, an old Xhosa lady is speaking to a young White psychiatrist. They sometimes feel like, wow this child is just speaking to me, she's just speaking to me, she's not respecting me, she's just throwing words at me. They don't understand that it's not that, its its because we, they raised us a different way than the other cultures.

P10: Age also ja. Old age people because it goes together with respect. You can't talk to an old aged lady about you know penis, vagina. There must be a nice word because the people tell you that hey, ek is 'n grootmens [I am a grownup], you can't speak like that. And who are you to talk to me like that? So, ja, I remember when I started here I was 23 years old.

When asked about the role that age plays in interpreting, quite a few participants spoke about how they think experience plays a role in interpreting. As can be seen below, participants explain how older interpreters (and also trained interpreters) will have more experience and will be better able to communicate with patients.

P1: [Laughter] . . . Well I don't know, but for myself, uhm, I think experience plays a role also, because look an older person has got more experience than a younger person. So that older person will know how to speak to the patient . . .

P3: Ek sal nie sê gereeld nie. Maar daar was al. Veral as hulle weet hoe lank jy nou al werk in die hospital. Ek dink daai tel baie. En hoe goed jy die pasiente ken.

[I would not say often, but it has happened. Especially when they know how long you have been working at the hospital. I think that counts for a lot. And how well you know the patients.]

P4: Ja, age does, because the youngsters are becoming very quickly to become edgy and ah furious. And now the old people, they take their own time [. . . inaudible . . .]. They have got experience on how to do their job, and interpreters who have been maybe trained to do the job, ja, they've got patience also. The youngsters don't have patience . . .

Two of the participants explained that there are certain differences between younger and older people. This reinforces the idea that it is a good idea to match patients and interpreters for age. The one participant explained how older people are more likely to take their time and be patient, whereas younger people are more likely to be impatient. One of the participants also argued that it is easier for them to understand patients closer to their age, as it is easier to relate to them. One participant also explained that older patients are less likely to want to speak to younger interpreters, as they might see them as a "child".

P4: Ja, age does, because the youngsters are becoming very quickly to become edgy and ah furious. And now the old people, they take their own time [. . . inaudible . . .]. They have got experience on how to do their job, and interpreters who have been maybe trained to do the job, ja, they've got patience also. The youngsters don't have patience. They want what they want now, the way they want it. But the old people, even though you can see if you are talking for the patient, the person is not saying what you are saying, or you are trying to make it up, lies to him [. . . inaudible . . .]. I want you to tell me exactly [. . . inaudible . . .].

P7: Ja, it's working working working. Because most of the patients that I've seen is young, from the drugs and I'm also young, so I understand most of the things that they are talking about. We, we living in the same lives, so I can quickly pick up what

they are talking about, but if it's an old woman or an old man, then, eish!, it's kind of getting difficult, because they will say like ancient things. They will talk about ancient stories and all that stuff. But it's not playing a big role, because ah, what the patient is saying, you, it's only that you're gonna convey to the doctor or clinician. So it's just playing a role, because it's, to the to the to the young ones, I mean to the elders and the to the young ones I understand quickly, I can pick up what they are saying, what they are talking about and what is the problem, but then the old one, people, then it's kind of not working, but I am trying.

P3: Die kultuur dink ek is veral tussen ons Swart mense, okay, en hulle wil nie maklik praat met, as hulle, as dit groot mense is ne, gaan hulle nie malkik praat met jou, omdat jy jonger is nie. Want hulle voel dat jy's die kind en hulle is die grootmens...

[The culture, I think, is especially between the Black people, okay, and they don't want to talk easily, if they, if it is grownups, they won't easily talk to you, because you are younger. Because they feel that you are the child and they are the grownup.]

One participant also stated that it can be difficult to interpret for older patients, as they become confused and forgetful.

P2: It does, it does play a role. Because let's say if a patient is very old, they become forgetful and they will, even my grandmother, she would ask me, who are you? But she knows me, I'm her son's daughter. So I think it does play a role, because sometimes they get confused as they are growing older.

Four of the participants indicated that they believe that age does not play a role during interpreting sessions. One participant's answer was a bit vague, it is unclear if they mean that age doesn't play a role or that they have never had to interpret for a patient where there has been a significant age gap.

P6: No ha ah, that doesn't. I don't think that does.

P9: Ok, I think age, I don't think that will be a problem.

5.3.2. The role of culture

There was a unanimous response by participants that culture plays an important role in interpreting. Different cultures have different ways of communicating, showing respect

and have certain practices that might seem odd to people from a different culture. Interpreters are entrusted with the task of effectively communicating not only the words of one person to another, but also having to explain their culture.

Interpreters often don't only share a language with patients, but also a culture. They then have the task of offering emotional support to patients (or in some cases calming them down).

P1: Yes, yes, and it's easier for the patient to calm down also, because at least you talk to the patient in the patient's language, ja.

As has been mentioned, different cultures have different practices, one such practice being the link between culture and gender, and what is acceptable for men and women to share with each other. In accordance with cultural rules, there are certain taboo topics and uncomfortable topics that are difficult to interpret. Interpreters thus have to step outside of their own comfort zone and might have to step outside the 'rules' of a culture to ensure that the patient receives adequate and appropriate care. It can also be uncomfortable for patients to talk about their culture. Different cultures also have different ways of showing respect and have different ways of communicating, as can be seen below.

P1: In our culture men don't talk about sex issues with women and stuff like that or their bodies you know, but if it's an older person, the patient, then I think it will be easy to open up, but if it's a young person they won't want to.

P4: It plays a big role. It plays a big role. Seeing that, ah, if you are a Xhosa person, you know if you are a Xhosa person and if you are whoever, ja, if you are a White person you know the tricks and ways and means, and you know when somebody is lying, even though you are not going to say he is lying, but you are going to give it, the feedback as is. [. . . inaudible . . .]. You give it back as is and then you'll see what you can do with the feedback. Ja, so it's a, ja. Ja.

P7: Not often man, but I'm saying sometimes it do come up and I feel uncomfortable talking about it, but at the end of the day I have to ah, to talk about it, because it's gonna help, it's helpful to the patient.

P7: I mean man, African men, they need to talk about those things and you're not comfortable to do, and you have to talk about it, because I mean the clinicians don't

understand, so I wanted to know the comfortability of those things and allow it to make sense.

P7: It can, because some of the, like on other situations, you have to speak about your culture, because it's about the patient. We're rendering a service, it's like people's principles. So if I'm hiding something's and, like respecting my culture at the end of the day, irrespective of my culture man, at the end of my day the patient is gonna suffer, because I'm hiding some information from the clinician, which is going to be valid information for him or for her to help the patient, so I'm hiding it, of which it's bad.

P11: Because there are words that you can speak to, with a Black person that you won't . . . there are words that you won't address like an elder guy who's Black because there are words that you don't use, words of respect, but now if you do it to the opposite person then you can just say any word because there is no language barrier there.

P13: Because of the patients they do respect their culture and it's not anywhere where they're suppose to talk about their culture and also there's sometimes women and men also. You can't tell a female if you are a female . . . you are a male you can't tell the female what your problem is based on culture.

One of the most prevalent topics that came out of the data when discussing culture, was the role of witchcraft, sangoma's, ancestors and spirits in the Black African culture. It might be difficult for someone who has a different cultural background to understand the importance of this, and the interpreter must then explain these practices to the listener.

P1: Yes it does, because you you would, especially in in in our Black culture, uhm, a person will talk maybe about witchcraft, you know, or witch doctors. Which another person maybe won't understand. So I think if if it is a person that know about those things, it is easier then to talk to the patient and then to talk to the doctor also. Ja

P2: It does, a lot. Because Xhosa people, sometimes there there there are people who who who can get, I'll say its schizophrenia, because they need to do some cultural activities, like maybe to become a sangoma, but they are denying it and running away from it. So I do think that it does play a role, because sometimes you'll find that in the

Eastern Cape, most of the times, when they do accept it and become a sangoma, then everything is fine, they're no longer like that. They are just fine.

P5: Ja. So I think for the interpretation it's a big role, especially in the psych hospital, because sometimes other patients even though they know the language, but some days they know, they can't speak, my ancestors doesn't allow me to speak in a foreign language. Something like that. So they've got all those, ja, things.

P5: The difficulties is most of the time on the patient's side. When the patient does not want to speak and the patient, ah, ja. Most of the time when the patient doesn't want to speak, because there are some patients, they don't want to speak, they say no I won't, I won't speak. Ja. Some they they they they think maybe they are in the [. . . inaudible. . .]. Some they just say no I can't speak because my ancestors tell me not to speak.

P7: Yes man. There was a definition of this, delusions and, ah, what do you call it, delusions and hallucinations, you see. When the, maybe the patient is hearing voices and all that stuff. So it's kind of like difficult to interpret to the doctor what is the patient saying, or what, because the patient will say, he's hearing this now and next thing he's hearing, and you don't know what actually. We, we have that believe in in our African aah, it's an African or, we, actually I would say as a Black African, we have that believe if a patient is having those delusions and hallucinations, it's something like bad spirit, although it's gonna be wrong when I'm interpreting to the doctor. Like if I'm saying, no it's a bad spirit. He or she wants to know exactly what is the patient saying, so that he can proceed with the [. . . inaudible . . .] or whatever, so that he knows what's going on. So I would just say in the [. . . inaudible . . .], no it's just a bad spirit, it's something that is put by someone like a witch or whatever, witchcraft or something like that.

P9: The meanings. Sometimes it helps you a little bit if you because there's this words you can't translate or like in English. Like this stuff of Sangomas and stuff like that because this guys they have that kind and so hearing voices and they will talk the words that don't exist to the dictionary.

P9: You know because most of the time we always talk a lot as cultural thing and then after that the doctor mos don't know what's the culture, you know, most of the

time. Then you will have to explain what's wrong because like for example if the guy is sick or hearing voices we would take that person as he's suppose to be Sangoma you know and to the doctor's side it's other way around you know. So to me it can play a role.

P10: Culture, that was one of the topics there. Culture in this sense for example myself. We don't do those, not believe in it, we don't do that. I grew up not having those cultural things and rituals and other stuff, slaughtering and all that. Say for example my father passed away in 1986 and say for example I've seen my father in my dreams, say for example I'm hungry, now Xhosa people believe that he's hungry. They need to slaughter a cow but he's not going to be a part of the slaughtering or the eating. So eat on behalf of him and whatsoever the ritual is but you know coming to interpreting for me it's difficult because I don't know these things.

P12: ... Sometimes there is a patient, sometimes there's parents who can't understand what is wrong with the patient you see because actually in our religion as Black people most of them when they come here, sometimes we speak to the parents of the patient. You will find out that they don't see that maybe their patient is sick because of a mental disorder. Or they think it's maybe...someone bewitched the doctor or that son or whatever. So by doing that interpretation course so I learned a lot. So I do understand now that there is a need of someone who must interpret to those parents who don't understand what is mental disorder, you see?

As one participant points out, culture can be a big problem. As has been seen above, there are many cultural aspects that need to be explained to clinicians, which furthers complicates mental health interviews, as clinicians might not understand these aspects of the culture. There are also certain words and terms that might not have direct translations from one language (or culture) to another.

P6: Ja, the culture, joh!, the culture is a big problem. Because like, because like hee . . . because there are terms and then the terms that are used, for example in my culture. In other people's culture, those terms are not available and then as an interpreter for example, it's difficult, it's very difficult to find a term to explain. You know, ja.

P5: Ja it's the culture when a . . . It comes out when the patient is saying things like the cultural things, like he's been, if, if I'm interpreting to the female doctor. The

doctor is asking, maybe the illness of the patient, maybe the patient started to be sick while he was a boy and if the doctor asking further questions even while the patient was in the bush, how was he. Then the, some of the patients, they take that as a secret, even if they tell me it was so and so and so, then they say no, don't tell the doctor, because it is a secret. It's where the culture comes.

P7: Oh, because it was something that, kind like happening in the, you know, sometimes when you're interpreting for the client, there's lot of things man that maybe, there's cultural things involved, there such things involved that they don't want to talk about, they not comfortable to talk about . . .

P12: Because maybe if the doctor is still maybe new on the field, maybe he won't understand a different cultures.

Although most of the participants used examples from Black African (or more specifically Xhosa) culture, one participant stated that there are many different cultures that they potentially get in contact with when interpreting. Every culture will have unique ideas of mental health and different practices that interpreters and clinicians have to negotiate.

P10: The Muslim and the whatsoever the Hindu. They've got people from Congo and all those kind of people, there's a lot of things that they don't do that we do and that we do that they don't do so, ja. You need to know about cultures.

As has been illustrated above, culture can have an enormous impact on not only interpreting, but mental health in general. Clinicians and interpreters must be aware of the impact that a person's culture can have on their wellbeing. The most direct way to ensure that a person's cultural beliefs are not lost during the session, is to match interpreter and patient on a cultural level.

5.3.3. The role of gender. There is clearly a strong link between culture and gender, as can be seen above, but gender on its own can also cause difficulties during interpreting sessions. It is therefore also preferable to match interpreters and patients on gender as well, as one of the participant's states below, it is easier for men to interpret for men, and women for women. Issues of respect are also raised by one of the participants, where it might be difficult for a female patient to talk about certain things to a male clinician or interpreter.

P1: It is easier for a man to go and interpret for a guy than a woman going to interpret there. So I think it does play a role.

P3: Dan die ander storie is die vrou wil nie maklik met die manlike dokter gesels nie. Dit gaan oor wedersydse respek tussen hulle. So ons sukkel eintlik daar bietjie, dan is dit goed wanneer hulle 'n vroue vertaler het, om dan aan die manlike dokter te verduidelik.

[Then the other thing is that women don't really want to speak to male doctors easily. It's about mutual respect. We struggle with that a bit, the, it's good when they have a female translator, to explain to the male doctor.]

There are certain topics that make it difficult and uncomfortable for interpreters when having to interpret for someone from a different gender. As can be seen below, sexual or private issues can make it difficult for interpreters to convey what patients are saying and it can become a problem as the patient might choose to not express their feelings, which might hinder the process.

P1: And this issue also about men. In our culture men don't talk about sex issues with women and stuff like that or their bodies you know, but if it's an older person the patient, then I think it will be easy to open up, but if it's a young person they won't want to.

P2: I would say gender plays a role a lot. Especially when it comes to gentleman, because if a gentleman, if you are translating for a gentleman, sometimes there are things that they think it's very difficult to talk to the ladies about and I am the lady, and they don't want to be very transparent on the other things, the deeper things, the more private things, part of their lives. So it does play a role.

P5: Yes. The gender, ah, it does. Because if the patient is a female and the doctor is a man or either if the patient is a man and the doctor is a female, then sometimes it becomes a problem for the patient to express his or her feeling.

P5: It's not specifically to the doctor, like us as interpreters, if I'm interpreting for a, for a female patient, then there are things that the doctor asks that the patient don't feel comfortable to speak out, because I'm a man. Most of the time I have noticed that

even if the doctor is a man, then they don't have a problem to express to the doctor, but when it comes to express to me as a man . . .

P7: That also play a role, because it, it's going back to the cultural things, because I have to talk about maybe, about her private parts or, and then I don't feel comfortable when the patient is maybe talking about her private parts and I'm a male. So it's kind of difficult, in the way of stopping the process, but for the work to be done and for the patient to be helped, I have to talk about it . . .

These taboo or uncomfortable topics can have the consequence that interpreters choose to withhold important information from the clinician. Interpreters might also choose to distance themselves from patients, in order to avoid the effects that interpreting for someone of a different gender might have for their professional life.

P7: Otherwise we will hide the valid information, we will hide the gender things and the cultural things and it's not gonna work, because we keeping the valid information that patient is saying and then we're not saying to the clinician.

P12: You see. Sometimes it is difficult to work with a female patient because of I'm a male so sometimes but we do understand the other patient they are sick but sometimes the management and the doctors seems that they believe too much what the patient said. So it is difficult for us to work in that female ward because sometimes they accuse us you see of maybe sexual harassment something like that. So to avoid all things you must keep yourself distant from the female patients so there is not a problem.

Only four of the 13 participants stated that they don't believe that gender has an effect on interpreting sessions.

P4: Gender probably isn't a problem. Gender isn't a problem, it might be a woman, it might be a man, but if you want what you want, I'll give it to you if you want it. Especially when its work related.

P6: I don't think that . . . I don't think that is a problem.

5.4. Theme 3: Views on interpreting

This theme is concerned with the participants' views on interpreting. The first part of the theme has to do with the participants acting as ad hoc interpreting. The next part focuses on the need for interpreters and how acting as interpreters has affected the participant's official duties. The last part of this theme will look at participant's views on the role of interpreters, issues and difficulties with interpreting, the importance of interpreting and lastly different style of interpreting.

5.4.1. Acting as an ad hoc interpreter. Although interpreting is not part of the majority of the participants' official duties, they have been asked to act as ad hoc interpreters, with varying degrees of frequency. Two of the participants indicated that ad hoc interpreting is part of their duties.

SH: Uhm and have you ever been asked to act as an unofficial interpreter?

P5: No, mmm, it was in my scope of work. When we applied for the post, then it was . . .

SH: Okay, so it's part of your . . .

P5: It's part of my duties yes.

SH: Was interpreting or is it part of your duties? Official duties?

P13: Yes that's what they told us it is part of your job.

Two of the participants indicated that they had never acted as an ad hoc interpreter, as can be seen below. They could therefore not comment on all of the topics and questions listed in the interview schedule.

SH: Ok, ok. And have you been asked to act as an interpreter on occasions?

P11: Never.

SH: And for how long have you been doing interpreting here at the Hospital?

P12: No I never do it but I was just interested. I just went to the course but I never do it.

Although acting as interpreters is not part of 11 of the participant's official duties, they have been asked to act as interpreters on several occasions.

SH: Okay, uhm, and have you ever been asked to act as an interpreter?

P1: Yes, several times. At the time we didn't have any interpreters . . .

SH: Have you ever been asked to act as an unofficial interpreter?

P4: Yes, we are unofficial interpreters. We just help out where it's needed, ja. Just like I'm working in the [. . . inaudible . . .] area, so there's lots of guys that doesn't understand how to speak English, so we need to interpret for them. So, big help here also.

SH: Okay. And have you ever been asked to act as an unofficial interpreter?

P7: As an interpreter, yes. Maybe occasions where I have been interpreting, ja . . .

SH: Okay. How often would you say do you interpret?

P5: Uhhh . . . When I started it was almost every day. I can say, at least four, four days a week.

One participant indicated that they were asked to interpret four to five times a week. It is clear that even though interpreting is not in their scope of duties, they still had a vital role to play to ensure that communication can take place between patient and clinician.

5.4.2. The need for interpreters. The data reveal that the participants realise that there is a language barrier and a big need for interpreters. The extra burden of interpreting is time consuming and has an effect on their official duties, as they are often called away to interpret without prior arrangements. The fact that there is sometimes nobody else to help out as an interpreter means that the participants had no choice but to leave their duties and help out where needed, because without their help, patients would not have had access to health care.

As can be seen below, participants identify that there is a need for interpreters (due to the language barrier), especially with regards to Black African patients. Sometimes it is just a fortunate coincidence that somebody is available to interpret for a patient. It is important that

patients receive adequate health care, but without the help of ad hoc interpreters, this is not always possible.

P1: Yes, several times. At the time we didn't have any interpreters. We had a big problem with our Black patients who couldn't speak English or Afrikaans. So fortunately I could speak the three languages. So they normally used me to interpret until such time that we got interpreters.

P1: Just yesterday there was a call and fortunately I was at the office and I picked up the phone and this person was a mother of one of the patients and she wanted to know if the child is here. I said yes and she was so glad, she wanted to know do you speak Xhosa and I said yes I speak Xhosa. She said I'm so glad, because it would have been difficult for me to express myself. Now see, that is why I say if a family member needs an interpreter sometimes.

P7: As an interpreter, yes. Maybe occasions where I have been interpreting ja, for occasions maybe like in our case normally if there is an African, an African patient that don't know how to speak English or don't know how to speak Afrikaans then I can, always interpreting for them, for the doctor you know. Then maybe there are problems, but we're trying to render the service. The patients must get the treatment.

P8: Then I find that, then I come across, that's, that lady couldn't explain what was wrong with the patient, with their patient. Then I just explain to the doctors. I said doctor sorry to interrupt but now they . . . I don't understand the Xhosa so now I'm trying to translate from English and say this and this.

P13: And because in Western Cape there we don't have . . . we've got the right people speaking Sesotho and all the other languages. There was supposed to be interpreters that speak Xhosa . . . at least all the languages, English, Afrikaans, Xhosa, Sotho because we do get a lot of Sotho speaking patients.

P3: Gelukkig is hier een of twee van die staff wat daai tale verstaan. So dan vergemaklik dit bietjie die storie. Maar as daai mense nie aan diens is nie, is dit verby.

[Luckily there are one or two of the staff that understands those languages. That makes the story a bit easier. But if those people are not on duty, it's done.]

The participants are asked to act as ad hoc interpreters as there is nobody else to fulfil this role. Without the help of ad hoc interpreters, clinicians would not be able to continue with interviews, which puts these patients at a disadvantage. It is problematic to note that people are asked to interpret merely because it is convenient. It is impossible to guarantee that patients receive adequate care, as the interpreter was merely used because it is convenient, with no assurance of their proficiency in fulfilling this role.

P5: Ja, uhm, I think it is a big role, because most of the patients that are coming from, to the hospital, not most, some of the patients, they don't understand uhm uhm uhm the language that the doctor is using. So for them it's very difficult, because uhm even when they are speaking and the doctor don't understand. Ja, then sometimes it becomes disadvantage for them.

P6: I was just doing it for the sake of, because of the, nobody to do it.

P7: It's also about the patients, but now in order for him to proceed, I must interpret for him, but luckily now we do have the interpreters now, just started, he just started.

P10: So I was now the convenient partner in this and I was being called here and there because next door was also a patient and I'm speaking three, four languages.

P10: Then I came. I wasn't call to come and interpret. I went out of my own because the patient was crying and saying speaking to herself saying she's not coming . . . she can't waist money all the time and then I asked her what was the problem then she explained to me. So I stood up going through to the nurse. I didn't come and say listen here I'm a nurse. I just said what is the problem can I help and then they said to me please can you please explain to her it is not her date today.

P13: And I feel like they are just using us because they were supposed to hire interpreters.

The main concern when using ad hoc interpreters is that patients receive adequate and timely health care, but when staff is called in to interpret, this affects their official duties. Interpreting is a very time consuming process and the participants are expected to stop what they are doing to assist with interpretation.

P1: Uhm . . . I think it was just time consuming, because then I had to leave my work and go and interpret for whoever and sometimes it wasn't for a long time, it depended

on the patient and what the doctor needed to know from the patient, but uh uh it was time consuming, ja.

SH: Okay. And did this role of interpreter effect your other duties?

P2: Yeah, sometimes, but not always. Because I was sometimes busy, if I'm very busy, concentrating on my work and then there is a patient and I need to stop, because the patient, uhm, I must be there immediately, because the doctor sees the patient now and then I must stop my work and go there. It was, it did not effect it that much.

P3: Dit gebeur, want jy's besig met die pasient en dan roep die dokter vir jou en hy vra gou gou vir jou om hom te help. Want miskien verstaan hy nie die pasient reg nie of die pasient wil nie met die dokter praat nie.

[It happens, because you are busy with the patient and then the doctor calls you and asks you to quickly help him. Because maybe he doesn't understand the patient or the patient doesn't want to speak to the doctor.]

P6: Ja, it did affect my other duties, because sometimes I'm busy with something else and then the doctor needs me at that particular time, because there's a patient that needs to be attended to. So, ja it did.

P7: Aaah, it doesn't. It interferes when, when, if I'm busy, you know. Like on Thursdays we have the clinic and if I'm busy, and then the doctor is seeing his client and he needs the interpreter there, then I have to leave what I was doing, go to him and and help him. And now it does, the job that I was doing, then it must be on hold, of which it is also important you see.

P9: Uhm, obviously it will interfere because it's during the working time.

SH: Ok, and does this interfere with your other duties when you have to interpret?

P10: So I had to leave my duties here to go run over to that side and, ja. So it does interfere a lot.

5.4.3. Role and importance of interpreting. Participants realise that the role of an interpreter is an important one and that they are helping the clinician and patient. Interpreters have an important contribution to make sure patients are treated quicker and more effectively.

P4: Uhm, . . . I'd say it's helpful to, to have me in the department as an interpreter, even though I'm not getting paid for it, but it's helpful. Coz I'm being used on things that they need me and ah ah ah I don't say, it's not, eeh, it's not part of work, because it's not my work, ja, as a OT.

P7: It's working well otherwise if I was not there, or I wasn't interpreting. Then the patient will suffer, you see. So my role is very important to interpret. It's a big role man, it's a big role, otherwise the doctor won't know anything. It's different language, he won't understand what the patient is trying, or whatever or who's accompanying the patient is trying to say. So the role of me interpreting, it's actually helping the patient, it's helping the doctor, it's helping everyone.

P9: As interpreter you, most of the guys they didn't go to school. So now you have the person who don't know the language to communicate nicely with the other one, like the doctor and the patient and at the same time the patient like he must be like well because he's sick mos. So he must be well but if you explain nicely to the doctor he will get the right medication, right help and everything you see. So that is why I think it was helping a little bit.

P3: Okay. Dis, dis okay. Ons help eintlik die pasient om gouer te herstel, sy medikasie kan aangepas word, behandeling en alles rondom die pasient se siekte . . . en die pasient se verblyf in die hospital kan iewat verkort word.

[Okay, it's okay. We are actually helping the patient to recover sooner, their medication can be adjusted, treatment and everything that has to do with the patient . . . and the patient's stay in the hospital can be shortened a bit.]

When asking one of the participants how they perceive their role as an interpreter, they seemed more concerned about how interpreting can help improve their own language ability.

P10: Because it also improves my Xhosa because in our institution it's more Afrikaans here. So in that way it improves my Xhosa and there's also words when I sometimes can't, I don't understand then I will ask what is the meaning of that to the Xhosa person. So in that way I also gain more in my Xhosa. My Xhosa is improving. It depends on whatever language, whatever language that is being posed a lot and I like to do that because what I noticed about interpreting it's never been done the way

it should be, for example with the Doctor and the patient. The Doctor asked me about, the patient was like saying something else. When the Doctor asked the patient was like saying something else when the Doctor asked the question. Ask her where is she feeling pain. Then she was like here and I wanted to know where. She said Isusu and I said talk to me your stomach she said here.

Apart from ensuring that communication can take place, ad hoc interpreters also often provide emotional support to patients. Due to the fact that the interpreter and the patient share a common language, they must keep the patient calm. One participant refers to the patients as her children, and says that the patients are like brothers and sisters.

P1: I had to speak to her with my language and try and calm her, because uh uh even if the doctor could have done it, she wouldn't have understood, so I took that role of calming her down by talking to her. I wanted to know what the problem was and she said she just want to go home. For me that was bad, because that was the first time that I came across a person who reacts that way, you know, ja. I think that is the only bad experience.

P1: Yes yes and it's easier for the patient to calm down also, because at least you talk to the patient in the patient's language, ja.

P7: No, if the patient is aggressive, you'll always mos try to calm him down the patient, try to explain why you are doing that, why are you asking those questions. Make him comfortable or make her comfortable, that he can calm down, he understands you, be on his level or her level then you get what you want.

P8: Like I would say all the patients are taken like mine, my children. So for if this one is doing this to this one then I'll say no man you are here. You are like brothers and sisters, you mustn't act like this to one another, act like just like ordinary children and all that.

P9: No, like to the patient most of the time you must be soft. If you're soft obvious then his tone will go down a little bit but if you're up then you will have a problem you know.

Apart from providing emotional support to patients, interpreters also believe that they must provide emotional support to family members of the patients, as illustrated below.

P12: I think I would be helpful to the parents because as far as I see there's a need of interpreting you see. Just to make sure they understand what is wrong to the patient because since I'm working here in ward 4 we are working with a mental illness patient. So when they get discharged you see there's a lot of changes but they come back within a few weeks, so I think there is something wrong that the parents did not do right at home.

5.4.4. Issues and difficulties with interpreting. There are numerous difficulties and issues that arise within interpreter-mediated sessions, as will be illustrated in the next section. The most prevalent and biggest concern with making use of ad hoc interpreters is the language barrier. Due to there being 11 official languages in South Africa, health care institutions are faced with the difficult task of providing care for patients who speak a variety of different languages. One participant points out that although, in the Western Cape for example, there are people that speak the language of participants, there are no interpreters available to help with communication.

P7: ...but it would be bad if the doctor don't get what I'm saying, don't get the message that I'm giving to him or her. So it, it would feel bad, because at the end of the day that patient would end up suffering, so it would feel bad.

P7: As an interpreter, yes. Maybe occasions where I have been interpreting, ja, for occasions maybe like in our case normally if there is an African, an African patient that don't know how to speak English or don't know how to speak Afrikaans then I can, always interpreting for them, for the doctor you know. Then maybe there are problems, but we're trying to render the service. The patients must get the treatment.

P10: Then she said to me, but they said, and they said but we said, and then the nurse actually admitted that it's either we don't understand each other. Then I said but if you know that patient is not understanding you why don't you get somebody because the patient was complaining that she came now all the way and every time she comes from Khayelitsha she must get money to get there because she was unemployed and she was crying.

One of the participants pointed out that although an interpreter and patient might speak the same language, they also have to contend with different dialects.

P8: It is sometimes because like I said I know Xhosa but there's some now, they will take, speak a deep Xhosa that I don't understand, what now they said . . .

Even if effective communication can take place between interpreter and patient, it can be difficult for interpreters to convey the message to the clinician, as languages are not directly interchangeable. There are certain words in Xhosa that cannot be translated directly into English.

P1: Yes, look, in English a word may be short but in Xhosa it will be a long word like a sentence. So it's up to you as interpreter to minimise it as much as possible.

P4: Yes. Sometimes you ah ah ah there are Xhosa words that you find it difficult to interpret, because they are very deep and now sometimes the words just flush away to interpret, to to convey it back to the doctor. So, you just try and give it back. The Afrikaans words sometimes, bombastic words.

P6: Ja, the culture, joh!, the culture is a big problem. Because like, because like, hee . . . because there are terms and then the terms that are used, for example in my culture. In other people's culture, those terms are not available and then as an interpreter for example, it's difficult, it's very difficult to find a term to explain. You know, ja.

P9: The meanings. Sometimes it helps you a little bit if you because there's this words you can't translate or like in English. Like this stuff of Sangomas and stuff like that because this guys they have that kind and so hearing voices and they will talk the words that don't exist to the dictionary.

P9: No, like you explain to the doctor if the language the word, you don't have the dinges, the meaning but you soema go to someone else and ask the word and the meaning of the word because this Sangoma language and so there's stuff we don't understand at all but the only thing I do is just explain to the doctor and then ask someone else whether he can help me with the word.

P10: It was not a nice experience because it's difficult when you get a pure Xhosa person whereby you then you know in English there's a few words in English that you can't explain in Xhosa. You don't have a specific word for that Xhosa, Xhosa word for that English difficult word.

P10: Because we tell her that we did this with the right artery and I mean in Xhosa there's no words for that and that person you can see she never went to school . . .

Due to the difficult nature of interpreting, it can leave the interpreters feeling helpless and defeated. The extra burden of interpreting can also be very stressful, as illustrated below.

P1: Ja, but you don't understand you see. You as an interpreter yourself don't understand, you are useless.

P2: So it was like. I, I actually felt like a fool when the doctor looked at me like, it was like him saying I don't know what I'm doing. So I felt like, well I don't think I'm worthy of this.

P4: So it was difficult and the doctor become so frustrated also and he was edgy. What are you saying to this patient? Do you say what I am saying to you now to this patient? Are you saying the same thing? Or are you just changing the story now, ja, so that it can suit you? And now I become disappointed.

P10: So it then becomes also difficult to explain that's actually stressful because in Hospital B there was a patient whose heart was on the right side. It's a child and the mother that time she was also from the rural areas and I'm telling you the Doctor tried to explain and the Doctor was actually getting stressed because I can't explain to the patient and I want her to so much understand and she was just saying yes, yes, yes and I said to Doctor, no auntie's not understanding, she don't understand what we're explaining.

As illustrated below, these feelings of helplessness and feeling defeated are compounded by clinicians getting frustrated and irritated by interpreters; and by patients that undermine the interpreters.

P10: They don't do anything. They get irritated sometimes, that's what I've noticed that they're irritated, they're not patient enough because they just want to get it done, the job done and go to the next person.

P1: Ja I understand their frustration of not having the Xhosa interpreters there but they need to ask in a nice way to make that person also feel valuable.

P13: Sometimes, ok, the other difficulties you'll get that the patient doesn't like . . . how can I put it? The patient undermines you as an interpreter and she doesn't want to talk to you. She only wants to talk to the doctors.

Interpreting can be a very emotional experience for ad hoc interpreters. They do not necessarily have the training or professional support structures to deal with the emotional content that may come up during mental health interviews. Furthermore, as participants indicated, patients can also play on the interpreter's emotions. Feeling helpless and defeated also contributes to the emotional impact that interpreting can have on ad hoc interpreters.

P1: Uh, ja. You see the thing is, when you, when you interpret, it's very difficult in a psychiatric situation, because the patient sometimes, uhm uhm, they play on your feelings, you know.

SH: Okay, uhm, thinking back as your experience as an interpreter, what kind of difficulties did you face?

P1: As I said, language is the first one and secondly, uhm, I found out that if you interpret for a person, as I said to you, the patients can sometimes play on your feelings, don't take it too hard. Ja, because at the end of the day you will be just as emotional as as the patient. And I, I, what I also feel is that not only the patients need interpreters.

P7: Actually they do, yes, because sometimes you feel sensitive or maybe it's a bad thing. Like like the history of the patient, maybe the patient wasn't born like that and maybe he got accident and terrible accidents, maybe he got accidents like three times or five times so he end up, and he was doing well and he was a clever, all that history. When the patient also explaining that, you also feel sensitive, you feel sad and all that, ja, emotional ah involvement of the patients. So sometimes you get to the way and they do ask what do you feel about this. They do ja, we're working, we're working well with the clinician sometimes you know.

P10: So that disturbed me because you know when you say sorry to a person you must at least . . . your face, your facial expression must show but they were like they just wanted to get done.

The participants are not necessarily trained in the field of mental health or interpreting, which also make the medical terminology difficult for them to understand and interpret.

P2: Ja, because I'm just an interpreter, I'm just a clerk. So I don't know the psychiatry part of it, I just know the accounts. So if they can just explain that this one is, is, has got such a sickness and then I will differentiate between those sicknesses.

One of the most prevalent difficulties that came out of the data is that the participant found it difficult to interpret when the patients are not talking sense. It is also difficult for interpreters to explain to clinicians that patients are not talking sense. This results in the interpreters leaving out things that patients said when interpreting it to the clinician, which undermines effective communication, as the clinician does not hear the full account of what the patient is trying to communicate. This can have a negative impact on the diagnoses and treatment of patients.

P2: The other difficulty is I, I, experience actually is the patients' side. Because the patient will actually, sometimes the patient will...they, the doctors will think that the patient is speaking Xhosa, but when you are with the patient and listening, you try to listen, but you just don't understand this language also. But it does sound like Xhosa and the patient will sometimes throw a Xhosa word, but it's a totally different language that you've never heard of. Ja, that's the difficulty. And when you explain it to the doctor, they will look at you like, oh ah ah. This one, ah ah.

P2: I try to explain to the doctor that I do not understand this language and its definitely not Xhosa, because if it was Xhosa, I would understand it, but he does throw some Xhosa words here and there, but it's a confusing language, a weird language.

P3: Ja, ek gaan kommunikeer met die pasient, maar somtyds weerhou ons van die goed wat die pasient sê van die dokter. Dit is wat gebeur, veral as dit klink of die pasient nonsens praat

[Yes, I go and communicate with the patient, but sometimes we withheld some of the things that the patients say from the doctor. That is what happens, especially if it seems as if the patient is speaking nonsense.]

P4: There was one. Also in ward 20. Ja, where the doctor was telling me to say something to the patient and I say something to the patient, but now the patient didn't aaah, didn't answer me the way the doctor wants me to do it. Ja, he just [. . . inaudible . . .] before he comes to the answer, ja and he go, ja, because he was sick. So now, that is why I say, I tried to explain to the doctor now as if I was a patient. When I listen to this patient I say, what are you saying? I was speaking in Xhosa then and he spoke back to me in Xhosa, but then I found out that even in Xhosa he was not in the content, ja, where the doctor and I want him to, ja, to respond.

P5: Like a, some of the patients they don't want to speak, some they come up to a point where they say, no why are you asking me all these questions. But there are patients who just, if the doctor ask a question then they respond to that question, even if they respond things that doesn't make sense, but as long as they respond it is easier for you.

P6: Difficulties, mmm, difficulties. It's when the patient is not making any kind of sense, any sense, is not talking anything like, even if, even if the patient is speaking my language, but I can't even hear what the patient is saying. And now the doctor is expecting me to now, to to give the feedback from that nonsense. That is like pure nonsense, I can't even explain what it is.

P8: Oh no, there's lots that are speaking and you get confused. But now at the same time shame they don't like what . . . what is it, they don't understand then why are they not like us, so you speaking.

P10: Because I can't interpret what the patient is saying. Maybe that's not what he or she expected to hear because I can't interpret something that the patient is not . . . when the Doctor ask me ask her where is her mother for example, then the patient answers something else. I can't interpret that. I just tell the Doctor she's not making sense now because I can understand what she's saying. She would say maybe tell me something or say something that is not related to the question. Now the Doctor wants me to interpret that and she'll interpret that in English. There's no interpreting for that.

Patients might try to bridge the language barrier with the limited language ability that they have, even though an ad hoc interpreter is available to them.

P2: Ja, there was a lady. It was an old lady actually and she was speaking Xhosa, but as we speak, she began to speak just a little bit of English and if you listen to that English, no it's not exactly what the doctor wants . . .

Another major difficulty for interpreters that is very prevalent in the data is when patients might not have the necessary insight into why they are at the hospital and why the clinician is asking them so many questions. This can lead to patients not wishing to communicate with the clinician and/or interpreter. Patients that refuse to talk to clinicians can be due to numerous factors, as illustrated below, where patients believe that the clinician/interpreter just wants to keep them there or they wish not to speak due to cultural reasons.

P3: Ja, hy's baie psychotic, hy's nog nie op die regte behandeling nie. Dan is dit moeilik, want dan dink die pasient somtyds dat jy die oorsaak is van hom, of jy wil hom nou net hier hou, omdat jy hom hier belang, maar hy wil nie hier wees nie, want hy't nie insig oor sy siekte nie.

[Yes, he's very psychotic, he's not on the correct medication yet. Then it is difficult, because then sometimes the patient think that you are the cause of him, or you just want to keep him there, because you (. . . inaudible . . .), but he does not want to be here, because he doesn't have insight into his illness.]

P3: Ja, ek sal sê die pasient praat nie alles nie, hy maak nie oop nie.

[Yes, I would say the patient doesn't tell you everything, they don't open up.]

P5: The difficulties is most of the time on the patient's side. When the patient does not want to speak and the patient ah, ja. Most of the time when the patient doesn't want to speak, because there are some patients, they don't want to speak, they say no I won't, I won't speak. Ja. Some they they they they think maybe they are in the [. . . inaudible . . .]. Some they just say no I can't speak because my ancestors tell me not to speak.

P5: Ja, a bad interpretation when the patient doesn't want to speak, or the patient becomes aggressive. He doesn't see any reason why the doctors are asking him a lot of questions. He's got that feeling that he's not sick.

P7: Oh, man no. You can have the obstacles, is maybe, the patients don't know what to tell you exactly what, what is like, maybe if the patient is doing some things, breaking windows, but he actually don't want to tell you and you have to dig all that information to him and it's kind of really difficult to convince him to explain what is wrong with him or what is wrong with her.

P12: It can be difficult sometimes when the patient is not talking not taking part you see maybe if you are not working close to that patient then it can be difficult to understand the patient.

P13: Well when the patient doesn't want to talk and cries and comes with stories and that I can't interpret.

Participants also indicated that patients will sometimes not be co-operative or the attitude of the patient and/or clinician can hinder interpreter-mediated sessions. The use of interpreting is not sufficiently embedded into the health care system, which can cause difficulties with regards to people's attitudes towards interpreters. Patients can also act aggressively towards interpreters.

P6: Because the other problem they were having, the people that are working here is that, the people that the people that are working here in the hospital, they don't really care about this interpreting thing. I mean now I'm talking about the other people, like the nursing staff, the clerks, let alone the doctors, because the doctors are the only people who are willing to have this bonding with the interpreters, but then the other people, they don't see this need of interpreting.

P10: It depends on the patient. It just depends on the patient because some patients they're not co-operative. Especially our intellectual disabled patients. You can't expect them to be what you want but then it's difficult to interpret for a person like that.

P10: And they didn't care about her explaining that she was told to come that day. They didn't bother to ask her who told you or can you give us a name so that they can do a follow up. People just don't care. They didn't care . . .

P7: Difficulties. Yeah okay. We're working with psycho, ah, psycho patients, so like if they, they acting or if they aggressive and all that stuff and you know to the, you

you you speaking to them, then he's aggressive and the you you you understand him in his language and he understand your language, then he get aggressive to you, then it's now difficult for you to explain it to the doctor you know, because it's so sensitive to him as a patient and to you, and he's angry and all that stuff, he wants to beat you ...

Due to the various difficulties and issues associated with the use of interpreters in the mental health setting, patients might not receive adequate care, which can lead to patients having more hospital visits, as illustrated below.

P12: Because you can see when the patient is coming back he's back to square one but when the patient is here in just a week then you can, there's a difference.

Lastly, due to the nature of ad hoc interpreting, it is impossible to judge the accuracy of interpretations, as neither clinician nor patient understands the language used when their message is conveyed to the intended hearer.

P2: And I was like, okay I am, but how does he know I'm not, because the last time I, I, I, he only understands English, but how does he know that I'm not interpreting exactly what he is saying. Ja ,ja.

5.4.5. Style of interpreting. The participants indicated that they use three types of interpreting. Interpreting word for word exactly, changing the words, but conveying the same message and lastly a combination of the two, starting with word for word interpretation, but switching over to changing the words and explaining the intended message.

Four of the 13 participants indicated that they interpret word for word. One participant stated that they try and stop the patient to interpret what they have said. Another participant stated that they learned during the in-service training course that they have to interpret word for word.

P7: You ah, I have to listen to the patient, because as I said, we're working with psycho patients. They just talk nonstop and then I just have to listen carefully what they are saying, then I'll try to stop him, now stop, then I can recall what he was saying, then I can explain word to word to the clinician what is he saying.

SH: And when you interpret, do you do it word for word exactly or do you change the words a bit so the meaning stays the same?

P9: That's where I learn to the course.

SH: Ja.

P9: Because it must be word to word. Not the word the other way around you see, like to make it sound nicely.

P10: I try to interpret word to word. That's what I'm saying. I've noticed when other people interpret they don't interpret exactly . . .

P11: It's better if you do it word for word so that the person that you're referring to, that you're interpreting for then can understand what is the problem with that person.

SH: Ok.

P11: Because now if you going to change it then the person won't understand.

Six of the participants indicated that they might change the exact words a bit, as long as the intended meaning still stays the same. This could be due to the fact that languages are not directly interchangeable or because they feel as if what the patient says does not make sense, so they try to convey it in such a way that it makes sense to the clinician. One participant stated that they used to change the words a bit, but that they learned in the in-service training course that they should interpret word for word.

P2: Ja, I just, I try the doctor and the patient understand, not word for word, because sometimes if you speak Xhosa and you try to interpret word for word. It might say something totally different in English. You see? And vice versa. So that's why I try to listen and then interpret what I'm hearing from the patient to the doctor.

P4: We use to do it like the way you think that the patient is saying, but as I learned at the interpreting course now, ah, you find that the clinicians they want us to say word to word the way the patient is saying it to you, you relay back to the clinician the way the patient is saying, even if the patient is swearing, you mustn't try to make it nice. You say he says this now.

P5: Uhm . . . I do. It's not like I'm uhm . . . interpreting word to word. Uhm, I'm interpreting in a way that the doctor can understand what the patient is saying.

P5: Yes, but even if I'm changing the words I might say exactly what the patient is saying, even if I am not saying word to word, but it must be exactly the same what the patient is saying. So that the doctor if the patient is, if the patient is saying something that doesn't make sense. So I must say exactly, even if I won't gonna say it word to word, but the doctor must understand what the patient is saying.

P6: You cannot interpret word to word. You must find a way, you must do it your own way. In fact, it must be in the same route as what the the the person was speaking.

P8: Look I know I don't, I don't change, I do change it a bit. Because sometimes it's what they say is, is useless. It's ineffective. So then I must try to explain to the doctor that its goes like this.

SH: Ja, and if you would interpret for a patient would you do it word for word exactly or would you change it a bit but the meaning stays the same?

P12: You can change it as long as the meaning is the same.

Three of the participants stated that they would start off doing word for word interpretation, but would then switch over to rather trying to convey the correct message, even if they have to adjust the words a bit. They indicated that they would move away from word for word interpreting if the patient does not understand the message that the clinician is attempting to convey.

P1: No, what I normally do, I interpret word for word and then if I can see that that a the patient doesn't understand properly, then I try, I don't change what the doctor has said, but I try to make it as easy as possible for the person to understand what the doctor is saying, yes.

P3: In die eerste plek doen jy dit word vir woord. Daarna as dit lyk as die pasient nie verstaan nie, dan maak jy dit makliker en eenvoudiger.

[In the beginning you do it word for word. After that if it seems as if the patient doesn't understand, then you make it easier and more simple.]

P13: Ok I do word for word what the doctor tells me everything. Only when the patient doesn't understand I need to go . . .

SH: Ok.

P13: to a other word.

5.5. Theme 4: Willingness to act as ad hoc interpreters

The majority of participants indicated that they had no previous experience as interpreters (before interpreting at their current place of work). There was however a willingness to learn and act as ad hoc interpreters. There are numerous participants that stated that they can communicate in a variety of different languages, and if they receive more formal training, they can be helpful as ad hoc interpreters in the mental health setting.

Two of the participants indicated that they had previous experience of interpreting, one helped out as an interpreter for a private company and the other had their first experience of interpreting when they were still at school.

P1: Aah, ja. I did interpreting for, it was a private company, unfortunately I can't remember their name now. They used me to interpret for, for workers who had issues with the company. Then I interpreted for those workers who couldn't speak English or Afrikaans.

SH: So before you came to the Hospital you actually had some previous experience?

P10: I was still a student at school.

The majority of participants (11 out of the 13) had no prior experience of interpreting before they acted as ad hoc interpreters at their current place of work. When asked the question whether they had any previous experience of interpreting before their employment at their current place of work, they replied as follows:

P5: No, no, it was my first time.

P7: Not at all, not at all. It was actually my first time to interpret for the clinicians here.

P9: No, no previous experience.

P11: No.

Even though the majority of participants had no prior experience of interpreting, they have acted as ad hoc interpreters at their current place of work for quite some time, stretching from a few months to 25 years.

P1: Uhm, I started working 2005 at Hospital C and the very same year I started interpreting and until last year.

P2: At Hospital C I think it was only . . . uhm . . . a few months. Ja, it was a few months, it was not something very formal that I signed for and everything. They just called me for interpreting.

P3: Uhm, ek werk nou al so 25 jaar by die hospital, maar ek kan nie presies sê nie. Dit gebeur nie op 'n gereelde basis nie okay. Maar so tussenin.

[Uhm, I've been working at the hospital for 25 years, but I can't say exactly. It does not happen on regular basis. Only now and again.]

P4: Ah, for many years. Plus minus eight years, ten to eight years.

P5: It's the . . . fourth year now.

P6: About 3 years, about 3 years.

P7: Aah, I got here just, I'm not doing the interpreting, ag, like occasionally. It's sometimes that when we receive that client so I can say, basically for two years man. Or for as long as I've been working here. If there's a client that came, then I interpret.

SH: Ok, and tell me, Sir, how long did you do interpreting?

P9: 2007. Because I start 2007, then now in 2011.

P13: It's five years now. I started working here in 2007.

When asked about what languages the participants can speak, eight of the participants indicated that they can speak three or more languages, unfortunately it is impossible to assess their fluency in the different languages. It was also interesting to note that two of the participants stated that they can only speak one language (Xhosa), even though the interviews took place in English and they interpret between English and Xhosa.

P1: I speak Xhosa. I speak English. I speak Afrikaans. I'm not very fluent in Sesotho, but I understand if a person speaks in Sotho, and I speak Zulu.

P2: Afrikaans, I do understand, but I can't fluently speak Afrikaans. English I'm fluent. Xhosa is my home language. And then Sesotho and Zulu.

P3: Ek is net Engels en Afrikaans.

[I am only English and Afrikaans.]

P4: I'd say Xhosa, I'm fluent in it. English, I speak it, it's my second language and Afrikaans, I know a little bit of it.

P5: The language that I speak is Xhosa, ja, I do understand Zulu as well. So if any patient is speaking Zulu then I can interpret. But most of the time it's Xhosa.

P6: The languages that I speak, it's only Xhosa, Zulu, English. Ja, it's only those.

P7: Okay, I'm speaking Xhosa, I'm fluent on it and it's my first language. And I speak English, I'm fluent on it and then I understand Afrikaans, I'm not fluent on it, ha ha, I speak basic Afrikaans [laughter]. Then I understand the other language like Sotho and Zulu, because they are kind of similar to the language that know, so I understand those languages as well. So I can easily interpret if they also don't understand.

P8: I speak English and Afrikaans. Part of Afrikaans and Xhosa.

P9: Xhosa.

P10: Afrikaans, Xhosa, English, Zulu and Xhosa is more or less the same. So I can speak Zulu and I can understand Zulu. So I would love to learn the other languages but I can hear them, a few words, I understand a few words of Setswana and Sotho.

P11: Xhosa and English.

P12: I speak Xhosa.

P13: My language is Xhosa and Afrikaans and English.

Quite a few of the participants indicated that they are interested in interpreting and they have a willingness to learn. They realise the importance of interpreting and would like to be helpful.

P2: How do I see myself as an . . . I actually enjoy interpreting actually. I think it's important, I think I'm playing an important role. Ja, because obviously I'm helping my department and I'm helping the patient. So I think my role as an interpreter is important. It is important.

P4: Uhm . . . I'd say it's helpful to, to have me in the department as an interpreter, even though I'm not getting paid for it, but it's helpful . . .

P5: Uhm, since we were invited uh to our supervisors uh and uh I was I was interested to go there so that I can get more information about how to conduct a interpretation . . .

P7: So I wanted actually to know more about this interpreting thing, because I was doing it, even though I'm not doing it often, I'm doing it. So I wanted to know the procedures and all the stuff, how to interpret, how if, if there's sensitive stuff.

SH: Ja, well if you think about your role as interpreter?

P10: I love to do that.

P12: No, unless I'm just interested to do more on interpreting so that I can understand it because I really like it.

One participant stated that they use to be interested in interpreting, but they have since lost this interest due to the attitude towards interpreting in the department he works at. He states that the department is not really interested in interpreting.

P6: Often I was interpreting and the doctors were very fond of me, because I was kind of the first person to interpret. The doctors were so, because that time I was so interested in doing that. But then uh uh, I'm not interested, because it's because of the way that they handle it. Because there are new people now working, the new people know there's a guy interpreting here and they are the ones who ah [. . . inaudible . . .]. But then, I'm not interested, because it's not the way that I thought it should be. In terms of, I mean the department doesn't really care about this interpreting thing, the

way in which people must be trained and that is why I'm not interested in this whole thing. Because of the way the department handled it, ja, they don't really worry about it so much.

P6: The thing is, I am not interested in this interpreting thing that is why I don't have proper answers.

5.6. Theme 5: The effectiveness of the in-service training course, subsequent interpreting sessions and interest in more formal training.

5.6.1. Why the participants attended the training course. Five of the participants stated that they were selected or asked to attend the training course, while the rest of the participants attended the training because they are interested in interpreting and want more knowledge in order to improve the interpreter-mediated sessions that they are involved in. As can be seen below, five of the participants were nominated to attend the training.

P3: Okay, ek was genomineer gewees en gestuur gewees deur nursing admin.

[Okay, I was nominated and sent by nursing admin.]

P6: It was not like kind of my decision. I mean like, since we've been asked to do so, we didn't disagree, we just attended, because we've been asked to do so.

P9: No, like my supervisor told me your name is selected to the, to that interpreting course.

P10: I didn't decide, I was just nominated to do it.

P13: No, my supervisor told me that I needed to go for an interpreting course.

The participants that attended the training because they were interested had various reasons for attending the course. They are aware that they need the necessary knowledge and skills in order to conduct a successful interpreting session, stating that they would like to learn more about the medical/biological terminology used during mental health interviews, how to present themselves during an interview and also to have a better understanding of the role that culture can have on a session. One participant also noted that they realise that they are being useful and would therefore want to have the necessary knowledge to be successful.

P1: Uhm, I attended it because I wanted to have the knowledge and uhm, because they used me. I, I, I actually wanted to know the background of the patient, of the sicknesses, so that when you interpret, you know what you are talking about, because sometimes we just interpreted and especially when the doctor comes with the medical terms and then we couldn't understand properly. That's why I was interested in the course.

P2: Because I think it would help me a lot if they teach me the skills of interpreting and how to present myself in front of the patient and everything. I thought it would help me. So I asked my, my, my department to take me to that course. Ja.

P4: The reason why I do that is because I've seen myself that I'm being useful. Because I've been helping out in the area where I work and if somebody wants to interpret . . .

P5: Uhm, since we were invited, uh to our supervisors, uh and, uh I was, I was interested to go there so that I can get more information about how to conduct a interpretation and, uhm and some of the doctors when they, when we interpreting for them, they uh, they use biological terms, which we don't know. So it was worth for me to go, ja.

P7: Oh, because it was something that, kind like happening in the, you know, sometimes when your interpreting for the client, there's lot of things man that maybe, there's cultural things involved, there such things involved that they don't want to talk about, they not comfortable to talk about. So I wanted actually to know more about this interpreting thing, because I was doing it, even though I'm not doing it often, I'm doing it. So I wanted to know the procedures and all the stuff, how to interpret, how if, if there's sensitive stuff. I mean man, African men, they need to talk about those things and you're not comfortable to do, and you have to talk about it, because I mean the clinicians don't understand, so I wanted to know the comfortability of those things and allow it to make sense

P8: It's the first time here and then also interested that if they said that, they going to give it there the list then I said, I would like to go this, interpretation course.

P12: It was my choice actually because my management asked me if I'm interested then I said yes.

5.6.2. Participants' experience of course. The majority of the participants had a positive experience of the training course. They found it to be interesting, an eye opener, very informing, good to learn and have more knowledge about, medical terminology for example, and what is expected of them during interpreting sessions.

P1: Well, uhm, firstly it was an eye opening for me and, uhm, I, I, I understood more about patient illnesses and, uhm not so much about the the the terms doctors use, because it is very difficult to understand, but I understood more about the patients illnesses and then I could relate where they are coming from you see. So for me that was an eye opener.

P2: It was very informing actually. It was, it gave me as much skills as I wanted. Ja, it was fine, it was relaxing, it was good for me and my interpreting

P3: Dit was nice. Ja, dit was interessant.

[It was nice. Yes, it was interesting.]

P5: Ja, the trai. . .the experience of the training course, uhm, is just . . . the way they conducted, they also talk about disease, which most of the time when we're interpreting, then the the the doctors are asking the symptoms and all of that. It was interesting.

P7: Wow, the training was extremely awesome and I, I, and I get lot of more knowledge there, they give us lot of more knowledge, even though it was too short, but ja, we did get lot of knowledge and I wish it could happen more more more more like, all the other people as well, so they could get that knowledge that we have. They did explain lot of things that we didn't know.

P8: It was very interesting. It was very interesting because like I said that now I will . . . it was interesting . . .

P9: No, like we if you're interpreting for the doctor or whatever, what happen you talk to the patient and then you tell the doctor what the patient said but if you see that it's not important the other part of the patient then you will realise no, to that course we get to know that the doctor need each and every word . . .

P12: Yes, the course was good.

P13: It was good. I did experience lots of things that I didn't know because I was only interpreting generally just but I the difficulties I did some of the guys that will get into work being interpreter.

Although the majority of the participants had a positive experience of the training, they did have some concerns. One participant feels that they did not get any proper experience from the training. Other concerns that were raised are that the training was too short and that although the training was interesting, they cannot be expected to have two different jobs.

P6: Mmmm. Not that much experience. I didn't get any kind of uh, I mean, there was no like proper experience from that, from that training.

P7: The course was too short man, really.

P10: It was not a nice experience because it's difficult when you get a pure Xhosa person whereby you then you know in English there's a few words in English that you can't explain in Xhosa. You don't have a specific word for that Xhosa, Xhosa word for that English difficult word.

P10: Ja, a lot but it's not going to work if I've got two duties to do. Nursing and that.

The majority of the participants felt that the training course met their expectations, was very helpful and covered everything that they needed to know.

P1: Yes, definitely, definitely.

P2: It did, it did actually meet my expectations.

P3: Ja, ja

[Yes yes]

P5: Yes, yes.

P5: Ja, the reason I'm saying that is, uhm, most of the things that we we, when I'm interpreting to the doctors, from the doctors to the clients, then they covered in the course.

P9: To that course almost everything was fruitful you see.

P10: It's helpful. There's a lot that was helpful but no it's not on when you've got two things to do.

P13: Yes, everything was interesting.

Only two of the participants felt that the training did not meet their expectations. This was due to the fact that they are only helping out with interpreting (it's not an official or permanent duty) and one participant felt that they did not receive enough information on how to deal with/conduct an interpreting session.

P4: Not per say. Ja, because we are not permanent interpreters, we are just temporal. Ja, and this interpreting cour. . .cour. . . . I forgot the name. Ha ha!

P6: No it didn't.

P4: That's what they said in the course. That it's not an official thing yet, so we have got to purpose to the higher people that this must be an official thing and it must, uhm be paid for in time to come. So for now it is just temporary.

P6: I say so because, the the the . . . like they were talking mos about the . . . ways in which, I mean they didn't talk about the ways in which how to handle it, I mean how to, because I, no I don't know how can I answer that, but then I do get, I didn't get any information.

5.6.3. What part of the training participants felt were helpful/not helpful. The most prominent theme that came out of the data when the participants were asked what part of the training was the most helpful, is that the participants received more knowledge with regards to the medical terminology that is used during mental health interviews, as can be seen below.

P1: Uhm. When they talked about schizophrenic. Uhm, I confused the patients were schizophrenic and patients who got other illnesses, but when they explained there, I could distinguish between the illnesses of the patients and I think that was very nice.

P5: Ja, it did, it did. Because it did cover the the the, like I say, sometimes we we we were, you know I didn't have an experience before I started interpret, but when they explain some of the disease and symptoms . . .

P6: Ja, like he, ja the terms that they are using, the doctors, the terms that are used by the doctors. Ja.

P7: Yes man. There was a definition of this, delusions and, ah, what do you call it, delusions and hallucinations, you see. When the, maybe the patient is hearing voices and all that stuff. So it's kind of like difficult to interpret to the doctor what is the patient saying, or what, because the patient will say, he's hearing this now and next thing he's hearing, and you don't know what actually . . .

P12: Yes we learned a lot about mental disorder psychosis because we never really know those types because I'm not in the nursing department but I learned a lot on that course.

Other areas of the training that the participants felt was most useful is the knowledge on how to handle interpreting sessions, hearing the experiences of other people, how to do direct interpretation and also what is expected from them during interpreting sessions.

P2: Hmm . . . Actually I would say the whole course, but there was a part when we had to say the experiences that we had and listening to the other persons experiences, it does help you, because it gives you the skill to, okay, I see the tactics actually on how to handle such a situations when interpreting. Ja.

P3: Die deel wat hulle vir ons verduidelik het oor hoe om direkte vertaling te doen, waar die pasient aan die dokter vertel, sy siekte, sy diagnose miskien, en dan kon ek dit beter aan die dokter verduidelik het in die taal wat die dokter verstaan het.

[The part where they explained to us how to do direct translation, where the patient tells the doctor, his illness, his diagnoses maybe, and then I could better explain it to the doctor in the language that he understands.]

P4: The knowledge of interpreting. Ah, because we were just interpreting . . . for the sake of interpreting. We didn't know exactly what interpreting entails. Ja, what did you want from us. So at least we had an idea now of what interpreting, from answering what should we do when we interpret, ja.

P4: What the expectation also of the clinical people, the doctors, from us as interpreters.

One participant noted that the training course was not fulfilling, stating that they received too little information and that it was not proper training. This was due to the short duration of the course, which was also identified by other participants, as can be seen below.

P6: I see it as a . . . It's something that, it's like more attention, some kind of attention, but I don't know how, because like the training that we attended was not fulfilling. In terms of interpreting, but then there's more that need to be done, I mean in this, when it comes to the training of these people that are called interpreters. Because you can't just be an interpreter if you are not trained, well trained. Because even the courts, from the courts, the interpreters, those people are well trained. It's unlike the situation now that we are facing. They give us little information and then they call it training, but the way I see it, it's not like proper training for people to get get to know.

P12: It was too short because we didn't understand a lot what they said but because of time limit then we had to leave it there but the time was too short for me.

P13: It was not enough. It was three days.

5.6.4. Participants' and researchers' suggestions to improve the training course.

Although the majority of the participants were satisfied with the training course and thought that it was suitable, the data did reveal some interesting suggestions for the course.

P2: Something that I would like them to do, I think I'm satisfied with the course actually. I don't think that there is anything that they should change. Everything is perfect for me, I don't know about other people, but it was fine for me.

P5: I think for for us, that training was suitable.

The need for more advance training and a longer training course was identified by participants. It must be kept in mind that interpreting is not part of the duties of 11 out of the 13 participants, and that they only act as interpreters occasionally when called upon.

P3: Van die kursus? Nee, maar ek sal net sê die kursus moes bietjie langer gewees het.

[About the course? No, but I will say that the course needs to be longer.]

P4: Ja, what we said last time, we said we need an advanced training.

P7: Ja, if it can be like everywhere man. If they can like, we do have the interpreters, the interpreters that we have, if they could help that knowledge as well, they can, they can put that knowledge even more. Ja, even if they can have more courses of it you see.

P7: Ja, that's the only suggestion I have. If they can make it even longer, if they can have it often, the course. They must provide the course to many institutions, because we are really struggling to interpret, because I never know those things, because [. . . inaudible . . .] it's just a bad spirit, but to their, their way it's, the patient is, is psychotic. Yes. So if they can provide us with more more more knowledge of interpreting, even though I'm not doing the interpreting, I'm not an interpreter, but there are days that if we do not have interpreter that day, I, then I can help, so I need to know that.

Some of the participants stated that it would be helpful to involve the clinicians and/or supervisors in the course more. When making use of interpreters, it is important that the interpreters are seen as part of the team, and not just a translating machine, as they could have valuable knowledge on the culture of the patient and things that might happen outside of the interview (as they have more regular contact with the patients). It is important that both clinician and interpreting have the skill to work with the other, including knowledge of each other's roles and possible difficulties that might arise during the session.

P6: To make it better? Like he, to make it better, I can involve the people, like the doctors themselves. The doctors, the people that [. . . inaudible . . .] and the interpreters, they must be there. Because it was only the people that were taking that course. [. . . inaudible . . .]. The doctors, they were not there. [. . . inaudible . . .].

P13: Ok, I think everybody that was there or let me talk about the classes they are doing there, the classes that are doing the job as interpreter, but also I think I'd also raised a point there that also they need to bring in the doctors or the supervisors, our supervisors so that they can know what cultures we went to because to them it's only to tell the person go into this ward to go and interpret. They don't know what the difficulties we get into when we have to.

Once again the importance of having a basic knowledge of medical terms and the role that culture can play was identified by participants.

P7: That also play a role, because it, it's going back to the cultural things, because I have to talk about maybe, about her private parts or, and then I don't feel comfortable when the patient is maybe talking about her private parts and I'm a male. So it's kind of difficult, in the way of stopping the process, but for the work to be done and for the patient to be helped, I have to talk about it. But it's kind of working, so I need need to have this session, this courses of this interpreting, to convince people to talk about this, because they are helpful. Otherwise we will hide the valid information, we will hide the gender things and the cultural things and it's not gonna work, because we keeping the valid information that patient is saying and then we're not saying to the clinician.

P10: We don't just want to be trained in just interpreting for the whole South Africa specifically in that line, medical words.

P10: Ja, so it's a bit difficult but it has to be mixed. The training must be about everything. Cultures, medical words and all that.

P10: Course so it would have been good if I knew like the heart for example. The Doctor tried to explain what they did and how they did it and blah blah blah. So I think if I was also proper in my, you know, if I was now . . . how can I put it? During my training if I was already trained with proper in knowing the heart and all that it would have been good.

One of the participants gave an example of a difficult interpreting session where the patient started screaming and the interpreter had to calm the patient down. It would benefit the training course if interpreters are made aware of different difficult situations that might arise during these sessions, and also how to cope with these situations.

P1: Aah, ja. I was once in one ward where there was this lady, uhm, I went to interpret for her and uh she was listening to what I was saying to her and the doctor was speaking to me and here she started screaming and she screamed at the top of her voice and I thought to myself, gosh what is happening now, and uhm because she, the doctor didn't understand her and I was also, didn't know what was happening, I had to speak to her with my language and try and calm her, because uh uh even if the doctor could have done it, she wouldn't have understood, so I took that role of calming her down by talking to her. I wanted to know what the problem was and she

said she just want to go home. For me that was bad, because that was the first time that I came across a person who reacts that way, you know, ja. I think that is the only bad experience.

5.6.5. Subsequent interpreting sessions. There are certain skills that the participants identified that would help them in subsequent interpreting sessions. The importance of listening skills was identified by participants; the need to go through in their heads the words that the clinician/patient used and be sure to use the exact same words; the need to be aware of the role that culture can play; and the need to be aware of boundaries during the session. Once again the importance of having basic knowledge of medical terminology was emphasised by participants. One participant also stated that they felt more comfortable after the training.

P2: Obviously, it was different. It was different, because I was using the skills that I learned from the course now. Because previously I was just interpreting, but now I was more informed and more skilled than previously.

P2: The listening skills first. Ja, because I was just listening and then I was just interpreting what I am hearing, instead of sometimes you need to play it in our head first and see what the patient is trying to say, before you interpret it to the doctor. And also the, the most difficult part was the cultural part of it, but when they explained it there by the course, on how to handle it, because I'm a Xhosa and the person I'm interpreting for is the Xhosa. So when they explain to me I don't need to go deep into the culture and everything, ja. It also helped me a lot. It did

P3:Ja, jy voel meer gemaklik. Gemakliker. Jy voel meer gemaklik met die pasient.

[Yes, you feel more comfortable. More comfortable. You feel more comfortable with the patient.]

P4: Uhm, not necessarily, because we are still doing the same thing, even though that now we've got a little bit of a knowledge. Now you know where your boundaries are, what to do and how much to do it. Ja, so at least we've got an idea and knowledge now.

SH: So that's maybe something you learned in the course that you do now.

P4: Ja, ja. So it was [. . . inaudible . . .] in the years we use to be lenient. I say, I can't say this to the doctor. Doctor he says 'jou ma se dinges' [something derogatory about your mother]. Ja, so at least we make it lies and say okay okay, you know.

P5: Yes, yes. Especially when you, when you, you, you've got the basics of what the, the doctor is asking. Like if the the the patient has got schizophrenia, then you know what is the schizophrenia and the symptoms and all that.

P5:Ja, it became helpful after I received the training. Because sometimes if you, if you, you, I'm a clerk and an interpreter as well. Then ah ah ah ah, I don't know the medical terms and I don't know, like if the patient has got a schizophrenia. Then I don't know what is the schizophrenia and what is the symptoms. But after I went to the training, when the doctor ask them, I can ask him this question. Although I won't know exactly, but I can see some signs and symptoms, ja.

P7: It go differently, because I have that knowledge now. So I had more knowledge than I had before. So I pick up some few things that the patient is saying and then I know how to convey the message. Not to convey the wrong message to the doctor, thinking that I'm conveying the right message, because I have that linking knowledge you see, from the course. The course was too short man, really.

P10: What can I say I feel actually good because I'm the only person who can do that and to explain to somebody else to interpret whatever the other person is saying. I don't know what else but it's just more improvement to me. To my languages that I speak.

P11: What I've had with the experience is that before you interpret you must first listen so that you can say whatever the person said. The exact words of that person.

Although the majority of participants stated that the training course helped them in subsequent interpreting sessions, and that they could use the skills that they learned during the course, not all of the participants felt that it was helpful. One of the participants stated that soon after the course, interpreters were employed at their place of work. It is unclear whether the participant was asked to act as an ad hoc interpreter after the training course. Another participant stated that they could not see any difference in subsequent sessions, mentioning that it is difficult to understand the medical terminology that clinicians use.

P1: Hmm . . . You I don't really know, because soon after we had the the the course, uhm, because our aim was for the hospitals to have interpreters who are full time in the hospital, so that they don't interfere with other work and so on. So I don't really know how it went with them, because soon after the course we got interpreters. So I cannot say.

P6: No, there was no change, I didn't see any change. Because even if these terms of the doctors, because those terms, you cannot, I cannot grapple those terms. Because now I can't even remember those terms.

5.6.6. Interest in further, more formal training courses. The majority of participants stated that they would be interested in further training, with only four participants saying that they are not interested. Those participants that are interested in further training made it obvious that they are definitely interested and there must be a full time training, which could potentially lead to a full time career as an interpreter.

P4: Yes. Yes, I would be interested.

P4: Aaaah . . . Not necessarily. It's just that we ask for an advanced training for the interpreting and the professors, they will give us a promise, but they just told us that they are going to enquire from the higher people. The interpreting course must be an official thing and ah that should be a work . . .

P7: I will definitely go, I will definitely go. I will be very interested to go.

P7: Not really man. Not really, the only thing that I want, and I'm putting a stamp on it, I want more of this course. If they can give more of this course, then everything will help.

P10: Full time training they mustn't be shy to train us. Full time a lekker [nice] salary, why not, I'll go for that.

P10: Do the training. Give us the training. Full time job. To make it a full time job.

One of the participants elaborated why they are interested in further training. They feel that it is necessary to gain more knowledge and experience in interpreting. It is important to have patience when acting as an interpreter, and they feel that if they are trained, this will be easier.

P4: Gain more knowledge and more experience and . . . and work, ja, with the knowledge.

P4: Ja, age does, because the youngsters are becoming very quickly to become edgy and ah furious. And now the old people, they take their own time [. . . inaudible . . .]. They have got experience on how to do their job, and interpreters who have been maybe trained to do the job, ja, they've got patience also.

Four of the participants stated that they are not interested in further training. One participant said that they are not long from retiring, but that it would be useful for younger people to attend more formal training. One of the participants explained that they used to be interested in interpreting, but due to the attitude of the department that he works at, and the fact that they don't seem to care about interpreting, that he has lost interest. The participant also explains that if the training changes and a more professional training is offered, that he might be interested again.

P1: You see, because now they have interpreters, I don't see why I should waste money and time for going for that and especially at my age now. It's not long before I retire, but I think for younger people it will be useful, because sometimes they do need interpreters. Like I said, I was an interpreter in a private company. So it might be useful for them, but for me now personally, no.

P5: Uhm . . . Since I . . . I don't think I will, I will be interpreting for long.

P6: No, for me, it's too late for me. I don't think I'm [. . . inaudible . . .]. Because ha ah, I don't think for me.

P11: I doubt it.

P6: The doctors were so, because that time I was so interested in doing that. But then uh uh, I'm not interested, because it's because of the way that they handle it. Because there are new people now working, the new people know there's a guy interpreting here and they are the ones who ah [. . . inaudible . . .]. But then, I'm not interested, because it's not the way that I thought it should be. In terms of, I mean the department doesn't really care about this interpreting thing, the way in which people must be trained and that is why I'm not interested in this whole thing. Because of the way the department handled it, ja, they don't really worry about it so much. Even though the

doctors, they kind of struggling with this, because, you know by by by giving you proper information when I am, when I when I when I when I'm explaining to you what the other person was saying, that is very important, because if you didn't get much information, then something there is not gonna come right to the patient.

P6: If they can change it and make it proper, if they can train people proper, then I can be interested, but unlike this short thing, course, they call it training. Ha ah, that why I'm not interested.

5.7. Theme 6: The importance of a working relationship between interpreters and clinicians.

It is important that clinicians and interpreters form a working relationship inside of the triad. They are part of a multidisciplinary team that must work towards the same goal, i.e., delivering the best possible health care to the patient. It is important that clinician and interpreter communicate with each other and discuss difficulties, confidentiality and the different roles that they will have inside of the triad. It could be especially helpful if the clinician discuss difficult medical terminology with the interpreter that might be used during the session. This can be accomplished by pre-sessions, debriefings and the clinician asking the interpreter's thoughts after the session.

5.7.1. Pre-sessions and during interpreter mediated sessions. The majority of participants argued that it would be helpful to have pre-sessions and for the clinician to guide them during interpreting sessions. Some of the participants also indicated that they do sometimes have pre-sessions or the clinicians sometimes explain stuff to them during sessions.

P1: Yes, yes, we do have.

SH: Do they do this before the patient comes in?

P5: Before the patient comes, not even before the patient comes, when the patient is here then he says this patient is so and so and he's got this and this.

P13: Some of the doctors they do tell me this is this patient she's sick with this but not all of them.

The participants argue that it would be beneficial for the clinician to guide them during the interpreter mediated sessions. The clinician can help interpreters with medical terminology, so that they have an idea of what the clinician is talking about, in order to make an accurate interpretation.

P1: Uhm . . . You know uhm uhm . . . because we had sessions in the hospital whereby the operational manager will tell us about this illness and that illness and a little bit of, they don't go deep into the patient's illness, but it's it's it's just to open your eyes and mind to know if they talk about uhm . . . schizophrenic or epilepsy. What to expect when it's happening or how to see uh . . . this person is going to have an epileptic [. . . inaudible . . .], then you can quickly go and call the sister or the doctor if the doctor is available. So in that way I don't think it's necessary for the doctor to speak to you first. You know, ja.

P2: Ja. Because I'm just an interpreter, I'm just a clerk. So I don't know the psychiatry part of it, I just know the accounts. So if they can just explain that this one is, is, has got such a sickness and then I will differentiate between those sicknesses.

Participants indicated that the thing that would be the most helpful for them would be if the clinician could give them guidance with regards to a background/history of the patient and if they discuss what to expect during the session. If interpreters know what to expect, they can make sure that they stay on topic and they will have a better idea of the goals that the clinician wants to accomplish.

P4: Uhm, I think the clinicians can help with the guidance. When they ask questions, they must guide me, so that I mustn't be out of proportion. I must stay in the content. If he wants this, then he must explain it and explain it precisely that I want this and then you can also convey to the patient or to the next person that you are interpreting for, so clearly and then ja.

SH: Is there anything that the clinicians do during the interpreting that makes it better or easier for you, like tell you what they expect or something like that. The doctors?

P5: Ja, ah since ah, ja, they do, they do tell us what they expect us to do, ah when we are interpreting. Like if, if you, ah meeting the doctor for the first time, and I never interpret for that doctor, the he explains that I'm expecting this and this and this for

this patient. Then it makes, it makes better and you you've got an understanding of what the doctor needs from the patient

P7: What, what actually the clinicians do when, when, when they see the patient like, they know their history, but they'll also try to, they'll try to meet you half way what you, what you're trying to explain the patient. They'll tell you, no the patient is currently doing this in the ward according to nurses that are there. So I actually want to know what is he saying and, so they're kind of giving their history, so that you also understand, because sometimes you don't even understand the patient, even though he's speaking your language, because he's saying some things differently and then again say what you wanted to say, so it's confusing. So if they give you a little bit of their history, so that we can understand, yes they do.

SH: And do you think that's helpful?

P7: Yes, that's really helpful. Otherwise I won't know, I would just say what the patient is saying. The patient is gonna say now this and then again say another thing. So, so it's not gonna work. So if I know a history, then it's helping, it's really helping.

Although the majority of participants indicated that the clinicians do offer pre-sessions, some of them said that the clinicians don't do anything and even get irritated during interpreter mediated sessions, as can be seen below.

SH: So would the doctor speak to you before the patient gets to you, maybe tell you a bit about the patient or maybe when the patient is there?

P6: No, they don't.

SH: It's fine, and tell me is there anything that the Doctors do during the interpreting sessions that help you with the whole process, the whole interpreting session?

P10: They don't do anything. They get irritated sometimes, that's what I've noticed that they're irritated, they're not patient enough because they just want to get it done, the job done and go to the next person.

5.7.2. Debriefings. It was quite clear from the data that the majority of participants were never offered a debriefing session after interpreting sessions.

P2: Uhm uhm, no. It was only in the course, only in the course.

P5: No.

P6: No, no.

P10: Never. I never.

There were only two participants that felt that debriefing sessions are not necessary, although one of them indicated that it will be helpful, even though they would not like to have a debriefing session with clinicians.

P5: I don't think it's necessary.

SH: Would you like something like that? How do you feel about that?

P13: No.

SH: Do you think that's helpful?

P13: Yes it is helpful.

The majority of participants stated that debriefing sessions would be helpful. Such sessions would give the interpreters the opportunity to discuss things that did not come up during the interpreting session and would also ensure that clinicians and interpreters keep the communication channels between them open, ensuring that they can discuss how the session went and if there were any difficulties or issues that were difficult to interpret. Two participants also indicated that they appreciate debriefing sessions, and that these sessions can also show them that the clinician appreciates the work that they are doing.

P2:Uhm, it would help, because uhm, if me and the doctor are working together now, because I'm interpreting for the doctor, but if he doesn't, we don't communicate, then I don't think our work will be perfect. Ja, I think we should communicate with the doctor. I just brief him on how how I see things on the interpreting side and how he wants me to do things, you see. Because sometimes I go, the doctor just told me, no you just interpret exactly what the patient is saying. And I was like, okay I am, but how does he know I'm not, because the last time I, I, I, he only understands English, but how does he know that I'm not interpreting exactly what he is saying. Jaja.

P3: Ek dink die mense sal.

[I think the people will.]

P7: Ja, just a bit. Not, not like a big, a long session, just to after we finish with the patient. Like how was that, did you feel comfortable doing that, you know.

P7: It is helping, because it also give a, it shows the appreciation to him, what I did for him. It's not that I was doing it for him actually, for I was doing it for the clinician, but actually for the patient, but it's also show her appreciation or his appreciation as the clinician that I helped her to continue, you know.

P8: They do sometimes, they do sometimes, like I've got one doctor that I appreciate.

P8: And his going to tell you the reason also . . . you have done a hundred percent here. You've done this and this and you even more add more to what I was thinking. So that is a good doctor, I appreciate that doctor, I don't know why did he left here.

P10: Well it depends. If it's in my ward. If I interpreted for a patient in the ward that I am in, then I think de-briefing is necessary but if it's somebody that I don't know.

5.7.3. Asking the interpreter's thoughts on the patients. The data revealed that about half of the participants were asked their thoughts on patients and half were not asked. The majority of the participants revealed that they believe it would be beneficial if clinicians ask their thoughts on the patients, for a variety of reasons.

One of the participants that stated that the clinicians do not ask their thoughts on patients stated that the session is not about them (as interpreters), but about the patient, as can be seen below.

SH: Okay, tell me, does the clinician ever ask you your thoughts about the patient?

P1: No, no, because the thing is, it's not about us, it's about the patient, ja.

P8: They do. [. . . inaudible . . .] they don't.

P10: Never.

As is illustrated below, some clinicians ask interpreters their thoughts on patients. One participant stated that they would just say what they feel like, whereas another participant makes an interesting point; that because they speak the same language as the patient, they might have some insight to share.

SH: Does the clinicians ever ask you your thoughts about the patients?

P4: When I was working in forensic, yes. They use to ask you, what do you think? But you just say whatever you feel like you see and then you just . . . ja.

P5: Yes, ja. Some of the doctors they do ask of do I see the patient, since I, I'm speaking the same language with patient, then he ask how do you see the patient.

P6: Ja, one particular, who was it, ja, there was one doctor who ask me and then I told him.

Only one participant stated that they don't think that it will be helpful if clinicians ask their thoughts on patients. Whereas two of the participants indicated that it could be helpful, but also that it might be dangerous, as they don't understand the different illnesses and may give the clinician the wrong information.

SH: Ok, do you think they should?

P9: No, it's not necessary.

P1: Uhm. Ag, maybe just in general, but uhm I, I don't think they they that needs to be taken much into consideration, because I might think different, because I don't understand the illness. You know, so I think it will be a little bit confusing for the doctor.

SH: And do you think that it is helpful if the doctor asks you?

P6: That can be helpful, but then what if sometimes the information that I am giving is also wrong, even now the doctor is asking now for me, even I'm also giving the wrong information. Even though that can be helpful, but that can be disadvantages here and there.

SH: So you think it can be helpful, but it can also . . .

P6: It can be dangerous sometimes, because I can give wrong information.

The majority of participants felt that it would be helpful and beneficial for the care of the patient if the clinicians asked their thoughts on the patients. Although the participants did not understand the medical issues that came up during the sessions, they might have been able to comment on something that the patient had said during the interview and might have been able to explain something to the clinician that they were unable to interpret during the

session. One of the participants stated that it would be a good idea to ask their thoughts on patients if they have multiple sessions with the same patient. One of the participants also felt that they should ask their thoughts on the patients, otherwise they would not care about interpreting as much.

P2: Ja I think that would help actually, because okay, I'll say this once again, I don't know about the medical side of everything, but I think after, after interpreting about the patient, I can be able to explain to the doctor what I'm seeing, though I'm not a doctor and everything, but maybe it would help the doctor, because I just interpreted what he is saying just now, but maybe there is something that I hear from him that I was not able to interpret that time.

SH: So jy dink dit help as hulle jou vra?

[So you think it helps when they ask you?]

SH: Uhm, do you think that was helpful?

P4: For me yes, it was helpful, because you have to stretch your knowledge. Not to know only one thing.

SH: Do you think that is helpful?

P5: Like if we we we, maybe I'm not interpreting for the doctor for the first time, maybe we've had another session, then he ask me can I see any improvement. Ja.

SH: So do you think it helps when they ask you your thoughts?

P7: Yes, yes, yes. Otherwise I won't do it with my heart, because I'm just doing it for him, you see.

SH: Do they? Ok, and do you think that's helpful?

P13: Do I think for them it's helpful?

Two of the participants indicated that they believe that clinicians might find their insight into the patient helpful, as they spend a considerable amount of time with the patient and therefore know the patients better. They might be able to comment on something that was not discussed during the session.

SH: Ok, and you think that's important?

P8: It is, it is because mostly they're there and you are here the whole day with these patients. So now you know this one doesn't like this. This one do this and now I have to explain to the doctor that one.

SH: And do you think they should ask you about . . .

P10: Especially for us in our case. We know the patients better than the Doctors.

One of the participants feels that the clinicians should ask their thoughts, but is clearly frustrated by their role as interpreter and how the clinicians see them, stating that the clinicians aren't interested in hearing anything from the interpreters.

SH: Ok, and what do you think?

P10: They just take you as an interpreter and that's it.

SH: Ja.

P10: I think they should.

SH: So it will help?

P10: Ja, but they don't actually. They don't want to hear from you. Nothing.

One of the most important reasons for pre-sessions, debriefings and asking interpreters thoughts is to ensure that a strong working relationship is formed between clinician and interpreter, where interpreters feel part of the team and not just as an interpreting tool. It is important that clinicians can rely on interpreters. Both the attitude of the clinician and interpreter can have a profound effect on the outcome of interpreter mediated sessions.

P4: Ja, but I had to calm myself down first. You don't have to be arrogant, doc, let's start from the bottom, from the start. Then he went back and I follow what he says and I say it back to the patient and then I give him what the patient is saying, even though the patient was sometimes swearing at you, I thought, I'll give it back like that and then he could find out okay.

P6: If I can be interested, I would like to have that, it would be more, I mean like if the doctors like, if the doctors, they must be more closer to the interpreters. By so doing, they can get information from the interpreters. Not like grab an interpreter with us in there, and then you ask that person to come and help you, then you don't talk to them, you don't have meetings.

P7: But there's no other difficulties that I have. As long as me and the clinician, we working together, we will convince the patient you see.

P10: Ja, it depends on the attitude the patient gets from you and the Doctor maybe but it's very difficult. It depends on the Doctor and the different . . .

P13: Ok, I think everybody that was there or let me talk about the classes they are doing there, the classes that are doing the job as interpreter but also I think I'd also raised a point there that also they need to bring in the doctors or the supervisors, our supervisors so that they can know what cultures we went to because to them it's only to tell the person go into this ward to go and interpret. They don't know what the difficulties we get into when we have to.

5.8. Conclusion

Six main themes were identified from the data, some with a number of subthemes.

As can be seen from the first theme, there were some instances of miscommunication and a language barrier between researcher and participants. Although these participants are only used from time to time as ad hoc interpreters, it is imperative that interpreters have excellent language skills in the two languages they are interpreting in.

The role that age, gender and culture has on mental health interviews can be very important, even more so when there is a complex triadic relationship between interpreter, patient and clinician. As could be seen from the data, these three factors are also connected to each other. It is difficult to separate age and gender from someone's culture. Different cultures will have different rules and social norms on how to communicate with someone from the opposite gender or from a different age group. It is almost impossible to separate the language barrier from cultural differences. Therefore it is important that both clinicians and interpreters are aware of cultural competence.

There was a realisation from participants that there is a big need for interpreters and also that interpreters have an important role to play in mental health services. Being ad hoc interpreters, the participants often had to leave their official duties to interpret. There were numerous difficulties that could be identified with regards to when the participants were asked to interpret. These were further compounded by the fact that interpreting can be an emotional experience and that participants often felt helpless, defeated and underappreciated.

The participants used three styles of interpreting, with the majority of participants stating that they would change the exact words a bit, as long as the intended meaning stays the same. The majority of participants had no previous experience of interpreting, but did show a willingness to learn and act as interpreters. The participants were either chosen to go to the training course or were interested in going. The majority of participants had a positive experience of the training course and felt as if it met their expectations. They stated that the course was mostly helpful, especially with regards to gaining more knowledge regarding medical terminology and how to handle interpreting sessions. Quite a few of the participants did however feel that the course was too short and that they needed more formal training, where the clinicians and/or supervisors are involved. The participants felt that there were certain skills that they could use in subsequent interpreting sessions, but due to interpreters being employed, they did not have a lot of interpreting sessions after the training. There was, however, a great interest in more formal training. The importance of a working relationship was also highlighted. Interpreters and clinicians need to have a good working relationship, which could be improved by pre-sessions, debriefings and the clinician asking interpreters their thoughts on the patients.

CHAPTER 6: DISCUSSION

6.1. Introduction

This chapter presents a discussion of the research findings (as identified in Chapter 5). As has been mentioned, there are six main themes, most of them with a number of subthemes.

6.2. Theme 1: Language barrier between researcher and participants

It was alarming that there was a language barrier between me and some of the participants. It has been noted that using bilingual staff to bridge the language barrier can have many practical advantages (Flores, 2006; Hadziabdic & Hjelm, 2013; Raval, 2006; Timmins, 2002), but it is of vital importance that the staff members being used are fully bilingual, as the most basic function of an interpreter is to understand and convey the spoken word. They are expected to listen to what the hearer has to say and accurately translate the meaning to a different language, which is not an easy task. This could potentially be made more difficult by a high pressure situation as can be found during interviews at mental health hospitals. There are many skills associated with acting as an interpreter, and being bilingual is not sufficient to ensure that effective communication will take place, but it is a necessary condition for the function to be fulfilled (Hadziabdic & Hjelm, 2013; Lee et al., 2014).

There were a few instances where I had to go through quite a bit of effort to ensure that the participants understood what I was asking of them. There were also instances where I would ask something and the participant would answer with something totally different to the topic under discussion. Furthermore, miscommunication was evident where a participant would speak of instances that happened outside of interpreting. There are strong indications that using bilingual staff may help with the clinical encounter, but the scope for misunderstanding may increase when it is assumed that people fulfilling an interpreting role are bilingual when they are not.

6.3. Theme 2: The role of age, culture and gender

Age, culture and gender can have a significant impact on interpreter-mediated sessions, and although these are more general observations, opposed to a direct result of the in-service training course, these issues constituted a very prominent theme throughout the data. As has been mentioned, the possibility exists that three people with different cultural

backgrounds and ages can be involved during interpreting sessions, potentially leading to complexities which go beyond issues of language.

The majority of participants identified age as an important factor during interpreting sessions, but instead of focussing on age on its own, they discussed the link between age, culture and showing respect. If the interpreter is older, they believe, it will be easier for them to take ownership of their interpretation, as the patient is more likely to show them respect. Interpreters who have been interpreting for longer may also have the necessary experience to make sure that effective communication can take place. On the flip side of the coin, it could also be that younger patients would not speak freely and disclose everything during a session, due to respect for the more senior interpreter. When it is older patients that are consulting a young clinician and/or interpreter, these patients could view the clinician/interpreter as a child and feel as if they are not showing them the necessary amount of respect. This may also lead to the patient not wishing to disclose personal information. There may also be certain topics that people from different age groups will not wish to discuss with one another.

According to one of the participants, interpreters who have been trained or who have more experience are also more likely to have patience. Being young and seen as a child is an issue that was mentioned repeatedly, and it may be argued that it could be better to match interpreters and patients for age, as this could make discussion of certain topics easier. The interpreters also believed that age-matched interpreters could have a better idea of what the patients experience. This is in line with the literature as well (Lee et al., 2014; Tribe & Lane, 2009). Intergenerational conflict will also play a role here (e.g., issues regarding stigma and respect) (Cross & Bloomer, 2010). One of the participants also explained that other factors come into play when working with older patients, for example, the fact that they can become forgetful (although patients of all ages may have memory challenges). Four of the participants believe that age does not play a role during interpreting sessions, but it is unclear whether they might have misunderstood the question and also if they possibly have not interpreted for a patient from a different age group than their own.

There is not only a strong link between health care and culture (Hayes-Bautista, 2003), but also between culture and language use (Hadziabdic & Hjelm, 2013). Many researchers argue that Western ideologies and constructs pertaining to mental health cannot fully be applied to populations that are heterogeneous (like South Africa); it is thus important that culturally competent care is provided (Hayes-Bautista, 2003; Lee et al., 2014; Luk, 2008;

Siegel et al., 2000; Vostanis, 2014). There are many examples of how the participants believe that culture can have a profound impact on interpreter-mediated sessions.

In a multicultural society like South Africa, there is a big possibility that patient and clinician will be from different cultures, and interpreters are tasked with explaining the culture of the patient/clinician to the other party. There are numerous issues that come up when working with people from different cultures, as has been seen earlier. People from different cultures will have unique beliefs and perceptions about mental health care (Anderson et al., 2003) and will have traditional and culture specific views of understanding an illness (Kim et al., 2011). This can be seen where certain cultures attribute negative connotations to mental health issues (Flynn et al., 2012) or where certain cultures express mental health problems as a physical complaint (Cross & Bloomer, 2010). A very prevalent example from the data was the belief in ancestors, witchcraft and isangoma in certain Black African cultures. As a participant explained, people from cultures where witchcraft, for example, do not have a prominent role will struggle to understand the message a person is trying to convey when speaking about such topics. The interpreter will then have to interpret this, which on its own can be very difficult, as these topics or certain words might be very culture specific, but they will also have to explain the meaning behind these concepts. Speaking to one's ancestors or hearing voices can be acceptable in one culture, and not associated with mental health problems. Another culture-specific example from the case study would be where someone might believe that they have a bad spirit that was put there by witchcraft and they are hearing voices because of this. A clinician with a mostly Western ideological background might conceptualise this as a delusion or hallucination. The interpreter must then explain this to both parties in a way that they would understand what the other is saying.

The fact that some of these words and/or concepts might not have a direct translation complicates this task. Interpreters must thus make sense of specific cultural linguistic codes (Cross & Bloomer, 2010). One participant explained that although they might have a similar cultural background (Xhosa, for example) to the patient, it is not a guarantee that they share cultural beliefs, as this can rely on different factors like their age and where they were raised. Patients might talk about certain rituals, for example, that the interpreters may not understand. As has been mentioned, according to Swartz et al. (2014), interpreters cannot be expected to speak on behalf of an entire culture. As cultural brokers, they are often expected to be experts on the cultural background of the patient, but as illustrated above, this is not a

guarantee that they share cultural beliefs and norms. Not only are there certain words that will be culture specific from the patient's side, but the interpreter must also explain the clinician's culture to patients. Interpreters must thus have knowledge of both the patient and clinician's world views, values and cultures (Dysart-Gale, 2007). One of the participants also raised the point that they sometimes have to interpret for patients that have a different culture from both them and the clinician, which illustrates the desirability of matching interpreters and patients on a cultural level, as it would be difficult for an interpreter to convey a cultural specific meaning that neither they or the clinician understands.

Regarding different age groups, different cultures have certain topics that are seen as taboo (Luk, 2008; Tribe & Tunariu, 2009; Westermeyer & Janca, 1997). Although the participants acknowledged that there are certain topics that would be difficult to discuss, like topics of a sexual nature for example, they also stated that it is important to interpret everything the patient and/or clinician says. They realised that, ultimately, the patient will suffer if they hide information that is uncomfortable to talk about. Once again the topic of respect came up when discussing culture. As has been mentioned, different cultures have different norms when it comes to showing respect and it is important for people to respect their cultures and also show the necessary respect when interpreting for someone from the same cultural background as them. This is something that might hinder mental health care, as interpreters might choose to not interpret everything that is said, despite their professed commitment to interpreting everything that is said. This very real dilemma for informal interpreters may be exacerbated in a context in which they are not sure of the rules, and are also not fully in command of both languages used in the encounter.

Culture and gender are also strongly linked, as it might be inappropriate for people from a certain culture to discuss certain topics with people from the opposite gender. Culture aside, gender on its own can also have an impact on interpreting sessions, as it could be easier for someone to discuss sensitive topics with someone from the same gender (though this may not be the case for all patients, and for some the opposite may be true). Due to being respectful towards someone from the opposite gender, participants feel that it would be better for women to translate for women, and men for men. It could be uncomfortable for people from opposite genders to discuss sensitive information, like sexual or private issues, which could lead to the interpreter/patient withholding important information. The analysis offered by the participants suggests gender matching, but it may be possible that some men might find it easier to discuss issues such as impotence and premature ejaculation with women, as

they may fear being ridiculed by men. Once again, when asked about the role of gender, quite a few of the participants linked gender with culture (the same as with age). It seems that it is difficult to separate these three, which further strengthens the argument to match interpreter and patient on all three of these characteristics. Four of the participants indicated that the gender of the patient/clinician did not have an impact on the interpreting session, but once again, it is unclear whether they understood the question correctly and also if they possibly have not interpreted for a patient from the opposite gender. The other possibility is also that, as one participant puts it: “Gender isn’t a problem, it might be a woman, it might be a man, but if you want what you want, I’ll give it to you if you want it”. This reiterates the importance of not leaving out any information when interpreting, as it might be vital to the diagnoses and/or treatment of the patient.

6.4. Theme 3: Views on interpreting

As all of the participants acted only as ad hoc interpreters, and interpreting is not part of their formal duties, I was interested in how they view interpreting. The subthemes that emerged from this theme include: how often they were asked to act as ad hoc interpreters; if they feel that there is a need for interpreters; the role and importance of interpreting; issues and difficulties associated with interpreting; and the style of interpreting used.

6.4.1. Acting as an ad hoc interpreter. Two of the participants indicated that interpreting is recognised as part of their official duties and two of them indicated that they had never been asked to interpret. The remaining 11 participants were asked to act as an ad hoc interpreter on a number of occasions when they were needed, with one participant stating that they were asked to interpret almost every day. The fact that this participant was asked to interpret so frequently supports the fact that there is a big need for interpreters (Schlemmer & Mash, 2006).

6.4.2. The need for interpreters. The participants are aware of the language barrier that exists and they, possibly more than other people, can see the need for the appointment of professional interpreters. It can be seen from the data that there are difficulties when communicating with African indigenous language-speaking, and especially Xhosa-speaking, patients. As stated earlier, Xhosa is an official language in the Western Cape and many of these patients are not proficient in Afrikaans or English (Kilian et al., 2014). The fact that there are many Xhosa patients that do not speak Afrikaans or English was again highlighted in the present study. Also problematic is the ad hoc manner in which interpreters are

appointed to interpret, based solely on their availability and whether they can speak the language of the patient. Consequently, patients are not receiving equal and adequate health care. As one participant states, there are people in the Western Cape that speak a variety of languages, but there are no interpreters available for these languages.

As can be seen from the data, these ad hoc interpreters are often asked to interpret due to the fact that there is no-one else available. The participants also believe that without their help, a lot of the patients would be at a great disadvantage. Although there are numerous errors associated with working with ad hoc interpreters (Drennan & Swartz, 2002), without these interpreters the whole process of mental health care might not be possible at all. It is clear from the data that the participants often interpret for patients because they feel it is the right thing to do and they want to help the patients, but due to the invisible nature of this work, it could lead to feelings of being used and exploited (Smith et al., 2013). Having to leave their official duties and help out with interpreting impacts on these staff members' already busy schedules (Dysart-Gale, 2007). This can not only have an impact on the emotional wellbeing of the participants, but can also affect their productivity in their official duties at the hospital. It can be seen from the data that the participants admitted that having to act as ad hoc interpreters is a very time consuming process and that they often had to stop what they were doing to help out with interpreting. They also had to put their work on hold immediately, as the clinicians see the patients at specific times and they are expected to be available then. Although time constraints are one of the reasons why professional interpreters aren't used (Baron et al., 2010; Kale & Syed, 2010), Lee et al. (2014) argue that using staff members to interpret can be just as time consuming.

6.4.3. Role and importance of interpreting. As has been mentioned, participants realise that they are fulfilling an important role. The fact that they are being helpful, but not being paid for this crucial role, is not lost on them. They believe that patients would suffer if they were not around to help out, as they essentially help to ensure that correct diagnoses can be made and that the patient can receive timely and appropriate care. What is interesting about these quotes is that the participants don't seem to have any sense (nor should they, as lay people) of how contested the ideas are about the roles of interpreting. It was also interesting to note that, when asked about how they see their role as interpreters, one interpreter seemed to be more interested in how their language skills can improve in their capacity as ad hoc interpreters. Although the participant might have misunderstood the question, it is very important that interpreters have excellent language skills. With this in

mind, it could also be useful to revisit a previous point, in that participants placed a lot of emphasis on experience. Interpreters with experience may be better equipped with essential skills to facilitate interpreter-mediated sessions, with language skills being an important part of this.

Participants also feel the need to provide emotional support to patients and feel as if calming the patient down and making them comfortable is the important thing (something they might not be equipped to do). It could be that participants feel this is part of their duty as ad hoc interpreter, because they share a common language with the patient. Interestingly, the infantilising of patients can also be seen where one participant calls the patients their “children”. Participants also believe that it is their duty to provide emotional support to family members of the patient as well. It is unclear whether this is something they want to do or believe that it is culturally appropriate to do. It has however been noted that the emotional support that interpreters provide can be a valuable resource to mental health services (Hsieh & Kramer, 2012).

6.4.4. Issues and difficulties with interpreting. As has been noted in the literature (Baker et al., 1998; Flores, 2005; Kilian et al., 2014; MacFarlane et al., 2008; Meeuwesen et al., 2009; Paone & Malott, 2008; Searight & Armock, 2013; Searight & Searight, 2009; Timmins, 2002; Tribe & Tunariu, 2009), there are numerous difficulties and errors associated with working with ad hoc interpreters. These errors are also more common when working with ad hoc interpreters, compared to professional interpreters (Searight & Armock, 2013). Although using ad hoc interpreters result in medical errors and a decreased quality of care when compared to professional interpreters, clinicians use ad hoc interpreters, which could be due to the general unavailability of professional interpreters.

One of the most prevalent difficulties, as can be seen from the data, is the fact that there are miscommunications due to the language barrier. These miscommunications can also have a negative effect on the interpreter, as this can result in them feeling bad, which could ultimately influence their ability to render the service. It is also important to note that even though patients and interpreters might speak the same language, they might speak different dialects of the same language, which can have a further negative impact on the language barrier. A good example of this in the Western Cape is that some patients/interpreters might speak a very traditional Xhosa, which could be difficult to understand for people that speak a more modern dialect of the language. As languages are also not directly interchangeable (Davidson, 2002; Hadziabdic & Hjelm, 2013; Luk, 2008; Temple & Edwards, 2002; Tribe &

Keefe, 2009), it can be difficult for ad hoc interpreters to convey the exact same message that the speaker intended. As one participant noted, a phrase or sentence might be much longer in Xhosa than in English. Interpreters might then choose to minimise their words and could end up omitting important information. Terminology and meaning can also be very culture specific, which leaves the interpreter with the difficult task of finding the correct words to ensure that an accurate interpretation can take place. This goes both ways, as there can be Western medical terminology that patients might not be able to understand, but there are also words from, for example, Black African cultures that would be difficult to communicate to the clinician (“Sangoma language” as one of the participants calls it).

As was noted above, the process of interpreting can have negative effects on the interpreters as well, as they end up feeling helpless and defeated. This already stressful experience is further compounded by the fact that clinicians can become frustrated and patients may at times undermine interpreters. As participants indicated, patients can also play on their emotions, which can lead to the experience of interpreting as emotionally taxing. Due to the sensitive nature of interpreting in the mental health setting, this can also be of concern. As was stated in the literature review, dealing with sensitive issues, traumatic information and relaying a patient’s personal information can be uncomfortable for ad hoc interpreters (Flores, 2006; McDowell et al., 2011; Paone & Malott, 2008). These interpreters are emotionally affected by this and can start feeling distressed (Doherty et al., 2010; Searight & Armock, 2013). As was noted by Smith et al. (2013), ad hoc interpreters often do not have the necessary professional supervision or access to the appropriate support systems to deal with the negative emotions that might have. One participant mentioned emotional involvement with the patients, which relates back to a point made earlier, that participants might feel it is their duty to comfort patients and offer emotional support to them. Apart from not having the necessary training to deal with the emotional content of interpreting sessions, ad hoc interpreters also do not necessarily have the training to accurately interpret medical terminology, especially because the terminology can be very culture specific.

It seems that one of the most prevalent difficulties associated with interpreting for the participants was that it is difficult to interpret when patients are not talking sense. The patients might be talking Xhosa, or some form of Xhosa, but it can be difficult for ad hoc interpreters to follow the conversation and even more difficult to convey the intended message to the clinician. Participants also choose to omit certain things when they are interpreting, if the patient is not making sense. This can have serious clinical consequences,

as the interpreter might leave out important information. The majority of the participants did, however, indicate that it is important to explain to the clinician that the patient is not making sense, but also that sometimes it is impossible to interpret something. Another difficulty that one of the participants mentions is that it could be that patients try to use the limited amount of English that they know. In this particular example, the patient did not answer the questions correctly. Apart from miscommunication in this example, it is not recommended that patients try and get by on their limited knowledge of a language, because, as Luk (2008) suggests, a link exists between a person's thoughts and the language they speak. Patients might end up concentrating so hard on communicating that important information is lost during the session.

The data also revealed that some patients might not wish to speak to clinicians due to numerous factors. Patients might not have the necessary insight to understand why they are at the hospital and might believe that the clinician/interpreter just wants to keep them there. Patients can also become aggressive due to their lack of insight. Cultural factors can also have an effect on patients not wishing to speak, as they might believe that their ancestors do not want them to speak. One participant also says that they have to convince patients to talk. Once again it seems as if participants feel that it is their responsibility to offer emotional support to patients. Linking to the previous point, patients can be uncooperative and have a bad attitude towards the interpreter. This can be understandable, as they might feel vulnerable to open up to an "outside" person.

What is worrying is that participants reported that clinicians and other staff members sometimes have a bad attitude towards the interpreters. As one participant puts it: ". . . the thing is, it's not about us, it's about the patient". The main objective of mental health care should be to ensure that the patient receives adequate health care, whether this is through the use of interpreters or without them. When interpreters are used, all staff members should be on board to ensure that the patient is helped. It is important that clinicians, and possibly other staff members, are trained to work with interpreters. The language barrier is embedded in our society, and all those involved should be aware of, and prepared regarding how to overcome it. If clinicians (and staff) are not properly trained to work with interpreters, they might feel as if the interpreters are interfering in what was traditionally seen as "their" sessions (Luk, 2008). Due to all these difficulties, patients end up not receiving adequate health care, which could lead to more visits to the hospital. Difficulties and errors are further compounded by the fact that it is difficult, or near impossible, to judge whether the ad hoc interpreter has done

a good job. Clinicians are thus unaware that these errors are taking place (Hadziabdic & Hjelm, 2013; Timmins, 2002).

6.4.5. Style of interpreting. Participants indicated that they used three types of interpreting styles, which can be identified as word-for-word interpreting, summary interpreting and a combination of the two. Four of the participants preferred to use word-for-word interpreting. One of the participants stated that they sometimes stop the patient to interpret. On the one hand this can be helpful, as the interpreter might forget what the patient said if they speak nonstop. On the other hand, it is not ideal to interrupt patients. Another participant said that they learned during the in-service training course that it is important to interpret word-for-word. Participants agreed that it is important to interpret exactly what the patient said in order for the clinician to understand what the problem is. Six of the participants said that they might change the words of the speaker a bit, and that the important part is that the intended message stays the same. It is sometimes impossible to translate one language to another exactly, which is why this style could be preferred. As has been noted earlier, languages are not directly interchangeable, and it is sometimes necessary to change words slightly. Xhosa is a good example of this, as there are Xhosa words that are not available in English, and vice versa. It can be argued that it is more important to convey the correct message/meaning and avoid misunderstandings than using the exact words. It is important that the clinician understands what the patient is trying to convey to them. The remaining three participants indicated that they would start off using word-for-word interpretations, but would then switch over to summary interpreting. The reason for the switch is when they realise that the patients do not understand the word-for-word interpreting. It is unclear whether they use word-for-word or summary interpreting when interpreting the words of the patient, as they said that they only switch over when the patient does not understand, but said nothing about the clinician.

6.5. Theme 4: Willingness to act as ad hoc interpreters

Very few of the participants had any previous experience of interpreting (before interpreting at their current place of work), but there was a great willingness to learn and act as ad hoc interpreters. Only two of the participants had previous experience of interpreting, however, it is unclear what this experience entailed, whether it had only happened once or twice or whether they had a lot of experience. The other 11 participants had no previous experience of interpreting, but some of them have had quite a bit of experience as ad hoc

interpreters at their current place of work. The one participant has been working at the hospital for 25 years, but it is unclear if this participant had been interpreting consistently. It must be noted that although these participants had been called to interpret, it only happened occasionally, as they were not employed as interpreters.

There is such a willingness to learn, combined with the fact that eight of the 13 participants can speak three or more languages (with two of them that can speak five different languages, with varying fluency, and one participant that speaks five languages and understands some words in another two languages). It is clear that staff members that speak a variety of languages are available and if they are properly trained, they can be an invaluable resource in overcoming the struggle against the language barrier. It must be noted that it was impossible for me to judge the fluency of the participants in the different languages. Coming back to a point made previously (the language barrier between me and the participants), two of the participants indicated that they only speak Xhosa, even though the interviews took place in English. It is unclear whether it can be inferred that they do not speak English as well as they speak Xhosa, or whether they believe that their English ability is not good enough to mention as one of the languages that they speak. There was a realisation by participants that they are playing an important role by acting as ad hoc interpreters and would like to help. One of the participants stated that they have lost their interest in interpreting, even though the clinician was fond of using them as an interpreter and they use to be interested. The reason for losing interest is because of the way their department handled the whole situation and that they, according to the participant, did not care about interpreting. Once again, this is alarming, as interpreting has become so much part of clinical work in South Africa.

6.6. Theme 5: The effectiveness of the in-service training course, subsequent interpreting sessions and interest in more formal training

6.6.1. Why the participants attended the training course. Out of the 13 participants, five were asked or nominated to attend the training course, whereas the remaining eight attended the course because they were interested in interpreting and wished to gain more knowledge in order to improve subsequent interpreting sessions. It is unclear whether the five that were asked to attend the training were also interested in the course and whether they only went because they were told to do so. The participants that attended the course because they were interested had various reasons for their interest. Two of the participants indicated that they were interested to learn more about the medical and biological

terminology that clinicians used, as they presumably do not have training with regards to these terminologies. One of these participants also said that they would like to know more about the background of the patient. The way that they structured their sentences, it seems that they were referring to the medical background of the patient. Three of the participants were interested in the more practical side of interpreting, which includes general skills of interpreting, how to present themselves during interpreting sessions, how to conduct an interpreting session and also the procedures of interpreter-mediated sessions. One participant stated that they see themselves as being useful. Another participant argued that generally clinicians do not understand some of the cultural aspects that could have an impact on interpreting sessions, which is why this participant is interested in the cultural side of interpreting and also how to interpret when there are sensitive issues or things that are uncomfortable to talk about. They wanted to understand the “comfortability” of such issues. Two of the participants did not give specific reasons why they were interested, and only stated that they were interested.

6.6.2. Participants’ experience of course. The majority of the participants had a positive experience of the training course, with only two participants that stated that it was not a positive or nice experience. These two participants argued that there was no proper experience and that it was not a nice experience. It seems as if one of these participants wanted to learn more about interpreting/translating certain words between English and Xhosa that are difficult to interpret, or where there is no direct translation into the other language. Another participant stated that they did not learn much about the medical terminology that clinicians use, and also that these terms were difficult to understand. Due to the short nature of the course, it would have been impossible to go into such detail, which is one of the reasons that it can be argued that more formal training needs to take place. It would be impossible to train ad hoc interpreters with regards to the complexity of interpreting in such a short space of time. The fact that the training course was too short and that they would like more training was also mentioned by participants. One participant also mentioned that it would not work if they had two duties (interpreting and nursing). There was however a generally positive response when asked what their experience of the course was. The participants called it eye opening, very informing, nice, extremely awesome, very interesting and good. Two of the participants stated that after the training course they understood more about patient illnesses and symptoms, and that they could more easily relate to what the clinicians were talking about. One participant stated that they found the course to be relaxing

and that it gave them the skills that they wanted to learn. Similarly, two other participants stated that they received a lot of knowledge and that the training course included a lot of things that they did not know. Two of the participants said that they learned more about different styles of interpreting. One participant said that they used to interpret generally, with another participant saying that they learned during the course that the clinician needs to know every single word that the patient says, even if it seems to be irrelevant. The majority of the participants felt that the training course met their expectations, that it was fruitful, helpful and that they covered everything in the course. Two of the participants stated that the training course did not meet their expectations. Both of them argued that they were not permanent interpreters and that it is not an official thing, that they were only used as ad hoc interpreters on a temporary basis. One participant stated that they did not receive enough information on how to handle it. It is unclear what the participant is referring to specifically, but presumably they are referring to interpreting in general.

6.6.3. What part of the training participants felt was helpful/not helpful. It seems that one of the parts of the training that participants felt was most helpful was when they learned more about different mental health disorders. Only one of the participants that stated that this was helpful used the word “terms”. It is therefore unclear whether the rest also insinuated that learning the different terms was helpful, and if it was more helpful to learn about the disorders in general. Although the course was probably too short for participants to gain in-depth knowledge of the different disorders, it seems as if it did help them distinguish between certain disorders (like schizophrenia) and symptoms (for example, delusions and hallucinations). It is impossible to judge if the participants actually have more insight into different disorders and symptoms after the training course and whether this was merely the part of the training that they enjoyed the most and could thus easily recall at the time of the interview. One participant mentioned that they felt it was helpful when everybody had a chance to reflect on their experience of interpreting. This offered them the opportunity to learn in a more practical way how to handle different situations that might arise during interpreting sessions. Another participant explained that the most helpful part of the training was when they learned how to do direct interpreting and how to explain things better to the clinician. One participant argued that it was helpful to learn more about interpreting in general and what interpreting entails. As the participant put it, before the training course: “we were just interpreting . . . for the sake of interpreting”. After the training course the participants had a better idea of what was expected of them, and more specifically what the

clinicians expect from them. One of the participants noted that the training was not fulfilling and that there was more that needed to be done. They did not see it as proper training, they received too little information, and to be an interpreter, you need to be well trained. This relates back to a point made earlier, that the training course was too short (three days) to be considered formal interpreter training.

6.6.4. Participants' and researcher's suggestions to improve the training course.

Although there was a general satisfaction with the training course, there were some interesting suggestions to improve the course. One of the participants noted that for them the training course was suitable. Presumably they are referring to ad hoc interpreters who only help out when they are needed. Once again there were suggestions to not only make the training course longer, but also to have more courses and also to have advanced training courses. There was a request for more knowledge. Something that has been evident throughout the data is that the participants realised the importance of interpreting and the importance of having interpreters that have received advanced and formal training. It is important that interpreters (whether ad hoc or professional) are treated as part of a multidisciplinary team (Tribe, 2007; Tribe & Lane, 2009). This can be related to a suggestion that two of the participants made, that the clinicians and supervisors must be involved in the training course. There was a joint workshop for interpreters and clinicians, but it is possible that participants felt that this was not adequate and that the clinicians should be more involved with the training. One participant argued that the clinicians were not aware of the difficulties that interpreters face, mentioning culture as an example. There were once again a few suggestions that the training should focus more on medical words/terminology and cultural aspects involved with interpreting. As before, the issue of feeling comfortable came up, for example talking about private parts and/or sensitive issues, especially when interpreting for the opposite sex. The training course could suggest ways for interpreters to approach such situations, or how to handle sensitive information if it arises. One participant argued that it is important that they talk about culture and sensitive issues when it comes up, but if they do not receive proper training they “will hide the valid information, [they] will hide the gender things and the cultural things and it's not gonna work, because we keeping the valid information that patient is saying and then we're not saying to the clinician”. As has been mentioned, it is of vital importance that interpreters convey everything that the patients say. One participant gave an example of how a patient started screaming at the top of her voice and the participant was unsure of what was happening. It is important that interpreters

are trained to manage difficult situations like this, despite it being impossible to cover every possible difficult situation in the training.

6.6.5. Subsequent interpreting sessions. Although participants did not have a lot of interpreting sessions after the training course, the majority of them agreed that subsequent sessions were different, as they could now use the knowledge and skills that they learned during the training course. Participants argued that they were now more informed and skilled to act as interpreters. Three of the participants talked about the importance of listening skills. It is important to listen carefully to what the speaker says and accurately convey the intended message, even if this means that you need to first play it out in your head, and that it is important that you interpret the exact same words that the speaker used. According to one participant they used to be more lenient before the training course and did not necessarily interpret everything that the patient said, especially if it was something that might be offensive. One participant also stated that after the training they had a better idea of their boundaries, with another participant arguing that they felt more comfortable after receiving the training. Once again, cultural aspects and medical terminology arose when we were discussing subsequent interpreting sessions. One participant stated that they were now better able to handle the cultural part of interpreter mediated sessions. According to this particular participant, they learned from the training course that it is not necessary to go into cultural issues in great depth, explaining everything. It is not clear whether the participant believes that it is not necessary to explain the culture of the patient to the clinician at all, or where one should draw the line when explaining the influence that culture might have. One participant explained that because they now had basic knowledge of different disorders and symptoms, this helped them in subsequent sessions. One participant stated that they could not see any difference in subsequent sessions, stating that they could not grapple with the terms used by clinicians and could not remember them after the training course. Another participant stated that they did not know if the training course had helped, as soon after the course, interpreters were employed at their place of work. Although the participant did not say so, it can be assumed that they were not involved in interpreting sessions after the training.

6.6.6. Interest in further, more formal training courses. Only four of the 13 participants stated that they were not interested in further, more formal training courses. The other nine participants seemed quite enthusiastic to attend more training, stating that it needs to be made an official thing where they could receive full time training and a full time job as an interpreter. One of the participants argued that it is important to gain more knowledge and

experience in order to act as an interpreter. They believe that if they are properly trained and have more experience, they will have the necessary skills to act as interpreter (like having patience for example). Three of the participants that are not interested in further training said that they are not interested in further training because of their age, that they would not be interpreting for much longer and that it was too late for them. One of these participants did however say that they were initially interested in interpreting and going for further training, but that they had changed their mind. The reason for their loss of interest was due to the way that “they” handled it. The participant stated that their department did not really care about interpreting and the way that interpreters should be trained, even though it was an issue that the clinicians were struggling with (the language barrier and interpreters). The participant further stated that if they could receive proper (more formal) training, then they might be interested again, but they did not consider the in-service training course as proper training.

6.7. Theme 6: The importance of a working relationship between interpreters and clinicians

Not only is the therapeutic relationship between patient and clinician of vital importance to mental health care (Doherty et al., 2010), but a much more complex triadic relationship is formed when an interpreter joins the session. It is critical that clinicians also develop a relationship with interpreters. Roles must be clearly defined within this newly formed therapeutic relationship, which can be done through proper planning from clinician and interpreter. They must work towards a common goal, i.e., the mental health of the patient. Issues that need to be discussed are difficult terminology, confidentiality, possible difficulties, boundaries and roles. When possible, clinician and interpreters must have pre-sessions and debriefings.

6.7.1. Pre-sessions and during interpreter mediated sessions. Some of the participants indicated that they have pre-sessions before they see the patient, with one participant stating that only some clinicians have pre-sessions. It could be beneficial if clinicians give interpreters an idea of what to expect during the session, especially with regards to the different disorders. This will ensure that the interpreter has a basic background of what could possibly be discussed during the session, help interpreters to stay on topic, and also help them to convey the intended message to the patient. It would be helpful if interpreters knew “what kind of patient you're dealing with”. This could be done by giving the interpreter a basic background or history on the patient. According to one participant it

would also help them understand better when there are certain difficulties, for example, when the patient is not making sense and talking in a confusing matter, even though they are speaking the same language as the interpreter. It is however of vital importance that both clinician and interpreter respect the confidentiality of the patient. Although some of the clinicians do offer pre-sessions, according to participants some clinicians do not do anything before the session starts. Clinicians can then become irritated during the session. According to one participant, clinicians just want to finish sessions and then move on to the next patient. It is understandable that clinicians might become frustrated and, due to time-constraints, move on to the next patient, but this is not fair on the interpreter or patient. The clinician has a responsibility to deliver the best possible health care to the patient, which will not happen if the session is rushed.

6.7.2. Debriefings. The majority of participants were never offered debriefing after interpreter-mediated sessions, even though only two of the participants felt that it was not necessary. One of the participants that stated they would not like debriefing sessions did however state that they believe it would be helpful. The rest of the participants believe that a debriefing session would be helpful. This would offer them the opportunity to discuss the session and also discuss possible difficulties that came up during the session, for example, if the patient maybe says something that the interpreter knows is not the truth. One participant argues that if interpreter and clinician do not communicate effectively, their work will not be perfect. A debriefing session would help improve communication and would offer the clinician an opportunity to tell the interpreter what they expect from them, and it would also offer the interpreter a chance to brief the clinician on how they see things from their side. Debriefing sessions could also be an opportunity for the clinician to give the interpreter some emotional support and offer them the opportunity to reflect on the emotional impact that interpreting might have on them (Raval, 2006). Two participants also mentioned that debriefing sessions would assist in showing them that the clinician appreciated their help. It must be remembered that the participants are ad hoc interpreters that are often pulled away from their official duties and that they do not receive extra money to help out as interpreters. They often help out because they know that without their help the process would not be possible and that they can help the patient. One participant felt that debriefing sessions would only be helpful if it is a patient that is in their ward. This could be because they feel that they might have some extra insight and can be an important resource for the clinician.

6.7.3. Asking the interpreter's thoughts on the patients. About half of the participants stated that the clinician would ask their thoughts on patients. One of these participants said that they would just say whatever they felt like, which would defeat the purpose of the exercise. Whereas another participant argued that, because they speak the same language as the participant, the clinician would ask their thoughts. This could help the clinician gain some insight into the world of the patient. Only one participant believed that it is not necessary for the clinician to ask their thoughts. Two participants believed it would be helpful, but also that it could be confusing and actually be a disadvantage. The participants do not necessarily understand the different disorders or symptoms and might give the clinician wrong information. The majority of participants believed that it could be a beneficial exercise, even though they do not have knowledge of the medical aspects of the session.

Debriefings would be a good opportunity for interpreters to explain to clinicians how they felt the session went and also if they felt that there had been an improvement in a patient (if they have had more than one session with the same patient). It is important to remember that participants have not had the necessary training to act as co-diagnosticians. One participant argued that debriefing sessions would help them improve their own knowledge, which would be beneficial for future interpreting sessions. One participant stated that debriefing sessions only started being helpful after they went to the training course and although they did not know everything, at least they could offer some insight and be helpful. One participant stated that if they did not receive debriefing sessions, they would not be doing the interpreting with their heart, as they were doing it for "him" (it is unclear whether the participant is referring to the clinician or the patient). Two of the participants argued that because they spend more time with the patients and essentially know them better than the clinician, they could offer valuable input and insight. One participant said that they believe debriefings would be helpful, but they are clearly frustrated by their role as interpreter and the way they are treated, stating that the clinicians do not want to hear from them. As has been mentioned before, it is important that clinician and interpreter work towards a common goal, and an important part of this would be that there is a strong and trusting relationship between interpreter and clinician. The therapeutic relationship between clinician and interpreter can be a very important part of mental health care during interpreter-mediated sessions, and debriefings and asking interpreters thoughts can contribute to a strong working relationship. It is important that the interpreters are not just seen and treated as a interpreting machine, but is rather treated as part of the team. The attitude of the clinician and interpreter can have a

decisive impact on the ultimate success of mental health interviews. According to participants clinicians should not be arrogant and should rather work more closely with interpreters. There needs to be communication between interpreter and clinician, and clinicians should not just take the closest ad hoc interpreter.

6.8. Conclusion

First and foremost, it is important that interpreters have excellent language skills in both languages that they are interpreting in, which was not always the case with the participants in the present study. I had to repeat and explain questions to some of the participants. Mental health staff and patients must be able to trust the language ability of interpreters, as it is impossible to judge how accurately they are conveying the intended message. Although not a direct result of the in-service training course, the role of age, gender and culture is a prominent theme in the data. Culture plays the most important role and cannot be separated from gender and age. It is important that mental health services offer culturally competent care.

Some of the most prominent difficulties that participants faced while interpreting include: patients not speaking sense, issues of respect, talking about sensitive issues, the fact that languages are not directly interchangeable, cultural issues and the emotional impact that interpreting can have on interpreters. Although 11 of the 13 participants had been asked to act as ad hoc interpreters on several occasions, interpreting is only part of two of the participants' official duties. They are often approached to interpret, as there is no-one else available to fulfil this role. Although the majority of the participants enjoy being helpful, the extra burden of interpreting keeps them away from their official duties and can also leave them feeling exploited. Participants realised the important role that interpreters can play in the mental health setting. It is interesting to note that several of the participants felt that as an interpreter, it is their role to offer emotional support to patients as well, going as far as referring to patients as their children.

The participants in the present study identified numerous difficulties when acting as ad hoc interpreters. The most prominent difficulties identified from the data include: miscommunications due to the language barrier; difficulties associated with interpreting words from one language to another, especially certain terminologies; patients that try to get by with their limited knowledge of English; patients not talking sense; patients that do not want to speak to clinicians and clinicians and other staff members that have a negative

attitude towards interpreters and interpreting. Furthermore, interpreting and the difficulties associated with it can leave interpreters feeling helpless and defeated, which contributes to the emotional impact that interpreting can have on participants.

Participants identified three styles of interpreting that they preferred to use. These include word-for-word interpreting, summary interpreting and a combination of the two. The majority (six) of participants used summary interpreting, where they might change the words of the speaker, but ensure that the intended message stays the same.

Only two participants had any previous experience of interpreting, but there was a willingness to learn and act as ad hoc interpreters. This willingness to learn, combined with the fact that eight of the participants indicated that they speak three or more languages, could be used as motivation to use in-service training courses to train staff members to act as interpreters. Eight of the participants attended the in-service training course as they wished to gain more knowledge about interpreting, whereas five participants were asked or nominated to attend the training course. Reasons for attending the in-service training course included learning more about the terminology used, background of the patient and how to handle cultural and sensitive issues pertaining to interpreting. Furthermore, participants wished to learn more general skills, like how to present themselves during interpreting sessions, how to correctly conduct interpreting sessions and also the procedures involved with interpreter-mediated sessions.

Only two participants stated that they did not have a positive experience of the training course. The majority of participants felt that the training course was helpful, mentioning learning about different mental disorders, learning about interpreting in general and being offered the opportunity to reflect on their experience of interpreting as being the most helpful. Although the majority felt that the training met their expectations, calling it eye opening and very interesting, there was a general consensus that the training course was too short. Participants suggested that the training courses be longer, more frequent, and more advanced. More specifically, participants wished to gain more knowledge about terminology and cultural aspects, how to handle sensitive information and difficult situations and also stated that clinicians and supervisors should be more involved in the training course.

Unfortunately, it is difficult to judge subsequent interpreting sessions, as interpreters were employed soon after the training course and participants did not have a lot of interpreting sessions after the training. They did however state that now they had basic

knowledge of interpreting and could use the knowledge and skills that they had learned during the training course. Nine of the 13 participants stated that they were interested in attending more formal training. One of the four participants that stated they were not interested did, however, say that they would be interested if they received more formal training.

It is important that there is a good working relationship between interpreter and clinician, as this will benefit the patient. To ensure a trusting relationship is formed and that everyone involved knows what is expected of them, clinicians and interpreters can make use of pre-sessions, debriefings and communicating during sessions.

CHAPTER 7: CONCLUSION

7.1. Conclusion

Even though all of the interviews were conducted in English and the participants interpret between English and another language, some of the participant's English was clearly not good enough to ensure that effective communication can take place during mental health interviews. The data collection interviews were conducted in very simple English, but even during these interviews some of the participants asked very elementary questions or could not understand what the interviewer was asking. This had the effect that participants did not answer questions with a straight answer. These participants were asked to interpret based on the fact that they understand a language (which is English in this case), but could not answer very simple questions. It could be that they did not understand the questions, but surely they are easier to understand than mental health concepts that could potentially come up during interpreting sessions. Some participants asked when they did not understand a question; whereas others would answer what they thought was expected from them. When asked about the role of gender in interpreting for example, one participant spoke about gender issues in general, outside of interpreting. This miscommunication occurred with at least three of the 13 participants. Interestingly, one participant stated that they are "trying to translate from English and say this and this". This shows that some of the participants are aware that their language ability might not be good enough, and that they are simply trying to interpret. When asked what languages the participant's speak, some of them didn't mention that they speak English. It could be that they think that it is assumed, as the interview took place in English. More alarming is the possibility that they do not consider their English ability to be good enough to mention. The question then arises why they would agree to interpret, possibly because they did not have a say in the matter.

One of the participants explained how she uses her age to demand respect from younger patients, which is not necessarily the correct thing to do, as it may hinder open and honest communication from the patient. The issue of respect arose frequently and plays a vital role in many African cultures. Older patients might see the younger clinicians and/or interpreters as children. In addition to interpreting the spoken word, these interpreters must also then manage this very complex situation to ensure that the patients receive adequate mental health care. Patients might choose not to disclose everything to these "children". Together with respect, there are also certain taboo topics and words that participants avoid

during interpreting sessions, which defeat the purpose of interpreting exactly what the clinician or patient has said. Apart from issues discussed above, one participant also highlighted the fact that it is easier to interpret for patients more similar to their age, as “we living in the same lives, so I can quickly pick up what they are talking about”. Whereas with an older patient, it might be difficult for young interpreters to understand what the patient is talking about.

The role that culture plays during interpreting sessions was very evident in the data. Both interpreters and patients want to respect their culture, which can unfortunately lead to important information that is not interpreted, withheld or hidden from the clinician. It is important to respect the culture of patients, but if certain issues are just pushed aside, it could have a negative impact on the effectiveness of health care. The participants also stated that due to their culture, the patients were sometimes unwilling to talk about their issues. It is unclear whether or not the patients were unwilling to speak to the interpreter, or rather told the interpreter not to translate what they have said. It seems as if the latter is the case in many situations and due to cultural beliefs and showing respect, it seems as if interpreters often obeyed the wishes of the patient, thus potentially withholding important information from the clinician. Similar issues were identified when discussing the role of gender.

Interpreters/patients wish not to discuss certain sensitive information, issues of showing respect and hiding valid information from clinician. Due to limited access to professional interpreters and an already overburdened work staff (or potential ad hoc interpreters), it is not always possible to match interpreters, patients and clinicians for age, gender and culture. The above mentioned difficulties will have to be overcome with what limited resources are available. Proper training is vital to ensure that both clinicians and interpreters are equipped to deal with difficulties associated with age, gender and culture when these arise.

Two of the thirteen participants indicated that interpreting is part of their official duties. Interestingly these participants gave similar job descriptions when asked about their duties at the hospital. They were also employed by the same hospital. The one identified himself as an administration clerk and the other as a ward clerk, both involved with patient admissions and discharges. One of these participants (P13) did seem a bit unsure of his role as interpreter at the hospital, or rather how official it actually is. When asked if it was part of his duties, he responded by saying, “Yes, that’s what they told us, it is part of your job”.

What is striking about this is that he shifts the blame/responsibility, maybe because he is unsure. There is no definite affirmation that it is in his job description, but rather that “they” told him that it is part of his job. It is impossible to say for sure if it states in these participants’ job descriptions whether interpreting is part of their official duties (and whether they are qualified to interpret). Simply telling them that it is their job to interpret (without official proof of this role) is an easy way to hide the fact that this is a form of exploitation and, furthermore, this leaves the participants no choice but to interpret and makes it impossible for them to refuse. This illustrates how vulnerable these participants can be with regards to fulfilling a vital part of the mental health interview.

Participant 5, whose role it is supposedly to interpret, stated that the in-service training course was enough and that they are not interested in further training, because they do not think that they will be interpreting for much longer. This raises further questions if interpreting is really part of their duties, or if they just believe it is, because they were told that it is. The other participant (participant 13) shows a bit more interest in more formal training and has valuable suggestions for bettering the training. Once again it is difficult to judge whether this is genuine interest, or merely interest because that is what he believes the researcher and the hospital want to hear. If he was told that interpreting is not part of his duties, would he still have such a great interest in further training? Although both of these participants identified interpreting as part of their duties, both of them stated that interpreting at their current place of employment was their first experience of interpreting. Which questions their qualification to have interpreting listed in their job descriptions. Even though the other 11 participants stated that interpreting is not part of their official duties, one of them said that when they started working at the hospital, they were asked to interpret almost every day, and at least four or five days a week. This can be seen as a form of exploitation.

There was generally an awareness from participants that there is a need for formal/professional interpreters. When discussing their role as interpreters, they used words and phrases like “. . . fortunately I was at the office . . .”, “Luckily” and “convenient partner”. It is a human rights issue to receive adequate health care and should not be seen as a lucky coincidence that somebody was available to interpret, because without these ad hoc interpreters the patient and clinician would be left stranded. Even though there are numerous difficulties and errors associated with the use of ad hoc interpreters, the patients must receive care and as can be seen from the data “for [the clinician] to proceed, I must interpret”, “because of the nobody to do it”. Apart from their presence being a fortunate coincidence,

participants felt that they had to interpret and that they are being used. These ad hoc participants are placed in a very vulnerable position, as they cannot really say no, but also as has been seen, some of the participant's language ability is not really good enough to ensure effective communication. One of the participants even admitted to going to interpret out of their own. Not only are they being used, but it has become so part of everyday life that they feel they have an obligation to interpret. As the interpreters and patients are often from a similar cultural background, some participants were even referring to the patients as their children, brothers and sisters, there can be a further feeling of obligation. Participants might feel that they must help "their" people.

The role that the participants fulfil as ad hoc interpreters is also invisible and very time consuming. They are expected to leave their official duties and immediately go and help with interpreting, which effects and interferes with their other duties. They are expected to fulfil a role that they are not being paid for, or in some instances do not even get as much as a thank you for. Apart from interpreting, participants also expressed that they feel as if it is their duty to provide emotional support for patients and their families. This is something that these participants take upon themselves, something that they are not necessarily trained for and may also be very emotionally taxing for them. This leads to an already overburdened staff that is taken away from their duties (leading to a lack of productivity) to perform an invisible job that they receive no compensation (financial or emotional) for.

Participants stated that even if they speak the same language as the patient, there are still some words or phrases that they do not understand or which are impossible to translate. So not only do some of the participants struggle with English, but when they have to translate to Xhosa for example, they are also struggling. Some participants admitted to trying to minimise translations, simply trying to give it back to the listener and having to go and ask another person the meaning of a word. Although it is unclear when they would ask other people for the meaning of words, presumably it would only be once the session has ended, which would mean that it is of no benefit to the patient. There is thus the possibility for language disturbances or errors when communicating both ways. This relates to a point made earlier; these participants cannot refuse when asked to interpret, but yet they are ill equipped to perform this role. This adds to the vulnerability of these ad hoc interpreters. Furthermore, the participants stated that they sometimes feel useless, like a fool and very stressed. Not only are they rendering an invisible and ungrateful service, but it is having a negative effect on their wellbeing. This is further escalated by clinicians who get irritated and frustrated, and

patients that undermine them. One has to question how well they are fulfilling their role as interpreter, or how much effort they are putting into it. In no way am I questioning their commitment, but due to numerous factors (i.e., they have no choice in the matter, are vulnerable, are aware of language errors, feel useless, are underappreciated, emotional taxing, etc.) it must be difficult to ensure that they are always performing to the best of their ability, especially when patients are also playing on their emotions.

One of the participants showed great insight when he stated that because the clinicians only understands English, they will not know whether or not he is giving accurate translations. Interestingly, this particular participant is an accounting clerk, which suggests that he might be a bit more educated than some of the other participants.

A number of the participants stated that they enjoy interpreting and are interested in learning more, even though they are not being paid for it. Even though participants show an interest in interpreting, when they were asked why they attended the in-service training course, a number of them said that they were nominated to attend the training, and that it was not their decision. Once again, they were told to do something that should not be expected of them. If they purely attended the training because of an interest, they would not have said that it was not their choice and that they were told that they needed to attend the training. Even though numerous participants stated that they were interested, wanted to gain more knowledge and the necessary skills, only one participant explicitly said that it was their choice to attend the training. There is the possibility that the participants are saying this because they feel as if it is the right answer. It is possible that they see interpreting as a step up in their social class and a way to play a more important role in the hospital. When asked whether the training met their expectations, 11 of the participants stated that it met their expectations. Once again, this could be because they believe that this is the desired response. Even though it was clearly stated to participants that I was not there to check up on them, they may still have associated me with the training course and believed that I was there to follow up on their responses. The participants who stated that the training course was not a good experience, were a supervisor, administration clerk and occupational therapy technician respectively. They are possibly a bit more educated than some of the other participants and were more likely to give honest answers and not give what they felt was the desired response, as they did not see interpreting as a move up the social ladder.

When asked what part of the training was the most helpful, the default answer was that they learned more about medical terminology and different diseases. This was the easiest answer to give, as this is an aspect of their role as interpreters that they are struggling with, but also it is a simple answer that does not need much thought. Due to the short nature of the training course, it would have been impossible to give them a basic knowledge of all the different diseases, symptoms, etc. It would be easy for them to say that this is the part of the training that helped most, but there is no way of judging how helpful it really was. Once again it was two participants, who presumably are better educated (administration clerk and accounting clerk), that deviated from the general answers. One participant stated that the most helpful part was when they were offered the opportunity to reflect on their experiences and listen to other people's experiences. This is a very interesting and important insight. They had the opportunity to learn from their peers and learn more about the difficulties and experiences that they have had in practice. The people that are involved in actual interpreting sessions at these hospitals will know best what to expect when involved in interpreter-mediated sessions. The other participant stated that the training was not fulfilling, and that it could not be considered to be proper training. Although numerous participants argued that the training was too short, he was one of the few participants that seemed displeased with the training. It could be that the other participants gave the desired answer and did not wish to say anything negative about the training. Possibly because they were afraid that this would somehow negatively affect their chances of one day getting a better paid job that involves more fulltime interpreting, not that that was a possibility that was communicated to them. Suggestions for further training followed a similar trend, stating that the course was suitable, but that it needs to be longer and there needs to be more training courses.

It is important that the clinicians give their input, as this would give the interpreters a better idea of what is expected of them. It could also potentially have offered both interpreters and clinicians the opportunity to discuss their respective roles. It was also suggested that clinicians/supervisors should be more involved with the training. This is interesting, as they might see it as an opportunity to impress the clinicians/supervisors, but more importantly it would shed some light on the important role that they play as interpreters. This would give the ad hoc interpreters the opportunity to discuss their role as interpreters with the clinicians, which could lead to more appreciation from the clinicians (which was clearly an issue for some of the participants). They help out with interpreting because they feel obligated to do

so, but the whole exercise would be made easier for them if they received credit for all the invisible work that they do.

Unfortunately it was difficult to judge the effectiveness of the training course through subsequent interpreting sessions. This is due to two reasons: I did not have access to these sessions (or sessions before the training) and soon after the training interpreters were employed at the different hospitals. It is difficult to judge from what the participants said if the training helped, as they could once again have reacted in what they believed to be the desired reaction, saying that it helped. The majority claimed that they could now use the skills and knowledge that they learned during the training, but you have to wonder how much they could have possibly learned in such a short time. Only one participant stated that there was no change after the training. Not surprising is that this is the same participant that argued that they did not receive any proper experience from the training, it was not fulfilling, did not meet their expectation, that it was too little information to constitute training and that he is not interested in further training.

Quite a few participants stated that they would be interested in further training, but it seems as if a major motivation for this is the promise of a better job. They believed that if they attended more advanced training, they could be offered a full time job with a good salary. It is alarming that one participant lost his interest in interpreting due to the way that interpreting has been handled and that his department does not care much about the role that interpreters play. This participant was clearly fed up with the way he was treated. They were “forced” into doing something that was not part of their duties; they were not compensated for and were shown no appreciation at times. The burden of these invisible duties has left a bitter taste in his mouth regarding interpreting, which might also be true for more participants.

The majority of participants argued that pre-sessions and post sessions would be beneficial. Yet only three stated that they are offered pre-sessions. During pre-sessions clinicians could guide interpreters, help them with difficult terminology, tell them what to expect, give them a bit of background on the patient and discuss possible difficulties that might arise. There are various possibilities why clinicians do not offer pre-sessions for interpreters. The obvious reason could be that they do not have time and that “they just want to get it done, the job done and go to the next person”. Possibly, they also might not appreciate the importance that interpreters can have in ensuring that the patient receives

adequate health care. Another possibility is that because they know that it is not professional interpreters, they might feel as if it would be a pointless exercise. They could also be concerned with issues of confidentiality and other ethical concerns and may wish to not share extra information about the patient with the interpreters. Much the same can be said for debriefings. About half of the participants stated that clinicians asked their thoughts on patients. Benefits of this is that they can discuss things that were not said during the session or things that the interpreter picked up that was difficult to explain to the clinician at the time. Participants also often spend much more time with patients and could offer clinicians valuable insight. One of the participants believed that it could actually be a disadvantage if they share their thoughts on patients, as they do not necessarily understand everything that was discussed during the session. One participant was noticeably upset when we discussed whether or not clinicians should ask their thoughts, stating that they believe that clinicians should ask their thoughts, but that they do not, because they do not want to hear from them. It is important that interpreters are seen as part of the multi-disciplinary team and not just seen as an interpreting tool that is used and then discarded. Clinicians need to respect the role that these ad hoc interpreters play in the health care process. Ultimately clinicians and interpreters need to work closely together to ensure that the patients receive the best possible care.

7.2. Limitations

The study was limited in scope. Not all the issues pertaining to interpreting could be addressed. An obvious limitation of this study is that I did not have access to actual interpreting sessions. Interpreting sessions are likely to be a lot different in reality compared to the accounts that I received from the participants. Another limitation is the fact that the in-service training course was conducted during August 2011, whereas the interviews were conducted between June and September 2012. This opens the possibility for loss of recall from the participants

7.3. Recommendations

There is clearly a gap in the literature regarding language issues and the use of interpreters. The effects of LEP on health outcomes (John-Baptiste et al., 2004) and working with interpreters has not received a lot of research attention (Searight & Armock, 2013; Tribe & Keefe, 2009). Although there has been a growing body of literature, the majority of research on interpreting in mental health comes from high-income countries (Kilian et al., 2014) and more research is needed in low- and middle-income countries (Kilian et al., 2014;

Swartz et al., 2014). Issues that were identified in mental health in South Africa 20 years ago still persist (Kilian et al., 2014). Further research is necessary to ensure that these issues are addressed.

REFERENCES

- Anderson, L. M., Scrimshaw, S. C., Fullilove, M. T., Fielding, J. E., Normand, J., & the Task Force on Community Preventive Services. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventive Medicine*, *24*, 68-79. doi:10.1016/S0749-3797(02)00657-8
- Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. *Medical Care*, *36*, 1461-1470. Retrieved from http://ovidsp.tx.ovid.com.ez.sun.ac.za/sp-3.40b/ovidweb.cgi?&S=JKIGFPECMMDDNDHHNCCLHFDCAJINAA00&Link+Set=S.sh.15.16.21.30%7c4%7csl_10
- Baron, D. S., Holterman, C., Shipster, P., Batson, S., & Alam, M. (2010). Seen but not heard - ethnic minorities' views of primary health care interpreting provision: A focus group study. *Primary Health Care Research & Development*, *11*, 132-141. doi:10.1017/S1463423609990399
- Bauer, A. M., & Alegria, M. A. (2010). Impact of patient language proficiency and interpreter service use on the quality of psychiatric care: A systematic review. *Psychiatric Services*, *61*, 765-773. doi:10.1176/appi.ps.61.8.765
- Bezuidenhout, L., & Borry, P. (2009). Examining the role of informal interpretation in medical interviews. *Journal of Medical Ethics*, *35*, 159-162. doi:10.1136/jme.2008.026286
- Bischoff, A., Bovier, P. A., Isah, R., Françoise, G., Ariel, E., & Louis, L. (2003). Language barriers between nurses and asylum seekers: Their impact on symptom reporting and referral. *Social Science & Medicine*, *57*, 503-512. Retrieved from

http://www.sciencedirect.com.ez.sun.ac.za/science?_ob=MImg&_imagekey=B6VBF-47TNMVP-3-8&_cdi=5925&_user=613892&_pii=S0277953602003763&_origin=browse&_zone=rslt_list_item&_coverDate=08%2F31%2F2003&_sk=999429996&wchp=dGLbVtb-zSkWb&md5=d29be9e4e20515fa32b0c9cec11b&ie=/sdarticle.pdf

Bischoff, A., Kurth, E., & Henley, A. (2012). Staying in the middle. A qualitative study of health care interpreters' perceptions of their work. *Interpreting, 14*, 1-22.
doi:10.1075/intp.14.1.01bis

Björn, G. J. (2005). Ethics and interpreting in psychotherapy with refugee children and families. *Nordic Journal of Psychiatry, 59*, 516-521. doi:10.1080/08039480500360740

Bless, C., Higson-Smith, C., & Kagee, A. (2006). *Fundamentals of social research methods: An African perspective* (4th ed.). Cape Town: Juta and Company LTD.

Bolton, J. (2002). The third presence: A psychiatrist's experience of working with non-English speaking patients and interpreters. *Transcultural Psychiatry, 39*, 97-114.
Retrieved from <http://tps.sagepub.com.ez.sun.ac.za/content/39/1/97.full.pdf+html>

Brach, C., Fraser, I., & Paez, K. (2005). Crossing the language chasm. *Health Affairs, 24*, 424-434. doi:10.1377/hlthaff.24.2.424

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brisset, C., Leanza, Y., & Laforest, K. (2013). Working with interpreters in health care: A systematic review and meta-ethnography of qualitative studies. *Patient Education and Counseling, 91*, 131. doi:10.1016/j.pec.2012.11.008

- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health, 21*, 87-108. doi:10.1080/14768320500230185
- Chapman, E., & Smith, J. A. (2002). Interpretative phenomenological analysis in the new genetics. *Journal of Health Psychology, 7*, 125-130. doi:10.1177/1359105302007002397
- Clarke, C. (2009). An introduction to interpretative phenomenological analysis: A useful approach for occupational therapy research. *British Journal of Occupational Therapy, 72*, 37-39. Retrieved from <http://www.ingentaconnect.com/content/cot/bjot/2009/00000072/00000001/art00006>
- Cross, W. M., & Bloomer, M. J. (2010). Extended boundaries: Clinical communication with culturally and linguistically diverse mental health clients and carers. *International Journal of Mental Health Nursing, 19*, 268-277. doi:10.1111/j.1447-0349.2010.00667.x
- Davidson, B. (2001). Questions in cross-linguistic medical encounters: The role of the hospital interpreter. *Anthropological Quarterly, 74*, 170-178. Retrieved from <http://web.a.ebscohost.com.ez.sun.ac.za/ehost/pdfviewer/pdfviewer?sid=cc8ae844-b249-47f7-b70b-2f11d15a04fc%40sessionmgr4001&vid=4&hid=4101>
- Davidson, B. (2002). A model for the construction of conversational common ground in interpreted discourse. *Journal of Pragmatics, 34*, 1273-1300. http://ac.els-cdn.com/S0378216602000255/1-s2.0-S0378216602000255-main.pdf?_tid=7967376e-9652-11e4-b395-00000aacb35f&acdnat=1420624349_35939af5b58b139abf2992473060b130

- Deumert, A. (2010). 'It would be nice if they could give us more language' – Serving South Africa's multilingual patient base. *Social Science & Medicine*, 71, 53-61.
doi:10.1016/j.socscimed.2010.03.036
- Doherty, S. M., MacIntyre, A. M., & Wyne, T. (2010). How does it feel for you? The emotional impact and specific challenges of mental health interpreting. *Mental Health Review Journal*, 15, 31-44. doi:10.5042/mhrj.2010.0657
- Drennan, G. (1999). Psychiatry, post-apartheid integration and the neglected role of language in South African institutional contexts. *Transcultural Psychiatry*, 36, 5-22.
doi:10.1177/136346159903600101
- Drennan, G., & Swartz, L. (2002). The paradoxical use of interpreting in psychiatry. *Social Science & Medicine*, 54, 1853-1866. Retrieved from
http://www.sciencedirect.com.ez.sun.ac.za/science?_ob=MIimg&_imagekey=B6VBF-45R762V-B-1&_cdi=5925&_user=613892&_pii=S0277953601001538&_origin=browse&_zone=rslt_list_item&_coverDate=06%2F30%2F2002&_sk=999459987&wchp=dGLzVtb-zSkWA&md5=d432f35c2441b2684b609e51e548168d&ie=/sdartic le.pdf
- Dysart-Gale, D. (2007). Clinicians and medical interpreters: Negotiating culturally appropriate care for patients with limited English ability. *Family & Community Health*, 30, 237-246. Retrieved from <http://ovidsp.tx.ovid.com.ez.sun.ac.za/sp-3.13.1a/ovidweb.cgi?WebLinkFrameset=1&S=OLAJFPOPALDDCFMLNCLKCBJCCOADAA00&returnUrl=ovidweb.cgi%3f%26Full%2bText%3dL%257cS.sh.22.23.26.29.33%257c0%257c00003727-200707000-00009%26S%3dOLAJFPOPALDDCFMLNCLKCBJCCOADAA00&directlink=http%3a%2f%2fgraphics.tx.ovid.com%2fovftpdfs%2fFPDDNCJCCBMLAL00%2ffs046>

%2fovft%2flive%2fgv025%2f00003727%2f00003727-200707000-00009.pdf&filename=Clinicians+and+Medical+Interpreters%3a+Negotiating+Cultural+ly+Appropriate+Care+for+Patients+With+Limited+English+Ability.&pdf_key=FPDD NCJCCBMLAL00&pdf_index=/fs046/ovft/live/gv025/00003727/00003727-200707000-00009&D=ovft

Firth, A. (2009). The lingua franca factor. *Intercultural Pragmatics*, 6, 147-170. doi:

10.1515/IPRG.2009.009

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review*, 62, 255-299.

doi:10.1177/1077558705275416

Flores, G. (2006). Language barriers to health care in the United States. *The New England Journal of Medicine*, 355, 229-231. Retrieved from

<http://www.nejm.org.ez.sun.ac.za/doi/pdf/10.1056/NEJMp058316>

Flynn, P. M., Ridgeway, J. L., Wieland, M. L., Williams, M. D., Haas, L. R., Kremers, W. K., & Breitkopf, C. R. (2012). Primary care utilization and mental health diagnoses among adult patients requiring interpreters: A retrospective cohort study. *Journal of General Internal Medicine*, 28, 386-391. doi:10.1007/s11606-012-2159-5

Hadziabdic, E., & Hjelm, K. (2013). Working with interpreters: Practical advice for use of an interpreter in healthcare. *International Journal of Evidence-Based Healthcare*, 11, 69-

76. doi:10.1111/1744-1609.12005

Hagan, S., Swartz., L., Kilian, S., Chiliza, B., Bisogno, P., & Joska, J. (2013). The accuracy of interpreting key psychiatric terms by ad hoc interpreters at a South African

psychiatric hospital. *African Journal of Psychiatry*, 16, 424-429. Retrieved from <http://dx.doi.org/10.4314/ajpsy.v16i6.54>

Hayes-Bautista, D. E. (2003). Research on culturally competent healthcare systems: Less sensitivity, more statistics. *American Journal of Preventive Medicine*, 24, 8-9. doi:10.1016/S0749-3797(02)00648-7

House, J. (2003). English as a lingua franca: A threat to multilingualism. *Journal of Sociolinguistics*, 7, 556-578. Retrieved from <http://ukonline-web.uni-koeln.de/remarks/d5134/rm2169656.pdf>

Hsieh, E. (2006). Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science & Medicine*, 62, 721-730. doi:10.1016/j.socscimed.2005.06.029

Hsieh, E., Ju, H., & Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research*, 20, 170-181. doi:10.1177/1049732309349935

Hsieh, E., & Kramer, E. M. (2012). Medical interpreters as tools: Dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling*, 89, 158-162. doi:10.1016/j.pec.2012.07.001

Hudelson, P., & Vilpert, S. (2009). Overcoming language barriers with foreign-language speaking patients: A survey to investigate intra-hospital variation in attitudes and practices. *BMC Health Service Research*, 9, 187-195. doi:10.1186/1472-6963/9/187

Hülmbauer, C., Böhringer, H., & Seidlhofer, B. (2008). Introducing English as a lingua

franca (ELF): Precursor and partner in intercultural communication. *Synergies Europe*, 3, 25-36. Retrieved from

<http://s3.amazonaws.com/academia.edu.documents/30870560/hulmbauer.pdf?AWSAccessKeyId=AKIAJ56TQJRTWSMTNPEA&Expires=1438253328&Signature=K%2FiNLVrPl4Mjkgom8tgtFcwvInM%3D&response-content-disposition=inline>

Jacobs, E. A., Diamond, L. C., & Stevak, L. (2010). The importance of teaching clinicians when and how to work with interpreters. *Patient Education and Counseling*, 78, 149-153. doi:10.1016/j.pec.2009.12.001

John-Baptiste, A., Naglie, G., Tomlinson, G., Alibhai, S.M.H., Etmells, E., Cheung, A., . . . Krahn, M. (2004). The effect of English language proficiency on length of stay and in-hospital mortality. *Journal of General Internal Medicine*, 19, 221-228. Retrieved from http://download.springer.com.ez.sun.ac.za/static/pdf/582/art%253A10.1111%252Fj.1525-1497.2004.21205.x.pdf?auth66=1420624874_b423464b14117ba47d203f46f8bbe0a5&ext=.pdf

Kale, E., & Syed, H. R. (2010). Language barriers and the use of interpreters in the public health service. A questionnaire-based survey. *Patient Education and Counseling*, 82, 187-191. doi:10.1016/j.pec.2010.05.002

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research*, 42, 727-754. doi:10.1111/j.1475-6773.2006.00629.x

- Kilian, S. (2007). *Interpreting practices in a psychiatric hospital: Interpreters' experiences and accuracy of interpreting of key psychiatric terms* (Unpublished master's thesis). University of Stellenbosch, Stellenbosch.
- Kilian, S., Swartz, L., Dowling, T., Dlali, M., & Chiliza, B. (2014). The potential consequences of informal interpreting practices for assessment of patients in a South African psychiatric hospital. *Social Science & Medicine*, *106*, 159-167.
doi:10.1016/j.socscimed.2014.01.019
- Kilian, S., Swartz, L., & Joska, J. (2010). Competence of interpreters in a South African psychiatric hospital in translating key psychiatric terms. *Psychiatric Services*, *61*, 309-312. Retrieved from
<http://www.psychservices.psychiatryonline.org/cgi/reprint/61/3/309>
- Kim, G., Aguado Loi, C. X., Chiriboga, D. A., Jang, Y., Parmelee, P., & Allen, R. S. (2011). Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *Journal of Psychiatric Research*, *45*, 104-110. doi:10.1016/j.jpsychires.2010.04.031
- Kleintjes, S., Lund, C., & Swartz, L. (2013). Organising for self-advocacy in mental health: Experiences from seven African countries. *African Journal of Psychiatry*, *16*, 187-195.
doi:<http://dx.doi.org/10.4314/ajpsy.v16i3.25>
- Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101-116). United Kingdom: John Wiley & Sons, Ltd.

- Lee, S. K., Sulaiman-Hill, C. R., & Thompson, S. C. (2014). Overcoming language barriers in community-based research with refugee and migrant populations: Options for using bilingual workers. *BMC International Health and Human Rights*, 14, 11-p. Retrieved from <http://www.biomedcentral.com/content/pdf/1472-698X-14-11.pdf>
- Lee, K. C., Winickoff, J. P., Kim, M. K., Campbell, E. G., Betancourt, J. R., Park, E. R., Maina, A. W., & Weissman, J. S. (2006). Resident physicians' use of professional and nonprofessional interpreters: A national survey. *Journal of the American Medical Association*, 9, 1049-1054. doi:10.1001/jama.296.9.1050
- Levin, M. E. (2006a). Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *South African Medical Journal*, 96, 1076-1079. Retrieved from http://search.sabinet.co.za.ez.sun.ac.za/WebZ/images/ejour/images/ejour/m_samj/m_samj_v96_n10_a20.pdf?sessionid=01-39880-1085040505&format=F
- Levin, M. E. (2006b). Different use of medical terminology and culture-specific models of disease affecting communication between Xhosa-speaking patients and English-speaking doctors at a South African paediatric teaching hospital. *South African Medical Journal*, 96, 1080-1084. Retrieved from http://search.sabinet.co.za.ez.sun.ac.za/WebZ/images/ejour/images/ejour/m_samj/m_samj_v96_n10_a21.pdf?sessionid=01-39880-1085040505&format=F
- Luk, S. (2008). Overcoming language barriers in psychiatric practice: Culturally sensitive and effective use of interpreters. *Journal of Immigrant & Refugee Studies*, 6, 545-566. doi:10.1080/15362940802480589

- MacFarlane, A., Glynn, L. G., Mosinkie, P. I., & Murphy, A. W. (2008). Response to language barriers in consultations with refugees and asylum seekers: A telephone survey of Irish general practitioners. *BMC Family Practice, 9*(68), 1-6.
doi:10.1186/1471-2296-9-68
- Maltby, H. J. (1999). Interpreters: A double-edged sword in nursing practice. *Journal of Transcultural Nursing, 10*, 248-254. doi:10.1177/104365969901000316
- Mauranen, A. (2009). Chunking in ELF: Expressions for managing interaction. *Intercultural Pragmatics, 6*, 217-233. doi: 10.1515/IPRG.2009.012
- McDowell, L., Messias, D. K. H., & Estrada, R. D. (2011). The work of language interpretation in health care: Complex, challenging, exhausting, and often invisible. *Journal of Transcultural Nursing, 22*, 137-147. doi:10.1177/1043659610395772
- Meeuwesen, L., Twilt, S., Thilje, J. D., & Harmsen, H. (2009). "Ne diyor?" (What does she say?): Informal interpreting in general practice. *Patient Education and Counseling, 81*, 198-203. doi:10.1016/j.pec.2009.10.005
- Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75*, 27-39. doi:10.1037/0002-9432.75.1.27
- Ono, N., Kiuchi, T., & Ishikawa, H. (2013). Development and pilot testing of a novel education method for training medical interpreters. *Patient Education and Counseling, 93*, 604-611. doi:10.1016/j.pec.2013.09.003
- Paone, T. R., & Malott, K. M. (2008). Using interpreters in mental health counseling: A literature review and recommendations. *Journal of Multicultural Counseling and Development, 36*, 130-142. doi:10.1002/j.2161-1912.2008.tb00077.x

Penn, C., & Watermeyer, J. (2012). When asides become central: Small talk and big talk in interpreted health interactions. *Patient Education and Counseling*, 88, 391-398.

doi:10.1016/j.pec.2012.06.016

Pérez-Stable, E. J., & Karliner, L. S. (2012). What do we know about patient-clinician interactions with interpreters? *Journal of General Internal Medicine*, 28, 339-341.

doi:10.1007/s11606-012-2290-3

Pottie, K., Ng, E., Spitzer, D., Mohammed, A., & Glazier, R. (2008). Language proficiency, gender and self-reported health: An analysis of the first two waves of the longitudinal survey of immigrants to Canada. *Canadian Journal of Public Health*, 99, 505-510.

Retrieved from

<http://search.proquest.com.ez.sun.ac.za/docview/232001035/fulltextPDF/AC24C20541E54C09PQ/19?accountid=14049>

Raval, H. (2006). Mental health training for bilingual co-workers in the context of working with people seeking asylum and refuge. *Primary Care Mental Health*, 4, 37-44.

Retrieved from

<http://web.a.ebscohost.com.ez.sun.ac.za/ehost/pdfviewer/pdfviewer?sid=0994419d-fa73-4782-ba17-44f8c86ea651%40sessionmgr4005&vid=3&hid=4201>

Reithofer, K. (2013). Comparing modes of communication: The effect of English as a lingua franca vs. interpreting. *Interpreting*, 15, 48-73. doi:10.1075/intp.15.1.03rei

Rosenberg, E., Lanza, Y., & Seller, R. (2007). Doctor-patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters.

Patient Education and Counseling, 67, 286-292. doi:10.1016/j.pec.2007.03.011

- Sarver, J., & Baker, D. W. (2000). Effect of language barriers on follow-up appointments after an emergency department visit. *Journal of General Internal Medicine*, 15, 256-264. Retrieved from http://download.springer.com.ez.sun.ac.za/static/pdf/843/art%253A10.1111%252Fj.1525-1497.2000.06469.x.pdf?auth66=1420707984_1b8e8170362968eceb7c9ae1ab93a4dd&ext=.pdf
- Schlemmer, A., & Mash, B. (2006). The effects of a language barrier in a South African district hospital. *South African Medical Journal*, 96, 1084-1087. Retrieved from http://search.sabinet.co.za.ez.sun.ac.za/WebZ/images/ejour/images/ejour/m_samj/m_samj_v96_n10_a22.pdf?sessionid=01-44386-627866917&format=F
- Searight, H. R., & Armock, J. A. (2013). Foreign language interpreters in mental health: A literature review and research agenda. *North American Journal of Psychology*, 15, 17-38. Retrieved from <http://web.b.ebscohost.com.ez.sun.ac.za/ehost/pdfviewer/pdfviewer?sid=75239d54-cc8d-43a1-8922-80e58937dc04%40sessionmgr115&vid=3&hid=107>
- Searight, H. R., & Searight, B. K. (2009). Working with foreign language interpreters: Recommendations for psychological practice. *Professional Psychology: Research and Practice*, 40, 444-451. doi:10.1037/a0016788
- Seidlhofer, B. (2005). Key concepts in ELT: English as a lingua franca. *English Language Teaching Journal*, 59, 339-341. Retrieved from http://didattica.uniroma2.it/assets/uploads/corsi/143781/Seidlhofer.English_as_a_lingua_franca_.ELT_Journal_copy_.pdf

- Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., & McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health*, 28, 91-106. Retrieved from http://download.springer.com/static/pdf/536/art%253A10.1023%252FA%253A1026603406481.pdf?auth66=1420708210_564edd63c81c4f3ef622723740e23e1c&ext=.pdf
- Smit, J., Van den Berg, C. E., Bekker, L., Seedat, S., & Stein, D. J. (2006). Translation and cross-cultural adaption of a mental health battery in an African setting. *African Health Sciences*, 6, 215-222. Retrieved from <http://www.ajol.info/index.php/ahs/article/view/6956/58199>
- Smith, J., Swartz, L., Kilian, S., & Chiliza, B. (2013). Mediating words, mediating worlds: Interpreting as hidden care work in a South African psychiatric institution. *Transcultural Psychiatry*, 50, 493-514. doi:10.1177/1363461513494993
- Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In L. Yardley (Ed.), *Material discourse of health and illness* (pp. 68-91). London: Routledge.
- Sobane, K., & Anthonissen, C. (2013). Linguistic resources and strategies used in multilingual communication in HIV/AIDS care centres in Lesotho. *Stellenbosch Papers in Linguistics Plus*, 42, 263-280. doi:10.5774/42-0-173
- Swartz, L., & Drennan, G. (2000). Beyond words: Notes on the 'irrelevance' of language to mental health services in South Africa. *Transcultural Psychiatry*, 37, 185-201. doi:10.1177/136346150003700202

- Swartz, L., Kilian, S., Twesigye, J., Attah, D., & Chiliza, B. (2014). Language, culture, and task shifting – an emerging challenge for global mental health. *Global Health Action*, 7. Retrieved from <http://dx.doi.org/10.3402/gha.v7.23433>
- Temple, B., & Edwards, R. (2002). Interpreters/translators and cross-language research: Reflexivity and border crossings. *International Journal of Qualitative Methods*, 1(2), 1-12. Retrieved from <https://ejournals.library.ualberta.ca/index.php/IJQM/article/view/4602/3776>
- Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: A review of the literature and guidelines for practice. *Journal of Midwifery & Women's Health*, 47, 80-96. doi:10.1016/S1526-9523(02)00218-0
- Tribe, R. (2007). Working with interpreters. *The Psychologist*, 20, 159-161. Retrieved from <http://roar.uel.ac.uk/377/1/Tribe%2CR.%282007%29The%20Psychologist%2020%283%29159-161.pdf>
- Tribe, R., & Keefe, A. (2009). Issues in using interpreters in therapeutic work with refugees. What is not being expressed? *European Journal of Psychotherapy & Counselling*, 11, 409-424. doi: 10.1080/13642530903444795
- Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal of Mental Health*, 18, 233-241. doi:10.1080/09638230701879102
- Tribe, R., & Morrissey, J. (2004). Good practice issues in working with interpreters in mental health. *Intervention*, 2, 129-142. Retrieved from <http://roar.uel.ac.uk/373/1/Tribe%2CR.%2CMorrissey%2CJ.%282004%29Intervention%202%282%29129-142.pdf>

- Tribe, R., & Tunariu, A. (2009). Mind your language: Working with interpreters in healthcare settings and therapeutic encounters. *Sexual and Relationship Therapy, 24*, 74-84. doi: 10.1080/14681990802666023
- VandenBos, G. R. (Ed.). (2007). *APA dictionary of psychology*. Washington, DC: American Psychological Association.
- Vostanis, P. (2014). Meeting the mental health needs of refugees and asylum seekers. *The British Journal of Psychiatry, 204*, 176-177. doi:10.1192/bjp.bp.113.134742
- Wallin, A., & Ahlström, G. (2006). Cross-cultural interview studies using interpreters: Systematic literature review. *Journal of Advanced Nursing, 55*, 723-735. doi:10.1111/j.1365-2648.2006.03963.x
- Watermeyer, J. (2011). "She will hear me": How a flexible interpreting style enables patients to manage the inclusion of interpreters in mediated pharmacy interactions. *Health Communication, 26*, 71-81. doi:10.1080/10410236.2011.527623
- Westermeyer, J. (2010). Linguistic competence of interpreters. *Psychiatric Services, 61*, 313. Retrieved from <http://ps.psychiatryonline.org/data/Journals/PSS/3904/10ps313.pdf>
- Westermeyer, J., & Janca, A. (1997). Language, culture and psychopathology: Conceptual and methodological issues. *Transcultural Psychiatry, 34*, 291-311. doi:10.1177/136346159703400301
- Wiener, E. S., & Rivera, M. I. (2004). Bridging language barriers: How to work with an interpreter. *Clinical Pediatric Emergency Medicine, 5*, 93-101. doi:10.1016/j.cpem.2004.01.007

Williams, M., & Bekker, S. (2008). Language policy and speech practice in Cape Town: An exploratory public health sector study. *South African Linguistic and Applied Language Studies*, 26, 171-183. Retrieved from <http://dx.doi.org/10.2989/SALALS.2008.26.1.13.428>

APPENDICES

Appendix A: Turn-it-in originality report



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All hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions.

Richard Anthony Hagan

*This is presented in fulfillment of the requirements for the degree of
Master of Arts in Psychology at Stellenbosch University*

Supervisor: Prof. L. Swartz
Faculty of Arts and Social Sciences
Department of Psychology
February 2015

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Appendix B: Ethical approval



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04 November 2011

MAILED

Prof L Swartz
Dep Of Psychology
Stellenbosch University
Main Campus
Stellenbosch

Dear Prof Swartz

Follow-up of participants in an in-service interpreting issues course.

ETHICS REFERENCE NO: N11/10/313

RE : APPROVED

It is a pleasure to inform you that a review panel of the Health Research Ethics Committee has approved the above-mentioned project on 2 November 2011, including the ethical aspects involved, for a period of one year from this date.

This project is therefore now registered and you can proceed with the work. Please quote the above-mentioned project number in ALL future correspondence. You may start with the project. Notwithstanding this approval, the Committee can request that work on this project be halted temporarily in anticipation of more information that they might deem necessary.

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.

Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr H el ene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

04 November 2011 14:15

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Tel: +27 21 938 9075 • Faks/Fax: +27 21 931 3352



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Approval Date: 2 November 2011

Expiry Date: 2 November 2012

Yours faithfully

MRS MERTRUDE DAVIDS
RESEARCH DEVELOPMENT AND SUPPORT
Tel: 021 938 9207 / E-mail: mertrude@sun.ac.za
Fax: 021 931 3352

04 November 2011 14:15

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Tel.: +27 21 938 9075 • Faks/Fax: +27 21 931 3352

Appendix C: Participant information leaflet and consent form

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: Ad hoc interpreters' experiences of an in-service training course and subsequent interpreter-mediated sessions.

REFERENCE NUMBER: N11/10/313

PRINCIPAL INVESTIGATOR: Sybrand Hagan

ADDRESS: 7 Stellenberg Street, Stellenbosch, 7600

CONTACT NUMBER:

SUPERVISOR: Prof. L Swartz

ADDRESS: Department of Psychology, University of Stellenbosch.

CONTACT NUMBER:

You are being invited to take part in a research project **on interpreting practices in psychiatric health care**. Please take some time to read the information presented here, which will explain the details of this project. Please ask me, Sybrand Hagan, the principal investigator or the supervisor, Prof Swartz, of the study any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Committee for Human Research at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

The study will take place at four different hospitals in the Western Cape. The data collection consists only out of one part, namely an informal, relaxed interview.

This study is being done to have a better understanding of what happens in actual interpreting sessions within a public psychiatric hospital. It is important to understand what happens in actual interpreting sessions in order to illustrate the crucial role played by interpreting services within psychiatric hospitals.

I, the principal investigator, will interview the individuals that at times act as interpreters and ask him/her to give their input on interpreting related topics.

Why have you been invited to participate?

As the interpreter you have been invited to participate since you are responsible for interpreting the words of the patient and medical staff during the interpreter-mediated diagnostic sessions. Your input could play a vital role in assisting the research team to understand what happens during actual interpreting sessions.

What will your responsibilities be?

You will be expected to respond to those interview topics that you wish to and to give your input.

Will you benefit from taking part in this research?

There is no financial benefit for you in participating in this study. However, your valuable input will allow the researcher to have a better understanding of how to improve interpreting services in psychiatric care. This will help the hospital to be more effective in treating patients and it will make the work of psychiatrists and other hospital staff easier.

Are there in risks involved in your taking part in this research?

There will be **no risks** involved in your taking part in this study.

Who will have access to information from the study?

Your input during the interviews will be used as part of a thesis and possible research articles. Any information that is obtained in this study and that can be identified with you will remain **confidential** and will be disclosed only with your permission or as required by law. Your identity will remain **anonymous** and will not be mentioned in the research assignment. It is only the research team, consisting of me and my supervisor that will have access to the information you provide in the interviews. Audio-recordings will also be kept in password protected electronic format. If research is to be published, you will remain anonymous and will not be mentioned.

Will you be paid to take part in this study and are there any costs involved?

No you will **not** be paid to take part in the study.

Your participation and withdrawal

You can choose whether to be in the study or not. If you volunteer to be in the study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. I, the investigator, may withdraw you from the research if circumstances which warrant doing so, for example if you feel uncomfortable during the interview.

Is there anything else that you should know or do?

- You can contact my supervisor Prof. Swartz at tel **021- 808 ****** if you have any further queries or encounter any problems.
- You can also contact me, Sybrand Hagan, at cell if you have any further queries or encounter any problems.
- You will receive a copy of this information and consent form for your own records.
- You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this study
- If you have questions regarding your rights as a research subject, contact Ms Maléne Fouché, email **mfouche@sun.ac.za** and tel **021-808 ******, at the Division for Research Development.

Declaration by participant

The information above was described to me by Sybrand Hagan in English and I am in command of this language or it was satisfactorily translated to me. I, the participant, was given the opportunity to ask questions and these questions were answered to my satisfaction.

By signing below, I agree to take part in a research study entitled: Ad hoc interpreter's experiences of an in-service training course and subsequent interpreter-mediated sessions.

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 2012.

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I, Sybrand Hagan declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I conducted this conversation in English and did not use an interpreter.

Signed at (*place*) on (*date*) 2012.

.....
Signature of investigator

.....
Signature of witness

Appendix D: Interview schedule

SEMI-STRUCTURED INTERVIEW SCHEDULE

I would like to discuss a few topics pertaining to the interpreting work that you are sometimes asked to do. I am not here to check up on you. The aim is rather to have a better understanding of what happens in an actual interpreter-mediated diagnostic session. Please explain your answer as best possible and give reasons where applicable.

- Please explain the role that you fulfil at your place of work.
- Have you ever been asked to act as an unofficial interpreter?
- Does the role as interpreter affect your other duties?
- For how long have you been doing interpreting at your place of work?
- Can you please describe the languages that you speak and how fluent you are in each?
- Do you have any previous experience as an interpreter before you came to this institution?
- Why did you decide to attend the interpreting training course in August of last year?
- What was your experience of the training course? Please explain.
- Did the training meet your expectations? Please explain.
- What part of the training do you think helped you the most? Please give examples.
- What part of the training was the least helpful? Please give examples.
- Do you any suggestions on how the training can be improved? Please explain and give examples.
- How do you perceive your role as an interpreter?
- Have the interpreting sessions changed since the training course? Please explain and give examples.
- Would you be interested in attending any more formal / follow up courses?

- Is there anything that clinicians do/can do before, during or after an interpreting session that would make the process better for you?
- What kind of difficulties (obstacles) have you experienced during an interpreting session? Please give examples
- Can you think of any way how these difficulties can be reduced?
- When you interpret, do you interpret word-for-word? Or do you convey the message by putting it in your own words?
- Does the clinician ever ask you about your thoughts about the patient after the interpreting session?
- Do you think the clinician should ask you your thoughts?
- Are you offered debriefing sessions (an opportunity to discuss your experience of the interpreter-mediated session after it has finished). If so, can you please give an example of this? If not, would you like to be offered a debriefing session?
- Do you know that some people have been employed this year to interpret?
- Have you had any contact with these interpreters?
- Are they affecting your work?
- Can you give me a specific example of a good interpreting session?
- Can you give me a specific example of a bad interpreting session?
- Do you think that culture plays a role in the interpreter-mediated sessions?
- Do you think that age plays a role in the interpreter-mediated sessions?
- Do you think that gender plays a role in the interpreter-mediated sessions?
- Is there anything else you would like to tell me?

Thank you very much for your time and input. It is much appreciated.