Three's a crowd: The process of triadic translation in a South African psychiatric institution.

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## Abstract:

Mental health care in South Africa has long been governed by inequalities (Foster & Swartz, 1997). During apartheid, those who did not speak English and Afrikaans could not access mental health services in the same way as those who did (Foster & Swartz, 1997). One main reason for this is the majority of mental health practitioners could not, and were not required to speak languages other than English and Afrikaans (Swartz, 1991). The South African mental health literature suggests that language and communication must be prioritised if there is to be an improvement in mental health care services for those individuals who do not speak English and Afrikaans (Bantjes, 1999; Drennan & Swartz, 1999; Swartz & Drennan, 2000; Swartz & MacGregor, 2002). Drawing on Prasad's (2002) interpretation of Gadamer's critical hermeneutic theory and utilising thematic networks analysis (Attride-Stirling, 2001), this study investigated the process of translated clinical assessment interviews within a psychiatric hospital in the Eastern Cape Province within South Africa. Results of the study revealed that contextual factors, issues concerning linguistic and cultural heritage, clinicians' role expectations regarding translators' role performance, as well as relational dynamics regarding individual levels of control and influence within the translation triad, all impacted on the effectiveness of communication, translation and service provision. These findings are supported by literature on the theory and practice of translation that identifies these issues as prominent (Robinson, 2003). Specific recommendations regarding the formalisation of translation practices within the hospital setting, as well as the familiarisation of clinical practitioners and psychiatric nurses with the intricacies of translation processes are offered.

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## Dedication:

**This study is dedicated to all those individuals who have suffered and continue to suffer in silence.**

# CHAPTER 1: INTRODUCTION AND CONTEXT

Language and communication is imperative in mental health care settings such as psychiatric hospitals. The identification of an individual's mental conditions; whether normal or abnormal, is based on a western biomedical nosology, where, the recognition of symptoms and elicitation of signs is ascertained predominantly through exchanges of both verbal and non-verbal communication between clinicians and their patients. One way in which this can be achieved is through the use of the psychiatric interview (Leff & Isaacs, 1990).

A paper published in 1999 indicates that the number of health professionals who are able to communicate with their patients in their mother tongue falls far short of satisfactory (Drennan & Swartz, 1999). According to Swartz, (1998, p. 33) this is a "result of a number of factors, including limited access to higher education for members of all language groups". South Africa is a country that for centuries has been dominated by racist and oppressive governments. The economic and social advancement of one race at the expense of another in the South African society extends from colonialism to Apartheid and has left a lasting mark still evident in today's supposedly reconciled society (Stead, 2002; Swartz & MacGregor, 2002).

Painter, Terre Blanche and Henderson (2006, p. 4) state that during Apartheid the political agenda of the time was translated into 'culture' where "the structural demands for class and especially racial inequality on which the political and economic dominance of the white minority rested, were treated as objective facts about the social environment –'differences' that could be studied in a scientifically neutral manner and managed rationally by psychology". Following this idea of difference as 'natural', the implementation of The Bantu Education Act (1953) ensured that separate education based on the principles that different races had different 'needs', became law (Burke, 2006). This act served to disadvantage people classified as 'black' by teaching a limited 'needs-based' syllabus in English and Afrikaans which prevented the majority of school leavers from obtaining entrance to secondary and tertiary education institutions. This, in effect, forced them into semi- and unskilled manual labour markets such as mining and domestic work.

By contrast, people classified as 'white' were provided with a high level of education which afforded them the opportunity to attend secondary and tertiary institutions. This allowed them to enter higher skilled professions, such as psychology, psychiatry and medicine (Burke, 2006). It is important to note that this racist ideology paved the way for how psychological phenomena were studied in the field of mental health throughout the 20th century as "apartheid beliefs and practices were intrinsically intertwined with psychology in South Africa in the latter half of the 20th century" (Stead, 2002, p. 79).

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Consequently, the Bantu Education Act (1953) laid the foundations for the current concerns facing multilingualism in South Africa today, as groups of individuals classified differently according to their race received separate disparate levels of education.

With the instalment of a majority elected government, new constitution and new legislation, South African social, political and economic spheres including government, labour, society and health and welfare, now began to focus on the achievement of integration and unification (Swartz & MacGregor, 2002). According to Swartz, Drennan and Crawford (1997, p. 167), the transition to democracy and the recognition of diversity (the declaration of 11 official languages) within the country was a representation of "the political necessity to redress power imbalances which existed previously along racial and language lines".

During the period of Apartheid there was a clear drive to present English and Afrikaans as the dominant languages in the country (Drennan, 1999). Moreover, notions of cross-cultural application of western psychiatric nosology were non-existent. This was compounded by the fact that education for many, consisted of limited tuition in English and/or Afrikaans promoting basic understanding of the dominant languages, but rarely fluency and proficiency. This meant that not only was the possibility of mental health care in African languages undermined, but the cross-cultural applicability of specific biomedical discourses in clinical psychology was taken for granted. Consequently, a large portion of society who were either illiterate or semi-literate could not have access to health care and, in particular, mental health care in their distinctive languages. Furthermore, the system of Apartheid served to institutionalize racism within mental health care disciplines, institutions and the manner of mental health care service delivery (Drennan, 1999).

For mental health professionals working in government posts today, the complexities that arise from the implementation of equality and integration within their day-to-day institutional practice are multifaceted. In a post-apartheid South Africa, clinicians now work with racially, culturally and linguistically diverse patients and colleagues. This change has had a profound effect on the clinical interview as many of the clinicians working in these posts are white, middle-class English and or Afrikaans speaking individuals. These clinicians are often challenged when working with a diverse range of patients over short periods of time, which can prove to be overburdening and often impossible (Drennan & Swartz, 1999). When in-patients and referrals do not speak English, are poorly educated and ethnically diverse, and clinicians are attempting to assess, diagnose and provide treatment for individuals that they cannot communicate with (Drennan, 1999), accuracy in diagnoses and hence adequate treatment can become problematic.

When clinicians are unable to adequately communicate with their patients due to the absence of a common language, accurate assessment, diagnosis and treatment of a patient is at risk as the assessment of individuals merely on their non-verbal behaviour is often not sufficient for diagnostic purposes (Swartz & Drennan, 2000). According to Drennan and Swartz (1999), the current lack of suitably trained mental health professionals who are able to speak one or more indigenous African languages has led to the development of an immense need for translation services within South Africa. The use of individuals, acting as 'translators', goes some way towards bridging the communication gap between clinician and patient, but introduces new complexities into the multi-disciplinary interaction. The traditional dyadic setting consisting of clinician and patient is transformed into a triad with the inclusion of a 'translator' (Swartz, 1998).

Translation in the South African mental health setting, although essential, is decidedly neglected as positions for professionally employed translators are few and far between. In the psychiatric institution translation occurs on an 'ad hoc' basis where bilingual staff members such as nursing, cleaning and security staff are expected to translate (Swartz, 1998). According to Drennan (1999, pp. 5-6), the use of bilingual staff members for translation has become "so much a part of the everyday experience of health care provision in South Africa as to make it almost invisible". Since the setting within which translation is practiced is multi-cultural and influenced heavily by the social and political realm, challenges relating to the 'language gap' between clinician and patient become overlooked. According to Swartz and Drennan (2000, p. 185), this is due to "the administrative constraints of an overburdened and bureaucratized health system". The use of translation as a strategy to bridge this 'language gap' has become so habitual in the daily routine of institutions that it has not warranted adequate attention, evaluation or structuring (Drennan, 1999).

The inability of clinicians to speak indigenous languages other than Afrikaans and English is compounded by the distinct lack of training in translation theory and practice for hospital staff who are involved in translation services. According to Swartz (1998), it is essential for clinicians to acknowledge that it is not only the translator that requires training but the clinician who is working with the translator as well. This allows for clinicians to better understand translation practices and allows them to develop their skills and enhance their work. Furthermore, Drennan & Swartz (1999) have argued that staff required to carry out translations often have no official position of employment as translators in the mental health care system). This is problematic as individuals acting as translators do not receive professional accreditation, financial incentive or additional time in which to carry out this extra work (Drennan, Levett & Swartz, 1991).

It must be noted that difficulties relating to language barriers in mental health practices stem from South Africa's past racial marginalization of citizens, which led to the unequal provision of services. The mental health profession is now burdened by a need to redress these past and prevailing inequalities. As mentioned before, according to Swartz (1996, p. 119), "within the mental health field, inadequate and discriminatory services were justified with recourse to the idea that different cultures had 'different' needs in the mental health field". This idea of 'different' needs and unequal availability of services provided for distinct races was reformed in 1990 with the desegregation of hospitals and clinics (Burke, 2006). Following from this, institutions are no longer separated along racial lines but rather, are registered to specific geographic areas around the country (Foster & Swartz, 1997). Swartz, Gibson & Swartz (1990) indicate that a process of transformation in psychology had been undertaken some time ago. More recent arguments have suggested that although the movement towards racial equality and integration within mental health care is in motion, this movement towards desegregation is a complex matter which extends far beyond racial integration alone (Swartz & MacGregor, 2002).

It is a widely held misconception that English is the amalgamating language in South Africa (Erasmus, 2003), but according to statistics cited by Painter et al. (2006), only 45% of South African residents claim that they have very little, if any, proficiency in English and only 10% of the population speak English as their first language. South Africans unable to speak English form the majority of people residing in rural areas, and who are predominantly unemployed and often under-skilled. This means that although individuals have access to psychiatric services, not being able to receive these services in their mother tongue places the language rights of the already previously disadvantaged at stake. For, according to the Pan South African Language Board, "every South African has the right to use the language of his/her choice, provided this is consistent with the rights of others" (PanSALB, 2010). Consequently, mental health care in South Africa runs the risk of silencing and marginalizing a large portion of the population as was the case during the Apartheid era (Erasmus, 2003).

Although the government's objective of desegregating institutions such as the mental health care institution, have been achieved, allowing for the improvement of physical and financial access to services for members of all racial, cultural and linguistic groups; one has to ask, whether the actual quality of government institutional services has changed and if so, has it changed for the better? According to Foster (2005), in her study on primary health care and neo-liberalism in post-Apartheid South Africa, the desegregation of government clinics has led to a re-segregation of health care along economic lines, as white predominantly upper class patients and professionals have primarily moved to the private health care sector. Together with this skills migration from government based mental health care to the private sector, is the fact that concurrently the practice of psychology in South Africa has

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largely become a private-practice profession (Richter, Griesel, Durrheim, Wilson, Surendorff & Asafo-Agyei, 1998). This drive away from government based mental health practice negatively influences already overburdened institutions as more clinicians are needed due to the decreasing amounts of qualified clinical practitioners willing to work within the hospital setting.

The availability of resources within the mental health care sector is an essential factor for improvement of services where "government and provincial government resources need to be made available for training, supporting, and employing mental health workers" (Stead, 2002, p. 83). As resources within the mental health care sector are limited and often unevenly distributed, this further inhibits the adequate implementation of new policies for training, support and improvement of translation services within institutions. According to Petersen (2000), within the health care sector, there has been much emphasis placed on service delivery and the achievement of institutional policies, rather than a focus on the quality of care or services provided. Moreover, in their study of the integration of two psychotherapeutic units in South Africa, Roth and Swartz (1992) found that one of the consequences of integration is that changes in ideology take preference to practical changes on a micro-level. This leads to a failure to address pertinent cultural issues as they are overlooked. According to Swartz and MacGregor (2002, p. 169):

> in a fractured society it is easy to equate 'integration' with 'healing'. In a poorly resourced society, it is
> equally easy to gloss over specific needs in the hope that broad social improvements will in themselves be
> sufficient to meet these needs. Both these pitfalls are a feature of contemporary South Africa.

South African mental health literature suggests that, although the new South African Constitution has made provisions for multilingualism, the issue of language use and communication must be prioritized if there is to be an improvement in mental health care services for those individuals who do not speak English and Afrikaans (Bantjes, 1999; Drennan & Swartz, 1999; Drennan & Swartz, 2002; Erasmus, 2003; Swartz & Drennan, 2000; Swartz & MacGregor, 2002). Only three particular researchers, namely Gerard Drennan, Leslie Swartz and Megan Bantjes have begun to investigate the process of 'ad hoc' translation, its effects and determinants in mental health care in South Africa and have provided specific recommendations for change. In a hermeneutic study on translation in clinical practice, Bantjes (1999) identified and described the effects of linguistic and cultural differences, the lack of clarity about interpreters' roles, and institutional power relations in inhibiting effective communication within the translation triad. Some of the abovementioned literature identifies potential problems which may be

encountered in translation settings, but offers very few practical recommendations on how these problems are negotiated and how communication can be improved.

It is important to note that South African literature on translation practices focuses on what Swartz, Drennan & Crawford (1997) term the 'add-in approach' to language diversity in mental health practice. The 'add-in approach' is the use of existing staff as translators which is the main approach to translation practices within the South African context (Swartz et al., 1997). According to Erasmus (2003), a lack of proficiency in the facilitation of language use and aptitude cannot be overlooked within the South African constitution as it forms part of democratic rights mentioned above. Consequently, there is a need for further research within the realm of 'add-in' approaches to translation practices and most importantly, how to maximize those practices within a fractured South African context.

Internationally, there have been important changes within the last century concerning health care delivery to patients who have limited proficiency in English (Angelelli, 2004). International research and literature within health care sectors has prioritized cross-cultural communication in a clinical setting by focusing on the need for, and use of, professionally trained translators and/or interpreters in providing equal access to health care services (Angelleli, 2004; Dingwaney, 1995; Wadensjö, 1998). Research and literature pertaining to the need for, and use of, professionally trained translators and/or interpreters within mental health care specifically is very limited (Raval, 2003; Wadensjö, 1998). Therefore, existing literature focuses on specific triadic processes such as interpreter roles, skills and knowledge, and guidelines for clinicians in working with professionally trained interpreters (Bolden, 2000; Gile, 1995; Kussmaul, 1995; Raval, 2003). Moreover, there is also a focus on examining how issues such as power dynamics, ethnicity, class and gender play out and are dealt with during interpreter interventions (Dingwaney, 1995).

The majority of international studies conducted on translation within the health care sectors state that the use of professionally trained and employed interpreters and clinicians does improve and, in many cases, enhance the quality of communication during the translation process for those members who form the triad (Karliner, Jacobs, Chen & Mutha, 2007). It must be noted that although international literature has made significant contributions to the understanding of translation practices, the majority of studies conducted focus predominantly on the growing number of linguistic minorities, such as refugees. This further highlights the need to provide linguistic services to individuals who do not speak the dominant language (Angelleli, 2004; Bolden, 2000; Raval, 2003).

Additionally, focus is given to specific factors concerning the use of professional translators enlisted through recruitment agencies and the relational dynamics between clinicians and translators in these

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contexts. This, according to Swartz et al. (1997) is viewed as the add-on approach to issues concerning language diversity and mental health practices. Swartz et al. (1997, p. 170) go on to state that "this approach argues that the best solution for language diversity in practices lies with the employment of interpreters". This, in contrast to the add-in approach implemented within a South African context, is representative of the approach the majority of international literature focuses on. Although the international literature has enhanced understanding in terms of translation practices in different contexts, certain recommendations concerning training in terms of techniques and strategies provided have limited application in the South African context. Multilingual service provision, language policies and development plans for health care institutions within the South African context is extremely underdeveloped and in some contexts non-existent. This bureaucratic lack of support does not facilitate the implementation of international recommendations for changes to the current 'ad hoc' nature of translation practices (Erasmus, 2003). It is important to note that much of the South African literature and studies on the use of translators and the translation process are out-of-date in comparison to international studies. Furthermore, there are no recent reports or research on translation in mental health care within South Africa, but the literature on the integration of health care and on language and communication suggests that little, or no progress has been made concerning the development of translation services (Foster, 2005; Painter et al., 2006). So, the need for more recent studies relating to the re-evaluation and re-structuring of translation services on a practical level within mental health care settings (such as psychiatric hospitals) in the South African context is highlighted.

# CHAPTER 2: THEORETICAL ORIENTATION

In this chapter the theoretical orientation of the research is made explicit. It is argued that hermeneutics forms the epistemological and philosophical basis for translation as a limited form of interpretation. This chapter focuses on the importance of language, how it is related to human thought and how it enables humans to create meaning as social beings. The daily process of meaning production and development of understanding is then considered during the process of translation.

## 2.1 Translation

### 2.1.1 What is 'Translation'?

According to Tugushev (2008), grammatically the word translation implies duality, where translation can refer to a process or an activity that involves bringing meaning across a linguistic gap. It can also refer to the end result of that process or activity, where "the final rendering of a text in another language is also called translation" (Tugushev, 2008, p. 8). It is important to note here that the words 'translation' and 'interpretation' are often used interchangeably throughout local and international literature. This can be problematic as both words carry with them specific assumptions and expectations. For example, following from the latter definition, theorists often assume that translation can be objectified and qualified in terms of universal accuracy and specific qualifications required by all translators (Tugushez, 2008). According to Tugushev (2008) this assumption concerning 'translation' does not encompass the first meaning. Although the word 'translation' can carry with it specific assumptions, according to the theoretical orientation of this study, translation is a *form* of interpretation and the former definition of translation is more appropriate and specific than the latter, broader meaning and the assumptions associated with 'interpretation'. Accordingly, the former definition raises questions concerning what exactly the process of translation entails and how meaning is generated or re-generated within this process.

Traditionally, the process of translation is thought of as an invisible manual activity used as a means of directly conveying word/s from one language into equivalent word/s of another language (Bolden, 2000). Traditional theorists assume that language is an abstract descriptive phenomenon, that is, language is merely a reflection of specific procedures and categories pre-existing in the social and natural world around us (Mornini, 2008; Potter & Wetherell, 1987). Swartz (1998) terms this the empiricist view of language and reality and this view is aligned with the assumptions of objectivity regarding translation mentioned above. According to Swartz (1998, p. 28) "this implies that different languages are no more than different sets of labels for realities which are common across the world". In

other words, the role that language plays in terms of meaning production within the empiricist view is solely to label the social and natural world around us. Furthermore, different labels can be identified and used to represent the same object/emotion/state in different languages. The art of translation then is seen as the process of merely identifying these labels which refer to the same thing in two different languages (Swartz, 1998).

In terms of methodology, theorists who align themselves with the aforementioned traditional view of language and translation work from a positivistic paradigm in their search for truth and understanding. According to Weber (2004, p. 1) ontologically, the paradigm of positivism maintains that person and object are separate and epistemologically, that an "objective reality exists beyond the human mind". The traditional positivistic model of translation, termed the conduit model, is seen as unidirectional and monological (Wadensjö, 1998) and one that does not align with current linguistic theory about meaning, reality and theory on translation as a non-verbatim activity (Swartz, 1998).

The traditional positivistic philosophy of the 19$^{th}$ Century was followed by a shift in philosophical paradigm characterized by the linguistic turn of the 20$^{th}$ Century (Zuidervaart, 2010). This shift involved a movement from understanding reality as objective and language as reflective of that reality, to a focus on interpreting ordinary language in daily usage and theorizing its pivotal role in meaning production (Tugushev, 2008). In effect, translation is viewed as the centre of the theory of language and the root of what the process of translation entails then lies within the fundamental problem of meaning (Tugushev, 2008). Thus, it is important to establish how language enables us to create meaning as social beings (Swartz, 1998). According to Tugushev (2008, p. 11) in understanding the process of translation "the aim is not to define what translation is, but to reframe the sphere of inquiry in a way that resists certain impositions of language". Consequently, specific philosophical and theoretical considerations concerning the relationship between meaning production, language and reality are essential in order to fully understand what the process of translation entails (Swartz, 1998).

Current translation theory identifies and highlights the fact that the act of translation is in fact more complex and intricate than previously thought (Angelelli, 2004; Morini, 2008; Venuti, 1992; Wadensjö, 1998). Tugushev (2008) proposes a view of translation grounded in philosophical hermeneutic thinking. He refers to philosophical hermeneutic theory in order to illustrate how hermeneutics is important to the first practical steps in the performance of translation. In doing so, Tugushev (2008) determined how meaning is generated during the process of translation and how the quality of a translation can be judged. It is important to note that hermeneutic theory is extensive and according to Rennie (2007) there are three main types of hermeneutics in contemporary thought, namely, methodological, philosophical and critical. Moving beyond a view of translation as the implementation

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of all-inclusive rules for linguistic equivalence, this research is aligned with current theory concerning the process of translation. For the purpose of this research, Tugushev's theory of translation as hermeneutics shall be considered with a focus on philosophical hermeneutic theory and Hans-George Gadamer's hermeneutic approach to interpretation.

Throughout the remainder of this chapter it will be argued both philosophically and critically that translation is a form of interpretation rather than a verbatim activity. Furthermore, the significant theoretical and practical influences that this view of translation has on translation practices and processes within the South African context will be examined. Consequently, the use of a critical hermeneutic approach to examining translation processes is appropriate within this study as it allows for an in-depth, intricate and critical examination of translation as a dynamic, contextual and multi-faceted phenomenon.

## 2.2 Translation as Hermeneutics

Following from debates concerning what the act of translation entails, if meaning is not an abstract phenomenon that is merely 'picked up' by the translator and moved across the linguistic gap as previously thought, how then is meaning constituted and re-constituted by translators during the process of translation? According to Tugushev (2008, p. 48) "these are the very problems of hermeneutics" and consequently, hermeneutics is important to a translator's activity.

'Hermeneutics' is a term that has its roots in Greek philosophy and "that covers many different levels of reflection" (Gadamer, 2006b, p. 29). Theoretically, hermeneutics emerged from questions concerning the authentic interpretation and meaning of Biblical scriptures (Radford, 2002). Translation, within the realm of the ordinary usage of hermeneutics then refers to "that of translating something foreign or unintelligible into the language everybody speaks and understands" (Gadamer, 2006b, p. 29). With the linguistic turn in the philosophy of the social sciences in the mid-20th century came shifts in thought regarding the merits and methodologies of the scientific tradition (Bjorn & Gjesdal, 2009). Consequently, an attempt was made to make sense of the world by formulating theories and methods of generating knowledge regarding human understanding based on interpretation. There was thus a need to develop "a set of universal rules for producing valid interpretations" which were ultimately based on the development of basic assumptions concerning what we as humans are able to know about reality (Haider, 2008, p. 15).

It is important to note that contemporary language theory was beginning to take shape at this time, as the acknowledgement of the interdependence of language and thinking was emphasised to a greater degree than ever before. This led to ideas relating to linguistic determinism which means that "there is

no thinking without language and no language without thinking" (Iser, 2000, p. 47). Linguistic determinism, which is commonly referred to as the Whorfian Hypothesis, maintains that language, thought and culture are related (McAfee, 2004). It is important to note that there are two versions of this hypothesis. The strong version maintains that language determines thought and cognitive categories are determined and limited by linguistic categories. The weaker version maintains that the use of linguistic categories influences human thought and determines certain kinds of non-linguistic behaviour (McAfee, 2004). In line with Tugushev's theory of translation as hermeneutics and Gadamer's hermeneutic approach to interpretation, this study adopts a weaker version of the Whorfian Hypothesis where the interrelationships between language and interpretation are emphasised.

According to Gadamer, (2006a), translation within the modern usage of hermeneutics today refers not only to the art of translation but to the ways in which translators are able to theoretically justify their work as translators due to the subjective nature of translation.


## 2.2.1 Philosophical Hermeneutics and Translation

Following from the development of an epistemologically informed classical and methodological hermeneutics, philosophers began to view the problem of human understanding not as an epistemological issue, but rather as a purely ontological one. In shifting their focus, philosophers returned to the basic assumptions concerning the nature of reality and how understanding is influenced within this paradigm of thought. This means that understanding was no longer seen as a universal process of human thinking, but rather understanding was reduced to "the basic being-in-motion of the existing human" (Gadamer, 2006b, p. 39). This means that understanding, or the human capability to understand, is the most basic movement of human existence. According to the Heidegger (as cited in Radford, 2002), hermeneutic understanding encompasses the fundamental conditions of man as a 'being in the world', that is, "the explication of the preconceptual apprehending of phenomena" (p. 6), or a prior hermeneutic situatedness regarding the immediate experience of the world. This preconceptual apprehension is, according to Heidegger, achieved through a reflexive consciousness of one's situatedness. According to Iser (2000, p. 52) "hermeneutics marks the stage at which interpretation becomes self-reflexive". This means that when humans reflect on their own position (thoughts and behaviour) in the world, understanding becomes possible as individual presuppositions are brought to the fore. In philosophical hermeneutic theory, the possibility of understanding following from the explication of the human ability to reflect consciously on ones situatedness is represented by the hermeneutic circle of inquiry.

In the hermeneutic circle of inquiry there is an operation between the parts and the whole which govern all interpretive activity (Iser, 2000). Alternatively, "as the whole is understood from the parts, so the parts can be understood from the whole" (Iser, 2000, p. 52). Particular knowledge allows individuals the ability to perceive general knowledge as one cannot have general knowledge in the absence of the particular knowledge from which it arises (Iser, 2000). Humans are thus able to create new understandings or meanings by moving in a hypothetical circular motion where interpretation relies on re-interpretation (Kinsella, 2006). In terms of the hermeneutic perspective and the hermeneutic circle of inquiry then, human understanding is viewed not from a logical definitive perspective, but rather from a more intuitive perspective (Prasad, 2002).

According to Sammel (2003, p. 159), drawing from Heideggerian philosophy and in contrast to traditional and methodological hermeneutics, Hans-George Gadamer wished to "clarify the conditions in which understanding takes place". In his attempt to humanize hermeneutics and determine a distinction between 'truth' and 'method', Gadamer emphasised that in order to understand ourselves, we must acknowledge that we are in essence "situated in a linguistically mediated, historical culture" (Ramberg & Gjesdal, 2009, p. 8). The focus for Gadamer then is concerns of language, meaning, history and the ways in which modern techno-science influences knowledge and understanding.

Adapted from the Heideggarian concept of the hermeneutic circle, Gadamer's theories focus on a concept termed 'the fusion of horizons' (Prasad, 2002). An important aspect within Gadamer's theory concerning 'horizons' and the 'fusion of horizons' is "what Gadamer termed the linguistic element of human existence" (Turnbull, 2004, p. 172). Gadamer (2006a) maintains that universal commonalities concerning human orientation to the world are built up and mediated through the use of language as a 'principle' rather than a 'fact'. Thus for Gadamer, the nature of human understanding or interpretation takes the form of a dialogue where the meaning of a text emerges through conversation between the interpreter and the text (Prasad, 2002). According to Malpas (2003 p. 10), "conversation always takes place in language and similarly Gadamer views understanding as always linguistically mediated". Following from this, Gadamer believed that human interpretation and understanding occurs within a 'horizon' that is historically, linguistically and contextually informed and where understanding within this 'horizon' is susceptible to change. Gadamer believed that human prejudices "define the limits and the potentialities of our horizon of understanding" (Gadamer, as cited in Peeters, 2005, p. 269).

According to Prasad (2002), when humans expand on their prejudices or horizons to include the horizons of a text they wish to interpret, they become aware of their historical situatedness and ultimately there is a 'fusion of horizons', achieved through the aforementioned dialogue between interpreter and text. Thus, by being aware of and reflecting upon their historical situatedness,

individuals are able to discover and gain, not only a deeper meaning and understanding of the text they are working with, but a more profound understanding of themselves as situated within historically bound 'horizons' as well (Bjorn & Gjesdal, 2009). According to Gadamer (2006, p. 17) "all extra-verbal forms of understanding go back to an understanding that unfolds in speaking and in speaking with another person". Moreover, Gadamer (2006b, p. 50) emphasises that:

> a conversation is not possible if one of the partners believes himself or herself to be in a clearly superior position in comparison with the other person, and assumes that he or she possesses a prior knowledge of the erroneous pre-judgments in which the other is tangled. But if one does this, one actually locks oneself into the circle of one's own prejudices.

In this view, meaning evolves through individual experience and interaction with others grounded in language. Consequently, no true singular or ultimate interpretation of a text exists (Radford, 2002). According to Gadamer (as cited in Peeters, 2005, p. 473) then,

> meaning, sense, and the world of the text are not independent of its encounter with the reader. That is, the act of interpretation is not posterior to the constitution of meaning, but neither is it solely responsible for its creation.

According to Tugushev (2008), this is the very predicament within which translation is situated, where the meaning of a text is not solely 'contained' within the text and thus the translator is not solely responsible for the production of the meaning of a text. As with the case of interpretation, meaning re-creation and understanding produced through translation is constrained by the 'historically bound horizon' of each individual translator. Consequently, interpretation and translation are assumed to be closely related as both phenomena are viewed as being instances of the same phenomenon, namely, understanding (Tugushev, 2008). The act of translating thus requires an understanding of what the text says, that is, the act of translating requires interpretation (Tugushev, 2008). Thus, according to Gadamer (as cited in Peeters, 2005, p. 387) translation of foreign languages is "an extreme case of hermeneutic difficulty" due to the nature and subjectivity of interpretation.

According to Eco (2001), it is important to note that although understanding forms the basis for both translation and interpretation, they are in fact not one and the same phenomenon. Rather, translation must be viewed as a limited form of interpretation, as the act of translation is constrained by the 'horizon' and relational context of the text the translator wishes to interpret (Eco, 2001). Although this is the case, questions concerning what the limitations of translation as a form of interpretation are and

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how the quality of a translation is able to be judged in terms of these limitations, are left unanswered by Eco (Tugushev, 2008).

Tugushev (2008) turns to Gadamer's theory of application within hermeneutics as an integral part of human understanding and interpretation. As mentioned above, Gadamer believed that language and conceptuality are primary for hermeneutic understanding (Malpas, 2003) as meanings are disclosed through interpretation and linguistically grounded through their assertion (Ramberg & Gjesdal, 2009). According to Tugushev (2008, p. 53),

> to understand something as a something of a certain kind means seeing past its peculiarities, its differences, and seeing that thing in its universality, in its sameness, from the perspective of a particular situation.

Thus, understanding always implies application in language, where interpretation involves determining sameness-in-difference. This is the same when translating foreign texts, as meaning is re-generated and displayed through the application of an understanding of a foreign text in language. It is important to note that this theory of application is functional when speaking of both written and face-to-face translations. According to Tugushev (2008, p. 54):

> interpretation and translation are two instances of the same fundamental phenomenon; not because translation involves interpretation or, as Eco suggests, because translation is a species of the genus interpretation, but because of the underlying phenomenon of performance of sameness-in-difference, which anchors both interpretation and translation as cases of understanding.

Thus, just as an interpretation of a text implies plurality as no 'correct' interpretation exists, so translation implies plurality and anti-objectivism and similarly there cannot be one correct translation of a text. Rather, translators sustain and re-generate meaning through interpretation by saying the same thing in different ways (Tugushev, 2008). According to Robinson (2003, p. 142) "a useful way of thinking about translation and language is that translators don't translate words; they translate what people do with words" and thereby, do things with words themselves. This leads to the question concerning the accuracy of translations. Is anyone able to translate and how is the accuracy of translations determined? According to Tugushev (2008), as the meaning-in-itself of a text or dialogue is not derived solely from that original text or dialogue, the end results of translations can only be compared with each other. For, if one was to compare a translation to the original text, this would be considered a form of interpretation/translation in itself in order to facilitate understanding (Tugushev,

2008). According to Sammel (2003) although Gadamer's work emphasises reflection on situation and historical contexts, it is also highly philosophical and lacks a critically reflective angle.

According to Habermas, in his critiques of Gadamer's philosophical hermeneutics, language is not only a medium for tradition, but for social control and power (Prasad, 2002). This means that, through historical processes, social structures are able to change linguistic structures and language is therefore seen as a vehicle for ideological and material constraints. These ideological and material constraints ultimately legitimate and perpetuate the "conditions that prevent the emergence of a language/tradition that would represent an authentic social consensus" (Prasad, 2002, p. 22). This means that, individual horizons do not only provide us with the 'how' of interpretation but they also set limits on what we as humans can engage with or interpret. This is aligned with the critical hermeneutic perspective implemented within this study, as interpretation involves a critique of the mentioned constraints and reflexivity becomes an important element for interpretation and understanding.

Following from above, a practical application of the philosophical and critical theory mentioned above concerning translation as hermeneutics is required.

## 2.3 Translation Theory and Practice

According to Wadensjö (1998, p. 8), translation is dialogical and "implies that meaning conveyed in and by talk is partly a joint product". Meaning conveyed through language is thus a product of reciprocity between people interacting. This means that translation processes are multi-layered and multi-directional in nature (Wadensjö, 1998). Consequently, face-to-face translation involves not only representing what people intend on doing with words but looks at how these intentions influence a person's behaviour as well as the relationship between the parties who are communicating. This is what Potter and Wetherell (1987, p. 22) term "the reflexive nature of talk".

For Wadensjö (1998), when investigating face-to-face interpretation it is important to acknowledge a distinction between 'talk as text' (defining what is being done) and 'talk as activity' (context and person). Furthermore, Robinson (2003) states that in terms of striving for equivalence, translators do so not only to maintain reliability in satisfying a client, but in order to satisfy "his/her own sense of cultural or ideological 'rightness' (p. 149). This is synonymous with Gadamer's fusion of horizons theory and Habermas' critical contributions to this theory. By relinquishing their prejudices and reflecting on the legitimacy of these prejudices, translators allow for a fusion of their horizon with the horizon of a text and social context, allowing for a more profound understanding of themselves as situated within a historically bound horizon (Bjorn & Gjesdal, 2009). It is important to note that face-

to-face translation practices are particularly complex, as interpersonal dynamics are at play, time restraints restrict practices and there are high demands regarding language fluency.

Therefore, due to the acknowledgment of the hermeneutic situatedness of each individual, current theories on translation are now more "operatively open and contextual" (most translation situations allow for more than one choice) (Morini, 2008, p. 33). Pragmatics is highly functional here in terms of the multi-layered and multi-directional nature of translation and how language is important for communication. According to Ceramella (2008, p. 8) looking at translation in terms of "discourse and structure, together with an analysis of construction and interpretation that links linguistics with psychology, has proven to be quite important in an attempt to realise what translators do when they translate". This means that in order to understand what translators do when they translate, we need to focus not only on language and its formulation, but on the way in which language is used in, and influenced by, specific contexts. Both Wadensjö (1998) and Robinson (2003) emphasise the importance of acknowledging how social systems influence meaning within the process of translation. The aims and methodology of this research are aligned with a pragmatic, critical hermeneutic view of translation.

## 2.3.1 Translation Theory and Practice in a South African context

Literature on the relationship between the theory and practice of translation in mental health care institutions in the South African context is negligible. Although South African research has focused on specific problems that surround translation in mental health care, there is a need for more in-depth research on the source and nature of these problems in terms of the association between how individuals practice translation within mental health care institutions without relevant training. According to Ceramella, (2008, p. 1), "we live in what we can call a qualification conscious society where the ability to practice most professions based on experience only is less and less accepted". This raises specific questions such as: can the act of translation based purely on experience be viewed as beneficial to the translation process and to those individuals involved in the translation process? Moreover, what complications, if any, arise from translation practices based purely on experience and how do these complications play out in terms of the facilitation of valid communication and accommodating understanding of a patient's mental illness?

Research has identified problematic areas specific to translation within mental health care in South Africa, namely, language, role, culture, power, race and gender (Bantjes, 1999; Drennan et al., 1991; Drennan & Swartz, 1999; Swartz, 1998). If problems related to these specific factors are prevalent within the South African context, then the level of mental health care provision is compromised as

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translation practices do not align with patient needs. The result is a less than desired level of mental health care provided as the institutional context does not facilitate healing. This means that culturally sensitive and valid assessment, diagnosis, and treatment of patients is at risk (Swartz & Drennan, 2000; Bantjes, 2006).

According to Thelen (as cited in Peeters, 2005, p. 41) "there can be few professions with such a yawning gap between theory and practice as we see in translation". Although this gap exists and the distinction between theory and practice of translation is blurred, it is essential that there is some form of co-operation and necessity between theory and practice (Morini, 2008). A collaboration or circular relationship between translation theory and practice enables each to benefit the other and "be beneficial to the translation process and ultimately help the translator" (Thelen, cited in Peeters, 2005, p. 48). Thelen (cited in Peeters, 2005, p. 48) states that the implementation of theory is a complex practice where "only that theory should be taught which is necessary for, and of direct relevance to, professional reflection on translations and problem solving".

Robinson (2003) emphasises the importance of the inclusion of experience in translation training programs. What translators learn outside of the class (engagement with the real world) and what translators are taught in class are essential for professional translation. According to Robinson (2003, p. 84) then:

> translation for the professional translator is a constant learning cycle that moves through the stages of instinct (unfocused readiness), experience (engagement with the real world), and habit ( a "promptitude of action"), and, within experience, through the stages of abduction (guesswork), induction (pattern-building), and deduction (rules, laws, theories); the translator is at once a professional for whom complex mental processes have become second nature (and thus subliminal), and a learner who must constantly face and solve new problems in conscious analytical ways.

Theory concerns specific rules, techniques and schemes about translation, and practice concerns the application or implementation of these specific rules, techniques and schemes (Peeters, 2005).

There exists a circular relationship between translation theory and practice in that translation theory is not only what is taught in training programs, but includes what translators learn through each experience of practicing translation (Robertson, 2003). This raises the question of the amount and nature of experience necessary or sufficient for professional translation. We have seen that the very process of translation is a site for multiple linguistic, cultural, institutional and political effects and determinants. In addition, the context, within which a translated process occurs, has a profound direct effect on the meaning generated (Angelelli, 2004; Swartz, 1998; Venuti, 1992; Wadensjö, 1998). Thus,

Robinson (2003) believes that the questions concerning adequate levels of experience necessary for professional translation can be misleading. As translation is highly influenced by the context within which it is occurring, translators are not able to always know what a specific job will require. Thus, the focus on experience in translation practices is not on how much experience is sufficient for effective translation, but rather on practitioners gaining as much experience with translation as possible in order to highlight the benefits or potential drawbacks of such experience for all individuals who are involved in the translation process and the effect this may have on individuals who require translation services for communication and understanding. Thus, as stated by Robinson, (2003, p. 99) "the more of the world one experiences, the better".

In the South African psychiatric institutional context, problems relating to linguistic, cultural, role and power effects and determinants that stem from translation practices may be the consequence of a lack of co-operation between experiential translation theory and practice. As individuals acting as translators have experiences in translation they develop experiential working knowledge of translation through the process of 'abduction' (the use of intuition) and 'induction' (pattern-building). This experiential working knowledge of translation processes then goes on to inform future experiences, creating well defined practical experience (Robinson, 2003). This practically illustrates the hermeneutic circle of inquiry; where through translating individuals are able to create new understandings or meanings by moving in a hypothetical circular motion where experience informs future experiences through interpretation and re-interpretation of those experiences. In other words, each individual is able to develop a type of personal experiential theory concerning translation practices, which is constantly informed by future experiences.

Individuals working with or as translators within mental health institutions often do so with little or no practical experience in translation, as they do not have the necessary tools to deal with what is required in practice. This means that individuals do so without any understanding or knowledge behind their practices (Robinson, 2003) and thus may not have developed an informed personally intuitive fore-arc of perception. Thus, a lack of personal and professional awareness stemming from a lack of practical experience may be the site for communication breakdown and confusion during the psychiatric interventions.

This research emphasises the importance of analysing how translation based only on experiential working knowledge of translation practices influences communication within translation processes on a day-to-day basis. This involves looking at the following: individuals' experiences in practicing translation; identifying how the problematic effects and determinants of language, culture and role arise in practice; if the facilitation of co-existence between experiential working knowledge of

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translation practices and theory of translation within the South African institutional context will increase individual awareness, knowledge and understanding of those translation practices, thereby enabling individuals to recognise problem areas as well as implement preventative techniques and strategies to overcome these problems.

# CHAPTER 3: LITERATURE REVIEW

Research and literature on the process of translation within psychiatric institutions in the South African context has received little attention. This is highlighted within this particular study and both local and international literature is reviewed here. Moreover, this study will argue for a critical hermeneutic research approach within an interpretive paradigm to studying the process of translation within psychiatric settings. The following three sections focus on factors which influence communication during the process of translation, namely, language, culture, and role. Furthermore, problems concerning role expectation and inter-disciplinary conflict are examined in terms of the translation process. As mentioned earlier, the lack of applicable literature relating to the specific techniques and strategies implemented by individuals during and for the process of translation within mental health care in the South African mental health care context was identified and highlighted. Literature relating to techniques and strategies applicable to the remit of this study has been integrated within the three sections of language, culture and role examined below.

## 3.1. Lost in Translation

As previously discussed, this study is aligned with a pragmatic, critically hermeneutic approach to language and translation. In this approach, it is assumed that as social beings, we construct meaning and negotiate reality through the use of language. According to Swartz, (1998, p. 28), translation in this model is a more complicated matter than in the conduit model as "it involves not simply changing labels for things in the world, but also a consideration of the role language plays in determining our emotional realities". This model is aligned to current theory on translation as it does not assume that translation is merely a technical activity (Angelelli, 2004). Rather, as social beings we make sense of the world through the intrinsic link between language and culture. Thus, translators should strive to understand verbal messages rather than focus on word equivalence (Robinson, 2003). With the acceptance of non-equivalence at word level and the need for a pragmatic view of translation, we need to examine the major inconsistencies and practical issues pertaining to the translation of languages.

According to Ceramella (2008), words acquire different lexical meanings within different countries and linguistic systems. Referring to Cruse's theory on the lexical meaning, Ceramella distinguishes four main types of meaning in words and utterances. The first is termed the propositional meaning which refers to how appropriately a word is used. According to Ceramella (2008), inaccurate translations often involve the propositional meanings of words. For example, the word 'lipstick' is used inappropriately if one says 'she wore lipstick on her eyes'.

The second lexical meaning looks at the expression of words or utterances. Swartz, (1998, p. 28-29) explains that "different languages develop different systems of vocabulary for emotions, and in different ways". Additionally, certain emotions are often expressed better in some languages than in others. Drennan et al. (1991), study the social relationships involved in the translation of the Beck Depression Inventory (BDI) from English into isiXhosa. In this study, they found that particular emotions such as 'sad' and the idea 'libido' were problematic when translating into isiXhosa. The word 'sad' was translated as 'khathazekile' and when back-translated was turned into worried and depressed. However, the back-translation of this term involved the inclusion of performative aspects of language (tone, gesture, inflection) that did not necessarily cross the linguistic gap, thereby complicating the translation of emotional states (Drennan et al., 1991).

A third lexical meaning is that of a presupposed meaning of a word or utterance, that is, particular words or expressions have restrictions in specific linguistic systems (Ceramella, 2008). For example, idiosyncratic or metaphoric expressions (such as "butterflies in his stomach") in English which implies nervousness, does not necessarily translate into another language and are thus in most cases not understood (Bantjes, 1999, p. 42). In the translation of the BDI from English to isiXhosa mentioned above, the translation of the word 'libido' (interest in sex) produced difficulties, which arose from the contextualization of the word 'libido' (Drennan et al., 1991). It was discovered that in English, 'libido' is an expression devoid of gender, in isiXhosa this is not the case. In isiXhosa, the idea of 'libido' devoid of a particular partner or specified practice is a concept that is not understood for it cannot be decontextualised as it can in English as it relies upon the context in order to produce meaning.

The fourth lexical meaning of words refers to an evoked meaning. According to Ceramella (2008), the evoked meaning of a word or utterance is derived from dialect and register. Dialect concerns geographical, social and temporal positioning of individuals and register refers to the levels in which individuals have been exposed to a particular language. For example, an additional finding in the translation of the BDI from English to isiXhosa, involved the idea that translations from English to isiXhosa vary in terms of the geographical positioning and socio-economic status of individuals. It is suggested that urban-Xhosa speaking individuals may no longer use the subtle word distinctions that rural-Xhosa speakers may use (Drennan et al., 1991). According to Westermeyer and Janca (1997, p. 292), "difference in dialect among social classes and geographic regions exists regarding subjective experience". This means that within the process of translation issues of dialect and register could negatively influence accurate communication as patients may speak indigenous languages that differ to languages spoken by staff members acting as translators.

It is important to note that there are practical issues relating to translation which arise not only from differing lexical meanings, but also from all linguistic sub-systems, such as the biomedical diagnostic frameworks used within the mental health care context. For example, phrases or medical terminology specific to mental health practices could be difficult or impossible to translate and thus individual understanding becomes constrained. This ultimately results in additional complexities for diagnoses achieved through translation services, as, for example, the translations and information important for diagnosis may become convoluted through extensive explanation of single words. According to Westermeyer and Janca (1997, p. 305), "assessing mental status in different educational, linguistic, class and ethnic or cultural groups can challenge the clinician working across language and culture". It is therefore important to examine how translation influences the accuracy of a patient's diagnosis if an individual's mental status is discovered through the use of translation.


3.1.1 The Assessment Process

In mental health care settings such as psychiatric hospitals, psychiatric interventions for those individuals suffering from mental conditions are based on a westernized biomedical nosology. This involves the recognition of symptoms and elicitation of signs through the use of the psychiatric interview. These symptoms and signs are then matched against categories of disorders or dysfunctions in order to formulate an accurate diagnosis and treatment program (Leff & Isaacs, 1990). According to Drennan (1999), while language is crucial to the entire course of mental health care, it is particularly important in the assessment process as this represents the first step in the therapeutic care of patients. The assessment process involves the collection of a case history of each patient as well as the implementation of a mental state examination. As stated by Leff and Isaacs (1990, p. 7), the retrieval of a systematic account of the clinical case history of a patient is "by far the most important aspect of the psychiatric interview", as in-depth information obtained from systematic history-taking "is an indispensable element in the diagnostic process".

Westermeyer and Janca (1997, p. 296), point out that "only in recent decades have psychiatrists and others recognised that expression of symptoms and signs across language and culture raises problems of meaning and understanding". The applicability of a western-based biomedical diagnostic and treatment model within the South African context is raised as potentially problematic. Although standardised measuring instruments and assessment methods are increasingly being used cross-culturally within psychiatry, clinicians still face difficulties in dealing with patients in terms of language and its use, specific cultural beliefs, as well as the application of particular assessment

methods to people of different languages or cultures (Buhrmann, 1977; Smit, van den Berg, Seedat, Bekker & Stein, 2006).

It has been emphasised that word equivalence is not a reality for translation. As most words do not have a direct equivalent, the meaning of certain symptoms and signs used to diagnose and treat a patient will vary from language to language and culture to culture. For example, in their study on the diagnosis of schizophrenia in Black and Indian patients, Cheetham and Griffiths (1981) found that the universal employment of diagnoses is highly controversial in that no vigorous and standardized approaches exist. Cheetham and Griffiths (1981) found that certain symptomatology was incorrectly associated with pathology resulting in misdiagnoses and mistaken treatment. In a more recent study on language as a barrier to care for Xhosa-speaking patients at a South African teaching hospital, Levin (2006, p. 1076) found that "language difficulty results in reduced patient understanding of diagnoses, medication and follow-up and non-adherence to medical advice in adult and pediatric settings". Thus, not only is a breakdown in communication problematic for clinicians and diagnoses, but also for patients' understanding of their illness and treatment as well.

Westermeyer and Janca (1997, p. 296) go on to state that the problems concerning the translation of meaning resulting in misunderstandings is challenging not only in verbal communication but in written forms of communication as well, namely, "questionnaires, rating scales, and psychological tests". For example, in their study on the translation of the Beck Depression Inventory, Drennan, et al. (1991), illustrate the limitations of biomedical discourse within a non-westernized context. Capturing the sexual desires of Xhosa-speaking people into a psychiatric symptom was found to be problematic and demonstrated the limitations of attempts at translating the BDI into isiXhosa. While some studies support the validity of translated assessment tools (Steele & Edwards, 2008), others argue strongly that there are specific limitations and biases in the process of the cross-cultural adaption of measuring instruments which cannot be ignored (Smit et al., 2006). This is particularly evident regarding the technical aspects of translation and equivalence as well as regarding the broader, more theoretical issues concerning the application of a western discipline and its regime of knowledge with its culturally and historically located models of diagnosis, pathology and assessment within non-western contexts.

Although the application of a westernized biomedical approach to mental illness has been questioned, recent literature and studies such as that conducted by Smit et al. (2006) and Steele and Edwards (2008) mentioned above, show that language and communication are being prioritised in research as the translatability of assessment tools is slowly being implemented.

## 3.2 Culture

Current linguistic theory emphasises that specific rules and acceptable sequences which form the basis for specific social systems, allow us to draw meaning and make sense of cultural phenomena (Potter & Wetherell, 1987). Thus, as these social systems are of a conventional nature, meaning production is in a sense pre-determined by these rules and acceptable sequences both in behaviour and talk. According to Swartz (1998, p. 7), "culture then is about the process of being and becoming a social being, about the rules of society and the ways in which these can be enacted, experienced and transmitted". In this sense, culture represents individual world-views, including individual shared traditions as well as customary linguistic practices (Ceramella, 2008). Secondly, "culture" refers to the wider social milieu in which various 'sub-cultures' or ethnicities may interact. As Swartz (1998, p. 7) states, 'culture' concerns the "rules of society".

### 3.2.1 Biomedical World vs. Life-World

The empiricist view of language is linked to scientific paradigms such as medicine and psychiatry (Swartz, Gibson & Swartz, 1990). Within medical and psychiatric regimes of knowledge, the main aspiration is the achievement of "positive social objectives through the use of carefully collected information" in order to co-ordinate complex social activities within the modern world (Louw, 2002, p. 3). As psychology is allied to the realm of medicine and psychiatry, an individual aligning themselves with a scientific positivist paradigm within psychology may assume that unchanging external realities exist which can be measured and ultimately controlled and manipulated (Terre Blanche & Durrheim, 2006).

This forms the basis for the western, biomedical diagnostic and treatment model used within psychiatric interventions, where symptoms and signs are recognised through the use of the psychiatric interview and matched against disorders or dysfunctions representing specific mental illnesses (Leff & Isaacs, 1990). The abstract labelling of human behaviour and realities is crucial in the diagnosis and treatment of patients, and language plays a vital role in determining diagnoses (Leff & Isaacs, 1990). According to Swartz et al. (1990), medicine, psychiatry and psychology have been criticised for their ability to exert a level of social power or control through the individualization of psychopathology, that is, the idea that social problems can be individualized.

When a clinician and patient do not share the same cultural values or norms, valid communication and understanding of beliefs and behaviour becomes challenging. In psychiatric assessment, patients use lay meaning to convey symptoms and experiences. Clinicians then make sense of this lay meaning by characterizing it into specific psychiatric symptoms and signs for diagnosis (Westermeyer & Janca,

1997). According to Smit et al. (2006) this is known as the universalistic position within cross-cultural psychiatry and assumes that a selection of universal emotional experiences or states exist independently of context, culture and language. Smit et al. (2006) go on to state that this universalistic position ignores cultural difference and assumes that westernized culture is the foundational culture upon which others are compared. This represents one of the major flaws and potentially ethnocentric pitfalls concerning the application of psychology and the western-based biomedical diagnostic and treatment model within institutions in the South African context. According to Swartz (1998, p. 57) even though psychiatric diagnosis follows a particular method and set of rules; "it remains a part of a cultural system of interacting with and making meaning in the world".

In line with a hermeneutic theory of interpretation, psychiatric diagnosis can therefore be seen as one interpretation/perspective of an individual's experience of illness. According to Westermeyer and Janca (1997, p. 233), "when cross-language assessment is added to the task of psychiatric assessment, the additional difficulty is immediately apparent". This study emphasises the importance of acknowledging how culture (both in terms of the individual clinician, nurse and patient as well as cultural discourses or social systems) influences the recognition of emotional experiences when interaction between clinician and patient is compounded by the use of translation processes. An examination of the influences that the role that translation exerts in terms of facilitating ideas that located meanings are transformed from one culture into western culturally located meanings (which are often seen as foundational), is needed. In doing so, specific implications for assessment, diagnoses and treatments are made explicit.

Consistent with the previously discussed linguistic and clinical knowledge in mental health care is the need for translators to know about a patient's cultural background and present lifestyle (Baylav, 2003). According to Westermeyer and Janca (1997, p. 297), there is a clear link between language and culture, where "culture shapes language to reflect different ways of conceptualizing feelings, cognitions and behaviours within the culture". A widely held misconception in translation practices is that translators are able to understand different cultures merely because they are able to speak the language relevant to that culture (Swartz, 1998). As explored previously, translation theory emphasises that translation cannot merely be the conveyance of words from one language to another, but that during the translation process, context is of great importance. The investigation of contexts in translation practices is essential when aligning with current theories of translation.

According to Dingwaney, (1995, p. 3), rather than focusing only on the equivalence of words, it is imperative that a translator bears in mind the "context (a world, a culture) from which these words arise and which they necessarily evoke and express". As translation is an inter-relational process of

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rendering the meaning of a 'source' language into a specific 'target' language, it is not only the world and culture of the patient that is under scrutiny, but that of each member forming the triad (Dingwaney, 1995). An individual's beliefs and behaviour arise from a combination of "normative cultural values", personal experience and perceptions (Angelleli, 2004, p. 19). Accordingly, translation theory and practice stresses the importance of studying both the 'source' and 'target' cultures of individuals involved in translation processes (Dingwaney, 1995). The inseparability of language and culture is emphasised here regarding broader societal norms as well as individual culturally located meanings which influence understanding. According to Morini (2008), new linguistic theory on translation must therefore be realistic as the first decisions translators make are of a pragmatic nature. Richardson (1998, p. 124) states that the pragmatic nature of translation is a matter of deixis, which is, "linking utterances to the contexts in which they are produced". In other words, translators must take into consideration not only the individual contexts from which utterances are derived but the broader social influences that may or may not influence what people say and how they say it. This is essentially what makes translation a multi-faceted and dynamic phenomenon that is extremely dependent on context.

According to Swartz (1998), individual descriptions of symptoms and experiences of distress are not shared by every culture. It may be the case that clinicians who are aligned with the biomedical realm assume that objective facts exist across cultures in terms of mental illness and thus, the assessment of emotional and cognitive states is problematic in the South African context. This is relevant in terms of the assumption of semantic equivalence in translation processes as well as social influences on the mental status of patients. Swartz (1998, p. 56) goes on to state that in many different countries "there is a tendency for personal distress to be expressed as bodily pains and problems". For example, in her study on communication problems in a multi-cultural South African setting, Herselman (1996, p. 158) found that when patients describe depression, they explain their symptoms in terms of bodily experiences such as "feet burn" or "heart is sore". According to Smit et al. (2006), the idea that emotional expression is socially constructed and thus dependent on context is known as the relativist position in cross-cultural psychiatry. Thus, when the lay meaning of distress, for example, is misunderstood due to different belief systems between clinicians and their patients, diagnosis becomes problematic.

This, according to Bolden (2000) is often the result of a difference in the "voice of medicine" and the "voice of the lifeworld" (p. 395). The 'voice of medicine' is scientific, objective and focuses on a decontextualized positivist/empiricist set of assumptions about reality and in contrast the 'voice of the lifeworld' is more descriptive and personalized (Bolden, 2000). For example, in their study on errors in the diagnosis of schizophrenia in Black and Indian patients, Cheetham and Griffiths, (1981) found that

frequent errors in diagnosis were attributed to the misinterpretation of culture-specific occurrences. Although advances in cross-cultural psychiatry now emphasise the acknowledgement of culture specific experiences, another difficulty concerning the translation of cultures is that words or phrases are often exclusively grounded in a particular culture as to render the translation impossible (Robertson, 2003). Consequently, when culture-bound concepts arise during assessment, good communication and clear understanding is dependent on how knowledgeable the translator is of all cultures in the triad (Ceramella, 2008).

According to Venuti (1992, pp. 10-11), translation requires critical evaluation concerning its "ideological and institutional determinants, resulting in detailed studies that situate the translated text in its social and historical circumstances and consider its cultural political role". This is in line with the dialogical view of interpreting put forward by Wadensjö (1998, p. 43) in that the act of interpreting focuses on "actions and interactions taking place in a concrete situation which represents a mixture of linguistic and social conventions and personal preference". In her book on interpretation as interaction, Wadensjö draws from theory put forward by Rommetveit where the presupposition of the dialogically based view of interpreting is that humans are social beings with individual minds embedded within a cultural collectiveness (Wadensjö, 1998).

Drawing from Foucault's notions of power/knowledge and discourse, Venuti explains that the transparent nature of certain discourse may lend itself to cultural exchanges that are not equal, resulting in unbalanced power relations (Venuti, 1992). This means that certain discourse may be used to mask underlying cultural and political bias and inequality. In her study on the way clinicians and translators construct meaning in translated psychological interventions, Bantjes, (2006) states that as there is no clear discourse around translation, this allows for translation to be viewed within the unofficial realm. The intricate nature of translation is rendered 'invisible' here, as the traditional empiricist view of language is upheld allowing for the permeation of power and control through translation practices because old inequalities are normalized and maintained.

Within South Africa during Apartheid, class divisions were constituted along racial lines and concepts such as 'class', 'race' and 'culture' were used in both political and economic spheres in order to establish and maintain the dominance of white minorities within society. Today, in post 1994 South Africa, although democracy was established, these concepts are still very much intertwined in contemporary South Africa and it is often very difficult to mention one without evoking the other. This makes it difficult to speak about 'race' and or 'class' as transparent and subject concepts which has prompted the use of other ways of marking social differences (Painter et al., 2006, p. 9). This is important to acknowledge as concepts such as 'culture' or 'ethnicity' are used interchangeably to mark

boundaries that were formerly designated by 'race' categories and therefore, disciplines such as the social sciences no longer seem to be supportive of racial segregation or ideology (Painter et al., 2006, p. 4). So, it can be said that the discrimination which pervaded South African societies and mental health institutions during apartheid and certain discourses used and/or conducted (both institutional and disciplinary) during this period, may still currently lend themselves to the perpetuation of inequality and racism today in more elusive ways. This means that the use of concepts such as 'race' and other social classifications in post-apartheid South Africa requires much sensitivity as power struggles between members of a triad could be interpreted as a racial concern between a white clinician and black nurse or to a struggle between individuals in different professions such as between a nurse and hospital superintendent or visa verse. Although the evident conceptual overlap with 'culture' and 'race' because of South Africa's history of racism, discrimination and inequality is acknowledged within this Thesis, the focus of discussion is more towards culturally aligned aspects of translation processes within this overlap as there is almost no direct references made by participants about racial dynamics. Rather, what emerged from the research material swayed more towards cultural beliefs and ideology and although 'racial' connotations may have been subliminal, one must be careful not to assume that this was the case if no direct references were made.

Returning to translation itself, it is important to note that any additional tensions within the triad will have a profound influence on the translation process and ultimately the level of care provided; for if hospital staff become despondent, the quality of the work performed is affected. Furthermore, according to Ceramella (2008, p. 5) in some instances, a translator can be seen as a "manipulator of reality at the expense of the source cultures and languages dominated by the hegemony of the target culture and languages". As 'culture' in the broader sense (society) allows us to draw meaning from local instances of 'culture' (shared meanings across and between cultures/ethnicities), through the process of translation, translators have control over the facilitation of understanding through their ability to reinforce or re-instate the dominant rules of society and/or the institution.

Following from this argument, it is not only the elicitation of symptoms and signs that may cause cross-cultural confusion. According to Levin (2006) the use of different medical terminology and culture-specific models of disease can also have a negative effect on communication between clinicians and their patients. The use of specialized terminology can be confusing for patients as the way in which they make sense of or understand illness is influenced not only by language and culture, but also by their level of education (Levin, 2006). According to Drennan et al. (1991, p. 363), the biomedical hierarchy and ideology "leads to a certain disregard for the historical and cultural processes which lead to socially constructed constellations of reality, based in language". As the psychiatrist (for example) is

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situated at the top of the biomedical hierarchy in the realm of mental illness, the patient's voice and story can be silenced as biomedical discourse and western ideology is seen as absolute. Although the clinician has power in terms of clinical decision making, if clinicians are unable to communicate with their patients, a certain amount of control and power needs to be delegated to the translator in order for the clinician to gain access to a patient (Kaufert & Koolage, 1984).

Translators thus assume an ambivalent location within the biomedical hierarchy where they are situated in the space between the doctor and patient (Crawford, 1994). According to Kaufert and Koolage (1984, p. 286), "the interpreter's knowledge of an indigenous language and culture conveys power only within the interpreting situation and is unaccredited as a professional or paraprofessional credential". Thus, in terms of diagnoses, clinicians are situated in a more powerful position than patients and interpreters. In terms of language and culture however, translators can assume a more powerful position than clinicians within the triad. As translators often share the same language and culture as the patient, patients may have a better association with the translator and thus feel more understood when a translator is present due to the development of rapport. In his study on the problems of language use in Cape Town's health services, Crawford (1994, p. 40) found that "doctors frequently felt anger towards the nurse/interpreter for being excluded from lengthy exchanges between nurse and patient ... and for the nurses' authoritarian attitude to the patient" Consequently, problems relating to the role of the clinician and translator and the presence of disciplinary hierarchies within the translation triad are important to consider as they can affect the flow of information and communication and ultimately the level of mental health care provided to patients.

## 3.3 Role

In the South African psychiatric institutional setting where there are currently no clearly defined positions for translators, translation occurs predominantly on an 'ad hoc' basis where bilingual staff members such as nursing, cleaning and security staff are expected to translate (Swartz, 1998). According to de Villiers, mentioned in Drennan (1999), it is often the case that black nursing staff view translating as an incidental but daily aspect of their work. According to Swartz et al. (1997), this means that translators assume a lower status in the medical hierarchy than clinicians and discrepancies between their status and lack of official posts for individuals acting as translators, means there is often no funding for translation. This renders translation as an invisible process and the translator as powerless. In her study on how interpreters manage their roles, Hsieh (2006) found that evidence of institutional hierarchy can create difficulty for interpreter roles. Moreover, Hsieh, (2006, p. 726) states that "the discrepancies between training for interpreters and the reality of medical encounters lead to

interpreters' awareness of their lower status in the health care system and their inability to correct the situation". A translator's varied role and role perception, status positions within an institution, and relationship to clinicians and patients are important aspects that affect the relationship dynamic and facilitation of communication within the translation process (Swartz et al., 1997).

Research on translation in mental health proposes varying models and positions concerning the roles that translators assume during translated interventions, but there is little focus on the practical aspects required in translated mental health consultations in varying contexts (Angelleli, 2004; Herselman, 1996; Petersen, 2000; Swartz, 1998; Westermeyer, 1990) This research is thus important in terms of understanding the practical aspects required within a particular context of translation and a translator's work. Bolden (2000) stresses the importance of investigating what happens in 'real life' medical encounters when a translator is introduced.

Although multiple models and approaches to the roles that translators and clinicians assume have come under investigation, no hard and fast rules relating to theory and practice exist for translators and clinicians in mental health settings in the South African context (Swartz et al., 1997). According to Raval (2003, p. 10) "the quality and type of service provision in any setting is influenced by the broader and local socio-political considerations, and the interplay between these". Furthermore, Raval (2003) goes on to state that translators are able to assume a number of different roles in terms of their level of experience, training and overall expertise. It is important to note that the focus here is not on which model or approach is by and large applicable to the South African context, but rather on what practical situations influencing communication before, during and after the translated assessment session arise from translators and clinicians assuming particular and often overlapping roles. Thus, by drawing on relevant aspects from translation theory and models we are able to analyse translated experiences by focusing on practical behaviour. In doing so, we are able to determine the ways in which this behaviour is influenced by the broader context in which translation takes place and in turn how this behaviour influences the facilitation of communication during translation within the mental health institutional setting.

In her study on how interpreters manage role conflict in provider-patient interactions, Hsieh (2006) stresses that the conflict that interpreters experience in terms of their roles is not only a result of role performance but also role expectation. Moreover, Hsieh, (2006, p. 729), states that successful communication in bilingual interactions is not dependent on an interpreter's linguistic ability alone but rather "the interpreter's ability to negotiate other speaker's communicative goals and identities". Thus, role expectation and role perception are essential aspects for producing meaning within the triad. This means that, how individuals perceive and define their own roles as well as each other's roles, which is,

the interdependence of all individuals, is important for the quality of communication experienced in the triad (Hsieh, 2006). According to Raval (2003), additional roles that translators may assume need to be incorporated into the job description of the translator as, if the translator assumes role/s which the clinician does not accept, conflicts may arise.

As translators and patients may have been previously disadvantaged and may assume a lower status to that of a clinician, there are historical and social issues of power, race and class that can become mirrored within the process of translation. In his study on language problems in the Cape, Crawford (1994, p. 35) found that "in most cases doctors did not appreciate the difficulties and ambiguities of the interpreters position". Additionally, Crawford (1994) found that clinicians became angry when interpreters were not available to interpret when needed. Nurses may resist the role of translator as they are expected to do so without professional or financial remuneration. This leaves nurses acting as translators in an 'invisible' and subjugated position. This position may reflect their socially and historically unequal and disempowered statuses in terms of race and class in South African society. So, in essence, the communicative behaviour of the clinician, patient and translator, produced within the broader context ultimately determines the level of communication achieved.

### 3.3.1 The Clinician's role

As individuals either working with or acting as translators within mental health institutions do so without professional training in translation processes, role expectation and role capabilities can become blurred. According to Robinson, (2003, p. 24) this is a matter of reliability in that "the demands placed on the translator by the attempt to be reliable from the user's point of view are sometimes impossible". As translation is such an essential process for clinicians who are unable to verbally communicate with their patients, high demands are made on individuals who are performing a translating role. These demands are often either unrealistic or over and above the expertise levels that individuals who are translating are capable of.

In some instances, clinicians may align themselves with the empiricist approach to language and culture and thus expect those individuals translating to do so verbatim. Clinicians may feel that in order to have clear communication and access to their patients, individuals interpreting must translate exactly what the patient is saying. As we have seen, in most cases of translation, equivalence itself is not a practical possibility due to semantic and cultural problems specific to translation mentioned in 3.2 above (Robinson, 2003). Individuals translating for clinicians who hold this empiricist view may then either attempt to translate in terms of what is expected of them, or with the use of deduction following on from what they have learnt from their own experience. In her study on conflicts in how interpreters

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manage their roles in provider-patient interactions, Hsieh (2006) found that one main source of conflict in role performance was unrealistic expectation. Interpreters reported that they strive to be invisible in provider-patient interactions but are also aware that this invisible role has multiple consequences and is often not practicable (Hsieh, 2006).

The training of clinicians in working with interpreters has received little attention in clinical literature. Miller, Martell, Pazdirek, Caruth and Lopez (2005), state that not only should clinicians be made more aware of the merits and limitations of the empiricist model of interpreting, but that clinicians need to recognise their role in working with translators and facilitating good communication. Furthermore, there is an emphasis on the use of briefing and de-briefing meetings and the implementation of explaining the nature and purpose of highly specific assessment and therapy techniques or exercises to translators before they are used in the session (Miller et al., 2005; Raval, 2003).

Awareness of the limitations of viewing translation as a pragmatic activity is needed from both clinician and translator in order to facilitate a process of communication that is beneficial to the patient and clinician (Robinson, 2003). Moreover, acceptance and awareness that meaning is lost during the process of translation can reduce high expectation and relieve unnecessary pressure placed on the translator. This allows for better understanding and communication to be achieved not only between clinician and patient but between clinician and translator as well.

In their study on the impact of interpreters' on the therapeutic process Miller et al. (2005) state that the way in which participants understand the interpreters role in the therapy process influences the therapeutic alliance formed between the clinician and client as well as the relationship formed between interpreter and clinician. As the inclusion of an interpreter transforms the originally dyadic interaction into triadic interaction, the therapist-client relationship becomes a more gradual process as it is transcended through the presence of the interpreter (Miller, et al., 2005).

3.3.2 The Translator's Role

According to Swartz (1998), the interpreted interview is a multi-complex, multi-directional activity within psychiatry in South Africa and consists of multiple levels of analysis, namely, the interpersonal level, the institutional level, the socio-political level and the international level. This is commensurate with Venuti's (1992) theory on translation of text as well as Wadensjö's (1998) dialogical model of face-to-face translation and is in line with the critical hermeneutic perspective of this study.

The first model concerning the role of translators in translated interviews, termed by Westermeyer (1990) as the 'Black Box Model', which assumes that translators hold an 'invisible' or contained

position during the translated interview (Swartz, 1998; Westermeyer, 1990). In this particular model, translators are required to simply act as non-invasive conduits, channeling messages (words and their meaning) from one language to another (Angellelli, 2004; Swartz, 1998). All of the above theorists, namely, Angelleli (2004), Swartz (1998) and Westermeyer (1990) state that this particular way of viewing translation is not recommended as it is one held by those who are inexperienced and uninformed in translation practice and theory. This model fails to take into consideration the interpersonal, institutional and socio-political levels of translation (Angelleli, 2004). We have seen that equivalence within translation of the psychiatric interview is not a realistic possibility. Emotional experiences and cultural phenomena are not translatable word-for-word, resulting in loss of meaning. According to Westermeyer (1990, p. 748) "this model does reflect how many clinicians and translators new to this clinical task, do perceive their mutual roles". If this model was to be employed and the loss of meaning ignored, both clinician and patient would receive incorrect translations increasing the chances of confusion and misdiagnoses.

Supplementary models concerning the role of the translator in the translated interview focus instead on the translator taking a more 'visible' position (Angelleli, 2004). Swartz (1998) asserts that the 'visible' translator can take the role of 'cultural broker' or 'client advocate', both of which involve establishing meaningful associations between socio-cultural groups of people. Herselman (1994, p. 85) states that "through cultural brokerage, messages, instructions, as well as beliefs and behaviour can be interpreted and translated from one group to another". The importance of cultural brokerage is emphasised in terms of assessment of the patient's behaviour (Swartz, 1998). When assessing mental illness "one needs to know whether a patient's beliefs are in keeping with the group he or she comes from" (Swartz, 1998, p. 36). In her study on the role of the nurse as cultural broker, Herselman (1994), states that nurses are suited for cultural brokerage as they often share the same socio-cultural orientation of patients but also have the relevant training in biomedicine.

It is important to note that this particular model of the 'cultural broker' can be problematic in that it presupposes that translators have a substantial amount of knowledge of both biomedical discourse and the cultural discourse of the amaXhosa involved (Herselman, 1994; Petersen, 2000). Translators thus have the ability to transcend ideas of the parameters or signs and symptoms of mental illness (biomedical knowledge) as well as understanding and transcending patient's experiences of their mental illness. Thus, nurses have the ability to serve either patients who consider themselves amaXhosa, or clinicians within biomedical health-care (Herselman, 1994) or both.

The availability of a common language and informal regular time spent between nurses and patients does allow for the formation of a closely developed relationship between the nurse-acting-as translator

and the patient. This allows for better understanding between the translator and the patient than between the clinician and the patient where communication is either non-existent or minimal (Swartz, 1998). This may affect the therapeutic alliance between clinician and patient where the clinician is excluded as patients may turn to nurses rather than doctors for understanding in terms of their illness or treatment (Herselman, 1994).

As clinicians are more qualified in biomedicine than nurses, this may negatively affect patient understanding of their assessment, diagnoses and treatment. Although nurses and patients may form an alliance in terms of understanding with regards to language and culture, nurses may attempt to align themselves more with clinicians. This is due to the disciplinary hierarchies evident within the institutional context, which may influence a nurse's decision making as they wish to fulfil clinicians' expectations of the translation process and diagnosis. This means that nurses may transform patients' located meanings of their illness into western cultural located meanings in order to 'box' a patient's experiences within biomedical discourse for diagnosis. Nurses may also avoid translating or explaining certain significant meanings specific to the culture shared by the nurse and the patient. In their study on nurses who double as interpreters within a US primary care setting, Elderkin-Thompson, Silver and Waitzkin (2001, p. 1354) found that when nurses avoided communicating cultural meanings in the clinical context, this was an "attempt to appear professional and to avoid information that appears to reflect unfavourably on their culture".

When the translator acts as 'client advocate', their role focuses on empowering the client by forming a relationship with them in order to improve the client's access to resources within the institution (Swartz, 1998). Swartz (1998) further argues that patients who are silenced because they do not speak the dominant language/s of an institution assume powerless positions within that institution. Emphasis is thus placed on "community needs and questions of power relationships across communities" (Swartz, 1998, p. 38). The basis for this model is the establishment of a trusting relationship between translator and patient where the translator acts as an advocate for the individual needs of patients. Drennan and Swartz (1999) in their investigation of institutional roles for interpreters in a post-apartheid South Africa, analyse the requirements and limitations of implementing the advocacy model. Drennan and Swartz (1999), emphasise that advocacy requires both micro and macro level recognition. On a micro-level this concerns the need for a certain quantum of expertise both in terms of interpreting skills and technical knowledge in medical contexts. On a macro-level there is a focus on the interpreter's access to management and the support received from other professionals (Drennan & Swartz, 1999). The implementation of this model within the South African context may intensify issues of resistance and dominance endemic to the three-way conversations that occur through the use of

interpreters. The interpreter and patient may form an alliance stronger than that which is established between clinician and patient, thus excluding the clinician from the interaction. In contrast to the 'cultural brokerage role' mentioned, if a nurse feels that a clinician's diagnosis is not comprehensive regarding the patient's cultural experience of their mental illness, they may communicate confusion and misunderstanding to the clinician for the patient's benefit. Consequently, translators may align themselves more with the cultural discourse shared between themselves and the patient than with the biomedical discourse of the clinician and the institution.

Lastly, other models of translation focus on elevating the translator's 'visibility' by viewing the translator as a functional part of the translation process. Westermeyer (1990) highlights the role of 'junior clinician' within the bilingual worker model. Within this model, the role of the translator as 'junior clinician' is to interview the patient alone under the supervision of the clinician. This model could be problematic if role expectation exceeds the clinical knowledge, skills and experience of the translator. This model is highly controversial in that if both translator and clinician do not have extensive professional training and experience in the clinical setting and with translation; problems concerning ethics and legitimacy could develop (Westermeyer, 1990). This model would be problematic in a South African context as many clinicians are inexperienced in working within the realm of translation and staff members acting as translators do not have adequate experience in translation within the domain of the psychiatric interview.

For Angelleli (2004, p. 8), a shift from invisibility to the visibility of the translator involves the translator assuming a more active role in the translated interaction as they are "co-constructing, repairing, and facilitating the talk". The 'co-constructor' is able to assist with linguistic barriers, social factors and cultural gaps by channelling information to the clinician and client. The 'co-constructor' is also seen as a facilitator for the development of trusting relationships and mutual respect for all parties involved in the translated interview (Angelleli, 2004). If the clinician and the translator have a good trusting relationship and both have experience in what they do and in working with one another, then this particular model may be a viable option within the South African context.

For Swartz (1998) translators are most visible as a 'junior colleague'. In this model, the role of the translator is in contrast to Westermeyer's (1990) 'junior clinician' role and is more clinically proficient than Angelleli's (2004) 'co-constructor' role. Although the translator requires adequate training, specific skills and professional experience, these attributes are functional in terms of diagnosis of the client during the translated interview as "the interpreter's opinions form part of the team judgment about the client" (Swartz, 1998, p. 38). In this model, the professional relationship between clinician and translator is a close one in that pre, current and post discussions of the patient are essential in

diagnosing the patient (Swartz, 1998). This model is problematic in the South African context as limited time, staff and resources do not facilitate pre, current, and post-discussion of patients.

Individuals involved in translation processes within South African institutions have no training in translation practices, knowledge of language theory and contextual influence and have minimal knowledge of its application to translation. According to Robinson, (2003, p. 2) "translators need to be able to process linguistic material quickly and efficiently; but they also need to recognise problem areas and to slow down to solve them in complex analytical ways". In institutional settings both time and labour are in short supply as hospitals are often understaffed and 'ad hoc' translators assume multiple roles, which in itself, is time-consuming and often confusing.

According to Baylav, (2003), translators working within hospitals should specialize in specific services such as mental health and thus receive training in the relevant procedures and terminology used in order to work efficiently with fellow staff members and assist service users. Translators should also be knowledgeable in both the source and target cultures they are working with (Ceramella, 2008). Individuals working as translators within mental health care require a certain quantum of clinical knowledge which facilitates mutual understanding between translator and clinician and clinician and patient (Angelelli, 2004). As theories on translation include both what is learnt in training and what is learnt through experience, Robinson (2003) goes on to stress the importance of sharing formulated deductions amongst translators. This would be extremely useful in the South African context, as no formal training (clinical or otherwise) exists for translators in mental health care.

# CHAPTER 4: METHODOLOGICAL ORIENTATION

## 4.1. Critical Hermeneutic Theory

According to Mason (2006), the strength of qualitative research lies within its focus on interpretation as playing a constructive role in the production of knowledge of social processes, change and social context. According to the philosophical underpinnings of hermeneutic understanding explored in Chapter 2 above, interpretivist ontology holds that the person (researcher) and reality are inseparable and that epistemologically, "knowledge of the world is intentionally constituted through a person's lived experience" (Zuidervaart, 2010, p. 1). Interpretive research focuses on producing or reifying knowledge of a phenomenon or a person's world view by looking at webs of meanings attached to the actual lived experience of participants (Krauss, 2005; Maykut & Morehouse, 1994). Also, interpretive research is associated with methods embedded in the understanding that humans comprehend and operate contextually with the use of language (Dickerson, 2002). According to Smith (2003, p. 2), the interpretive approach to understanding human experience emphasises the importance of language, "as a fundamental property of human communication, interpretation and understanding", where language is seen as productive in the construction of meaning and individual world views.

Hermeneutics, as a form of inquiry, is mainly concerned with the description of human experience through interpretation of individual experiences and perception (Tugushev, 2008). In transforming philosophical hermeneutics, which has been criticized for failing to incorporate critical judgment and reflection (Bjorn & Gjesdal, 2009); theorists such as Habermas (1990) and Apel (1980) "developed a more comprehensive hermeneutics of critique and emancipation" (Prasad, 2002, p. 16). This means that in critical theory there is a movement from description, to evaluation where description of what is apparent in the life-world is taken a step further to include a critique of that life-world in an attempt to change it (Radford, 2002). Although critical thinking in terms of hermeneutics is a newly developed perspective, it has value in terms of enriching interpretation and changing social and cultural contexts. This study is aligned with the Critical Hermeneutic perspective as an interpretive method of inquiry.

According to Prasad (2002, p. 96), "empirical research done from a critical hermeneutic perspective is premised upon five key concepts: the hermeneutic circle; hermeneutic horizons; the fusion of horizons; the rejection of author-intentionality; and critique". In Chapter 2, the first four key concepts were examined regarding philosophical hermeneutics, the production of meaning and the development of understanding during the process of translation. In this chapter, hermeneutics is used as the method of inquiry into the process of translation within a psychiatric institution, with the inclusion of the fifth

key concept 'critique'. The hermeneutic circle as a method of inquiry maintains that understanding and meaning is generated through the movement of a hypothetical circle where interpretation relies on re-interpretation (Kinsella, 2006). From this perspective, the hermeneutic circle forms an operation where the parts can only be understood in terms of the whole, and the whole can only be understood in terms of the parts (Iser, 2000).

The concept of the hermeneutic horizon highlights the historical situatedness of understanding where human interpretation and understanding occurs within a 'horizon' that represents an individual's historic-cultural context (Prasad, 2002). Consequently, the researcher's interpretation of a text is constrained by her informed perspective (horizon).

From a hermeneutic perspective, the historical situatedness of the researcher in interpreting text, assumes a fundamental productive role in terms of understanding. The 'fusion' of horizon emphasises a type of synthesis that occurs through a dialogue between the 'horizon' of a text and the 'horizon' of the researcher (Prasad, 2002). In this instance the researcher is able to gain a deeper meaning and understanding of not only the text she is interpreting, but also a more profound understanding of herself as situated within a 'horizon' (Bjorn & Gjesdal, 2009) that is limited by historical, social, ideological and material constraints.

In this instance we return to Gadamer's hermeneutics, where the meaning of a text is always derived from a conversation between interpreter and text (Gadamer as cited in Prasad, 2002). According to Gadamer (as cited in Prasad, 2002, p. 21), "the meaning of a text [always] goes beyond its author" and "the text at all times represent(s) more than the author intended". This means that the meaning of a text is not demarcated by an author's 'original' intentions for producing a text but rather forms part of the interpretation through the 'fusion of horizons' (Prasad, 2002). Prasad (2002, p. 97), goes on to state that "this rejection, in turn, paves the way for the moment of critique in interpretation".

Following from this point, the rejection of author intentionality in critical hermeneutic interpretation is not only a conversation between the interpreter and text, but includes an evaluation of the ideological and material constraints that limit our particular horizons in order to arrive at understanding.

Following from above then, as stated by Prasad (2002), the actual process of conducting a critical hermeneutic inquiry can be divided into four stages within which the five key concepts mentioned above are applied.

In stage one; chosen texts are studied in terms of language and themes which are derived from an intended textual method of inquiry (Prasad, 2002). The method of inquiry used in this study is that of thematic networks analysis (Attride-Sterling, 2001).

In traditional hermeneutic methods, assumptions about phenomena are 'bracketed' in terms of their value laden status as text is given meaning through the position or interpretation of the researcher. Critical hermeneutics on the other hand, accepts the value laden distortions of meaning in terms of our historically situated positions as beings in the world, but takes interpretation one step further by acknowledging distortions stemming from prevailing power structures of the contextual situation of phenomena (Bjorn & Gjesdal, 2009). This leads to stage two of a critical hermeneutic inquiry, where there is a close examination of the social, cultural, historical and institutional context in which the text was produced (Prasad, 2002). So, according to Radford, (2002, p. 13) "hermeneutics stops at the point of saying knowledge and understanding is historically and socially bound...critical hermeneutics continues where traditional hermeneutics leaves off, by embarking on an examination of those social and historical conditions which make understanding possible".

Stage three is characterised by the application of the hermeneutic circle of inquiry where an interpretation of the text "is produced through the constituting relationship between what the researcher considers the abstracted meaning of the text and what she or he has foregrounded as the anchored context in which the text is produced" (Prasad, 2002, p. 97). Critical hermeneutics then aims to add an additional level to the hermeneutic circle where the meanings articulated by individuals are interpreted in terms of not only the 'whole' phenomenon, as in traditional hermeneutics, but also in terms of the socio-cultural context in which the phenomenon is situated. The fourth stage of a critical hermeneutic inquiry is characterized by a hypothetical closing of the hermeneutic circle as the interpretation or understanding of the symbolic meaning of texts is achieved. The fifth key concept of critique is applied here through a cooperative understanding of "how contextual events determined the contents of the text, but also how the texts in turn contributed to re-actualization or maintaining the dynamics of cultural narratives or forms of sense-making extant within the larger context" (Prasad, 2002, p. 97). Therefore, critical interpretation is to work from a conceptual framework to elicit the specific relationship between text and context and then to act upon specific structures where hermeneutics becomes an agent for change (Radford, 2002).

Drawing on the theory of critical hermeneutics as a method of inquiry, the aims of this study are as follows:

1.  To theorize the phenomenon of translation within a psychiatric institutional setting, in terms of the complications which arise from a process based purely on experiential working knowledge of translation practices. This is achieved through the examination and analyses of the personal

experiences of individuals who are active participants within the process of translation on a day-to-day basis.

2. By conducting an analysis based on a critical hermeneutic stance, provide recommendations for change relating to ways in which participants understand and experience the process of translation in mental health care.

## 4.2. Research Method

### 4.2.1. Participants and Sampling

Due to the ethically sensitive nature of the setting in which this study was conducted, namely a psychiatric hospital in the Eastern Cape, it was important to make contact with specific gatekeepers to gain access into the hospital. Following contact with a principle psychiatrist at the hospital, written ethical permission was obtained from the Eastern Cape provincial Health Department as well as the Hospital's Academic and Research Committee. This particular hospital was chosen as a suitable site for this research as it met the requirements of the study, that is, the hospital contains a large number of patients who are either unable to speak, or have limited proficiency in, English. Moreover, clinicians working at the hospital are predominantly English and Afrikaans speaking. In this setting the use of bilingual/multilingual staff members for translation is a daily occurrence, making the hospital an ideal setting for the study of translation practices.

In qualitative research, the usefulness of small sample sizes is encouraged as generalisability of findings is not emphasised as a main objective in the same way as it is in quantitative research (Marshall, 1996). As participants required for this study were chosen from a hospital that was understaffed at the time of data collection, the availability of staff and patients who were able to participate in the study was of some concern. Therefore, considering the availability of participants, 11 participants were selected. This small sample size was deemed adequate to provide sufficient data to answer the aims of this study. The participant sampling and recruitment method used in this particular study was based on a purposeful sampling strategy. In this particular method of sampling, participants are chosen based on the anticipated characteristics of the most productive sample able to achieve the aims of the study (Marshall, 1996). The variety of the participants in the sample was drawn from a range of individuals (clinicians and nurses) who had different levels of experience in the translation process.

Knowledge of translation processes was initially based on evidence obtained through attendance at weekly ward rounds at the hospital, as well as through immersion in the available literature. This informed participant selection criteria. The main theoretical assumption on which this study is based

was identified, where a gap exists in translation theory and practice within the South African context. Furthermore, it was assumed that translation in mental health care in psychiatric institutions in South Africa was in crisis and in dire need of improvement. It was also assumed that I would find the nurses acting as translators showing complete resistance to their involvement in the translation process. I was also highly critical of the clinicians' engagement with the nurses acting as translators and evidence of racial discrimination was also expected. These theoretical assumptions and pre-conceived ideas concerning the process of translation and the inter-personal dynamics within this process informed participant selection criteria. These selection criteria highlighted the need for participants who only have experience in working within translation processes on a daily basis, but have no formal training in translation theory or practice.

Due to the ethically sensitive nature of this study (especially considering the fragile mental conditions of patients involved in the interviews), it was important to consult with the professional opinion of two principle psychiatrists to determine which patients would be legally and ethically suited for the study. Originally, participant selection was to be based on voluntary admissions to the hospital under section 25 of the Mental Health Care Act 17 of 2002. This was to ensure that patients would be able to give informed consent for participation in the study and to ensure that legal and ethical concerns were adequately dealt with. At the time of data collection however, there were no patients currently residing at the hospital who met this criterion. Through further investigation and in-depth discussions with principal psychiatrists at the hospital, it was established that involuntarily admitted patients would also be able to provide ethically and legally sound informed consent. This was based on the clinical assessment and judgment of the principal psychiatrists. The change from voluntary patients to involuntary patients as participants had minimal effect on the participant selection criteria. Patients were thus only observed in terms of their interaction with others in the triad but were not individually interviewed. Furthermore, the anonymity of patients and the confidentiality of information was maintained.

The participant selection criteria were as follows: nurses and clinicians should preferably have worked together in the past and nurses (in both junior and senior positions) should preferably have worked within translator-mediated consultations as translators on a daily basis at the hospital. Clinicians (in both intern and established positions) should also have worked with nurses acting as translators on a daily basis. Patients needed to be unable to speak the same language as the clinician and thus translation services were required. Moreover, patients would need to be able to provide ethically and legally sound informed consent. This would be based on clinical assessments conducted by principal psychiatrists at the hospital under investigation.

It is important to note that the participant selection criteria were determined by three important factors: the need for participants to meet the required range of experience in translation processes in terms of the aforementioned parameters; the availability of staff at the time of data collection; as well as the pre-conceived assumptions held by the researcher. Material was collected from two particular wards at the hospital. One psychiatrist, one psychologist, four different nursing staff acting as translators and five patients were approached to participate in the study.

As I did not speak the same language as the patients, additional contributors were required for assistance with translation during the process of data transcription. Consequently, two independent translators were sourced for the translation of particular material collected. The selection criteria for the independent translators were as follows: translators were not to be affiliated with participants in any way and needed to have previous experience in translating text from isiXhosa to English and vice versa.

### 4.2.2 Independent Translators and Translation Dilemmas

In this study, data was collected in both English and isiXhosa. Two independent translators were employed in order to translate the isiXhosa spoken in the recorded assessment observations into English to allow the researcher to read and understand the assessment observations. As the epistemological positioning of this study is Interpretive, the theoretical positioning of this study holds that one's position as an individual in the world is context specific, that is, one's location in the world influences the way in which one perceives (understands and produces meaning) the world. Therefore, in concurrence with the critical hermeneutic view of interpretation, it is important to acknowledge the way in which the independent translators form part of the process of knowledge production. According to Temple and Young (2004) the involvement of translators within a qualitative study raises specific questions concerning the extent to which the translator(s) are included in the research process and their contribution to the analysis and findings of the collected material. It is important to note that the independent translators were not involved with the individual interviews and did not play an active role in the analysis of the research material.

According to Temple and Young (2004, p. 164), "there is no neutral position from which to translate and the power relationships within research need to be acknowledged". In order to reduce bias, I ensured that both translators were not affiliated to the hospital or the participants in any way and had little knowledge of the aims of the research study. In using independent translators not affiliated with the participants, my intentions were to prevent alliances forming between the external translators and

participants in order to minimize the two translators' preconceived conclusions or biases whilst working with the research material.

The independent translators were paid for their involvement in the study. In order to achieve a high level of professionalism from the independent translators, a written contract was drawn up and signed by both the researcher and translators (See Appendix 2). This binding contract stipulated the time limits required for the translation, the necessary requirements of the translation and ensured that the researcher would be liable for payment. Payment was discussed and agreed upon by the researcher and independent translators. Furthermore, the contract stipulated specific confidentiality waivers to ensure anonymity of participant information.

In this study, the independent translators were used solely for the purpose of translation in order check the accuracy of the nurses' translation in the assessment observations. Two independent translators were employed in order to verify and compare the translations. As mentioned above, translations cannot be evaluated in terms of their accuracy and validity. Rather, the end results of translations can only be compared with each other (Tugushev, 2008). As two independent translators were used for the translation of the assessment sessions, this allowed the independent translators to discuss the choices they had to make in producing the translated text and to compare their translations with one another. Furthermore, any concerns regarding culture-specific non-verbal behaviour was discussed with the independent translators. This was an interesting experience as reflectively, the researcher was assuming a position similar to that of the clinician during the process of translation. These particular discussions provided insights into the processes of interpretation and re-interpretation of the meaning conveyed in the recorded assessment sessions. Consequently, a certain level of trust in the competence of the independent translators was required as I was unable to evaluate the translations myself. This was trust was warranted as the various comparisons of the translations demonstrated a high degree of correspondence.

## 4.3 Collection of Research Material

Two distinct forms of material were obtained in this study through the use of source and method triangulation. Triangulation allowed the researcher to become immersed in the particular setting in which the material was collected by viewing the phenomena of translation from multiple angles (Meijer, Verloop & Beijaard, 2002). Within this study, triangulation provided an in-depth understanding of translation in practice, where understanding extended beyond a mere description of translation processes.

## 4.3.1 Naturalistic Observation

Conventional, naturalistic observation was implemented as a method of inquiry throughout this study. Within qualitative research, observation is one of the oldest and most commonly used methods of inquiry. It is concerned with understanding 'real' people as they experience life in everyday situations (Banister, 1994). Naturalistic observation is a type of observation that one could say people take part in every day. For researchers within the realm of the social sciences, naturalistic observation is a process of actively studying phenomena in action on a regular and repeated basis in order to answer theoretical questions pertaining to the phenomena (Adler & Adler, 1998). Naturalistic observation is well adapted to multiple settings and allows researchers to "gain entrée to settings" (Adler & Adler, 1998, p. 89).

Firstly, in order to gain access to, and to become familiar with, the research setting, weekly ward rounds where participants were present were attended. A simple form of naturalistic observation was conducted. According to Angrosino and Mays de Perez (2000) this is the first step in the observation process and is termed 'descriptive' observation. No checklists were used here and simple note taking in the form of open-ended narratives of everything observed was implemented (Angrosino & Mays de Perez, 2000). The focus of observation during the ward rounds was broad and no interaction between the researcher and participants occurred during this stage of the research process.

The observations of the ward rounds were implemented purely to develop an introductory understanding of, and familiarization with, the context in which the translated consultations play out. This means that multiple cultures, forms of language and clinical settings other than that which the researcher was familiar with, were under investigation. Material obtained was not analysed, but used to develop awareness of contextual dynamics. Consequently, through this introduction into the clinical setting of the study, a fore-arc of understanding was beginning to take shape as the mentioned pre-conceived ideas about the process of translation became questionable. It is important to note that the confidentiality of any sensitive material that emerged during the observed ward rounds was ensured through the signing of a registered confidentiality form. This form was provided by the hospital and stipulated the level of privacy required and was informed by particular ethical and legal criteria of the hospital.

### 4.3.2 Naturalistic Observation and Audio-Recording

Once a sufficient introduction to translation as it occurs within the clinical setting of the hospital had been achieved, translated assessment sessions were observed and audio-recorded as they ordinarily occur during the assessment of patients. This part of the data collection consisted of six translated assessment interviews occurring within two separate wards within the hospital.

The observation and audio-recording of the translated assessment sessions was only carried out once all participants had read, understood and signed the relevant consent forms provided (See Appendix 1). Consent forms were provided in both English and isiXhosa in order to promote informed consent in terms of participant understanding of the study. Each signed consent form was based on the five important issues to be covered in a consent form suggested by Seidman (1998). The consent forms stipulated the following details: for, by whom, and to what end the research was to be used; the potential risks involved for, and vulnerability of, the participants; the participants' rights to participate, review the terms of their involvement, or to withdraw from the research process; and the maintenance of the confidentiality and anonymity of participants' identities (Seidman, 1998).

Confidentiality and anonymity were ensured as only the researcher, her supervisor and the independent translators had access to the collected data. Material was securely stored with controlled access. Furthermore, the use of pseudonyms was used to maintain anonymity of participants. The consent forms also included the requirements of participation once participants had volunteered to take part in the research process. Both clinicians participating in the research were English speaking and were content with reading the consent forms themselves. Nurses who spoke both English and isiXhosa were given the choice of signing either an English form, or an isiXhosa form. For those patients who were only isiXhosa speaking, the nurse present for the observation was requested to read through the consent form with the patient and translate any questions the patients had concerning their involvement within the research process.

In each translated assessment session, a clinician, nurse and patient were present and the assessment interviews were approximately twenty minutes in duration. Naturalistic observation was once again implemented during the assessment sessions. In contrast to the naturalistic observation conducted during ward rounds, here the observation was more focused and lengthy in order to identify specific verbal exchanges and behaviour pertinent to communication breakdown during the process of translation. This, according to Angrosino and Mays de Perez (2000) is the second stage of the observation process and is termed 'focused' observation. This stage is characterized by the researcher's theoretical and practical familiarization with the phenomena and context under investigation allowing the researcher the ability to sift out irrelevant information (Angrosino & Mays de Perez, 2000).

During this initial stage of data collection within the study, non-verbal behaviour was identified as an essential part of the communication process. Interactions between participants were observed, specifically, where they sat in relation to one another, eye-contact, particular hand gestures and overall body language was observed and recorded. It is important to note here that according to Dlomo (2009, p. 1) "non-verbal behaviour is culturally determined and people tend to transfer it to inter-cultural

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situations". The researcher was aware that cultural differences exist regarding non-verbal behaviour and any concerns relating to these differences were informally discussed with the independent translators. In terms of verbal actions, instances of confusion, disruption or discrepancies with what was said in the assessment sessions that resulted in misunderstandings between participants, repetition, and the need for re-phrasing were investigated. For example, if patients responded to questions asked with long pauses and perplexed looks (frowning) this was noted as an instance of confusion. Observations were then made regarding whether the patient responded to the correct context of the question showing understanding, or if the patient either did not respond or responded out of context, showing misunderstanding of the question posed.

A further essential aspect investigated involved how misunderstandings are dealt with by participants as they play out before, during, or after the translated assessment sessions. The identification of a particular problem which obstructed effective communication; was followed by the inspection of whether or not particular strategies were employed by members of the triad (clinician and nurse respectively) in order to deal with arising problems and containment of the patient. Observations made during the assessment sessions were recorded in the form of both verbatim and narrative personal field notes. These field notes were handwritten and included mostly descriptive information about the context and participant interaction. Reflexive notes were also recorded concerning the position and potential impact, feelings and interpretations in assuming the position of observer (Banister, 1994).

As mentioned above, the translated assessment sessions were also audio-recorded with the use of a tape-recorder. According to Banister (1994), personal field notes are functional when used in conjunction with additional more formal recordings. Here, field notes recorded were analysed in conjunction with the formal audio-transcripts. The audio-recordings of the assessment sessions represented a 'slice of life' concerning the translated assessment sessions on a daily basis. This allowed for observations to be made concerning nuances of both verbal (audio-recordings) and non-verbal behaviour (observations) in the translated assessment sessions. In doing so, the triadic translator-mediated interactions were observed in their natural settings allowing for a clearer representation of context and interactions.

Whilst obtaining participant consent, and during the observation of assessment sessions, it was my intention to assume a peripheral membership role. In assuming this peripheral role, observations and interactions with participants were close enough without compromising activities during the assessment sessions. Both covert and overt stances were possible whilst a peripheral membership role was assumed (Adler & Adler, 1998). In achieving this, the researcher was able to develop rapport with participants, creating a level of trust (Angrosino & Mays de Perez, 2000). Implementing consent forms as a briefing

mechanism before the observations ensured a level of honesty, sincerity, anonymity and confidentiality. This allowed participants to feel comfortable and able to openly discuss personal information. Furthermore, I was constantly aware of and sensitive to the fragile mental status of patients who may be in distress. In order to prevent any harm to patients and to adequately deal with patients who may become distressed during the assessment sessions, the professional opinions of clinicians and nurses participating in the study was sought before and after the assessment sessions.

Naturalistic observation as a data collection method in conjunction with more formal audio-recording allowed for a contextualized understanding of verbal as well as the nuances of non-verbal behaviour evident in translator-mediated consultations.

### 4.3.3. In-depth Interviews and Audio-Recording

The second data collection technique within this particular study took the form of semi-structured in-depth interviewing. In-depth interviewing is a common technique for data collection used within a qualitative research approach and is flexible and dynamic in terms of the method used (Taylor & Bogdan, 1998). According to Taylor and Bogdan, (1998) in-depth qualitative interviewing is a form of face-to-face social interaction where a researcher focuses on obtaining an understanding of participants' perspectives and attitudes concerning their lives and experiences as expressed or described in their own words. Interviewing as a method of data collection in qualitative research was deemed appropriate to obtain the type of information needed to address the aims of this study. This allowed for different people to be questioned regarding how they experience translation processes in the clinical setting. Interviewing as a method was also suited to the time constraints of the study and of participants working at the hospital at the time of data collection (Taylor & Bogdan, 1998).

For the purpose of this study, six participants (two clinicians and four nurses) were approached to be individually interviewed with the use of in-depth semi-structured interviews. All six interviews were audio-recorded and were approximately one hour in duration. Each interview was informed by similar interview schedules. An interview schedule covers a list of ideas or questions that direct certain topics needed to be covered during the interview itself (Taylor & Bogdan, 1998). Furthermore, Taylor and Bogdan (1998) state that the use of an interview schedule presupposes a certain degree of knowledge about the phenomenon/a under investigation. With the use of theoretical knowledge and understandings obtained from observations made, helpful and clear interview schedules were formed. The interview schedules for the clinicians and the nurses took the form of five sub-sections including introductory and concluding questions which were intended not only to give the schedules formality but to ease participants in and out of the interviews. The five sub-sections of the interview schedules were based

on questions formulated from both the literature as well as pre-conceived ideas re-formulated from the subsequent introduction into the hospital context and observations of assessment sessions.

As this research has noted three main interrelated factors that influence the translation process namely, language, culture and role (Bantjes, 1999) three of the interview schedule sub-sections were formulated in concurrence with these factors. Some questions explored the semantic errors specific to translation, participant understanding of the relationship between language and culture, individual role perception and role perception of other members of the triad. An additional two sub-sections were included which covered questions concerning the gap in translation theory and practice. These sub-sections included questions about training and briefing within the daily process of translation as well as the contributions and drawbacks of the process of translation based purely on experience. Specific questions explored the contributions and drawbacks of the translated interview process in terms of assessment and diagnosis of patients including participant opinions of training and briefing and the lack thereof.

As the translation process was observed and audio-recorded during the assessment sessions; this allowed for specific experiential examples to be pulled from the assessment sessions and used as examples within the in-depth interviews. For example, problems identified within the translated assessment sessions were used as illustrations during the in-depth interviews. This allowed participants to reflect on their practices and explore in more depth how specific problems come about in terms of individual involvement and individual perception of others involvement. The use of examples from the assessment sessions in the individual in-depth interviews enabled a deeper exploration into participant's experiences of translation by gaining clarification whilst still being sensitive and open enough to allowing participants to talk freely (Taylor & Bogdan, 1998).

According to Kinsella (2006), contextualization of individual experiences is important in revealing parts which essentially clarify the overall understanding of the experience as a whole. In drawing from examples from observations made during the ward rounds and assessment sessions, cultural, social, historical, economic and linguistic factors were explored which contextualized the participants' experiences. This process of re-visiting instances from the observations also created room for discussion during the individual interviews. Furthermore, it served as a method of cross-checking the data, where, by drawing from sources of data from the observations and using that data in the interviews, allowed for the checking or clarifying the accuracy of interpretations made with participants (Taylor & Bogdan, 1998). This method of inquiry facilitated the flow of the interviews and created rapport between participants and researcher.

According to Kvale (1996, p. 6), it is important to note that the use of interviews does not represent a conversation between equal partners as "the topic of the interview is introduced by the researcher, who also critically follows up on the subject's answers to his or her question". Furthermore, Taylor and Bogdan (1998) state that, participants may feel powerless as a result of their economic or social status. According to Angrosino and Mays de Perez, (2000, p. 680), "we often function in terms of an ideology that leads us to expect power working downward from white, westernized institutions to various subordinated or marginalized people". This was an important reflexive issue in terms of my position as a white, English speaking research student and how participants perceived my role and status within the research context. For example, as all of the nurses who participated in the study are black, the relevant differences regarding race and power could have influenced specific interactions and material obtained from the interactions between myself as researcher and certain participants.

It is important to note that the use of in-depth interviewing allowed participants to convey and reflect on their own experiences of translation processes. This reflection allowed participants to critically examine their experiences through the identification of problematic or difficult situations that arise in day-to-day practices and their involvement in those problematic situations. In doing so, participants were able to communicate particular strategies incorporated in their day-to-day practices which assist them in dealing with or preventing particular problems. Participants were then also asked to provide their ideas concerning training within the realm of translation practices and theory. Furthermore, as interviewing is a form of social interaction, what participants speak of during the interview itself is influenced by how they view the interviewer and how they think the interviewer sees them (Taylor & Bogdan, 1998). According to Taylor and Bogdan (1998), through the interview process, just as researchers are able to formulate a level of understanding, participants are able to gain new insights and understandings of their experiences. For example, at the end of some of the individual interviews, the participants communicated that they felt that by going through the experience of being interviewed they were forced to re-evaluate their position within the translation process which allowed them to be more reflective in terms of how they are able to influence the flow of communication during the interview process.

## 4.4 Qualitative Interpretation of Textual Material

According to Bradley, Curry and Devers (2007), qualitative research does not proclaim to be a uniform way in which to approach research methods or procedures. Consequently, no singular method exists to conduct qualitative analysis. Rather, analysis is seen as the interpretation of experience within qualitative research and different methods of analysis are suited to the differing epistemological,

ontological and methodological concerns of a particular study (Scheillerup, 2008). It is important to note that qualitative analysis is an on-going process that is undertaken throughout the course of a study beginning with the early stage of material collection and continuing throughout the study (Bradley et al., 2007).

As the analysis of material in this manner is only one informed interpretation of meaning and understanding, it is important for the researcher to justify their interpretation in terms of an explicit description of the research steps, theoretical justification and the production of a logical argument (Bergman & Coxon, 2005), that is grounded and supported by individual examples from the data (Merrick, 1999). This is then judged by the reader, who produces an independent interpretation of the findings. This means that, the legitimization of a study "depends on the relationship between the researcher and the research process, as well as, between the researcher and the interpretive community" (Merrick, 1999, p. 30).

### 4.4.1. Thematic Networks Analysis

Traditional thematic analysis is a common technique used in the analysis of qualitative material. It is a theoretically flexible method wherein researchers identify, analyse and establish specific patterns or themes from material text (Braun & Clarke, 2006). This occurs within different levels of the text in order to better understand phenomena and their dynamics (Braun & Clarke, 2006). Thematic networks analysis is a principled method that aims to organise and make explicit the analytic procedures of moving from text material to interpretation and vice versa. Therefore, according to Attride-Stirling (2001, p. 387) "thematic analysis seek to unearth the themes salient in a text at different levels, and thematic networks are used to facilitate the structuring and depiction of these themes". Consequently, it is important to note that thematic networks analysis is not a newly developed means of analysing material. Rather, thematic networks can be seen as tools used during the analysis process that share key elements pertaining to hermeneutic interpretation (Attride-Stirling, 2001).

Thematic networks analysis is comprised of a three stage, six step process similar to common qualitative thematic analysis with the inclusion of the thematic network approach. The steps in analysis using thematic networks as defined by Attride-Sterling (2001) are as follows:

**Stage A: "Reduction or breakdown of text"** (Attride-Sterling, 2001, p. 391)
*Step 1: Code Material*
The use of coding in order to manage the extensive amount of text material derived from the collection of this material is a commonly used first step in thematic networks analysis. Codes are derived either

on the basis of theoretical interests that guide the research question, or in terms of significant issues that are identified from the material text itself, or both. It is important that codes have overt boundaries so as to avoid text becoming redundant. Once the codes have been established, the researcher, making sure he/she focuses on detail and completes the process with rigour, then uses this coding framework to reduce the material into manageable sections. These sections could comprise of full passages, quotes or even single words (Attride-Sterling, 2001).

## *Step 2: Identify Themes*

This step is characterised by sorting through the different coded text segments to determine potential themes (Braun & Clarke, 2006). As the potential themes emerge from the text they are refined into more manageable sets of themes. Themes are refined here until they are broad enough to summarize ideas with the use of multiple text segments, but also specific enough to avoid repetition (Attride-Sterling, 2001). This is one of the most important steps in the process of analysis as it involves intense interpretation of material text in order to determine patterns and structures.

## *Step 3: Construct the Networks*

The structuring of thematic networks is based on establishing three levels of themes. Following from above, themes established in step 2, are now grouped into smaller parcels in terms of the content of those themes and the overall theoretical grounding of each theme (Attride-Stirling, 2001). It is important for the researcher to not group too many themes in one parcel, as the aim of thematic networks is to assist the researcher by simplifying or reducing large amounts of text. Once the groups have been established and re-named, these groups now constitute the 'basic themes' within the thematic networks (Attride-Stirling, 2001, p. 388). Due to the simplistic nature of basic themes, they need to be constantly thought of holistically within context.

Once the basic themes are established, the construction of thematic networks is followed by the establishment of the organising themes. Basic groups are once again parcelled into clusters which fall under shared subject matter that "summarize the principle assumptions of a group of Basic Themes" (Attride-Stirling, 2001, p. 389). Once the groups (Organising Themes) and sub-groups (Basic Themes) have been established, the researcher now moves towards determining the main point of a particular piece of material text. Drawing from the basic themes the researcher needs to "summarize the claim, proposition, argument, assertion or assumption that the Organising Themes are about" in terms of a given issue or reality (Attride-Stirling, 2001, p. 392-393). In other words, the researcher needs to determine the super-ordinate themes (Global Themes) of the text as a whole. According to Attride-

Stirling (2001, p. 389) global themes act as both a "summary of the main themes and a revealing interpretation of the texts". Once all the global themes have been established, it is important for the researcher to verify and refine the final thematic networks. This is achieved by the researcher double checking that each thematic network reflects the material and that the material supports the developed networks (Attride-Stirling, 2001).

**Stage B: "exploration of text"** (Attride-Stirling, 2001, p.391)

*Step 4: Describe and Explore Thematic Networks*

This is one of the most important stages of analysis and corresponds to the joining of the interpretation of the material text with text itself. Within this stage, the researcher has now moved from an identified phase of simple themes to a more descriptive, explanatory phase (Attride-Stirling, 2001). This allows for the emergence of detailed themes and the use of text segments in support of thematic augmentation. The material text is then read, using the developed thematic networks as tools, to reach a deeper level of analysis in understanding the meaning of the text.

*Step 5: Summarize Thematic Networks*

Aligned with the movement between part and whole evident in hermeneutic analysis, the objective of summarizing the main themes from step four is to reveal unequivocal patterns and themes that characterize the thematic networks operative in the text (Attride-Stirling, 2001).

**Stage C: Integration of Exploration**

*Step 6: Interpret Patterns*

The summit of the theory and text is reached here, as an essential stage in analysis, where deductions from thematic networks are linked to relevant theory. According to Attride-Stirling (2001, p. 402), the aim is to "take the key conceptual findings in the summaries of each thematic network, and pool them together into a cohesive story by relating them back to the original questions and the theoretical grounding of the research". This is done not only in an effort to explore the themes identified, but as a measure for constant comparison and contrasting for either reifying themes with previously identified themes evident in literature, or newly found themes evident from text.

*4.4.2. The Analysis Process*

The first and most important step of the analysis process was to record personal notes concerning the positioning of the researcher in this study. As mentioned before, qualitative analysis is an on-going

process throughout a study and starts at the stage of material collection (Scheillerup, 2008). After each observation of the assessment sessions and after each individual interview, I recorded my thoughts in terms of the contextual setting of the research, the inter-personal dynamics within this context, as well as interactions with and between participants, which stood out or were of interest. My impressions concerning the process of translation within the institutional setting and my positioning during the observation and interviewing processes were also recorded.

Although it has been established that no single method exists to conduct qualitative analysis (Bradley et al., 2007), phase one of a thematic analysis guide provided by Braun and Clarke (2006) was followed, which allowed the researcher to immerse and familiarize herself with the material text. The first step within the first phase of analysis involved the transcription of verbal material and allowed for familiarisation with the text. According to Braun and Clarke (2006), the transcription of verbal material is one of the most fundamental steps within the analysis process as it is recognised as an *interpretive act*. The second step within the first phase of the analysis process put forward by Braun and Clarke (2006) involved immersion with the material text through reading and re-reading the material. During this procedure of reading the material repeatedly, the text was actively, but informally viewed in terms of emerging meanings and patterns. Furthermore, notes were made of ideas concerning the structure of the coding framework for the process of thematic networks analysis.

Once the researcher had familiarized herself with the material text, attention was turned to the Thematic Networks Analysis technique stipulated above (Attride-Stirling, 2001). As two collection methods were used within this study, the amount of material obtained from these two methods was extensive. The use of thematic networks was useful in this study as the material collected from multiple instances required clear organization in order to allow for comparison of themes identified from each collection method. Furthermore, as the material became more organized and themes became clearer, the hermeneutic circle of understanding became more distinct and explorative.

Once the end of Stage A of the Thematic Networks Analysis (Attride-Stirling, 2001) was reached for each observation and individual interview, multiple thematic networks had been developed. These included identifying the main concepts, objects and functions of each assessment observation. Following this, the observations of the assessment sessions were examined as a whole and the overall global thematic networks for the assessment observations were determined by comparing and contrasting the thematic networks developed to determine correlations or inconsistencies between them. The same process was then implemented for the individual interviews, that is, they were analysed as a group and the *overall* thematic networks were determined. Once this was complete, the analysis then continued through Stage B ("exploration of text") and Stage C ("integration of exploration") of the

Thematic Networks method of analysis (Attride-Stirling, 2001, p. 391). As the analysis moved between text and context, this allowed for verification of meanings produced. This in turn created legitimacy for the interpretations drawn from individual experiences.

In support of the aims of this study, where instances of confusion or misunderstandings were identified, further analysis was employed to examine how individual members of the translation triad dealt with these problems as they occurred. This assisted the researcher with the critical stage of the hermeneutic inquiry as practical solutions to problems were used in the development of recommendations provided in the study. According to Kvale (1996, p. 48), "the interpretation of an interview will stop when the meanings of the different themes make sensible patterns and enter into coherent unity". This is characterized by the fourth stage of a critical hermeneutic inquiry by the hypothetical closing of the hermeneutic circle as the interpretation of the symbolic meaning of texts is achieved.

Moving beyond a simplistic identification and description of translation in practice, the analysis took a more critical stance. This was done by providing practical and theoretical recommendations for informal training of clinicians and nursing staff regarding translator-mediated assessment consultations of patients. These recommendations were provided with the intention of improving day-to-day translated interactions, the quality of communication experienced within particular institutional settings and patient assessment care. Furthermore, it is hoped that results generated by this study, in conjunction with existing theory, would raise further questions about institutional policies relating to linguistic and cultural matters. These include issues concerning the allocation of resources for language and communication in South African mental health care services.

Two particular qualitative material collection methods were implemented in this study. According to May (1993, p. 114) "the more varied the scenes that one views or circumstances that one experiences, the more one can understand actions in social context". Therefore, the use of multiple methods of material collection allowed for the emergence of in-depth, extensive text to be analysed. Understandings of translation in practice were also clear and well formulated in terms of the experience and meaning production, as results extending from one collection method were used to inform subsequent material collection. This allowed for the clarification and revalidation of meanings identified. This is aligned with the theoretical orientation of the study, as a forwards and backwards motion between analyses of material collected and between emerging themes and existing literature was used to provide a clearer understanding of the meanings produced in context. The circular motion used in this analysis is important for studying translator-mediated interaction. This is because triadic

interactions related to the process of translation are complex and interlinking factors evident are context specific.

## 4.5. Research Legitimisation

Quantitative research, aligned with a positivist paradigm, focuses on 'scientific' rigour and credibility in terms of the reliability and validity of experimental and measurement designs and statistical testing conducted (Horsburgh, 2003). The knowledge or 'facts' produced within quantitative research are assumed to be highly objective and thus a clear representation of the 'truth' of phenomena under investigation (Merrick, 1999). The debatable notion that specific criteria for evaluating quantitative research are appropriate for qualitative research is highlighted within this particular study. According to (Horsburgh, 2003, p. 312), the "application of quantitative conceptualizations of reliability and validity is inappropriate in evaluating qualitative research as the purpose and focus of the paradigms are not directly comparable". In qualitative research then, observation, analysis and interpretation are seen as subjective. Furthermore, in terms of the interpretive paradigm, rigour focuses on design coherence, the appropriateness and implementation of sampling, material collection and analysis methods and the depth, detail and comprehensiveness and coherence of the analysis that is produced (Bergman & Coxon, 2005).

According to Ceci, Limacher and McLeod (2002), an essential aspect in qualitative research is the acknowledgement of the constructed nature of knowledge, where, the process of knowledge construction in qualitative research is open to the creation of multiple interpretations of the text. Therefore, the position of the researcher is epistemologically relevant in qualitative research where "all knowledge and claims to knowledge are reflexive of the process, assumptions, location, history and context of the knowing and knower" (Merrick, 1999, p. 28). This is known as the 'double hermeneutic' in qualitative research (Rennie, 1999). The researcher actively reflects and acknowledges the impact that his/her actions and decisions have on the meaning and context of the experience of phenomena under investigation. Thus, an important element of legitimizing qualitative research is the concept of reflexivity. Here, the researcher identifies and provides a "clear explication of theoretical, methodological and analytic decisions" made throughout a study (Horsburgh, 2003, p. 308). This allows for a clear representation of the foundations upon which specific findings have been grounded.

According to Holloway and Todres (2003), there is a close relationship between the consistency and coherence of a research study where if the study is consistent, that is 'hangs together' then the study will emerge as coherent. The chief questions in this regard concern whether the empirical claims made by the researcher fit with the approach and methods used within the study if the research question(s)

have been answered appropriately. In qualitative research the implementation of particular mechanisms is essential in order to ensure authenticity, trustworthiness, consistency and coherence. A particular mechanism that can be implemented is the use of triangulation, that is, the combined use of multiple methods of inquiry. Meijer, Verloop and Beijaard, (2002) draw attention to five types of triangulation in qualitative research namely, triangulation by source, triangulation by method, triangulation by researcher, triangulation by theory and triangulation by type of material. According to Golofshani (2003), the use of triangulation strengthens a study as it enriches data by portraying different constructs of reality. Furthermore, if the same conclusions are arrived at when triangulation is implemented, this illustrates the consistency and coherence of the research study (Kelliher, 2005). In this study triangulation by type of material was used and obtained with the use of two forms of inquiry, namely, observation and interview material. By cross-checking these two types of material, the authenticity and trustworthiness of the material obtained was supported which contributed to the legitimization of the research study.

The legitimisation of the findings of a study is highly dependent on the researcher's responsiveness, that is, the researcher's ability to remain open, sensitive and insightful in terms of sample appropriateness and methods used in meeting the aims of the research (Morse, Barrett, Mayan, Olson & Spiers, 2002). This includes concerns about research design flexibility, participant sampling and the generalizability of findings. According to Horsburgh (2003, p. 311) "in qualitative research, the collection and analysis of data proceed concomitantly throughout the study". Research design flexibility is important as evidence of adaptation and redesign authenticates the research process by explicating specific rationale concerning decisions made and discussions of the effects of decisions made on the overall study.

According to Kvale, (1996) the pragmatic rationale of a study is dependent on the way in which the results of the study transcend into the real world and implement change. The subjective experiences and perception of individuals and the context specificity of those experiences must be acknowledged in terms of the epistemological interpretative positioning of qualitative research. An important aspect in terms of the legitimization of a study concerns the role of categories. As mentioned in the use of thematic networks analysis, in order to facilitate the products and process of analysis and to provide clarity for the reader of a study, the findings are presented in terms of the specific categories or themes that emerge (Attride-Stirling, 2001). Horsburgh (2003, p. 309) emphasises that, "complexity and contradiction are elemental to human existence" and therefore:

the imposition of a neat structure upon data has the potential to create order at the expense of accuracy and it may be misleading to view categories as discrete, self-sufficient entities, if appreciation of their interdependence is a prerequisite to understanding of the overall context.

In terms of the critical hermeneutic approach of this study, it is important that the use of categories and its influence on understanding is highlighted. This is particularly relevant to this study on translation practices, as the emergent themes are influential and are interrelated with one another and the specific contexts within which they occur.

# CHAPTER 5: INTERPRETATION PROCESS AND FINDINGS

In order to ground the hermeneutic interpretations derived from the interpretative inquiry used in this analysis, it is important to gain a more profound appreciation and deeper insight into the conditions under which translation occurs within the psychiatric hospital. This chapter provides an outline depicting the context of the research through the presentation of material from the observations and interviews. In highlighting the research milieu, this chapter aims to firstly identify those who translate and why, and by whom they are approached to do so. Secondly, the focus is shifted to the institutional settings within which translation is required – the assessment session. Assessment sessions within the institution form the beginning of the therapeutic process for patients, as they play a vital role in the elicitation of patient information for diagnosis and case formulation. Lastly, the broader institutional setting is examined in terms of the bureaucratic supporting context and institutional guidelines within which translation occurs on a day-to-day basis. An overall examination of the contextual setting of this study allows the interpreted thematic networks, identified in the second part of this chapter, to materialize as enmeshed within an institutional environment that is highly influential on translation practices.

The second section of this chapter focuses on the first stage of the thematic networks analysis. In this stage, each emergent thematic network is discussed. For each network a table is presented, serving as an illustration of the coding of the material text into the final emergence basic, organising and global themes that make up each thematic network. This is then followed by a description of each thematic network, where themes are supported by material text segments drawn from the collected data of either interviews or observations.

It is important to note that the triadic interaction factors specific to translation processes evident within this study are extremely complex, interlinked and context specific. Therefore, although the findings of this study are illustrated separately in a clear and concise manner with the use of thematic networks, it is essential for the reader to understand that realistically the emergent themes are interrelated with one another and the specific contexts within which they occur.

## 5.1 Context of the Research

The transcription conventions implemented in terms of the material text are as follows: R1 represents the researcher; C1 represents the Principal Psychiatrist observed and interviewed. C2 represents the Intern Psychologist observed and interviewed. N1, N2 and N3 represent the senior nurses observed and

interviewed. N4 represents the junior nurse observed and interviewed. P1, P2, P3, P4, P5 and P6 represent the six patients who were observed during their assessment sessions. Furthermore, in order to ensure anonymity of the hospital context of this study, any mention or reference made to the hospital or its location is represented by the use of location A and B. It is important to note that although the use of punctuation in the transcribed texts is to some degree my own semantic imposition on what was said during the assessment observations and individual interviews, the use of some punctuation in the form of full stops and commas are important for clarity. Furthermore, all bold in the material extracts is my added emphasis to stress important sections of the text.

## 5.1.1 Who Translates and Why?

It was observed that there are no individuals who are professionally appointed as independent translators who work at the hospital. Rather, it was observed and reported by participants that individuals employed at the hospital namely, clinicians, nurses, social workers and even security guards are approached on a daily basis to translate. Furthermore, it was observed that it is predominantly nurses who are approached to translate.

*Extract 1 Interview 6*

*(C2): that has happened to me before where I ended up having to ask the security guard to translate for me because there were no nurses around.*

*Extract 2 Interview 6*

*(C2): that is the way it works because there aren't any permanent translators here at the hospital. You just ask whoever is available at the time whatever nurses are available.*

It was observed and reported in the individual interviews that nurses are the most likely individuals to be approached for translation as they more often than not speak the same language and share the same cultural orientation as the patient who requires the translation. Nurses also need to be present during the clinical assessment sessions:

*Extract 3 Interview 3*

*(C1): I approach it from the point of view that the nurse has to be present and therefore seeing that the nurse is present and given our demographics and seeing that the nurse is likely to speak the same language as the patient, the nurse is the one that translates.*

When interviewed about their professional positions within the hospital, the nurses referred to themselves not as translators but rather as either junior or senior professional nurses. Each of the nurses interviewed were African and spoke isiXhosa as a first language and English as a second language. In all four interviews, the nurses stated that they did not think that they were fluent in English.

It was observed that the current amateur nature of translation services in the hospital is compounded by instances where more than one individual is approached or asked to translate during one patient's assessment session. The matter of multiple individuals acting as translators in one assessment session was discussed in more detail during the individual interviews. It emerged that the use of more than one individual acting as translator can be both problematic and helpful for the facilitation of communication during the assessment session.

*Extract 4 Interview 6*

*(R1): In the one assessment session I observed, there was one nurse that started with us and then there was an interruption and we got a new nurse, does this happen often? Do you think it had any effect on the interaction, if so, how?*

*(C2): I mean obviously it is disruptive. For a start any disruption to an interview is hard enough...these are Acute Psychotic people you know they are very ill. Sometimes it is hard enough to try and get them to open up and sometimes with one nurse and they just getting there you know...then another nurse comes in. It can throw them off or make them wanna close up again just when they were starting to open up. So in that way it can be negative.*

In extract 4 above, C2 states that the use of more than one individual acting as translator in one assessment session can cause confusion, be disruptive and have a negative impact on the elicitation of information from the patient being assessed. In the individual interview, C2 also states that the use of multiple translators can be both problematic and helpful as some individuals who are approached to translate have more experience in translating within a psychiatric institutional context than others. C2 states that individuals with more experience are better equipped at eliciting information from patients than others with less experience.

In terms of the positive or helpful aspect of the use of multiple translators, some of the nurses stated that if they are battling to understand a patient, they are then able to request help from another nurse, social worker or even a security guard. In extract 5 below, N2 states that this is particularly helpful when the patient's dialect is different to that of the nurses or if the nurse does not know a particular English word.

*(N2): Sometimes I'll be interpreting and then somewhere I will get stuck you know. Sometimes they would come with different Xhosa words from different and then I don't know. Then we are having staff be it nurses or social workers from other areas then they will be helpful in translating.*

## 5.1.2 The Assessment Setting

During some of the assessment sessions, multiple interruptions were observed which broke the flow of the assessment sessions. These physical interruptions included phone calls, people walking in and out of the room in which the assessment was taking place as well as changes in room venue if the room was needed for something or someone else. None of the participants seemed perturbed when the interruptions occurred during the assessment sessions and no mention was made by participants of the interruptions during the individual interviews. It seemed that the interruptions were common occurrences during the assessment sessions and no attempts were made by the participants to avoid these interruptions.

## 5.1.3 The Institutional Setting

It was observed in the assessment sessions that there is no set schedule for nurses in terms of times, dates or venues regarding when they are required to translate. Rather, through the observations and discussions during the individual interviews, it materialised that nurses are merely approached by clinicians before the assessment session when they are needed for translation. As N1 states in extract 6 below, nurses base their work on the clinician's schedules.

*Extract 6 Interview 1*

*(N1): the doctor has a schedule for the whole week so we know when he is coming to see the patients.*

In extract 7 below, C2 explains that there are no guidelines to work with in terms of who translates or when they are expected to do so. C2 also states that junior nurses are usually approached first as senior nurses are often too busy to help with translation. This is problematic as junior nurses may not have as much experience in translation services as senior nurses do. Therefore, it was observed that translation within the institution occurs almost incidentally on a day-to-day basis.

*Extract 7 Interview 6*

*(C2): there aren't any permanent translators here at the hospital you just ask whoever is available at the time, whatever nurses are available. It is usually the junior nurses because the senior nurses will never ever translate for you because they are busy all the time.*

As mentioned, all of the nurses who were individually interviewed stated that they are not professional translators and that their professional position at the hospital stands as professional nurses. The nurses stated that the particular translation duties required of them, in conjunction with the inconsistent work schedules of clinicians which they are required to follow, can take time away from their duties as nurses because they are not professional translators but rather professional nurses.

*Extract 8 Interview 2*

*(N2): I strongly feel that it takes away time as nurses because I have got some of my work to do and if a psychologist comes he or she comes for his part of work. We have tried to accommodate that in our day-to-day programs, but sometimes you find that one would come anytime. Like if you were scheduled to come today and there is no time so you come tomorrow and there is no-one and we feel that we must just try and help you because you did not have time yesterday but you did the following day.*

Another contextual problem that was observed and discussed was the rotation of staff between wards within the hospital. Both C1 and C2 stated that nurses are often constantly rotated between wards. C1 stated that this rotation can be disruptive for the formation of a good working relationship between clinicians and nurses in terms of translation. C1 stated that as he works with the nurses acting as translators, a relationship forms where each individual gets acquainted with the way in which the other works. Furthermore, C1 states that this relationship is important for the facilitation of good communication and accurate translation during the assessment sessions. In extract 9 below, N2 reiterates the points made by C1 in terms of staff rotation and its effect on the working relationship between clinicians and nurses.

*Extract 9 Interview 2*

*(N2)...but I think they get used to each doctor will get used to that nurse translating for him and he is comfortable with that one translating for him. You know how the work relations are? One doctor will feel comfortable if that nurse is interpreting for him...and of course with nursing staff as well one would feel very comfortable to work with that particular psychologist and or doctor you know it just happens you know".*

It is evident that the use of translation during patient assessment is influenced considerably by the institutional context where foundational support, time and resources are limited. Specific contextual factors materialised as influencing the daily duties of employees at the hospital. Specifically, negative implications emerged in terms of the type of conditions patient assessment takes place in, individual role capacity and institutional working relationships. All of which ultimately influence the work systems available and psychiatric services delivered to patients by clinicians and nurses.

In the individual interviews, both C1 and C2 state that regardless of the current shortcomings of translation within the psychiatric institutional setting, in their experience, translation as a process is more beneficial in terms of its structure now, in comparison to not having anybody to translate for them. All four nurses (N1, N2, N3 and N4) state that their main priority is to the patients and their wellbeing and therefore, they are willing to help where they can.

## 5.2. Exploration of Material

Six Global themes emerged during the interpretation of the material from the observations and individual interviews. Each global theme was informed by the four factors which influence communication during the process of translation identified in the literature namely, language, translator's role, clinician's role and culture. Furthermore, problems concerning role expectation and institutional conflict informed the fifth global theme. The additional sixth global theme focuses on specific techniques and strategies that individuals implement on a day-to-day basis during the assessment sessions in order to facilitate communication specific to the process of translation.

## 5.2.1 Global Theme 1: Language, Meaning and Reality

Table 1

*Global Theme: Language Meaning and Reality*

| Codes | Issues Discussed | Basic Theme | Organising Theme | Global Theme |
|---|---|---|---|---|
| Definitions<br>Needs<br>Ideas<br>Expectation<br>Terminology<br>Equivalence | Understanding<br>Ideas of translation<br>Verbatim vs. Meaning<br>Culture<br>Meaning | 1. Conflicting views-defining translation<br>2. Practical Examples of translation difficulty: Angry vs. Aggressive Feelings | 1. Verbatim translation vs. Interpretation | LANGUAGE MEANING AND REALITY |
| Expectation<br>Language-difference<br>Meaning<br>Context<br>Fluency | Summarizing<br>Confusion<br>Clinical Knowledge<br>Clinical communication<br>Role expectation<br>(Clinician and nurse) | 3. Contextual change in interview direction<br>4. Fluency in English | 2. Communication and practical understanding | |

This thematic network was informed by the roles linguistic and cultural discourses play in the production of meaning drawn from translation practices based purely on experiential working knowledge within the context of mental health institutional assessment practices. This included the relationship between how derived meanings inform individual expectation and behaviour in relation to translation practices and how this behaviour further informs meaning production. Thus, the thematic network of language, meaning and reality emerged from an examination of participant knowledge of

the role of language and their conceptualizations of translation and its outcomes. This thematic network constitutes two organising themes and four basic themes. Discussions of participants' perceptions of what the translation process entails highlighted fundamental tensions surrounding the relationship between expected outcomes of the translation process and the day-to-day realistic practical outcomes of this process that include specific systematic errors unique to the process of translation.

### 5.2.1.1 Organising Theme 1: Verbatim Translation vs. Interpretation

*Basic Theme 1: Conflicting Views*

In the first basic theme, discrepancies emerged between the clinicians and the nurses acting as translators' perceptions of the process of translation and what the expected outcomes of that translation process should be. In extract 10 below, C1 states that translation is a verbatim activity where nurses acting as translators are expected to state word for word what the patient is saying and what the clinician is saying to the patient.

*Extract 10 Interview 3*

*(C1): Translation in the clinical world to me means verbatim translation of the words used. Not an interpretation or paraphrasing or distilling of the gist or general purport of what the other person is saying.*

Furthermore, in extract 11 below, C1 states that knowing what the patient is saying word-for-word is essential for the identification of pathology for diagnosis.

*Extract 11 Interview 3*

*(C1): You see it is supposed to...I am having a conversation with the patient or I am interacting and I am picking up psychopathology in the end of the interaction. If I don't understand the language I am going to miss a certain quantum of the psychopathology...So what I need is an online translation. I need an online real time access to what they are saying right because the more online, the more immediate it is the better*

In extract 12 below C2 was unsure of the difference between translation and interpretation. Although she acknowledges the importance of culture and meaning she also has the expectation of word for word translation.

*Extract 12 Interview 6*

*(C2):...I think it is changing words from one language into another so that the other person can know what you are speaking about...I have been told that technically the term translation actually refers to written stuff and interpretation is spoken. I think translation is more about directly saying one thing to another thing and interpretation is more looking deeper into meanings and cultural stuff...*

Three of the four nurses explained that they are aware that both C1 and C2 expect them to translate word for word. In extract 13 below, N1 then goes on to state that this expectation is often not possible.

*Extract 13 Interview 1*

(N1): it is **difficult** to say **each** and **every word** of what the patient has said when interpreting.

Through the individual interviews it emerged that the nurses were aware of the clinicians' expectations of verbatim translation, which creates difficulties for nurses in terms of linguistic incompatibility. In the nurses' experience, verbatim translation or translating word-for-word is not always a practical possibility. Therefore, clinicians' high expectations do not align with the practical possibilities experienced by nurses. This can be problematic for clinicians in terms of diagnoses and may result in role tension or stress for nurses. Both of these factors could compound the institutional hierarchical tensions evident in the hospital between clinicians and nurses.

## Basic Theme 2: Practical Examples of Translation Difficulty

### (a) Angry vs. Aggressive

*Extract 14 Observation 2:*

C1: *Right so tell us about your mental illness.*

N2: *Explain to us about your disturbance, your mentally disturbed brain.*

P1: *I usually get sick once in a year.*

N2: *Mm Mm*

P1: *I also get **angry**.*

N 2: *Mmm*

P1: *I speak louder.*

N2: *Okay, ah I must I must speaking by saying that I must once or twice mentally unstable a year and um I become, when I am mentally unwell I become **aggressive**. I **assault people without any reason**. Ah, when I'm talking I raise my voice.*

In extract 14 above, there is an inconsistency between the words 'angry' and 'aggressive'. The patient states that they get *'angry'* which suggests the emotional state of anger. The nurse then translates the word *'angry'* into *'aggressive'*. Furthermore, N2 summarised what the patient had said and added additional information in the translation which was not mentioned by the patient *'I assault people without any reason'*. This word and meaning discrepancy could lead the clinician to believe that the patient becomes physically aggressive rather than emotionally angry. In terms of C1's expected outcomes of the translation, N2 does not translate verbatim what the patient is saying. This means that N2 may have found it difficult to find equivalent words in isiXhosa that mean the same thing in

English. For example, "I speak louder" became "I raise my voice". Additionally, N2 may have misunderstood what the patient was meaning with the word 'angry' and therefore, through the translation, 'angry' became 'aggressive'.

## (b) Feelings

### Extract 15 Observation 2:

C1: Okay stop, *how did you feel* when you were reciting that list of yours?

N2: as you were quickly reciting your shopping list, how did you feel? *What do you feel in the body?*

P1: I feel nothing

In extract 15 above, in questioning the patient, C1 may have wanted to determine either the emotional condition and/or physical experience of the patient by stating *'how did you feel?'* This line of questioning was distorted as N2 specifies through the translation that the intended meaning of the question was physical feelings only *'what do you feel in the body?'* rather than emotional feelings.

### Extract 16 Observation 3

P1: alright, does that mean you have access to those feelings?

N2: Does this mean that you know what you felt.

P3: *I didn't know what I was doing*

N2: to feel, not to do like in the funeral, you felt heart breaking so when you were ill. Are there any things you felt when you were sick?

P3: I don't know about that.

N 2: I don't know

In extract 16 above, there is confusion in terms of whether the patient was experiencing an emotional state and or a physical state. By substituting the word *'feelings'* for *'to feel'* and *'felt'* it emerged that the patient misunderstood the question and answered *'I didn't know what I was doing'*, implying once again a physical experience rather than an emotional experience.

The first organising theme of Verbatim Translation vs. Interpretation relates to participants' perceptions of what the process of translation actually entails. According to this first basic theme, both clinicians perceive translation as a verbatim activity where nurses assume a conduit role. It emerged that the clinician's expectations of the intended outcomes of the process were not aligned with the realistic outcomes on a practical level experienced by nurses acting as translators regarding the systematic errors unique to translation. Nurses' perceptions of translation are based on what is

realistically possible on a day-to-day practical level and clinicians' perceptions of translation are based on desired outcomes expected.

The second basic theme represents two practical illustrations which portray the systematic errors and loss of meaning unique to the process of translation. The examples of translating emotions and feelings are viewed as closely connected to the inconsistencies between translation as a verbatim activity and the day-to-day practical expectations of the translation process.

It is important to note that the two basic themes identified so far can be interpreted in terms of the nurses' misinterpretations due to a lack of training and/or experience, cultural factors and role expectations during the process of translation. For example, the translation of feelings and emotions is relevant to culture-specific experiences as individuals from different cultures experience things differently. This means that emotions and feelings may be experienced as physical reactions rather than emotional feelings. In terms of my interpretation, basic themes 1 and 2 show that when clinicians and nurses have differing ideas of what the process of translation entails and what the expected outcomes of that process should be, instances of confusion and misunderstandings that are inherent to the translation process are augmented. Nurses feel a certain pressure to meet the expected outcomes maintained by the clinician regardless of their awareness of the practical limitations of translating. This can become confusing for nurses and further complicate translations that are already less than ideal. Furthermore, this could also create tension between clinicians and nurses if clinicians' expectations are not met.

5.2.1.2 Organising Theme 2: Communication and Practical Understanding

(a) Basic Theme 3: Context Change

During the assessment sessions, clinicians may address specific questions to formulate a prevailing context in order to elicit information about a patient's mental status (context 1-question-translation-answer-context 1). Due to the systematic language errors unique to translation and the role that the translator assumes during the assessment interview, the intended meaning of questions may change, causing the direction of the assessment interview context to change (context 1-question-translation-answer-context 2)

Extract 17 Observation 5

(C2): these demons make you talk too much? What do they make you talk about any specific thing?

(N3): Do you talk things that are understandable or things that are not concrete? Maybe are these things in your brain?

(P5): No they are not in the brain

In extract 17, C2 wanted the direction of the interview questioning to focus on what the demons make the patient talk about. Through the translation, N3 changes the direction of the assessment interview to ideas of what the patient himself talks about, and ideas about the patient's brain.

*Extract 18 Interview 2*

*(N2): I think it's not a very easy task to perform because there are problems as far as translation is because sometimes the person that you are helping, let us say I am helping the doctor that needs the translation, sometimes when he or she asks some questions and he gets answers from me, sometimes it is not what he or she expected meaning sometimes when I translate it changes the whole question when I translate because there is you know English is a different language to Xhosa.*

In extract 18 above, N2 acknowledges that the intended meaning of a question can change through the translation and that in these instances clinicians can become confused when patients do not answer the intended question. Rather, the altered question posed by the nurse is answered creating a change in context. Therefore, patients' responses could differ completely to what is expected from the intended questioning and direction of the assessment interview.

## (b) Basic Theme 4: English Fluency

*Extract 19 Interview 2*

*(N2): and of course helping, just helping with translation does not mean that we are excellent in our languages you know.*

In the individual interviews with the nurses, it emerged that the nurses acting as translators are not fluent in English.

*Extract 20 Interview 6*

*(C2): Well the language that I would use the words that I would use so I would use a lot simpler. I try and put it in more kind of (pause) simple terms that I think would be easier to translate you know easier for because sometimes the nurse themselves their English is not very good. So I maybe when I might use the word 'express' then I would rather use the word 'show' you know something like that and the way I ask the question would be different as well.*

In extract 20 above, C2 states that in her experiences, if the nurse who is translating has a limited proficiency in English, assessment questions directed to the patients may need simplification or need to be consciously posed in different ways.

In some of the assessment session observations, C1 used specific English terminology or phrases in his formulation of questioning the patient. Some of these words or phrases used by C1 included *'shed much light'*, *'harboured'* and *'ostracised'*.

(N2): *some of English words you can't really get in Xhosa language, now you've got to borrow from the English word to get a Xhosa word*

In extract 21 above, N2 once again highlights the fact that verbatim translation is not always a practical possibility. Furthermore, when participants were questioned about how well each member of the triad understood another member, it was found that most participants felt that in their experience, nurses have a better understanding of patients than clinicians. Participants did not comment on levels of understanding between clinicians and nurses.

This organising theme of Communication and Practical Understanding relates to the idea that a lack of communication between clinicians and nurses acting as translators' can have an effect on the type and flow of information elicited in the assessment interview. This shows that if there is a lack of or poor communication between clinicians and nurses, confusion and misunderstanding that are inherent to the translation process are augmented.. A need for better communication concerning the systematic errors unique to translation that may cause a change in the intended direction of an interview (represented by basic theme 3), and the role translators assume, how this role influences translation and what the translators intentions are in terms of the role/s assumed is identified. Furthermore, awareness is needed in terms of question formulation and execution. C1's lack of awareness of the realistic practical limitations and level of English proficiency of nurses can influence not only the nurses' ability to translate but the clinician's understanding and awareness of the outcomes of the translation itself. The emergent organising theme of Communication and Practical Understanding is linked to both the clinician and translator's role/s and the influence that these role/s have on the translation process.

In this global theme, my interpretation was informed by the idea that there is a substantial gap in participants' knowledge in terms of translation theory and practice. This is substantially due to a lack of training. If participants do not have specific knowledge about what the process of translation entails in terms of what is practically possible in the South African context, misunderstanding can occur. Participant awareness and knowledge of both theoretical concerns and practical guidelines of the process of translation were found to be limited. In basing the analysis on the aforementioned assumption, it emerged that when clinicians and nurses have conflicting ideas about what the process of translation entails and what the expected outcomes of the process of translation should be, confusion and misunderstandings are a common occurrence. Additionally, if these confusions and misunderstandings are not communicated, the flow and level of communication is impeded which may result in erroneous patient assessment.

## 5.2.2. Global Theme 2: Culture

Table 2

*Global Theme: Culture*

| Codes | Issues Discussed | Themes identified | Organising Theme | Global Theme |
|---|---|---|---|---|
| Cultural Experience<br>Cultural phenomenon<br>Experience<br>Belief System | Understanding<br>Awareness<br>Cultural orientation<br>Explanation<br>Valid diagnoses<br>Convenience<br>Experience | 5. Cultural Homogeneity | Cultural Understanding | |
| | | | | CULTURE |
| Geographical Position<br>Dialect<br>Understanding<br>Perception | Cultural difference<br>Understanding<br>Phenomenon<br>Experiences<br>Practical problems<br>Confusion | 6. Cultural Heterogeneity | | |

Following from the thematic network of language, meaning and reality, it emerged that it is not only language which plays a significant role in the production of meaning drawn from translation practices based purely on experiential working knowledge, but specific cultural discourses and individual culturally informed sub-systems which are intrinsically linked with language. Therefore, theoretically and analytically, the thematic network of culture emerged from an examination of the ways in which culture informs participant perception of language and translation, and how these perceptions further influence participants' understanding of their own position and that of others in the triad. This emerged as being closely linked to participants' reflections on individual role performance in the triad.

### 5.2.2.1 Organising Theme 1: Cultural Understanding

#### (a) Basic Theme 5: Cultural Homogeneity

From the observations of the assessment sessions and the individual interviews it emerged that patients would often refer to occurrences or experiences specific to their cultural orientation.

Extract 22 below serves as an illustration of P4's experience of becoming a traditional healer and the experience of "thwasa".

*Extract 22 Observation 4*

*P4: I'm saying that I'm still a traditional healer*

*N2: I'm saying that I'm still a traditional healer*

*C1: but I was interested to know how you knew you were a traditional healer?*

*N2: What I'm interested in is that, how did you start all this of yours to become a traditional healer?*

*P4: The elders at home asked me to tshawe and accept that I'm a traditional healer. They wanted to kill me*

*N2: Who are the elders?*

*P4: Witch-doctors*

*N2: Okay, my ancestors referred me to thwasa and then for...for what?*

*P2: For accepting that I must be a traditional healer*

*N2: Okay for thwasa's school but eXhawe decided to bewitch me*

*C1: so did you have a thwasa experience?*

*N2: were you thwasa?*

*P4: yes I was*

*N2: yes I was thwasa*

*C1: what did that entail?*

*N2: What is this thwasa thing all about? What does it involve?*

*P4: It involves me to be a traditional healer*

*N2: okay thwasa is when one is going to be inyanga the traditional healer*

In the individual interviews it was established that all of the nurses share the same cultural orientation as the patients. Participants were asked their perception of who they think understands the patient better during the assessment sessions. Both the clinicians and nurses stated that they thought the nurses understood the patient better, as they share the same language and culture as the patients.

*Extract 23 Interview 1*

*(N1): ...you will find that the patient will talk about things that are cultural and when you are translating whatever...thwasa you see that means that it is stating that you must go for training for to be trained as a traditional healer and we will talk about rituals. Some of the doctors now at least they know a bit about our culture Xhosa.*

In extract 23 above, N1 states that patients often refer to cultural phenomena or experiences during the assessment sessions. N1 also mentions that *some* of the clinicians have limited or no knowledge and understanding of the amaXhosa culture.

*Extract 24 Interview 6*

*(C2): I mean I know a little about their culture but I don't know that much. So the way I will ask a question is from my point of view you know my western views or whatever and the way I understand things but then having the nurse there, they will be able to translate things so that they will know what I mean and they will be able to translate it in terms or you know into ways that the patient will be familiar and able to understand which I wouldn't be able to do on my own you know. Sometimes, you can actually get more when the translators are there than when you are just speaking English.*

In extract 24 above, C2 states that the nurses are able to explain and communicate better with the patients than she is able to. C2 states that nurses are *"able to translate things"* to the patients so that *"the patient will be familiar and able to understand"*. Furthermore, C2, in referring to the nurses also states that *"they will know what I mean and they will be able to translate it"*. This reveals C2's assumptions and expectations regarding the translation process. C2 assumes that the nurse will always know and understand what the clinician says and means. This is representative of an unrealistic expectation and is closely linked to the clinician's perception of translation as a verbatim activity rather than a form of interpretation.

According to N4 in extract 25 below and C2 above, nurses understand the patient's culture and have extensive knowledge concerning cultural experiences and phenomena and the meaning this has for the patients. Nurses are seen to be more able in assisting clinicians with their understanding by providing explanations concerning the significance of culture-specific experiences.

*Extract 25 Interview 4*

*N4: It is like we know how to do our things, like we do our things different from the other cultures, so to me I think it can help cause I know how we do the things so I can explain more.*

## *(b) Basic Theme 6: Cultural Heterogeneity*

*Extract 26 Interview 2*

*N2: ...for instance, if I am translating for doctor who is an English speaking person and I am translating into Xhosa, for the patient who is from other areas of the (location A) our Xhosa differs. Did you know that? There is a different Xhosa being spoken in (location A) and in (location B).*

*Extract 27 Interview 2*

*N2: He is a Xhosa speaking from (location A), I am a Xhosa speaking from (location B) so our talking differs. Fortunately our other doctors are aware of that, because we explain these things to the doctors so that they are aware of what is going on. Sometimes he will refer to, sometimes for instance I will make an example, say for instance we say in (location B) "I kissed her" we say 'dimphuzile' and then those other areas from (location A) they will say 'dimqamizile'*

During the individual interviews it was found that languages differ not only between cultures, but within cultures as well. In extracts 26 and 27 above, N2 explains that there is a difference in the dialect of the isiXhosa language depending on the geographical positioning of individuals.

*Extract 28 Interview 2*

*N2: Sometimes it becomes difficult because I don't know some things in my own culture... so I struggle but in that instance I try and say whatever the patient is saying to the doctor even if I don't have an understanding...*

In extract 28 above, N2 states that even though she shares the same culture with the patient, she herself may not understand certain dialects within the isiXhosa language including certain cultural phenomena experienced by patients.

The notion of cultural understanding concerns the participants' understanding of one another in terms of their respective cultures. The emergent basic theme of cultural homogeneity is important as it illustrates the constructive aspect of nurses working as translators. The cultural understanding that nurses share with patients is seen as helpful for both the clinician and the patient. Nurses are able to broaden clinicians' limited understandings of their patients' cultures and cultural experiences and are also able to enhance patients understanding. Therefore, an additional paradoxical expectation is placed on the nurses' role as translator. Clinicians may expect nurses to have a clear understanding of not only what they say (linked to extract 24 above-*"they will know what I mean and they will be able to translate it"*) but what the patient says and means as well. The paradoxical expectation that emerged is further complicated by the basic theme of differences in culture which illustrates that even though certain individuals may share a similar cultural orientation, this does not mean that complete understanding in terms of the phenomena is experienced, as differences within the amaXhosa exist.

In this particular thematic network, the global theme of Culture consists of one organising theme of Cultural Understanding. Nurses acting as translators were found to assist clinicians in their understanding of their patient's culture and cultural experiences. This helps clinicians when determining an accurate assessment and providing an accurate diagnosis of the patient. Nurses also perceived themselves as being able to assist patients in their understanding as well. This idea of assistance in the understanding of broader cultural orientations is closely linked to the nurse's role and position of the clinician within the process of translation.

The position of both the clinician and the nurses acting as translators in the translation process involves making questions and answers that originate in two different cultural frameworks intelligible to one another and the patient. This can be highly problematic and challenging within the South African context where clinicians are situated as cultural outsiders in terms of understanding the patient's broader cultural orientation and the importance of those experiences regarding the patient's mental illness. Nurses on the other hand are situated as cultural insiders. This is significant for role expectation and role performance. Clinicians emerged as being dependent on nurses for understanding and clarity of the patients' experiences. Difficulties that nurses experience beyond the systematic linguistic errors unique to translation, were evident in the notion of differences within culture. This means that the geographical, linguistic and sub-cultural positioning of patients and clinicians is highly

influential for the nurses understanding of the broader cultural orientation of patients, and the need to meet the expectations of the clinician.

### 5.2.3 Global Theme 3: Translator's Role

Table 3

*Global Theme: Translator's Role*

| Codes | Issues Discussed | Themes identified | Organising Theme | Global Theme |
|---|---|---|---|---|
| Duties<br>Awareness<br>Ad Hoc Interpreting<br>Perception<br>Clinical questioning<br>Clarification | Professionalism<br>Multiple translators<br>Teamwork<br>Experience<br>Insight<br>Conduit model<br>Resistance<br>Convenience<br>Awareness<br>Convenience<br>Overlapping tasks<br>Multiple roles<br>High expectation<br>Time Staff<br>Knowledge<br>Confusion | 7. Invisibility<br>8. Nurses Perception<br>9. Effects on duties<br>10. Translator role resistance | Role Perception | TRANSLATOR ROLE |
| Instances of confusion<br>Need for clarity<br>Additional explanation<br>Practical problems<br>Misinterpretation<br>Tasks<br>Role as nurse<br>Role as clinician<br>Repetition<br>Simplification<br>Inaccurate translation | Indirect translation<br>Confusion<br>Misunderstanding<br>Confusion<br>Practical<br>knowledge and<br>experience<br>Doctor + Patient<br>Translator +<br>Patient<br>Exclusion<br>Understanding | 11. First/Third person Reference<br>12. Translation of Rapport<br>13. Clinical exercise<br>14. Assisting with clinical exercise<br>15. Completing questions<br>16. Additional questioning & clarification<br>17. Lengthy Interaction | Practical Difficulties | |

This thematic network was informed by participants' linguistically and culturally informed perceptions of translation and the nurses' role/s in this translation process. The thematic network of translator role emerged from an examination of both clinicians' perceptions of the necessary skills and capabilities of nurses as well as the nurses' reflection on their own skills and capabilities in terms of the roles they assume during the assessment sessions. This thematic network constitutes two organising themes and eleven basic themes. Discussions of participants' perceptions of what the translator's role involves highlighted fundamental differences in ideas concerning the visibility of the nurses position and how certain levels of role visibility and role expectation influences nurses role performance.

## 5.2.3.1 Organising Theme 1: Role Perception

### (a) Basic Theme 7: Invisibility

*Extract 29 Interview 3*

*(C1): the translation should be invisible...it should be as close to a normal interaction as possible. Alright and the more the translator becomes present and interactive in that interaction the less real the interaction is and more unnatural it becomes. So the best translator is one that is not obvious. One will only notice the difference if the translator is absent... the best translator is inconspicuous*

Both C1 and C2 state that a translator needs to assume an invisible role when translating during the assessment interview. In extract 29 above, C1 states that when they are assessing a patient, the interaction needs to be *'normal'*, that is, the interaction needs to be as if the clinician is speaking and interacting directly with the patient.

*Extract 30 Interview 6*

*(C2): Obviously there is a professional interaction going on where the translator later would be aware of cues and things that are clinically important and may alert me to such things. But as far as the translation is concerned, the interaction is with the patient not with the translator. It must not be with the translator. The translator must be invisible*

*Extract 31 Interview 3*

*(C1): but whilst I mean that nurse should still be present as a nurse and watch out for things and look for signs, and be able to discuss that with me. But when they are operating as the translator, the translator role must be as inconspicuous as possible.*

In extracts 30 and 31, C1 and C2 state that when the nurse is acting both as a nurse and a translator, they need to fulfil 'professional' and 'clinical' duties as a nurse who is present in an assessment session. However, in terms of the nurse's role as translator, their position within the assessment interview should be invisible.

In both the clinicians' experiences, nurses should assume a 'visible' role in terms of their clinical duties as nurse. This involves relaying clinical information about the patient to the clinician. Nurses then assume an *'invisible'* role in terms of their duties as translators. Although the nurse is *'physically'* present their presence should be *'inconspicuous'* within the process of translation.

### (b) Basic Theme 8: Nurses' Perception

N1, N2 and N4 are all aware that their roles during the assessment interview imply a certain duality. They are also aware that as nurses, it is not their duty to act as a translator. In extract 32 below, N1

states that because there are few clinicians that speak the same language as their patients they (meaning nurses) are expected to translate for the clinicians.

*Extract 32 Interview 1*

*(N1): You know as a professional nurse we are not supposed to be interpreters because of the problems that are in the institution. We find that many doctors are not speaking the language and most of the patients are Xhosa speaking so as a result, the doctors, they don't understand what the patients are saying, cause there are few of them that speak English and therefore we have to interpret for the doctors and also for the psychologists.*

Furthermore, the nurses are also aware that because they must be present in the assessment interviews in terms of their clinical nursing purposes, they are then in a convenient position for being asked to translate.

*Extract 33 Interview 2*

*(N2): ...the thing is when doctor comes to see this patient I must be here and prepare the patient for doctor and if I see that this one does not speak English then I will stay.*

*Extract 34 Interview 1*

*(N1): Well, it depends. At times the patient is here with the doctor and I also need to be here to report on the behaviour of the patient. If the doctor is going to see the patient it is fine because there should be a professional nurse around so that he can give a report about the patient. How is he doing in the ward and his behaviour and also so that because the doctor may be able to ask questions about the behaviour or he may order something or some new treatment, or maybe refer to some so this should be allowed.*

*Extract 35 Interview 5*

*(N4): No when the doctor comes we translate because we have to monitor the patient and give information about the patient. So we have to give that information to the doctor not only to translate.*

The notion of how nurses perceive their role as translator in basic theme 8 reveals their awareness of the dual roles they perform during the assessment sessions. However, they do not mention whether their roles should be 'visible' or 'invisible', but they are aware that their clinical role as nurse (being present to relay clinical information about patients to clinicians) allows for a certain quantum of convenience in terms of them assuming the role of translator as well.

## (c) Basic Theme 9: Effects on Duties

Following from basic themes 7 and 8 above, it emerged that a nurse assumes two particular roles during the assessment interview, the role of clinical nurse and the role of translator. In extract 36 and 37 below, N1 states that translation is time-consuming and detracts from his time for doing *"other things"*. In extract 30 below, N2 states that that the hospital is understaffed and the act of translating is time-consuming. N2 goes on to state that both of these factors take up time and reduce effort put in to her duties as a clinical nurse.

*Extract 36 Interview 1*

*(N1): ...at times we don't end up doing what we are supposed to as a nurse because we don't have the time, because it takes up most of your time when there were other things you should have done.*

*Extract 37 Interview 2*

*(N2):...you are just so short staffed you've got to go and help with translation sometimes it really takes our time.*

In extracts 38 and 39 below, N2 and N4 state that in some instances they feel that assuming the role of translator actually assists them in their role as clinical nurse.

*Extract 38 Interview 2*

*(N2): I think it helps us because sometimes a patient is not the same every day and sometimes the patient is not open to all of us. So sometimes the patient opens up when doctor is around during the translation as a nurse you also get to have some other important information from the patient cause as nurses we also do our assessments and then we get to one to one basis with the patient you know and sometimes there is a different person like a psychologist and they open up and then during the translation you get to know ok this patient has been hiding this information all along and now he is opening up so...*

*Extract 39 Interview 5*

*(N4): ...because most of the time we are helping the doctor and translating with the doctor so sometimes it increases your knowledge as well.*

N2 states that patients are often more *'open'* when they are being interviewed by a clinician. N2 states that when she translates for a clinician, she is able to learn more about a patient and their illness by seeing the patient both during her own interview with the patient and the clinician's interview with the patient. N4 states that in helping the clinician with translation, she is able to learn from the experience as *"it increases your knowledge"*.

Basic theme 9 concerns participant perceptions in terms of nurses' dual roles as translator and clinical nurse. The effects of assuming this unprofessional role of translator has on the nurse's professional clinical role in terms of time and workload is examined. It emerged that the nurse's role as translator can be both a hindrance and helpful influence with respect to the nurse's clinical role.

### (d) Basic Theme 10: Translator Role Resistance

#### Extract 40 Interview 6

*(C2): Well I have had nurses who refuse and claim that they are busy but then you just see them sitting eating their lunch so they actually not busy. But I have never had anyone just blatantly refusing. If I did have someone blatantly refusing well there is nothing I can do about it because as I said before, it is not their responsibility and you know I could see myself doing something like that sometimes. I mean if I am frustrated and not meaning anything personally to the person that is asking me but if I say had a bad day at work and I'm overloaded and now I eventually get a break and now someone is asking me to translate I might blatantly refuse you know. They not my boss, I don't owe them anything so I might blatantly refuse too you know. So, I can completely understand how that would happen so if they did do that I would just say ok you know I wouldn't take it further.*

In extract 40 above, C2 speaks of nurses who may resist their role as translator, in other words, nurses may not wish to translate for a clinician. C2 states that she understands why there may be resistance in terms of translator roles as she is aware of the fact that nurses are not employed as professional translators. C2 also acknowledges that nurses may be *'overloaded'* and that if a nurse does not wish to assist with translations there is nothing C2 can do about it.

#### Extract 41 Interview 3

*(C1): Well it is not uncommon to find resistance in translating and translation done with apparent less than ideal fervour conviction, resulting in a technically poorer translation with a sense of dissatisfaction with the process. The translator is sort of forced into doing it, has not choice in the matter and fundamentally disagrees with the notion of having to translate.*

In extract 41 above, C1 states that 'the translator' (referring to the nurse acting as translator) is *'forced'* into translating. Even though they are not employed as professional translators they often have no choice in terms of translating. Furthermore, C1 states that nurses may also disagree with the fact that they are required to translate and in his experience this may result in a poorer translation.

Organising theme 1 Role Perception is relevant to the way in which clinicians perceive the nurses role and the way in which nurses view their own roles during the assessment sessions. According to this organising theme 1, in both the clinicians and the nurses experiences, the nurse are perceived as

having to assume a dual role during the assessment interview and may be resistant towards their role as translator.

### 5.2.3.2 Organising Theme 2: Practical Difficulties

*(a) Basic Theme 11: First/Third Person Reference*

In extract 42 below, N4 states that when she is translating for a clinician or the patient she makes a point in using first person reference.

*Extract 42 Interview 5*

(N4): *I put it direct. I use 'I' when the patient says 'I'm sleeping well' I don't say 'she is sleeping well'. I use the same words of the patient.*

*Extract 43 Observation 1*

*C1: Okay what did I ask you to explain to me?*

*N2: **The psychiatrist** asked you to explain what to him?*

*P1: What psychiatrist?*

*N2: **The psychiatrist***

*P1: The psychiatrist asked me to explain about my head injury*

*N2: you said I must explain to you about the head injury*

*C1: No no the last thing that I asked you*

*N2: The last thing that **the psychiatrist** asked*

*P1: Now*

*N2: Yes*

*P1: The psychiatrist was asking why they brought me in the hospital.*

*N 2: you were asking why am I admitted into this hospital.*

*C1: okay it had something to do with that but it was a bit more specific*

In observation 1 extract 43 above, it emerged that N2 did not translate directly from the psychiatrist to the patient, where, N2 states *'the psychiatrist'* instead of *'I'*. In this instance the patient became confused and did not know which psychiatrist the nurse was referring to. This confusion, caused by an indirect translation was observed as a common occurrence within the assessment sessions, and in each instance of indirect translation, confusion and misunderstandings occurred, either for the clinician or the patient. This confusion or misunderstanding influenced the course and momentum of communication as the length of the assessment interviews were increased as confusions or misunderstandings had to be dealt with.

In basic theme 11 the importance of direct first person referral within translation is illustrated. If the clinician or the patient is referred to in the third person during the translation, this can cause confusion and often results in a lengthy translation.

## (b) Basic Theme 12: Translation of Rapport

*Extract 44 Observation 6*

C2: *It just bothers you. Ok, sure. I can imagine that must be quite difficult. Ok your mother do you hear have your mother been talking the same amount for the last, you say it's been three months all the time. Does your mother speak the same amount or been giving you more recently or less.*

N4: *Does she speak more or less?*

P6: *She speaks a lot*

N4: *Too much*

In observation 6 extract 44 above, N4 does not translate the clinician's response to the patient and the empathic statement made for the patient *'I can imagine that must be quite difficult'*. N4 also summarizes C2's questioning. It emerged that because the nurse did not relay the response or the empathic statement, the patient was unaware that the clinician was trying to relay compassion and understanding in order to develop rapport with the patient. The nurse's failure to relay the clinician's empathic response may have been influenced by the length of C2's questioning.

If empathic information relating to rapport between clinician and patient is not clearly stated and/or is omitted, patients may not feel understood by the clinician and this may in turn influence the relationship between the clinician and the patient.

## (c) Basic Theme 13: Clinical Exercises/ Incorrect Translation

It was observed during the assessment sessions that clinicians may ask patients to complete specific clinical exercises. These exercises are used for the assessment of the patient's mental functioning for the purpose of diagnosis. It was observed that the translation of certain exercises was problematic.

*Extract 45 Observation 1*

C1: *I want to interrupt you right there, I asked you to count back from 20 by subtracting three each time. Alright now subtracting three from 20 doesn't give you 19...Make sure you understand it.*

N2: *Understand clearly, its twenty that you asked to start in and coming forward but when you do that take three understand in your numbers ahead*

P2: *Subtracting three?*

N2: *I am saying look its twenty you must go forward and when you do that you must subtract three...Come back and minus three.*

P2: (LONG PAUSE)

P 2: 17


In observation 1 extract 45 above, whilst translating the clinical exercise to the patient, N2 provides the patient with incorrect instructions. Instead of stating that the patient must subtract three or go backwards from 20, the nurse instructs the patient to *'come forward'* or *'go forward'*. The nurse then ends by stating that the patient must *'minus three'*. From the observation 1 field notes, the patient was recorded 'looking confused' and 'worried'. This is problematic as the incorrect translations may have caused additional stress to a patient that may already be in distress (the reason they are seeking mental health care).

The patient's confusion and worry may also stem from the fact that P2 may be under pressure to complete the clinical exercise, but does not understand the exercise due to the incorrect instruction given by the nurse through the translation. In terms of patient assessment and diagnosis then, the clinician may misinterpret the patient's confusion as symptoms of mental distress and/or instability. The importance for individuals acting as translators to have clinical knowledge and understanding of the purpose of specific clinical exercises in order to accurately interpret them to patients is highlighted. Furthermore, the applicability of western clinical techniques, instruments, exercises and the structuring of assessment questions within the South African context are also highlighted.


## (d) Basic Theme 14: Clinical Exercise Assistance

Basic theme 14 as a practical illustration shows that during certain assessment sessions, nurses were observed to be assisting patients with clinical exercises or with answering clinical questions posed by the clinician. When patients were observed to be having difficulty with the exercises or with answering questions, nurses were observed assisting or encouraging patients. In the observation field notes it was recorded that during one particular exercise, the patient was observed to be heavily reliant on the nurse where constant eye contact was maintained, and the patient was observed to be looking to the nurse for answers. N2 was recorded as trying to help the patient by encouraging the patient to 'hurry' with the exercise where responses to this particular exercise, were based on the use of time limits for assessment of mental functioning.


*Extract 46 Interview 1*

*N1: at times we help the patient even though we are not supposed to help because in a way he is being assessed when he is given a task to do, to see whether he is going to be able to do the task that he has been asked to do to see whether he is, how far he is, assessing his mental illness*

In extract 46 above, when asked about assisting patients with clinical exercises, N1 responded that he is aware of the fact that nurses should not assist patients as the exercises or questions posed serve a specific diagnostic function, but that in some instances they do.

*Extract 47 Interview 6*

*C2: I do think it is negative because obviously when you are doing these exercises I mean as a psychologist the whole point of it is to try and assess I mean for example, if you doing like a projective like a drawing or something like that, the whole idea is that you are trying to give them as little as you trying to tell them as little as possible because you are trying to get them to project and when the nurses help them and say 'oh no you can draw a girl' when you have told them like 'no just draw any person' for example, they are actually then kinda giving ideas to the patient and then renders the I mean then you can't actually tell...*

In extract 47 above, C2 states that when nurses assist patients with exercises or questioning, it has a negative impact on the diagnostic purpose of the exercise or question. C2 goes on to state that in her experience, this is due to the fact that she is unable to distinguish between issues that arise on the part of the nurse's translation or relevant issues concerning the patient's diagnosis.

*Extract 48 Interview 2*

*N2:... cause sometimes the patients don't get the question the first time so you have got to try and explain now the question and sometimes you are now like giving the patients some clues in a way now but you are trying to explain the question because sometimes they don't quickly get the question and then you have got to make a simpler to make a better explanation.*

*Extract 49 Interview 1*

*N1: now the nurse had to explain now that because you are speaking in English and I am trying to get the patient to understand you know it is not um the fact that I was ah giving answers for this patient but I was trying to simplify the statement for her but unfortunately from this simplification of the statement the patient can get to get the answers in a way.*

In extracts 48 and 49 above, N1 and N2 explain that in some instances patients do not understand the questions or exercises posed by the clinician. Both N1 and N2 state that in their experiences, in these instances simplification or clarification is needed in order for the patient to understand what the clinician is asking of them. Through this process of re-explanation, clarification or simplification, N1 and N2 explain that in some instances patients are able to deduce the expected 'correct' responses or answers to the exercises or questions.

Basic Themes 13 and 14 illustrate how misunderstandings or confusion occur when nurses are required to translate clinical exercises given to patients for diagnostic purposes. In Basic Theme 13, the

nurse incorrectly translates particular instructions regarding the clinical exercise, given to the patient by the clinician. This caused confusion and resulted in a lengthy interaction and translation. It emerged that an incorrect translation rendered the clinical exercise diagnostically ineffective. In basic themes 13 and 14, nurses were found to in some instances assist patients in completing clinical exercises. In some cases this was interpreted as a fault on the part of the nurse and in others it was found to be due to the systematic errors unique to the process of translation.

### (e) Basic Theme 15: Completing Clinician's Questions

*Extract 50 Observation 3*

Psychiatrist 1: **That's right but how do you feel when I tell you that...**

Nurse 2: **How do you feel when people are scared of you?**

Patient 3: *I feel sad*

Nurse 2: *I feel sad.*

During the observations, it emerged that on some occasions, when a clinician poses a question to the patient, the nurse would begin translating the question before the clinician has completed the question. In these instances, the nurse completes the question for the clinician.

*Extract 51 Interview 1*

*N1: sometimes since you know if you use a certain doctor then you know what he is going to ask about the dates, you know what day is it today. When they are asking that we also ask the month and the year cause we know they are going to ask that.*

*Extract 52 Interview 2*

*N2: I have been doing it for quite a long time but sometime if you are going to be so quick to say whatever maybe when the doctor is finishing up it is a different question so you have got to be sure. But in some instances you know you sort of finish up cause you know he has started off with these words and now he is going to finish up.*

In extracts 51 and 52 above, N1 and N2 report that in their experience of translating for particular clinicians, they have gained knowledge in terms of questioning sequences, that is, what specific questions follow on from another. N2 goes on to state that she is aware of the fact that in some cases, nurses are too quick to pose the clinicians question for them as the clinician may wish to ask a different question than what the nurse expected them to ask.

## (f) Basic Theme 16: Additional Questioning and Clarification

In extracts 53-55 below, it was observed that in certain instances nurses may pose additional questions to the patients without being prompted by the clinicians first.

### Extract 53 Observation 1

C1: Okay, what else?

N2: What else?

P1: I don't sleep.

N2: **When?**

P1: At night.

N2: okay and then I don't sleep at night.


### Extract 54 Observation 5

C2: Do you know who is putting the poison in the food?

N3: Do you know who it is that puts poison in the food?

P5: Yes I know

N3: **Who?**

P5: M.S

N3: **What is M.S to you?**

P5: My cousin sister

N3: Yes, it's my cousin sister M.S


### Extract 55 Observation 3

C1: do you know somebody who died that was close to you?

N2: Is there anyone close to you who died?

P3: It's a brother. Mother's Sister

N2: **Your mother's sister?**

P3: Yes.

N2: it's my aunt


These instances were interpreted as a need for clarification concerning what the patient had said or to find out more information about what the patient had said. N2's intentions or motivation for needing clarification or specific details from the patients is examined. This was interpreted as being related to concerns about the translator's dual role/s as clinical nurse and translator. In terms of role overlap, N2 may be confused as to what specific expertise or skills are required from her for patient assessment in relation to her role/s as clinical nurse and translator. The nurses' 'invisible' status in the institution is also under question here, as N2 may in fact want to assert her role as translator in a more acknowledged

realm within the assessment session. N2 may have posed her own questions in order to assume a certain quantum of influence over the assessment interview, setting in motion specific performance that is beyond what is expected of her and which she may feel would put her in a position that is better acknowledged and involves more control.

Basic Themes 15 and 16 illustrate role confusion, where in both examples, it emerged that nurses assume a certain level of control over the assessment sessions by assuming a similar role to that of the clinician. Both of these themes are linked to the level of experience and clinical knowledge a nurse has in terms of clinical assessment and translation.

## (g) Basic Theme 17: Lengthy Interaction

### Extract 56 Interview 1

*N1: ...the reason I am repeating the question is that the patient didn't understand the question so I will re-phrase the question so that he can answer what I have asked. So you repeat the same thing 'no I didn't ask you that I asked you this question so you must answer' so you end up saying to the doctor what the patient has said and then the doctor says no I didn't ask this, why are you answering this.*

In extract 56 above, N1 reported that due to the complex nature of translation, interactions between the nurse and the patient can be a lengthy occurrence. According to N1, the lengthy interaction between nurses and patients is often a result of the need for repetition, clarification or simplification of questions posed by the clinician if the patient does not understand them. Furthermore, it was observed that in these instances short translations of the lengthy conversation is relayed to clinicians. In each instance, clinicians were reported as looking confused. When asked about this, C1 replied:

### Extract 57 Interview 3

*C1: ...because the biggest deterrent to the use of translation and you may note that I use translation and not interpretation right the biggest stumbling block is compulsion on the part of the translator is to get to the facts and not just translate right. I will decide what is going on I don't want an interpretation or opinion on what is going on*

When asked the same question C2 replied more positively in stating that when the nurse and patient interact for lengthy periods of time, it actually assists C2 in terms of patient observation and provides her with more time to *'take notes'.*

### Extract 58 Interview 6

*C2: yes definitely it does and it also gives me more time to make observations because while the um translator is speaking to the patient then I can observe the patient because it is harder to take notes and try and ask questions and make*

*observations or whatever or facial expressions or how distracted they are where as it is much easier to see when they are interacting with someone else...*

Basic theme 17 illustrates the resulting effect of themes 15 and 16 on the translation process. Instances of lengthy interaction between nurses and patients caused confusion for clinician's as translations of these lengthy interactions were short in comparison to the length of the isiXhosa conversation.

With reference to the nurses' role/s, the practical illustrations show how different practical problems relating to these roles that are encountered emerged as negatively impeding the flow of communication during the assessment sessions.

The two organising themes of Role Perception and Practical Illustrations made up the global theme of Translator Role. This included what roles the nurse acting as translator assumes, the perceptions that the participants have of these roles and how they react to them. Furthermore, illustrations of particular practical problems relating to the nurses dual roles as translator and clinical nurse were explored and examined in terms of how they may influence the translation process and influence the flow of communication during the assessment interviews. It is important to note that the practical difficulties highlighted also illustrate the ambiguity that surrounds both the nurses roles as clinical nurse and translator and what the relationship between these two roles should be if any.

## 5.2.4 Global Theme 4: Clinician's Role

Table 4

*Global Theme: Clinician's Role*

| Codes | Issues Discussed | Themes identified | Organising Theme | Global Theme |
|---|---|---|---|---|
| Perception | Conduit model | 16. Clinicians' perception | | |
| Duties/roles | Lack of awareness | 17. Nurses' perception | | ♪ |
| Attitudes | Involvement | | | |
| Openness | Insight | | Role Perception | |
| Awareness | Resistance | | | |
| Techniques | Convenience | | | |
| Solutions | Time | | | |
| | High Expectation | | | |
| | | | | CLINICIAN ROLE |
| Questioning | Practical Problems | 18. First/Third person | | |
| Role Awareness | Training | reference | | |
| Insight | Confusion | 19. Clinicians' Questioning | | |
| Techniques | Perception | | Practical Difficulties | |
| Solutions | Consistency | | | |

This thematic network was informed by participants' linguistically and culturally informed perceptions of translation and the clinicians' role/s in this translation process. The thematic network of clinicians'

role emerged from an examination of clinicians' perceptions of the necessary skills and capabilities that they may require as well as my own imposition of the nurses' lack of reflection on the clinician's skills and capabilities in terms of the roles clinicians assume during the assessment sessions. This thematic network constitutes two organising themes and four basic themes. Discussions of participants' perceptions or lack thereof concerning what the clinicians' role involves during the translation process highlighted fundamental ideas concerning the clinicians' awareness of their position and the impact this position has on the translation process. Contradictions also emerged in terms of the clinicians' assumptions about language and translation and what occurs in practice.

## 5.2.4.1 Organising Theme 1: Role Perception

### (a) Basic Theme 18: Clinicians' Perception

During the individual interviews with C1 and C2, it was found that both C1 and C2 did not demonstrate awareness of the role/s that they may assume during the process of translation other than their clinical role of psychiatrist and/or psychologist in terms of the assessment sessions. Both C1 and C2 were asked to comment on any techniques they implement before, during or after the assessment session, in order to improve and ensure clear communication within the process of translation. In extract 59 below, C1 states that the role/s he assumes and techniques he uses relate only to the clinical process of the assessment session.

*Extract 59 Interview 1*

*C1: Yes, but that is a different role, that is as another professional involved in a clinical process.*

In extract 60 below, C2 states that her role remains the same regardless of whether there is a translator present or not.

*Extract 60 Interview 6*

*C2: I see my role as pretty much the same but you know there is someone else there but um I try and still see it that I am still the clinician and I just have somebody trying to help me.*

When asked about pre and post-briefing sessions that clinicians could implement before, during and after the assessment sessions, in extract 61 below, C2 mentions that as clinicians, their time schedules do not allow them to do so.

*Extract 61 Interview 6*

*C2: No actually I don't, not because I don't think it is important but generally there is not time I mean like you saw today generally I see patients in-between... still after you have seen them you still have to go and make notes, you have to keep notes in your own file and in the ward file and then I usually have other clients or other ward rounds or other places to go. So I don't actually have time to then still sit with the nurses and talk to them so...*

In the individual interviews, both C1 and C2 focused mainly on discussions of their role as clinicians and little or no mention was given to ideas relating to the their involvement in the translation process.

## (b) Basic Theme 19: Nurses' Perception

Following from above, during the individual interviews, nurses were questioned about their perceptions of what the clinician's role/s should be during the assessment sessions in terms of translation. Little or no mention was given to ideas relating to the clinicians involvement in terms of the translation process and all of the nurses were observed looking 'confused' when questioned about the clinician's role. This is significant as basic theme 19 is therefore not an emergent theme but is rather an imposition of my interpretation as researcher of this study. The observed 'confusion' was interpreted as a combination of two factors. Firstly, misunderstanding and confusion was interpreted as stemming from the nurses limited English proficiency and the implications for interview execution in terms of simplifying the interview questions successively. Secondly, the 'confusion' observed was also interpreted as a result of nurses reluctance to comment or reflect on the clinicians' positions within the assessment sessions.

The organising theme of Role Perception relates to the ways in which clinicians and nurses view the clinician's role, if any, within the translation process. According to this organising theme, clinicians do not feel that they assume any additional role/s other than their clinical professional roles of psychiatrist or psychologist. Nurses did not express their perceptions concerning the clinicians' roles. In both Basic Themes 18 and 19, resistance to questions posed was observed and reported. Both C1 and C2 failed to answer questions concerning their role in the translation process directly, and often re-directed the questions to a different context or issue. Similarly, the nurses' lack of understanding or resistance to answering questions about the clinicians' role/s was also observed and recorded in the observation field notes.

## 5.2.4.2 Organising Theme 2: Practical Difficulties

### (a) Basic Theme 20: First/Third Person Reference

*Extract 62 Interview 6*

C2: *I always try to for example I will never talk to the translator, well I will talk to the translator but I will look at the patient too and I will be like oh 'you said this, what did you mean by this?' Instead of 'what did she mean by this?' So,* **sometimes I forget myself and I don't always do** *that but generally that's what I try and do…*

In extract 62 above, C2 states that when a translator is present in the assessment session, she tries to use first-person referral. C2 goes on to state that she is aware of the fact that she does not always implement this "*sometimes I forget myself and I don't always do that*".

*Extract 63 Observation 5*

C2: *So what* **does she, she told me** *that these demons cause nerves what else can* **she** *tell me about these demons?*

N3: *These things how did they come?*

P5: *I speak a lot because of them.*

N3: *she makes me talk too much these demons*

Extract 63 above, serves as an illustration of when and how C2 does not implement the first-person referral where the patient is referred to as 'she' not 'you'. In this example, *both* C2 and N3 refer to the patient indirectly. This is linked to ideas of exclusion where the patient is the one being excluded from the triad. Furthermore, N3 mistranslates the clinician's question where the clinician wants the patient to tell her more about the demons, but through the translation N3 changes the question to where or how the demons surface. This may have been a result of the lengthy statement made by the clinician (see theme 21, below) as well as the third-person referral to the patient.

In extract 64 below, C1 states that he also uses first-person reference when working with a translator. C1's explanation is closely linked to his view of the translator's role or presence as 'invisible' during the assessment interview where the translator's presence is being excluded from the triadic interaction during the assessment session.

*Extract 64 Interview 3*

*(C1): when I interview someone through a translator I don't address the translator I speak to the patient and the translator is simply the medium it is like subtitles in a movie.*

## (b) Basic Theme 21: Clinicians' Questioning

In the assessment session observations both C1 and C2 were observed in some instances to be posing more than one question or making lengthy statements without giving the nurse time to translate in-between questions. This double-barrelled/lengthy questioning is illustrated by extract 65 below.

### Extract 65 Interview 3

*(C1): you have given me a clear indication what the brains are about, you said mental illness somehow concerns the brain, so is something wrong with your brain?*

### Extract 66 Observation 6

*C2: How long have you been? So, does this happen when you, you only hear your mother when you're eating?*

*N4: Do you hear your mother when you're eating only?*

*P6: Yes*

*N4: Yes when I'm eating.*

In extract 66 above, C2 asks the patient two questions after one another and N4 does not translate each question separately. Rather N4 condenses both questions and poses them to the patient as one question.

Organising theme 2, concerns the practical illustrations of problems that may occur relevant to the particulars of a clinician's position within the assessment sessions when working with a translator. These practical problems were found to impede the flow or accuracy of communication during the assessment sessions as misunderstandings or insufficient time allocations for translations resulted in condensed or invalid translations.

In basic theme 18 (clinicians' perceptions of own role) and theme 19 (translators' perceptions of clinician's role), it emerged that clinicians perceive their role when working with a translator as purely a clinical one. This emerged as contradictory to basic theme 20 (first-third person reference), where C1 and C2 state that they try and use first-person referral when working with a translator. This illustrates an additional awareness required in the contained clinical role that C1 and C2 adamantly refer to, as clinicians now have to be aware of the way in which they address the patient. In basic theme 21 (Double-Barrelled/Lengthy Questioning), it emerged that C1 and C2 are not aware of the ways in which question formulation and execution influences the flow of communication. This includes a lack of awareness of the influences their questioning have on the translator's ability to translate during assessment sessions.

Ideas relating to participant perception of clinicians' role/s during the translation process and the practical illustrations of this role/s made up the global theme 3 (Clinicians' Role). Clinicians did not

portray awareness of a position or role they may assume when working with a translator other than their professional roles required as clinicians. This was contradicted by the illustrations of particular practical problems relating to the clinicians' roles that were explored. Furthermore, examples were provided of daily occurrences on the part of clinicians that influence the translation process and which may affect communication during assessment sessions. Clinicians' lack of awareness concerning their roles in translation is interpreted as stemming from the 'ad hoc' nature of translation services within the institutional setting, their perceptions of translation, as well as the institutional hierarchy. This emerged as informing clinicians' perceptions of translator roles as well as their own positioning. Clinicians' lack of awareness concerning their position when working with a translator places all responsibility for accurate translation on the nurses who are held solely accountable for difficulties with translation. Furthermore, nurse's lack of expression of their perceptions of clinicians' roles emerged as evidence of institutional hierarchy.

### 5.2.5 Global Theme 5: Dimensions of Exclusion, Influence and Control

Table 5

*Global Theme: Dimensions of Exclusion, Influence and Control*

| Codes | Issues Discussed | Themes identified | Organising Theme | Global Theme |
|---|---|---|---|---|
| Lengthy Interaction Feelings of powerlessness Expectation Control | Exclusion Systematic errors Conduit model Language Understanding Awareness | 22. Feelings of exclusion | 1. Three's a Crowd | DIMENSIONS OF EXCLUSION, INFLUENCE AND CONTROL |
| Hierarchies Conflict Status Expectation | Understanding Relationship dynamics Profession dynamics Institutional setting Resistance Permeation of power and control | 23. Nurses influence and control 24. Clinicians influence and control | 2. Institutional Hierarchy | |

This thematic network was informed by ideas relating to participants' perceptions concerning feelings of exclusion and clinicians' perceptions concerning the amount of influence and control that each individual exerts within the context of assessment practices. This thematic network constitutes two organising themes and three basic themes. Clinicians' discussions highlighted fundamental ideas relating to how participant perceptions of language and translation influence their sentiments and behaviour in terms of feelings of exclusion, levels of control and influence, role expectation and role duality. Furthermore, the nurses' lack of reflections regarding issues of influence and control within the

triad during assessment sessions highlighted concerns of institutional hierarchies evident relating to the contextual setting within which translation takes place.

## 5.2.5.1 Organising Theme 1: Three's a Crowd

### (a) Basic Theme 22: Feelings of exclusion

*Extract 67 Interview 1*

*(N1): I feel that they are left out because even with us, sometimes they will speak Afrikaans and we don't know Afrikaans and then you don't know what they are saying and you feel left out...*

In extract 67 above, N1 states that in some of his translator experiences, when the clinician and patient have a conversation in Afrikaans he feels *'left out'* due to his inability to fully understand and speak Afrikaans. It emerged that the nurse acting as translator was excluded from the triadic interaction. It is important to note here that if the clinician and the patient share the same language of Afrikaans and communication is therefore not a problem, the nurse's duality of roles (clinical nurse and translator) collapses. This is interesting as N1 still reports feeling excluded. This may be related to how the nurses' dual roles overlap even when a nurse's primary role is not that of translator but rather that of clinical nurse. This raises questions concerning confusion not only in terms of what is expected of the nurse as translator, but also what is expected of the nurse in terms of their clinical role during the assessment sessions. These expectations can become blurred, resulting in confusion. This may also be related to hierarchical dynamics and the need for nurses to assume a more 'visible' position in both their roles as clinical nurse and translator.

In the individual interviews, C1, C2 and N1 spoke of instances where the interaction or conversation between either the clinician and patient, or nurse and patient, is lengthy. In these instances, it emerged that the third individual making up the translation triad may feel *'left out'* of the interaction. Therefore, either the nurse acting as translator or the clinician is excluded from the triadic interaction.

*Extract 68 Interview 3*

*(C1): yes that happens um and that mostly has to do with the quest for facts. The clinically more savvy nurse or translator won't do that and in a situation like that I sometimes stop and say tell me what he is saying, tell me **exactly** what he has said*

In extract 68 above, C1 explains that nurses, who are clinically more experienced, do not allow for their interaction with the patient to be too lengthy. Furthermore, C1 states that when this does occur he will stop the nurse and ask her to explain *'exactly'* what was said between the patient and nurse. The exclusion of the clinician emerged as significant here. If nurses acting as translators assume a 'visible'

position through lengthy interactions with patients, the clinician experiences feelings of exclusion. This is important as the clinician's feelings of exclusion may inform their perception of the translator's role in terms of translation as 'invisible'.

The organising theme of three's a crowd relates to the participants' feelings in terms of being an individual in the triad as well as a member of the triad. This is represented by Basic Theme 22 where participants speak of experiencing feelings of exclusion from the triadic interaction. It emerged that this included instances where language and the systematic errors unique to translation that affect the length of interactions were catalysts for participant's feeling 'left out'. Furthermore, tensions were evident in terms of how clinicians' feelings of exclusion may inform their assumptions of the translator's role as 'invisible' and translation as unacknowledged. Furthermore, if the translator's role needs to be invisible then the clinician's position regarding translation difficulties becomes conveniently invisible as well. This further influences the clinician's lack of awareness of their position within the triad and how this position impacts on communication.

### 5.2.5.2 Organising Theme 2: Institutional Hierarchy

*Extract 69 Interview 3*

*(C1): There has been, it is a seasonal thing where there has been conflict between nurses as a group and clinicians as a group but does it concern translation, and I could say with reasonable certainty that it does not involve translation...translation is the scapegoat, the surrogate, the thing that can be targeted because it is an inability that the clinician has and an ability that the nurse has and the nurse then feels or appears to feel exploited or not recognised enough. It is symptomatic of age old tensions between nurses and clinicians.*

In extract 69 above, C1 states that hierarchical tensions between clinicians and nurses are often mistaken as tensions about translation dynamics during the assessment sessions. C1 believes that translation is an easy target as it is something that a nurse can do that clinicians cannot.

### *(a) Basic Theme 23: Nurses Influence and control*

*Extract 70 Interview 6*

*(C2): it depends...some nurses you can just tell that they are not interested at all...they very reluctantly ask the patients questions and that obviously affects the way the patients are going to answer as well and the way they are asking the questions is like 'she wants to know this, goodness knows why' and you know that kind of attitude of saying it...you can pick it up in the way they are asking and you know the patient is not going to be that keen to answer either if that is the way they are being asked questions...*

In extract 70 above, C2 states that when nurses' translate, they have the ability to influence patients within the assessment sessions. This is related predominantly to the patient's answers to questions, their ideas and feelings towards the clinical interview as well as their ideas and feelings towards the clinician. Nurses did not directly mention anything about specific instances, or their ability and intentions to control the assessment sessions, but mainly related the influence they have to their ability to understand languages and cultures. Rather, the nurses' ability to control the actual assessment interview emerged from the practical illustrations relating to the nurses role as translator.

### (b) Basic Theme 24: Clinician's Influence and control

#### Extract 71 Interview 1

*(C1): the biggest stumbling block is compulsion on the part of the translator is to get to the facts and not just translate right. I will decide what is going on. **I don't want an interpretation or opinion on what is going on...** because otherwise why do I bother seeing the patient? Why don't I just hear from the nurse what is going on?*

In extract 71 above, C1 states that translators need to merely 'translate' and not give their opinion. In the individual interview, it was observed that C1 became dominating and spoke with a certain 'air' during extract 71 above. The clinician's perception of the translator needing to assume an 'invisible' position within the translation process is evident. In terms of the observations made of way in which the C1 spoke during extract 71 above, this can be interpreted as an articulation of rank within the institutional hierarchy mentioned above.

#### Extract 72 Interview 6

*C2: I know some of my other colleagues, they also see you know nurses on a different level...you know I see things strongly the other way round you know that there isn't a nurses responsibility so if they refuse it is fine but I know of other people that don't see it that way so they kind of have this attitude that like "...I am the clinician here you know you are lower, you are just a nurse, so you better help..."*

In extract 72 above, C2 speaks of different levels and statuses between clinicians and nurses, that some clinicians feel exist within the institutional setting. C2 believes that some clinicians feel that because they are clinicians they have a higher status than nurses and that nurses should take orders from them. This in turn may affect clinicians' expectations and behaviours towards nurses.

*C2: yes I do think so and I mean sometimes you can see it between psychiatrists and psychologists you know, psychiatrists think that they are **better than psychologists** and they have to do everything merely because they are psychologists you know so I do think it is discipline related*

In extract 73 above, C2 goes on to state that these levels or statuses are related to institutional hierarchies and believes that they not only exist between nurses and clinicians, but are also evident between psychologists and psychiatrists. C2 states that some psychiatrists believe that *they are 'better' than psychologists*. Furthermore, C2 implies that psychologists are required to fulfil certain duties as a result of their positioning within the institutional hierarchy *'and they have to do everything merely because they are psychologists'*. Again, it is important to note that nurses did not directly reflect on the clinicians' ability and intentions to control or influence the assessment sessions.

In this particular organising theme, evidence of a clear institutional hierarchy emerged where the psychiatrist forms the pinnacle of the hierarchy followed by the psychologist followed by the nurse who assumes the last two levels of the hierarchy first as professional nurse then as amateur translator. It also emerged that tasks and expectations are passed down this institutional hierarchy where C1 and C2 believe that psychologists and nurses are expected to fulfil certain criteria relating to their position within the hierarchy. Ideas concerning clinicians' perceptions of the amount of control and influence that each individual has in terms of their involvement in the translation process as well as their professional statuses is therefore related to institutional hierarchical dynamics. This means that the nurses' ranking within the institutional hierarchy is related to the way in which C1 and C2 perceive the amount of influence and control that nurses have during the translation process within the assessment session.

It is evident that C1 still feels strongly about the translators 'invisibility' and need for verbatim translations. No direct mention was made concerning institutional hierarchical dynamics by the nurses during the individual interviews. This emerged as interesting and may be reflective of three particular instances. Firstly, it may relate to the nurses' awareness of their lower status in the institutional hierarchy and secondly, nurses may not want to comment on issues of control and influence in fear of being reprimanded for saying the wrong thing. Thirdly, the nurses may just be more concerned with the patient and assessment rather than with concerns about influence and control. In terms of the way in which C1 and C2 perceive their own levels of influence and control within the translation process, C1 and C2's reflection may be related to their institutional positing rather than their positioning within the

assessment sessions. This is important as it is evidence of both clinicians' lack of awareness of their role during the process of translation.

In this thematic network, two organising themes made up the global theme of Dimensions of Exclusion, Influence and Control. Material emerged in support of tensions that exist between the individual members of the translation triad and in terms of role perception and expectation within the assessment setting. Instances where language and the systematic errors unique to translation affect the length of interactions were catalysts for participant's feeling 'left out'. Additionally, tensions were evident in terms of broader institutional hierarchies and the influence that the clinicians ranking within this hierarchy has on their expectations and assumptions of the role of translators within the translation triad during assessment. Furthermore, clinicians' feelings of exclusion identified, may inform their perception of the translator's role and translation as 'invisible'.

The identification of conflict or tension concerning institutional hierarchy and teamwork and feelings of exclusion is important as underlying resistance or negative feelings between the members that make up the translation triad could ultimately influence both the level of translation and communication within the triad as well as the participants' professional working relationships. Furthermore, tensions within the triad that emerge during assessment sessions could have a detrimental effect on patients who are in a fragile state due to their mental illness.

## 5.2.6. Global Theme 6: Strategies and Skills

Table 6

*Global Theme: Strategies and Skills*

| Codes | Issues Discussed | Themes identified | Organising Theme | Global Theme |
|---|---|---|---|---|
| Macro practical solutions | Awareness | 25. Add-on Approach to translation | | |
| Context | Institutional setting/context | 26. Training | Contextual Strategies | |
| Roles | Indigenous language | | | |
| Recommendations | training | | | |
| Professionalism | Internal/external | | | |
| Understanding | employment | | | |
| Attitude | Internal/external training | | | |
| Knowledge | | | | |
| Intentions | | | | STRATEGIES AND SKILLS |
| Guidance | Training | 27.Linguistic and cultural heterogeneity | | |
| Instructions | Questioning | | | |
| Internal/external employment | Clinical Knowledge | 28. Clinical Knowledge and Application | | |
| | Clinical Application | | | |
| Internal/external training | Practice | 29. Practical Experience and Awareness | Necessary Skills | |
| Micro practical solutions | Teamwork | 30. Communication | | |
| | Communication | | | |
| | Briefing | 31. Briefing and De-briefing sessions. | | |

This thematic network was informed by ideas relating to participants perceptions concerning specific strategies that need to be applied to the assessment and institutional setting of the hospital and certain skills that clinicians and nurses may need within daily practice during translation processes. Two organising themes and seven basic themes made up the global theme of strategies and skills. The importance of this global theme must be emphasised as it is illustrative of participant's ability to constructively reflect on their daily practices which is important concerning specific recommendations made within this study (see chapter seven).

### 5.2.6.1 Organising Theme 1: Contextual Strategies

#### (a) Basic Theme 25: Add-on Approach to Translation

Extract 74 Interview 6

*C2: I don't think that translating should be the nurse's job and I think what we really need are people who are trained as interpreters and that are only interpreters...*

In the individual interviews, the majority of the participants mentioned that they believe nurses should not be requested to translate. In extract 74 above, C2 states that a solution to the fact that nurses are requested to translate, would be the employment of an independent translator who is professionally trained and employed only in their capacity as a translator. This is interpreted as stemming from the nurses resistance to their roles as translators which is linked to the unacknowledged position nurses assume as translators and the invisible nature in which translation occurs within the hospital.

Extract 75 Interview 2

*N2: I guess I feel that doctors as well should try and get into these languages now like in (location A) they should learn Xhosa now*

In the individual interviews with the nurses, two of the four nurses mention that in their experience they believe clinicians' should 'try' and learn the indigenous languages of patients. This mentioned strategy is important as it emerged as one of the only reflections that nurses provided concerning the clinicians position and role relating to communication difficulties within the institution.

#### (c) Basic Theme 26: Training

Extract 77 Interview 2

*N2: ... as yet the hospital has not as yet started thinking about employing someone for translation so the people that are helping now they are the ones that should be in serviced or trained or whatever...*

From the individual interviews with participants, it emerged that none of the participants (nurses or clinicians), have had any formal training in translation theory and or practice. The nurses were then asked their perception as to whether or not they think they need training in terms of translation. All of the nurses stated that if they were to be continually requested to translate, that is, if the hospital did not employ an independent translator who was trained and employed only to translate, then training would be beneficial. This is important as it shows that nurses are aware of the fact that they require training in translation practices and that they are willing to undergo training if it was provided to them.

*Extract 78 Interview 2*

*N2: So I am trying to say now if there was sort of a special training for nurses to undergo then it would be fine because if we know that this nurse has not undergone the training then we should not be asking this nurse to help with translation.*

In extract 78 above, N2 states that if training was provided then it would allow for the distinction between who is capable and should be approached to translate and who does not have training and should not be approached to translate. This is important, as it may provide more structure for translation services. N2's awareness of the benefits of training is illustrated here. Furthermore, it is important to consider that the nurses' openness to training in translation practices may result from the job status and remuneration implications that formal training may encourage. This means that the nurses intentions for wanting formal training may extend beyond altruistic concerns for patients, for if formal training was provided, nurses who have extra qualification may be more 'visible' and acknowledge within the institution.

C1 and C2 were asked whether or not they believe that clinicians require training in working with translators.

*Extract 79 Interview 6*

*C2: I think maybe training for the clinicians should not necessarily be about teaching and that sort of thing but rather a forum for discussion. Where other people have more experience with other more experienced clinicians that have worked in this kind of setting for longer term that you can discuss it and see from their experience. Because I don't think there are any hard and fast rules um with this kind of this and obviously as I have said it varies from person to person. But if you have somebody who has that wide range of experience well then you can discuss it and say 'well I find that this helped' you know that kind of training so to speak I think will be helpful.*

In extract 79 above, C2 states that she does not think that clinicians require formal training in terms of working with translators. Rather, C2 states that she believes that *'a forum for discussion'* will allow clinicians to discuss and share their experiences of working with translators. Furthermore, C2 states

that those individuals who have more experience than others can share their experiences with one another. Although C2's awareness of the need for some form of communication between clinicians is highlighted here, C2 does not mention that communication is needed between clinicians and nurses in terms of translation practices. This may be linked to hierarchical dynamics evident where translators are seen as the potential problem rather than errors specific to translation, issues of role expectation and clinicians attitudes to nurses acting as translators and the translation process itself.

*Extract 80 Interview 6*

*C2: Um yes because if things stay the same as they are now where nurses are translating and then they would need training and that is good.*

In extract 80 above, C2 states that if nurses are continually requested to translate then formal training for the nurses who are translating is required. This is interesting as C2 clearly feels that clinicians' do not require formal training but nurses do. This is linked to ideas relating to the clinicians lack of awareness of their role within the translation process, their perception of institutional hierarchies and concerns about clinicians level of control and influence within the assessment session.

The employment of independent translators and bilingual/multilingual clinicians and the implementation of training programs identified each represent a change that some of the participants suggested would be helpful in facilitating effective communication during the process of translation. The two basic themes identified were grouped within the organizational theme of contextual solutions, as each suggestion provided by the participants relates to changes that are needed in terms of the supporting structures for translation services within the hospital.

## 5.2.7.2 Organising Theme 2: Necessary Skills

During the individual interviews a need for certain skills and application of those skills that participants may require was highlighted and discussed. Therefore, ideas concerning training emerged as an organising theme in itself. This included practical skills for nurses acting as translators and for clinicians in working with translators on a daily basis.

### (a) Basic Theme 27: Linguistic and cultural heterogeneity

*Extract 81 Interview 2*

*N2: with the training they should, we should be for instance I am saying now there is a Xhosa speaking from (location A) and I am a Xhosa speaking from (location B) you know then there should be it is totally different. Well, in some areas we don't differ but in some we do so they should um also include the languages used in certain areas.*

In extract 81 above, N2 emphasises that there is a need for awareness of the existence of different dialects within different languages and how this complicates role performance in terms of translation processes.

*Extract 82 Interview 1*

*N1: If I don't know the slang I will always ask the patients, what does that mean? If I don't know then I will tell them the patient used this slang and I don't know what that means.*

In extract 82 above, N1 states that in his experience, patients may use certain types of slang in their speech that he does not understand. N1 states that when this happens, he may ask the patient to explain the slang or he may inform the clinician that he does not understand what the patient is saying. This is linked from ideas relating to differences in culture highlighted within the global theme of culture.

Difficulties arising from the systematic errors and culturally located experiences unique to the process of translation are highlighted here. Furthermore, the importance and need for awareness concerning these difficulties by both clinicians and nurses acting as translators is also highlighted.

*(b) Basic Theme 28: Clinical knowledge and Application*

*Extract 83 Interview 3*

*C1: they would need fairly rigorous training in psychopathology and in the clinical process... well your problem is already half solved because if someone has clinical savvy then it will become translation and move away from interpretation. Because they will realise that **this is not a quest for facts** it's **um observing a person's mind at work** and we declare the workings of the mind largely through verbal communication. A person with a requisite quantum of clinical savvy would translate and not interpret.*

In extract 83 above, C1 highlights the required knowledge and skills for nurses specifically relating to mental health care and the application of this knowledge concerning psychiatry, psychopathology and the overall clinical process is highlighted by C1. C1 also states that if translators have this clinical knowledge it will assist them to translate and not interpret. This statement made by C1 is interpreted as self-contradictory. For, if the clinical assessment is *"not a quest for facts"* but *"observing a person's mind at work"* then there is no direct access to a person's mind. Therefore translating literally is in fact not a possibility and all we are left with is interpretation. What C1 argues for, is that clinicians are required to interpret a *person's mind at work* but translators are permitted only to translate. This is related to C1's empiricist and conduit ideas of language and translation.

*N2: ... if doctor asks questions, you should not be rephrasing it to the patient and you shouldn't be changing anything from what the doctor is saying you know...So things like that should be part of training so people should know not to do things like that...*

In extract 84 above, N2 states that it is important for individuals who are translating to not rephrase the clinician's questions to the patient during the assessment sessions. This seems contradictory as the importance of awareness concerning the systematic errors unique to translation was highlighted by the nurses in global theme 1 (Language, meaning and reality). From the interpretation of the observations and interview with N2, in extract 84 N2 is referring to the clinical importance of the way in which doctors phrase their questions for the elicitation of symptoms of mental illness. From the extract above, the practical limitations of literal translation are once again highlighted. Therefore, N2's suggestion may be relevant or may be stemming from clinicians' high expectations of role performance concerning translation practices as well as the institutional hierarchical status of individuals.

In extract 85 below, C1 states that the reason nurses do not have training in clinical knowledge and application of this knowledge in terms of mental health care, is due to the initial inadequate teaching and training nurses receive during their tertiary education.

*Extract 85 Interview 3*

*C1: But if a person doesn't have well evolved clinical concept, then I don't think you could expect that from a nurse, given their training and experience in the general nursing, but not primarily psychiatric exposure. But **this is not an indictment on the specific nurse or her intelligence. It is actually an indictment on the educational system and the tertiary education system** where the average nurse does not have the needed clinical savvy*

The statement made by C1 in extract 85 above is functional concerning the different levels of experience that nurses have in terms of mental health care. Tertiary education for mental health clinicians is focused on clinical knowledge and application. Nurses on the other hand may not foresee the context in which they will work, be it general health care or mental health care. This is problematic when nurses are expected to translate in mental health care hospitals or clinical contexts that are highly influential on the translation process. Therefore, training relating to the specific context within which translation occurs is important for nurses acting as translators.

## (c) Basic Theme 29: Practical Experience and Awareness

### Extract 86 Interview 3

*C1: so the good translator and the skills that the translator can learn um include things like an awareness of their impact on the process and an ability to separate those practices.*

In extract 86 above, C1 emphasises that nurses who are acting as translators need to be aware of how their dual position in the triad influences the translation process. C1 also goes on to state that nurses need to have the *"ability to separate those practices"*. C1 is referring to the nurses' dual role as clinical nurse and translator here. Although C1 raises an important point, the position and influence of clinicians on the translation process is ignored and the responsibility of translation is once again placed solely on nurses.

### Extract 87 Interview 3

*C1: By demonstrating what to do and getting them to practice. If you have translated in the correct way often enough that will become **habit** and that will be the way you translate.*

In extract 87 above, C1 emphasises the importance of practical experience in terms of translating. C1 goes on to state that the more experiences a nurse accrues in terms of translating, the more this will eventually allow the nurse to translate out of *'habit'*. Although the need for experience and importance of developing experiential working knowledge is highlighted by C1, it is important to note that C1 does not refer to the experience required by clinicians in working with translators and the affects that this experience has in terms of translation processes.

## (d) Basic Theme 30: Communication

In the assessment sessions, it was observed that in some instances patients spoke very fast and may ramble. In the individual interviews, some of the nurses stated that this can be confusing in terms of translating what the patient has said, as they are unable to make sense of the patient's speech and are unable to remember everything that the patient says.

### Extract 88 Interview 1

*N1: What some of the other nurses do is when a patient speaks for a long time, you must stop the patient so that you can translate it in parts so that you finish up because if you don't stop the patient then you won't remember what to translate. So you must stop the patient to translate so that you can finish up.*

In extract 88 above, N1 states that in order to deal with rambling, the nurse may ask the patient to stop and then translate what the patient is saying in segments or parts. This is linked to and may account for ideas relating to lengthy interaction between nurses and patients. Communication between clinicians and nurses concerning instances of lengthy interaction is needed to avoid tension, feelings of exclusion and conflict that may arise from these instances.

<u>Extract 89 Interview 2</u>

*N2: That is why I personally feel free to ask the doctor to please **repeat** whatever he is saying so that I know I am giving the patient the correct words that doctor has just said because sometimes you really, some other things slip because doctor you know has said three different things in you know saying at the same time so you have got to be honest and say you know doctor please you said this am I correct?*

In extract 89 above, N2 states that when clinicians ask patients double-barrelled questions or provide lengthy statements that are difficult for the nurse to follow and translate, she will ask the clinician to repeat what they have said. If she has not understood the statement or question posed by the clinician correctly, then she will ask the clinician to explain. Instances where nurses asked the clinician to repeat or explain questions were evident during the observed assessment sessions.

In extracts 90 below, N1 states that if conflict arose between the nurse and clinician during the assessment of a patient, he/she would mention this to the clinician. Furthermore, N1 states that their main concern is the patient. So, in order for differences between the nurse and the clinician to *not* affect the patient, this should be communicated and resolved with the clinician. This emerged as interesting as although the nurses show confidence in terms of sorting out tensions with clinicians, nurse resistance in answering questions that relate to the clinicians' role or position within the triad has been highlighted throughout this chapter. This may illustrate that although nurses are aware that communication is needed between clinicians and nurses, this is complicated by hierarchical dynamics evident.

<u>Extract 90 Interview 1</u>

*N1: In that case we would have to talk so that we can sort it out because at the end of the day we are not translators we are just assisting for the benefit of the patient so that the patient can go out of the hospital because they are here and they need to be assisted so that they can also go home just as any other patient so for the benefit of the patient it is better to just sit down and iron out the problems*

<u>(a) Basic Theme 31: Briefing and De-briefing Sessions</u>

In extract 91 below, N2 states that having a discussion with the clinician after the assessment session with a patient would be beneficial. N2 states that this will allow her to provide explanations for the

decisions she makes regarding translations in the assessment sessions. In doing so, the clinician will be aware of any problems that the nurse may have experienced during the assessment session and can be provided with insight into the complexities of the process of translation as a whole.

*Extract 91 Interview 2*

*N2: ...you know sometimes when we discuss a patient, the patient is with us. Afterwards we could try and have the discussion that you are talking about now to try and make them aware, I mean the doctors now, to try and make them aware that sometimes we need to do this and sometimes we need to do this in our translation so they should have a clue of what is happening...*

In extract 92 below, C2 states that at times she will speak to the nurse that is translating for her and inform the nurse of particular instructions that the nurse needs to be aware of during the assessment sessions. C2 also states that this is especially helpful if she has not worked with the nurse before or if the nurse is inexperienced in terms of translating.

*Extract 92 Interview 6*

*C2: then I would tell him before you know 'please don't add anything extra in' and then I kinda emphasise it again you know just give my instructions and nothing else. I found that in that particular case it helped so that is one thing I will do. Or um I will for example in the beginning when I was new and didn't have much experience and I didn't know what nurses start helping the patients or whatever whereas now sometimes if I don't know the nurse before we have even said anything, I will say you know please don't help the patient or do or if or sometimes if I forget to say that when I see they are about to say something to the patient, I'll say 'don't say anything or don't help the patient' or I'll ask them 'what are you going to tell them' before they tell them.*

In relation to ideas concerning the necessary skills required by individuals working within the process of translation, it is interesting to note that the skills that clinicians require in terms of working with translators emerged as substantially less than that which is required by translators. This is interesting and is linked to that fact that the suggestions made concerning the skills nurses' required were prescribed predominantly by clinicians. This is interpreted as being related to the influence that the institutional hierarchy evident within the hospital has on participant perceptions of the translation process, and their reflection concerning role performance and role expectation.

# CHAPTER 6: DISCUSSION

In this chapter, the second and third stages of the analysis are combined to produce an analytic discussion of the study material. This chapter focuses on a discussion of the research setting and of the six global themes identified and illustrated in the previous chapter. A discussion of the thematic networks identified in the analysis consolidates the material and grounds the main deductions within the generated texts. This was achieved by relating these deductions to the relevant theory of translation and determining how these themes correspond to the reality of the psychiatric assessment context that was under investigation in this study. Furthermore, a cross examination of how each basic theme, organising theme and global theme relate to one another is provided. This allows for a comprehensive understanding of the translation process.

## 6.1. Research Setting: The context of the hospital

The unacknowledged state and 'ad hoc' nature in which translation occurs within psychiatric institutions has been well documented in the South African literature (Drennan 1999; Drennan 2000; Swartz 1998). This was found to be the case within this research setting. No professionally appointed translators are employed within the hospital and any bilingual staff member employed at the hospital can be approached and expected to translate. This is supportive of the 'add-in approach' to translation in mental health care settings (Swartz et al., 1997). Staff members acting as translators do not have any formal training in translation theory or practice. Junior nurses were found to be the most commonly approached bilingual and/or multilingual staff members for translation within the institution.

A certain quantum of convenience is assumed here. Nurses more often than not share the same language and cultural orientation with many patients, and they are required to be clinically present during the assessment of a patient. This means that they are deemed to be the most likely individuals to be approached for translation. According to Drennan et al. (1991) individuals acting as translators do not receive professional accreditation, financial incentive or additional time in which to carry out this additional work. This is supported by the findings of this study as the nurses who are expected to translate do not receive any of the mentioned benefits for the translation work that they are doing on a daily basis. Furthermore, it emerged that nurses do not see themselves as professional translators but rather as professional nurses who translate.

Although translation processes emerged as unacknowledged and 'ad hoc' in nature, each participant (nurses and clinicians) involved in the translation process was able to speak about their experiences,

and reflect on their translation work by providing their perspectives on how translation plays out on a daily basis. This included focusing on both positive and negative aspects of the translation process.

It was clear that the way in which participants experience and perceive the process of translation within the institution is influenced by administrative constraints and the daily routine of patient assessment within the hospital. The need for prioritising language and communication, and for a focus on pertinent contextual changes in practice within mental health care settings, such as the institution has been well documented in both national and international literature (Angellelli, 2004; Dingwaney & Maier, 1995; Erasmus, 2003; Roth & Swartz, 1992; Swartz & MacGregor, 2002; Wadensjö, 1998).

The findings of this study illustrate the need for attention, evaluation and intervention in terms of translation practices for patient assessment in an institutional setting. Factors such as interruptions during the assessment sessions, a lack of set schedules for nurses and clinicians in terms of translating and the constant rotation of staff were found to be disruptive to translation and the patient assessment processes. Furthermore, these factors emerged as a negative influence on the working relationship between nurses, clinicians and patients. According to Swartz and Drennan (2000) valid assessment, diagnosis and treatment of patients is compromised when clinicians are unable to adequately communicate with patients. Therefore, practical structural changes concerning language and communication were identified as in need of attention, re-evaluation and intervention. Implementing well-developed contextual support for translation may reduce tension and improve the working relationship between nurses and clinicians. This will improve communication and assist individuals in their daily work activities, allowing for better psychiatric assessment and care for patients.

## 6.2. The Global Theme of Language, Meaning and Reality.

The gap between the expected outcomes of the translation process and the practical outcomes of this process was central in the conceptualisation of the global theme of Language, Meaning and Reality.

Throughout this study, it has been emphasised that clinicians may align themselves with the traditional empiricist view of language and the conduit model of translation, where the desired outcome of translation is word equivalence (Robinson, 2003). When discussing issues concerning participant perception of language and translation, both clinician participants were found to uphold these traditional perspectives. Their understanding of translation practices emphasised the need for word equivalence, that is, verbatim translation for the assessment and diagnosis of patients' mental illness. Throughout this discussion chapter, it will become evident how prescribing to traditional views of language and translation is problematic in practice. This is particularly evident regarding unrealistic role expectation, role capabilities, awareness of how each individual influences the translation process

and awareness of the cross-cultural use of the psychiatric interview, all of which are evident in the emergent material of this study.

Current theory on language and the process of translation emphasises non-equivalence at word level as translation is seen as a form of interpretation in terms of instantiating sameness-in-difference which emphasises plurality and anti-objectivism (Morino, 2008; Robinson, 2003; Tugushev, 2008). Therefore, a more pragmatic view of translation and its outcomes in terms of how language is influential for communication is highlighted in this study. When discussing issues concerning participant perception of language and translation, nurse participants' perceptions were found to be highly influenced by two specific concepts. Firstly, nurses were found to base their ideas of language and translation on the experiential working knowledge they obtain through their experiences of assuming the role of translator. Secondly, nurses' perceptions are influenced by the need to meet clinicians' role expectations of verbatim translation mentioned above.

It is important to note that current ideas regarding a more pragmatic view of translation processes can be problematic for clinicians as disordered use of language is one of the key signs clinicians use to assess their patients for the presence of a disordered state of mind. Specific use of language (down to appropriate propositional use of words and grammar) is therefore seen as potentially indicative of symptoms of mental illness. If clinicians get meaning-interpretation rather than word equivalence, they may be less able to use the patient's language as an indicator of the level of order/disorder of their mental state. This may be why clinicians align themselves to empiricist views of language and conduit models of translation, as the paradigmatic models of the relationship between language and mental functioning assumed in the western biomedical models of mental health is recognised within this view and model (Swartz, 1998).

As individuals either working with or acting as translators within mental health care institutions do so without professional training in translation, the necessary alignment between role expectations and role capabilities can become disjointed. Robinson (2003) states that as equivalence is not a realistic assumption for the process of translation, translators may strive for equivalence to satisfy clinician's expectations. This is a matter of reliability in that "the demands placed on the translator by the attempt to be reliable from the user's point of view are sometimes impossible" (Robinson 2003, p. 24).

As translation is such an essential process for clinicians who are unable to verbally communicate with their patients, high demands are made on individuals who are performing a translator role. These demands are often either unrealistic, or not comparable with the capability or skills that individuals who are translating possess. This means that the expected roles that individuals acting as translators are required to perform may not align with what is practically possible regarding the translation process.

This is evident within the findings of this study, where a gap between role expectations and role capabilities was apparent as the association between participant perceptions of language and translation is limited.

In her study on conflicts in how interpreters manage their roles in provider-patient interactions, Hsieh (2006) found that one main source of conflict in role performance was unrealistic expectation. Interpreters reported that they strive to be invisible in provider-patient interactions but are also aware that this invisible role has multiple consequences and is often not practicable (Hsieh, 2006). The findings of this study are supportive of the study conducted by Hsieh (2006). In this study it emerged that nurses are aware of the limited practical possibilities for word equivalent translation required by western biomedical models of mental health. Nurses also demonstrated an awareness of clinicians' high expectations in terms of verbatim translations and the pressure to meet these expectations regardless of the practical difficulties. As in the study conducted by Hsieh (2006), in terms of the nurses in this study, evidence of role conflict may be a result of the internal conflict nurses experience regarding what they are practically capable of and what is expected of them.

Clinicians expressed limited awareness and knowledge of the mentioned complexities highlighted by current translation theory and practice. Clinicians also expressed limited awareness of the impracticality of their expectations of the outcomes of translation processes. According to Robinson (2003), a lack of personal and professional awareness may be the site for communication breakdown and confusion during psychiatric interventions. Therefore, in the findings of this study, the clinician's lack of awareness of the complex nature and their high expectations regarding translation processes may account for additional confusion during the assessment sessions. This means that if a nurse is not capable of translating word-for-word what the patient is saying, confusion may result as patient's responses do not meet the clinicians' expectations. Therefore, if both clinicians and nurses have more shared and pragmatically/culturally sensitive views of the process of translation, this would contribute to more nuanced understandings of what is happening when misunderstandings occur. This means that when systematic or surprising complexities or difficulties within translated processes arise, clinicians and nurses who have more aligned views of translation would be able to implement more satisfactory resolutions of translation problems with the absence of the additional confusion and differing expectations of the translation process.

In this study, practical language-based inconsistencies were found to detract from the effectiveness of the flow of communication during the assessment sessions. As mentioned, current theories on language and translation emphasise plurality, where interpretation involves determining sameness-in-difference (Tugushev, 2008). This is the same when translating foreign texts as well as face-to-face

translations as meaning is re-generated and displayed through the application of an understanding of a foreign text in language (Tugushev, 2008). Therefore, specific limitations of the translation process within the realm of patient assessment need to be communicated. Specifically, the importance and variation of the lexical meanings of words and utterances across languages and cultures is highlighted (Bjorn & Gjesdal, 2009; Tugushev, 2008). This is important as, the occurrence of inaccurate translations often involves the propositional meanings of words (Ceramella, 2008). This is related to the relationship between language and mental functioning assumed in the western biomedical model of mental health mentioned above.

In the examples of practical difficulties experienced during translation processes, it was found that when questioning the patient, both in terms of the clinician's intended meaning and through the nurse's mistranslations, emotional experiences and physical experiences were confused. Swartz (1998, p. 56) states that in many different countries "there is a tendency for personal distress to be expressed as bodily pains and problems". In the example of *angry vs. aggressive*, the nurse's cultural expressions of personal distress may account for the change in the patient's response through the translation. In another light, as N2 summarises and provides her own additional information regarding the patient's response, N2 may have misinterpreted the patient's emotional response for a physical sensation or somatic expression. Consequently, this influenced the intended meaning of the patient's response which could have a confounding influence on the clinician's assessment of the patients mental functioning. For example, in N2's translation she states *'I assault people without any reason'*. In this case, the clinician may think that the patient is a danger to himself or others and that he is physically or verbally aggressive for no reason.

Literature on the process of translation emphasises that the investigation of contexts in translation practices is essential. According to Dingwaney (1995, p. 3), rather than focusing only on the equivalence of words, a "translator must attend to contexts ... from which these words arise and which they necessarily evoke and express". As translation is an inter-related process of rendering the meaning of a 'source' language into a specific 'target' language, it is not only the world and culture of the patient that is under scrutiny, but that of each member forming the triad (Dingwaney, 1995). An individual's beliefs and behaviour arise from a combination of "normative cultural values", personal experience and perceptions (Angelleli, 2004, p. 19). Accordingly, translation theory stresses the importance of studying both the 'source' and 'target' cultures of individuals involved in translation processes (Dingwaney, 1995). The inseparability of language in terms of the propositional meanings of words and cultural orientations of individuals is emphasised in both the mentioned literature and the

findings of this study. According to Morini (2008), new linguistic theory on translation must therefore be realistic as the first decisions translators make are of a pragmatic nature.

In the example of *'feelings'* represented by extract 15 below, as N2 and the patient shared the same amaXhosa cultural orientation, the translation may have in fact been culturally sound but clinically unsound.

*Extract 15 Observation 2:*

*C1: Okay stop,* **how did you feel** *when you were reciting that list of yours?*

*N2: as you were quickly reciting your shopping list, how did you feel?* **What do you feel in the body?**

*P1: I feel nothing*

In N2's experience she translated the clinician's intended meaning of the question, but then added an additional question relating to the patient's bodily sensations/somatic expressions of emotions rather than referring directly to the patient's emotions. In terms of the translations made, it emerged that the question may have been added due to cultural differences so that the patient would have a better understanding of the question. In another light, the patient's response to the question reveals the possibility of mistranslation as the patient's answer could be a response to the nurse's second question about bodily sensations and not the first relating to emotions. This particular illustration, depicted in extract 15 above, shows the intricacy of translation processes.

Furthermore, the sensitive nature of transforming located meanings from the amaXhosa cultural context into western culturally located meanings is emphasised. Within the literature, this is identified as the difference in the 'voice of medicine' and the 'voice of the lifeworld' (Boldqn, 2000; Herselman, 1996; Swartz, 1998). Whether the nurse decided to add the second question for cultural reasons to help the patient understand or for personal reasons, this affected the patient's response and ultimately the context of the interview and the clinical information obtained. For example, from the patient's response, the clinician may be tempted to record characteristics such as 'flattened affect'. If this is the case and the patient was responding to the second question, this may have potential implications for diagnosis. This means that a lack of communication in terms of the patient's lay-meaning of their symptoms and experiences and the systematic errors unique to translation processes does not facilitate the clinician's understanding of the patient's emotional experiences (thoughts and emotional feelings) for diagnosis.

According to Crawford (1994), interpreters assume an ambivalent location within the biomedical hierarchy as they are situated in the space between the doctor and patient. Therefore, within this study, concerns of role expectation and role performance and the dissociation between the two are closely

linked to the nurse's role as translator in terms of the pragmatic decisions and alliances made by the nurse during the process of translation.

Following from above, the need for explanation in the form of participant communication between nurses and clinicians is highlighted within the practical example of changes in context and issues relating to the nurses' proficiency in English. This is particularly relevant in terms of the systematic errors unique to translation regarding misunderstandings that may occur concerning diagnosis.

In the example of changes in context, the ways in which specific clinical questioning is used during patient assessment and the complication that can arise from this usage are illustrated.

_Extract 17 Observation 5_

_(C2): these demons make you talk too much? What do they make you talk about-any specific thing?_

_(N3): Do you talk things that are understandable or things that are not concrete? Maybe are these things in your brain?_

_(P5): No they are not in the brain_

In this example, complications arose as the clinician's intended questions relating to the thought and speech processes of the patient were disrupted by a change in context, through N3's translations, to physical ideas concerning the brain and its functioning. This change in context represented by extract 17 above caused disruption and confusion for the clinician as the patient's answer to the question did not correspond with the initial questioning. Therefore, the clinician was unable to elicit specific and clinically relevant information for the assessment of mental functioning.

Lastly, in the example regarding English fluency, the nurse's lack of proficiency in English influenced the translation process. In this study it emerged that clinicians' use of clinical terminology and phrases specific to the English language during the assessment interview was problematic. Nurses were incapable of translating specific words or phrases, as they themselves did not understand them. This is linked to the clinician's role in working with individuals acting as translators.

The training of clinicians in working with interpreters has received little attention in clinical literature. Miller, Martell, Pazdirek, Caruth and Lopez (2005), state that not only should clinicians be made more aware of the merits and limitations of the empiricist model of interpreting, but that clinicians need to recognise their role in working with translators and facilitating good communication. If clinicians assume that nurses are able to speak English fluently, they will not be aware of the impact that their questioning may have on the translation process as they have the expectation that nurses understand everything that is said. Furthermore, if the clinician's unrealistic expectations are not met,

this may reflect badly on the nurse's capabilities and skills, resulting in conflict or tension between nurses and clinicians.

According to (Miller et al., 2005; Raval, 2003), explaining the nature and purpose of highly specific language relevant to assessment, therapy techniques, or exercises, to translators before they are used in the session is important. Moreover, the need for clinicians to be aware of specific difficulties in working with untrained translators in terms of language and its usage is highlighted both within the literature and within this study. Therefore, in this study it emerged that besides the nurses' skills and capabilities, the clinicians' ability to work with translators, their perceptions of language and translation, and the influence this has on practice is also important to fully understand problems that arise in translation.

## 6.3. The Global Theme of Culture

Participant perceptions of who understands each other better in terms of cultural orientation within the assessment sessions were central in the conceptualisation of the global theme of Culture.

A widely held misconception in translation practices is that translators are able to understand different cultures merely because they are able to speak the language relevant to that culture (Swartz, 1998). Consequently, literature on translation theory and practice emphasises not only that translation cannot merely be the conveyance of words from one language to another, but also that during the translation process, a "translator must attend to the contexts (a world, a culture) from which these words arise and which they necessarily evoke and express" (Dingwaney, 1995, p. 3). In this study, it emerged that when nurses who are acting as translators share the same cultural\orientation with the patient, they more often than not are assumed to understand the patient better than the clinician does. This is supposedly due to their knowledge and experience of phenomena and the modes of expression of subjective experiences specific to the amaXhosa culture. This was interpreted as a potentially positive aspect in terms of nurses acting as translators. Nurses are then able to help clinicians to understand their patients better through increasing clinicians' knowledge of the patients' culture and the culturally located interpretations and articulations of their experiences. It also emerged that the nurses felt that they are able to assist not only the clinician in terms of their understanding but the patients as well.

According to Ceramella (2008), when culture-bound concepts arise during assessment, good communication and clear understanding is dependent on how knowledgeable the translator is of both cultures. Swartz (1998) asserts that the 'visible' translator can take the role of 'cultural broker' or 'client advocate', both of which involve establishing meaningful associations between socio-cultural

groups of people. Herselman (1994, p. 85) states that "through cultural brokerage, messages, instructions, as well as beliefs and behaviour can be interpreted and translated from one group to another". The importance of cultural brokerage is emphasised in terms of assessment of the patient's behaviour where "one needs to know whether a patient's beliefs are in keeping with the group he or she comes from" (Swartz, 1998, p. 36). In her study on the role of the nurse as cultural broker, Herselman (1994), states that nurses are suited for cultural brokerage as they often share the same socio-cultural orientation of patients, but also have the relevant training in biomedicine. The role of 'cultural broker' emerged as a functional one within the assessment sessions of this study, as nurses and clinicians both emphasised how important and helpful nurses are when they translate. This is attributed to the nurses' ability to assist clinicians to understand their patients, which assists the clinicians to assess mental illness.

However, this particular model of the 'cultural broker' can be problematic in that it presupposes that translators have a substantial amount of knowledge of both biomedical discourse and the amaXhosa cultural discourse involved (Herselman, 1994; Petersen, 2000). Instances relating to similarities in culture where nurses are able to assist both the clinician and the patient in their understanding during translation processes, are highlighted both within the literature and the findings of this study. Although nurses and patients may form an alliance in terms of understanding with regards to language and culture, nurses may also align themselves more with clinicians.

In referring to the findings of this study, institutional hierarchies evident within the hospital may influence nurses' decision-making in order to fulfil clinicians' expectations of the translation process. This means that nurses may transform a patient's culturally-located understandings of their illness into western culturally-located meanings in order to make the patient's experiences intelligible within biomedical discourse, rendering the patient amendable for diagnosis. At the same time however, nurses may avoid translating or explaining certain significant meanings specific to the culture shared by nurse and patient out of fear that the clinician may criticise that which is 'different' or 'other'. In this way, important symptoms related to culturally situated experiences can be overlooked, resulting in the potential exclusion and misdiagnosis of the patient.

In terms of the findings of this study, it was unclear whether or not nurses were aligning themselves more with clinicians or patients. This means that in many of the extracts from the individual interviews with nurses, it was often unclear whether the nurses' main intentions or practical reasons for the translations were to help the patients, or to align themselves to the clinicians. Statements such as the one in extract 64 emerged as non-specific and vague.

*N4: It is like we know how to do our things, like we do our things different from the other cultures, so to me **I think it can*** *
**help cause I know how we do the things so I can explain more.***

N2 and N4 state that they can be helpful to both clinicians and patients. Furthermore, in terms of being helpful to clinicians, it was interpreted that most of the nurses did so to assist the clinicians with the diagnosis of patients. Therefore, it emerged that nurses wanted to help clinicians because they ultimately wanted to help patients receive good care in terms of assessment and diagnosis.

Regarding differences within culture, it emerged that the nurses' understanding of the patient in terms of their culture is limited in some instances. Differences between nurses' and patients' cultural experiences and dialects within the isiXhosa language can be problematic. According to Westermeyer and Janca (1997, p. 292), "difference in dialect among social classes and geographic regions exists regarding subjective experience". This is highlighted both within the literature (Drennan et al., 1991), and the findings of this study. The findings of this study in relation to differences in culture illustrate that even though nurses share the same general linguistic heritage and broad cultural orientation as patients', it does not necessarily follow that they have a complete understanding of the patient's experience. According to Angelleli, (2004, p. 19), an individual's beliefs and behaviour arise from a combination of "normative cultural values", personal experience and perceptions. Ideas concerning differences in culture found in this study mirror ideas expressed in the literature, as patients experiences are informed not only by broad cultural values but by personal experience dependent upon their geographical positioning and socio-economic status. Nurses' awareness of these limitations to their understanding of the patient in this study was regarded as functional and important for the assessment of patients.

Instances where the geographical positioning of patients influences or hinders the nurses' translations may in fact be the potential site for role stress. Nurses may be unable to fulfil clinicians' expectations and the need for understanding in terms of the patient's broad cultural orientation and linguistic heritage, and thus may come under scrutiny or judgment by clinicians. Differences in culture are linked to questions regarding who translates, which concern the positive aspects of the occurrence of multiple translators in one assessment session. If a nurse who is translating does not understand the patient's cultural experience or specific dialect, they are able to ask for assistance during the translation, or to ask someone to take over translating for them. This emerged as functional in this study regarding deterring the stress that may arise due to the nurse not being able to fulfil the high role expectations mentioned above. Although positive influences emerged, the negative influences of

multiple translators must not be overlooked in terms of disruptions caused to both the assessment sessions and the professional relationship between clinician and nurse. Furthermore, in seeking a second opinion or help from a second person may reflect badly on the nurses' competencies and may be confusing for patients.

It has been noted that, because nurses often share their cultural heritage with patients and have familiarity with both cultural and biomedical discourses, this may influence unrealistic assumptions and expectations held by clinicians concerning the translators' role. This is particularly relevant in terms of the visible role of cultural broker (Swartz, 1998). In this study, there is evidence of ambivalence here, as the expectation that linguistic translation includes translation of culture, contradicts clinicians' ideas of translation along the lines of the conduit model. Although there is evidence that nurses are aware of this contradiction, clinicians' perceptions and role expectations seem distorted. This distortion may account for clinicians' confusion in terms of the nurse's visibility when assuming the role of translator. This means that although clinicians align themselves with the conduit model of translation, their role expectations are often not aligned with this view. This may be the foundation for resistance and poor communication between clinicians and nurses.

## 6.4 The Global Theme of Translator's Role

Participant perceptions of the duality of the nurses' role during the assessment sessions were central in the conceptualisation of the global theme of Translator's Role.

In all of the participants' experiences, nurses were perceived as assuming a clinical role as professional nurse and an amateur role as translator. This is represented by both the clinicians' and the nurses' perceptions of the roles nurses assume when translating. It emerged that according to the clinicians, when the nurse assumes the role of translator, this role should be an 'invisible' one. When the nurse assumes the role of clinical nurse (being present to relay clinical information about patients to clinicians) this role should be 'visible' or 'present'. As mentioned earlier, the conflict that interpreters experience in terms of their roles is not only as a result of role performance but also role expectation (Hsieh, 2006). Therefore, role expectation and role perception are essential aspects of the production of meaning within the triad. How individuals perceive and define their own roles as well as each others' is important for the quality of communication experienced in the triad (Hsieh, 2006). In my interpretation, viewing translation as a verbatim activity can account for clinicians' perception of nurses assuming an 'invisible' position in their role as translator. This may also be a reflection of both C1 and C2's limited understanding of the complexity of the process of translation.

In identifying the participants' perception of the translators' role, it emerged that although clinicians and nurses both perceive the role of translator as a dual one, these perceptions have implications for the practical execution of this dual role. Clinicians' expectations of translator invisibility are associated with the black box model where translators are required to act as non-invasive conduits, channelling messages from one language to another (Angelleli, 2004; Swartz, 1998), expecting nurses who are translating to do so verbatim. Both clinicians in this study feel that in order to have clear communication and access to their patients, individuals interpreting must translate exactly what the patient is saying. As we have seen, in most cases of translation, equivalence itself is not a practical possibility due to semantic and cultural problems specific to translation mentioned above (Robinson, 2003).

Angellelli (2004), Swartz (1998) and Westermeyer (1990), state that this particular 'black box model' of translation is not recommended as it is held by those who are inexperienced and uninformed in translation theory and practice. Consequently, this model fails to take into consideration the interpersonal, institutional and socio-political levels of translation (Angelleli, 2004). We have seen that equivalence within translation of the psychiatric interview is not a realistic possibility. Emotional experiences and cultural phenomena are not translatable word-for-word, resulting in loss of meaning. According to Westermeyer (1990, p. 748) "this model does reflect how many clinicians and translators new to this clinical task, do perceive their mutual roles". Therefore, if clinicians perceive this conduit model as the only model that can be employed and the subsequent loss of meaning and complexity specific to translation processes is ignored, both clinician and patient may receive invalid translations increasing the chances of confusion and misdiagnoses. Problems arising from the implementation of the 'black box model' are further compounded by the clinicians' expectations that nurses must remain both present and visible during their clinical duties as nurse. This means that when nurses assume the contradictory dual role/s of translator *and* nurse, the complexity of the demands on nurses' thought processes and behaviours during the assessment sessions increases.

Empirical and theoretical literature on translation in the South African context emphasises that translation occurs predominantly on an 'ad hoc' basis within the psychiatric institutional setting, where there are currently no clearly defined positions for translators (Swartz, 1998). According to de Villiers, as argued in Drennan (1999), it is often the case that black nursing staff view translating as an incidental but daily aspect of their work. In this study, the nurses' perceptions of their role as translator and the evidence of resistance to this role could be inter-linked with the contextual setting of the hospital within which translation occurs. Nurses are not employed professionally as translators and thus receive no administrative or financial benefits for translating. No administrative guidelines exist, that

is, no set schedules stipulating times, dates or venues for when they are required to translate exist and nurses are therefore burdened with extra workloads which have no structure and do not provide them with any additional benefits. These contextual factors could account for the observed and reported resistance to their role as translators within this study.

Therefore, the context within which translation occurs on a daily basis may facilitate and structure participant perceptions in terms of the unrealistic role/s nurses are expected to fulfil. This renders the entire process as 'invisible' and individuals acting as translators within an 'invisible' process are expected to assume an 'invisible' position themselves. This is problematic as translators and the process of translation itself is once again reduced to an unacknowledged practice. This means that re-structuring and re-evaluation of these practices and the positions individuals assume within these practices may again be overlooked or ignored.

According to Angelleli (2004), individuals working as translators within mental health care require a certain quantum of clinical knowledge which facilitates mutual understanding between translator and clinician and clinician and patient. Through the examination of the nurses' perceptions of their role as translators it emerged that nurses already have a certain quantum of clinical knowledge and experience due to their professional status as nurses. This means that they are then in a convenient position for being expected to translate. Theoretical models of translation in mental health care abound, but little mention is given to the complications and role conflict that arise in the South African context when the dual role/s of clinical nurse and translator are assumed by nurses.

Following from the clinicians' and nurses' perceptions concerning the dual role translators assume it emerged that because the nurses are expected to assume these parallel roles, specific problems relating to the nurses duties concerning role conflict or role overlap were identified. Nurses' perceptions of their role as translator were based predominantly on the difficulty nurses experience in assuming both a 'visible' and an 'invisible' role simultaneously. All of the nurses in this study expressed some form of resistance to their role/s as translators. Due to the limitations on time and labour within institutional settings, 'ad hoc' translators who assume multiple roles can become confused and overwhelmed (Swartz, 1998). This resistance can therefore be interpreted as stemming from the nurses unacknowledged position within the institution as they do not receive professional accreditation, financial incentive or additional time in which to fulfil the role of translator. Additionally, evidence of nurses' resistance may be interpreted as deriving from the 'invisible' role translators are expected to assume during the assessment session. It was evident that the nurses are aware of the practical limitations of this 'invisible' role. Therefore, this resistance can also be interpreted as an imposition of the nurse's presence in order to communicate something hierarchical to the clinicians. It may be

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possible that instances of mistranslation may be read as occasions when nurses acting as translators are asserting their presence in the triad by complexifying the process of assessment and drawing attention to the difficulties inherent in translation.

It is important to note that although all of the nurses interviewed experienced conflict in terms of their dual roles during the assessment sessions, two of the four nurses expressed that in some instances, the multiple roles that they assume have a more positive association. The nurses' role as translator assists their role as clinical nurse as important information for patient assessment and diagnoses is elicited when the clinician is assessing the patient and the nurse assumes a translator role.

Concerning the nurses' resistance to their role/s as translators, both clinicians expressed that they are aware that some nurses may choose not to translate or may demonstrate resistance towards the translation process. This was interpreted as stemming from the unacknowledged position of translators within the hospital and the over-burdening work loads of fulfilling a dual role. This position may be reflective of their socially and historically unequal and disempowered statuses in terms of race and class in South African society. Furthermore, C1 acknowledges that in his experience, as nurses may not agree with the fact that they are 'required' to translate, this has a negative impact on the quality of the translations produced.

In his study on language problems in hospitals in the Cape, Crawford (1994, p. 35) found that "in most cases doctors did not appreciate the difficulties and ambiguities of the interpreters position". Furthermore, Crawford (1994) found that clinicians became angry when interpreters were not available to interpret when needed. The findings of this study were interpreted as similar to the findings produced by Crawford (1994). Although evidence of resistance to translation emerged, it is unclear whether the resistance identified in this study stems from concerns about race, class and/or gender. Rather, in my interpretation, the nurses' resistance to the translation process may have been as a consequence of their amateur, unacknowledged and subordinated position in terms of fulfilling a role where no professional accreditation, financial incentive or additional time is provided.

Therefore, ideas relating to the clinicians' and nurses' perceptions of translator role resistance may be linked to the assessment and institutional contexts. These contexts influence perceptions of translation as 'ad hoc' and translators' positions as unacknowledged. Additionally, this is linked to clinicians' perceptions of translation as an 'invisible' activity which are aligned with the assessment and institutional setting within which translation occurs. Therefore, both the contextual setting of the study and clinicians' perceptions of translation emerged as facilitating the subordinate and unacknowledged positioning of nurses who act as translators. It also emerged that certain instances where nurses may disrupt the taken-for-granted 'invisible' status of this role can be interpreted as the

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nurses' imposition of their presence. So, in essence, the communicative behaviour of the clinician, patient and translator, produced within the broader contextual setting, ultimately determines the level of communication achieved. For example, if a translator's position within the broader institutional setting is assumed to be ad hoc, this view can extend to participants' views of translators' role/s within the assessment sessions with patients. This may influence the relationship between clinician and translator and, in turn, influence the level of communication achieved and of service provided to patients.

Several instances of practical difficulty emerged from the material, showing specific complexities inherent in the translation process. These instances served as practical illustrations of the ways in which the dual role/s assumed by nurses during the assessment sessions influence one another in complex and multiple ways and impact on the level of communication achieved. In some instances the nurses' role as professional nurse and amateur translator emerged as impacting negatively on one another, whilst in other instances the influence was found to be beneficial and positive. The practical illustrations also revealed evidence of role confusion during the assessment interviews which had negative consequences for the elicitation of clinically relevant information and communication within the triad. Through the interpretation of the material, each basic theme was found to be connected to either the nurse's role as clinical nurse, or as translator, or to stem from the overlap between these roles.

Instances where the use of first/third person reference was significant served as practical illustrations of the difficulties that surround the nurse's role as translator. As mentioned, no hard and fast rules exist for translators and clinicians relating to translation processes in mental health settings in the South African context (Swartz, et al., 1997). Therefore, it is important to note that the focus here is not on which model or approach is applicable to the South African context. The focus is rather on what practical situations influencing communication (before, during and after the translated assessment session) arise from translators and clinicians assuming particular and often overlapping roles. This means that, by drawing on relevant aspects from translation theory and models, we are able to analyse translated experiences by focusing on practical behaviour. In doing so, we are able to determine the ways in which this behaviour is influenced by the broader context and how it in turn influences the facilitation of communication during translation within the mental health care institution.

Therefore, specific instances where first/third person references are problematic are linked to clinicians' perceptions of the translators' role as invisible and where the application of the 'black box model' of translation is seen as desirable or functional. It emerged in this study that, if nurses do not use direct referral when translating, confusion and misunderstandings occur for the patient, clinician or both patient and clinician. This is linked to instances where participants feel excluded where the 'voice' or 'presence' of the clinician or patient is lost through the use of third-person referrals during the

translations. It is important to note that these feelings of exclusion could negatively influence disciplinary interactions between clinicians and nurses, as well as run the risk of rendering the patient 'voiceless'. This is highly influential in terms of patient assessment and diagnoses as conflict between clinicians and nurses could result in a less than ideal translation.

The practical illustrations mentioned above reveal problems that may arise from role overlap. These show the importance of clinical experience and knowledge needed by both clinicians and nurses acting as translators for the facilitation of good communication and accurate diagnoses during the assessment sessions. Both clinicians and nurses need to be aware of the clinical aspects of assessment during the translation process. For example, the practical illustration of translation of rapport from clinician to patient was important for the formulation of a doctor-patient relationship.

*Extract 37 Observation 6*

*C2: **It just bothers you**. Ok, sure. I **can imagine that must be quite difficult**. Ok your mother do you hear have your mother been talking the same amount for the last, you say it's been three months all the time. Does your mother speak the same amount or been giving you more recently or less.*

*N4: Does she speak more or less?*

*P6: She speaks a lot*

*N4: Too much*

In the example represented by extract 37, N4 did not translate the clinician's response or empathic statement made to the patient. Furthermore, N4 summarized the clinician's questions that followed. This is interpreted as a negative influence on the flow of important information between the clinician and the patient. Part of the clinicians' clinical role in mental health care is to make patients feel understood and cared for. In this example, the clinician not only used double-barrelled questioning but also did not give the nurse time to translate everything that the clinician said. Furthermore, the clinician's recognition of the patient's feelings and response to those feelings was not transferred to the patient. Consequently, the clinician failed to acknowledge the complexity of the translator's role and the nurse failed to relay information that ultimately may have served as functional in improving the quality of rapport or the relationship between the clinician and patient.

Specific difficulties relating to the importance of translators' understanding of the relevance of clinical exercises undertaken during the assessment sessions emerged from the material.

*Extract 38 Observation 1*

*C1: I want to interrupt you right there, I asked you to **count back from 20 by subtracting three each time**. Alright now subtracting three from 20 doesn't give you 19...Make sure you understand it.*

*N2: Understand clearly, its twenty that you asked to start in and **coming forward but when you do that take three***

*understand in your numbers ahead*

*P2: Subtracting three?*

*N2: I am saying look its **twenty you must go forward and when you do that you must subtract three**...Come back and*

*minus three.*

*P2: (LONG PAUSE)*

*P 2: 17*


In extract 38 above, confusion arose from the explanation of the clinical exercise through the nurse's translation from the clinician to the patient. This example is important as it demonstrates poor translation on the part of the nurse. The patient clearly understands the basic concept of the exercise but is then confused by the nurse's inability to translate the instructions effectively.

The second practical difficulty relating to the use and translation of clinical exercises raises specific concerns about the transference of meaning and the application of these exercises. Specifically, this relates to the practical limitations of nurses' abilities during the process of translation. Although, the problematic nature and potential for bias regarding the translatability and applicability of western clinical techniques, instruments, exercises and the structuring of assessment questions within the South African context is highlighted in this study, some studies still argue for their usefulness

According to Westermeyer and Janca (1997, p. 233) "when cross-language assessment is added to the task of psychiatric assessment, the additional difficulty is immediately apparent". Concerns about the application of a western-based biomedical diagnostic and treatment model, within the South African context is raised in both the literature and findings of this study. Although standardised measuring instruments and assessment methods are increasingly being used cross-culturally within psychiatry, clinicians still face difficulties in dealing with patients in terms of language and its use, specific cultural beliefs as well as the application of particular assessment methods to people of different languages or cultures (Buhrmann, 1977; Smit, van den Berg, Seedat, Bekker & Stein, 2006).

The translation of specific clinical exercises in this study illustrates how translation can negatively compound the application of specific western diagnostic techniques within the South African context and vice versa. Through the use of translation in this study it was noted that, patients were often assisted in answering or completing specific exercises which ultimately removes from the validity or intended purpose of the clinical exercise.

Instances where nurses complete clinicians' questions, or ask additional questions, or have a lengthy interaction with patients illustrate the confusion that may occur due to the overlapping of clinical and translator roles of nurses. An important point that that requires emphasis relates to the apparent lack of

structuring and clarity of the particulars concerning the nurse's clinical role and role as translator during the assessment sessions. This means that if the nurses dual roles are not clearly stipulated or profiled, nurses may become confused in terms of when to assume their clinical role and when to assume their role as translator. In these instances, nurses may assume the role of 'junior clinician' (Westermeyer, 1990) or 'junior colleague' (Swartz, 1998). In terms of these roles, the translator requires adequate training, specific skills and professional experience. Furthermore, Swartz (1998) emphasises that in this model, the professional relationship between clinician and translator needs to be a close one in that pre, current and post discussions of the patient are essential in formulating a diagnosis of a patient's condition.

This is linked to clinical knowledge and the level of experience nurses have of mental health care practices. The more experience nurses have regarding clinical knowledge and the more established their working relationships with clinicians are, the more knowledgeable they become concerning the clinical interview, the kinds of clinical information needed from patients, clinical question sequencing and how each individual clinician approaches the clinical interview. This can have both a positive and negative effect on the translated assessment process. In terms of the positive effects, nurses may be able to elicit good clinical information from the patient relating to assessment and diagnosis. On the other hand, nurses may presume that they have adequate clinical knowledge of patients and assessment and may ask the wrong questions in the wrong sequence. This may intrude on the clinician's role and nurses may miss the point of the clinical assessment interview. Moreover, such assumptions presuppose that there is a set clinical sequence for questioning and when nurses assume the abovementioned roles without support from the clinicians; this may cause tension between nurses and clinicians. At the same time, these behaviours are linked to clinicians' beliefs that nurses *should* have a certain amount of clinical knowledge in order to be effective translators. This is significant as nurses in effect become trapped between a rock and a hard place. Furthermore, this is linked to unrealistic and undefined nursing profiles both in terms of nurses' clinical role and their role as translator.

Assuming such a model during assessment can be problematic in the South African context as the limited time, staff and resources do not facilitate pre, current, and post-discussions of patients' assessment sessions. This is relevant as confusion and conflict between clinicians and nurses may arise from nurses assuming the role of junior colleague without co-operation and support from the clinicians. In relation to the participants' conflicting views of translation in this study, regarding the translators' role as visible or invisible, if clinicians view the process of translation and the role that translators assume as invisible, they may not support nurses who assume a more active, 'visible' role of junior colleague. Again, it is important to emphasise concerns about the nature of the junior colleague role in

relation to the nurse's role as clinical nurse and or translator. This is a complex issue that needs to be addressed as the majority of international literature on translator roles focuses on the use of independent translators rather than individuals who double as translators in their daily work (Elderkin-Thompson et al., 2001; Swartz, 1998; Westermeyer, 1990).

Therefore, the literature and findings of this study identifies the need for a re-structuring in terms of current models for translator roles within mental health care in the South African context. This is relevant for individuals already employed within the institutional setting who double as translators and who often assume dual roles during the assessment process (Elderkin-Thompson et al., 2001). This is in comparison to individuals who are independently employed as translators and thus only assume the role of translator.

Instances concerning the translator's role/s are linked to ideas concerning the influence and control that nurses have during the assessment sessions. In some instances translators manipulate meanings specific to a source culture into meanings specific to a more dominant target culture. In these instances, translators may have control over the facilitation of understanding through their ability to reinforce or re-instate the dominant norms of society and/or the institution. Therefore, additional tension arising from issues of control and influence in relation to role overlap and role confusion will have a profound influence on the translation process and ultimately the level of care provided.

## 6.5. The Global Theme of Clinician's Role

Participant perceptions of the role clinicians assume when working with a translator are central in the conceptualisation of the role that clinicians assume when working with a translator;

The role clinicians assume and the training they require when working with a translator has received little attention in literature concerning translation and mental health care. Miller et al. (2005), state that not only should clinicians be made more aware of the merits and limitations of the empiricist model of interpreting, but they also need to recognise their role in working with translators and facilitating good communication. In this study, regarding the clinicians' perceptions of their roles, participants did not express such an awareness or recognition of their role in working with translators. The findings of this study are supportive of the literature (Miller et al., 2005). This lack of awareness of their role in the translation triad may stem from clinicians' perpetual application of the empiricist model of translation. If translation is viewed as 'ad hoc' in nature and translators are positioned as 'invisible' by clinicians, this will negatively influence clinicians' perceptions of their involvement in and influence on the translation process.

Furthermore, it is important to note that clinicians' perceptions of their role in the translation triad seems rooted in their assumptions that their expectations, attitudes and behaviour are unproblematic and therefore do not need to be examined. This is problematic as it places all the responsibility for the translation process on the nurses and clinicians are able to hold them accountable for any difficulties with translation. This is closely related to the clinicians' unrealistic expectations of nurses and the translation process as well as their hierarchically informed perceptions of the nurses' positioning within the institution. If nurses do not meet clinician's unrealistic expectations and translation difficulties arise, responsibility is thrust down the disciplinary hierarchy and is placed on the nurse acting as translator.

Nurses in this study exhibited confusion over and reluctance to answer questions posed to them about the clinicians' role/s. Again, it is important to note that this reading of the translators' perception of the clinicians' position within the triad is my interpretation of the nurses' reluctance in answering questions on this aspect of the translation process. The nurses' 'confusion' and reluctance was interpreted as a combination of three factors. Firstly, misunderstanding and confusion was interpreted as stemming from the nurses limited proficiency in English and the implications of this for the execution of the interviews. Secondly, the nurses' response may be related to my presence as researcher and intrusion in the hospital context. In my interpretation, my presence may have been reflective of the position or presence of the clinicians. This is an important reflexive concern that is addressed in Chapter 7.

Thirdly, the 'confusion' observed was also interpreted as a result of nurses reluctance to comment or reflect openly on the clinicians' positions within the assessment sessions. According to Hsieh, (2006, p. 726) "the discrepancies between training for interpreters and the reality of medical encounters lead to interpreters awareness of their lower status in the health care system and their inability to correct the situation". This renders the translator or nurse as powerless (Swartz et al., 1997). Consequently, how the translator sees the clinician's role within the triad could be related to evidence of hierarchical dynamics. Nurses may not want to reflect on the clinician's position as they may be aware of their perceived lower status within the institutional hierarchy in relation to the clinicians more powerful position and thus may be too afraid or feel unable to comment. This is important as the way in which each individual within the triad views their own roles and the roles of others influences the translation process and outcomes.

Two practical illustrations represent how the clinicians' presence or position influences communication when a translator is present during assessment sessions. The practical example of first/third-person reference illustrates instances where both C1 and C2 try and implement the use of

first person reference in order to avoid confusion and foster better communication during the assessment. Instances where clinicians fail to use first person reference are interpreted as related to the practical applicability of both clinicians' assumptions about the translation process, the conduit model of translation and their lack of reflexivity about their own role in the triad. This means that if clinicians are not aware of their position within the translation triad, they will not use specific skills or strategies such as first person reference when working with a translator.

Furthermore, the practical difficulties of first/third person referral as a strategy used by clinicians are linked to similar strategies of first/third person referral used by nurses. In these instances, it is important for both the nurses acting as translators and the clinicians working with translators to implement this particular strategy. The notion of first/third person reference is used by clinicians and nurses acting as translators in order to avoid confusion during the assessment sessions. Although the use of first-person referral does help to avoid patient confusion and serves to prevent the exclusion of the patient, a further negative effect was the exclusion of either the clinician or the translator from the triadic interaction during the assessment session. If the clinician or the translator uses first-person referral, then either the clinicians' or the translators' presence is excluded from the triad as they are not talked about during the assessment.

The second practical example is related to the clinicians' questioning and the ways in which clinicians formulate and execute questions within the psychiatric assessment interview. This illustrates how these questions influence the translations and flow of communication during the assessment sessions. This practical example is closely linked to concerns of language, the clinician's awareness of their position within the triad as well as concerns of institutional hierarchy. It has emerged that clinicians are often not aware of the practical limitation of empiricist views of language and conduit models of translation. Furthermore, clinicians are also not aware of the impact that their presence has on the translation process and therefore responsibilities relating to translation difficulties are pinned predominately on nurses. This means that clinicians' lack of awareness influences their behaviour in terms of how questions are formulated and implemented.

Concerning the clinicians' role within the translation triad, it emerged that there is a contradiction in terms of the clinicians' perceptions of their positions and the practical illustrations. In terms of the clinicians' role perception, it emerged that clinicians do not have awareness of the influences that their position within the triad has on the translation process. The practical examples of first/third-person reference and clinicians' questioning are clear illustrations of the influence that clinicians have on the flow of communication during the translation process. According to Robinson (2003) being aware of the limitations of the conduit model of translation by viewing translation as a pragmatic activity, is

necessary for both clinician and translator. This will facilitate a process of communication that is beneficial to the patient and clinician. This position is supported by the findings of this study where the importance of clinicians' awareness of their position and its impact on translation is stressed.

The contradiction between clinicians' own role perceptions and what they do in practice is linked to notions of translator and clinician role/s within the translation triad. It emerged that there is a tension between translator and clinician roles and the perceptions that each member of the triad has of the other. This tension is interpreted as deriving from the 'ad hoc' nature of translation services within the hospital setting. This means that the 'ad hoc' nature of translation services is upheld by clinicians' perceptions of translator roles as 'invisible'. This is further influenced by the clinicians' lack of awareness relating to their own position during translation processes and the influence this position has on communication. Nurses' perceptions of their roles were informed by their unacknowledged position as translators within the hospital; their working knowledge derived from practical experiences of assuming an 'invisible' position when acting as translators; and clinicians' unrealistic expectations of translation processes and outcomes.

It has been emphasised both within the literature and the findings of this study that meaning conveyed through language is a product of reciprocity between people interacting and that translation processes are multi-layered and multi-directional in nature (Wadensjö, 1998). This means that translation involves not only representing what people intend on doing with words, but how these intentions influence a person's behaviour and the inter-personal relationship between parties who are communicating. This is what Potter and Wetherell (1987, p. 22) term "the reflexive nature of talk".

The findings of this study emerged as supportive of this notion, where the tension between translator and clinician roles and the perceptions that each individual has of the other impacts greatly on the translation process. In line with Wadensjö (1998).and Potter and Wetherell (1987), for the participants of this study, the nurses' or clinicians' perceptions or intentions in terms of translation and its outcomes are interpreted as affecting the ways in which they behave and interact with one another during assessment sessions. Consequently, if the nurses' understandings of translation are not aligned with the clinicians' understandings of translation and vice versa, certain behaviour expressed during the translations within the assessments will not be understood by either party. This ultimately creates confusion and misunderstandings which eventually has a negative effect on assessment service delivery in the hospital.

## 6.6. The Global Theme of Dimensions of Exclusion, Influence and Control

Participant perceptions concerning the amount of influence and control that each individual in the triad has or exerts were central in the conceptualisation of the global theme of Dimensions of Exclusion, Influence and Control.

Firstly, it emerged that in the clinicians' or nurses' experiences as individual members within the translation triad they may, at times, feel excluded due to concerns about language and the systematic errors unique to translation processes. This highlights issues concerning translation as a 'visible' or 'invisible' activity. Furthermore, the importance of how language is used in, and influenced by, specific contexts is functional here.

*Extract 68 Interview 1*

*(N1): I feel that they are left out because even with us, sometimes they will speak Afrikaans and we don't know Afrikaans and then you don't know what they are saying and you feel left out...*

In extract 68 for example, the psychiatrist's linguistic abilities influenced the negative feelings experienced by N1 who does not have this ability. This is linked to the dual roles that the nurses assume during assessment sessions. It is important to note here that if the clinician and the patient share the same language of Afrikaans and communication is therefore not a problem, the nurse's duality of roles (clinical nurse and translator) collapses. It is therefore interesting that N1 still experiences feelings of exclusion even when the primary role of nurse as translator falls away. This is again linked to the invisibility of the nurses' role as translator. Tensions concerning the nurses' need to be positioned more visibly may account for nurses feelings of exclusion regardless of whether communication between clinician and patient is problematic or not. As nurses have a certain amount of control and influence during translations within the assessment sessions, when this influence and control is diminished, this may account for their feelings of exclusion. Furthermore, this is reflective of the institutional hierarchy evident in this study, as nurses position within this hierarchy is emphasised when they experience feelings of exclusion and vice versa.

It also emerged that specific institutional hierarchical structures are evident amongst clinicians and between clinicians and nurses within the hospital setting. This was seen to be highly influential for participants' ideas concerning who has more influence and control during the assessment. In term of the amount of influence and control that nurses have, it emerged that in the clinicians' experiences, nurses have a certain quantum of influence and control over the assessment sessions in terms of their

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position as translators. This included patients' answers to questions, their ideas and feelings towards the clinical interview as well as their ideas and feelings towards the clinicians themselves.

Through the clinicians' talk about the amount of influence and control that they have during the assessment sessions, ideas concerning who is situated within which level of the institutional hierarchy emerged. Within this hierarchy, psychiatrists may perceive their professional status as situated at the top level. Their position is then followed by psychologists and then by the nurses who assume the last two levels of the hierarchy first as professional nurse and then as amateur translator. Furthermore, evidence of expectations held by psychiatrists and psychologists in terms of following orders or the fulfilment of certain criteria in terms of individuals positioning within the hierarchy was identified. This may be related to the positioning of individuals in terms of their respective specialisations within the institution or racial hierarchies stemming from apartheid where the black nurse would assume a less powerful position than the white clinician.

According to Hsieh (2006), evidence of institutional hierarchy further complicates the translation process in terms of role performance and role expectation. This is significant and is supported by the findings of this study. Evidence of institutional hierarchy was interpreted as informing clinicians' perceptions in terms of role expectation, the maintaining of institutional hierarchies and the nature of translation in the hospital setting. Furthermore, clinicians' ideas of nurses assuming the bottom two levels of the institutional hierarchy in the hospital are linked to the unacknowledged and 'ad hoc' nature of translation in the hospital. The interplay between the assessment and institutional context and participant perception is once again highlighted.

It is important to note that only the clinicians' (C1 and C2) spoke of concerns about the influence and control that each individual member has in terms of the translation triad within the hospital setting. This emerged as significant as it may be reflective of the nurses' awareness of their lower status in the institutional hierarchy and unacknowledged position within the institutional setting. In other words, nurses may feel that they are valued less and have less authority, influence and control than clinicians within the hospital setting and within assessment sessions as a result of their respective specialities. This may also be evidence that nurses feel afraid or powerless in terms of responding to the interview questions that reflect on the clinicians positioning within the process of translation. The importance of the way in which each individual within the triad views their own roles and the role of others influences the outcomes of the translation process is highlighted.

In terms of nurses assuming translation roles that are more 'visible' (for example, the role of cultural broker), the availability of a common language and informal regular time spent between nurses and patients does allow for the formation of a close relationship between the nurse-acting-as translator and

the patient. This in turn allows for better understanding to form between translator and patient than between clinician and patient where communication is either non-existent or minimal (Swartz, 1998). Consequently, this may detract from the therapeutic alliance between clinician and patient where the clinician is excluded, as patients may turn to nurses rather than doctors for understanding in terms of their illness or treatment (Herselman, 1994). Findings of this study relating to participant feelings of exclusion and the nurses influence and control, is supported by the literature. It emerged that in most instances, nurses have the ability to translate and thus to communicate more effectively with patients than clinicians do. Clinicians may feel that their higher positioning within the institutional hierarchy is under threat as nurses have an ability which they do not have. Therefore, an additional interpretation to that made in the literature is emphasised here. The *feelings of* exclusion of the clinician may stem from clinicians' being protective of their position within the institutional hierarchy, in contrast to a focus on the formation of a doctor-patient relationship or rapport.

## 6.7. The Global Theme of Strategies and Skills

Participant perceptions of specific strategies that need to be applied to the assessment and institutional setting of the hospital formed the foundation for the global theme of Strategies and Skills. Furthermore, participant perceptions concerning certain skills that individuals may need in practice during translation processes were central to the conceptualisation of this global theme. In terms of the supporting structures for translation services within the hospital, particular strategies that relate to the contextual setting of the hospital, which participants feel should be implemented were highlighted. Ultimately, participants feel that the hospital should employ independent professional translators and bilingual/multilingual clinicians. This is aligned to the add-on approach to translation highlighted by Swartz (1998). Furthermore, nurses feel that if they are continually approached to translate, they require training. Empirical and theoretical literature on translation in the South African context emphasises the need for the availability of resources within the mental health care sector as an essential factor for the improvement of services where "government and provincial government resources need to be made available for training, supporting, and employing mental health workers" (Stead, 2002, p. 83).

As resources within the mental health care sector are limited and often unevenly distributed, this further inhibits the adequate implementation of new policies, training, support and improvement of translation services within institutions. The expressed need for the employment of independent translators, bilingual/multilingual clinicians and the training of practitioners in translation processes that emerged in this first organising theme is supported by the literature (Stead, 2002; Swartz, 1998;

Swartz & Drennan, 2000). Limited or unevenly distributed resources within the mental health care sector ultimately fail to facilitate the employment of independent professional translators or training in translation theory and practice for those individuals who currently work with or as translators in the hospital (Drennan, 1999). It is important to note that although the integration of bilingual/multilingual clinicians who are able to speak one or more African languages within tertiary education is growing, the current lack of suitably trained mental health professionals working within institutional settings who are able to speak these languages still results in an immense need for professional translation services (Drennan & Swartz, 1999). Although the literature stated above is not current, it does still support current conclusions indicating that sufficient change has not yet happened.

Literature on the relationship between the theory and practice of translation in mental health care institutions in the South African context is negligible. Although a gap exists between the theory and practice of translation and the distinction between the two is often blurred, it is essential to stress the necessity of aligning translation theory and practice (Morini, 2008). A collaboration or circular relationship between translation theory and practice enables each to benefit the other and "be beneficial to the translation process and ultimately help the translator" (Thelen, 2005, p. 48). Thelen (2005) states that, the implementation of theory is a complex practice where "only that theory should be taught which is necessary for, and of direct relevance to, professional reflection on translations and problem solving" (Thelen, 2005, p. 48). In light of this study, training in translation processes would need to focus on add-on approaches to translation within the realm of mental health care assessments and diagnostics.

Robinson (2003) emphasises the importance of the inclusion of experience in translation training programmes. As mentioned before, for Robinson (2003), what translators learn experientially is as important for professional translation as their theoretical knowledge of the processes involved. We have seen that the very process of translation is a site for multiple effects and determinants, namely, linguistic, cultural, institutional and political. Furthermore, the context, within which a translated process occurs, has a profound direct effect on the meaning generated (Angelelli, 2004; Swartz, 1998; Venuti, 1992; Wadensjö, 1998).

Therefore, Robinson (2003) believes that the questions concerning adequate levels of experience necessary for professional translation can be misleading. As translation is highly influenced by the context within which it occurs, translators are not always able to know what a specific job will require. Therefore, the focus on experience in translation practices is not merely focused on what is sufficient, but rather on gaining as much experience as possible. According to Robinson (2003, p. 99), "the more of the world one experiences the better". The material that emerged in this study highlights that most

of the strategies and skills that emerged were suggested by the two clinicians and two of the four nurses who had the most experience working with translation processes in mental health care.

The second organising theme that emerged focuses on the skills required by nurses acting as translators and those skills required by clinicians working with nurses acting as translators. Firstly, it emerged from ideas concerning cultural heterogeneity that there is a need to focus on the difficulties that differences in the dialect of the isiXhosa language pose for translators trying to understand a patient's culturally-located experiences. This illustrates that even though individuals may share a similar cultural orientation; this does not amount to a complete understanding of each other's experiences, as differences within the isiXhosa language and amaXhosa culture exist. This emphasises the importance of an awareness of the existence of different dialects within languages and the difficulties this can pose for translation.

The necessary skills documented in the basic theme of clinical knowledge and application highlight the importance of specific clinical knowledge of mental illness and mental health practices and the application of this knowledge by nurses during translation practices. In this theme contradictions and inconsistencies emerged concerning the participants' perceptions of why and how clinical knowledge and the application of this knowledge are important for translation processes. It emerged that participant perceptions were clouded by ideas of role expectation and performance.

*Extract 83 Interview 3*

*C1: they would need fairly rigorous training in psychopathology and in the clinical process... well your problem is already half solved because if someone has clinical savvy then it will become translation and move away from interpretation. Because they will realise that **this is not a quest for facts** it's **um observing a person's mind at work** and we declare the workings of the mind largely through verbal communication. On that a person with a requisite quantum of clinical savvy would translate and not interpret.*

In terms of extracts 83 above, it emerged that C1 is self-contradictory regarding his ideas about what the process of translation entails and this ultimately creates confusion when trying to explain that clinical knowledge affords nurses the ability to translate and not interpret. Therefore, what C1 argues for is that clinicians should interpret a *person's mind at work* whilst translators should only translate and are not permitted to interpret. This view of translators' roles may be influenced by the clinicians perceived positioning within the emergent hierarchy mentioned above. Clinicians view themselves as forming the pinnacle of the hierarchy which, in turn, influences their perception of the nurses' role as 'black box' or conduit. According to the theoretical orientation of this study, translation is not a verbatim activity where nurses merely act as conduits, but is rather understood as a form of

interpretation where meaning is re-generated and displayed through the application of an understanding of a foreign text in language (Tugushev, 2008). Therefore, clinical knowledge will ultimately assist nurses in their interpretations and the application of understanding of these interpretations in the English or isiXhosa language.

Ideas concerning levels of practical experience and awareness highlight the need for working experience and the importance of developing experiential working knowledge in terms of translation processes.

Both the findings of this study and the literature highlight the need for gaining as much working experience (Robertson, 2003) and importance of developing experiential working knowledge and awareness regarding translation processes in the hospital and other mental health care settings. It is important to note this basic theme focuses only on the experience that is required by nurses working as translators as no mention is given of the experience clinicians need in working with translators and the effects this experience has in terms of translation processes. This is linked to ideas of clinicians' high expectations of nurses acting as translators and clinicians lack of awareness of the position they assume during the process of translation. This includes the influences that this position has on assessment service delivery. Furthermore, this is also linked to ideas of the clinician's perceived positioning within the institutional hierarchy and the ways in which this perception influences the clinician's thought processes during the assessment sessions.

The need for clear communication between clinicians, nurses and patients is highlighted within this study. The importance of communication emerged from concerns about instances when members of the triad do not understand one another resulting in confusion and conflict. This includes instances when nurses do not understand what patients are saying due to the effects of their illness on sense-making and speech; when nurses do not understand the clinicians' questions or statements in terms of specific phrases, particular words or the length of the questions posed; and instances where nurses and clinicians may experience conflict.

A circular relationship is evident here between participants' need for practical experience and awareness and the facilitation of communication. If communication is fostered when the mentioned instances occur, this will increase both the clinician's and the nurse's awareness of the problems that each may be facing during the assessment, resulting in more refined working knowledge of translation practices. Ultimately, clear, open and honest communication will improve translation processes resulting in improved assessment service delivery to patients.

It emerged that there is a need for the implementation of briefing and de-briefing sessions between nurses and clinicians before and after assessment sessions. The use of these briefing and de-briefing

sessions is important for discussions related to clinically relevant information that nurses need to be aware of during the assessment sessions as well as information pertaining to problems or concerns that may arise for nurses in terms of the translation process. The implementation of briefing and de-briefing sessions is linked to clear communication between clinicians and nurses. The use of briefing and de-briefing sessions here will facilitate communication between nurses and clinicians as these sessions will be time set aside to improve clinician's and nurse's practices regarding assessment, the translation process and valid diagnosis of patients.

It is important to note that the suggestions made concerning required skills that participants should have come primarily from the clinicians and that these suggestions are related mostly to the skills that nurses require. This is interpreted as being closely related to the influence that the institutional hierarchy evident within the hospital has on participant perceptions of the translation process and role performance. As the institutional setting within which translation occurs facilitates the unacknowledged 'ad hoc' nature of translation this enhances clinicians' perceptions of translators as assuming an 'invisible' position during assessment sessions and nurses awareness of their unacknowledged and invisible status within the hospital. Even though translators are perceived in this capacity, impractical expectations and pressures in terms of role performance are evident throughout this study. According to Robinson (2003) as individuals working as translators within mental health institutions often do so with little or no theory or practical experience in translation, they do not have the necessary tools to deal with what is required in practice. This means that they do so without any understanding or knowledge behind their practices. Therefore, a lack of personal and professional awareness stemming from a lack of informed practical experience may be the site for communication breakdown and confusion during the psychiatric assessment sessions.

The findings of this study are argued to be supportive of the literature as participants (predominantly clinicians) have a lack of personal and professional awareness of current translation theories and their influences on practical experiences of translation. Rather, clinicians are obstinate in terms of their perceptions of the process of translation and its expected outcomes. This is problematic in a context where clinicians form the top layers of the institutional hierarchy and where nurses are less powerful and ultimately work towards fulfilling clinician's expectations. Nurses do so whilst trying to stay true to the working knowledge they obtain from acting as translators and fulfilling translation responsibilities that they are actually not obliged to perform.

# CHAPTER 7: CONCLUSIONS

The main theoretical assumption upon which this study is based is that a gap exists between translation theory and practice and therefore, that the foundation upon which the process of translation occurs on a daily basis is participants' working experiential knowledge. The aim of this study was to theorise the phenomenon of translation in terms of the complications which arise from a process based purely on experiential working knowledge and to provide recommendations for improvement or change. Following from this, recommendations are based on participants' reflections on their experiences of translation in practice and my conceptual framework concerning improvements. These recommendations include contextual changes as well as the engagement with participant perceptions of the process of translation and the ways in which these perceptions inform their behaviour in practice.

## 7.1. Summary of Findings

In summarising the findings of this study, it is important to note that translation services carried out on a daily basis by the participants of this study were not informed by translation theory and related practice. Therefore, participant practices are based purely on experiential working knowledge, which in some instances was limited. Therefore, a lack of personal and professional awareness, stemming from a lack of theoretically informed and often limited practical experience was identified as the foundation upon which communication breakdown and confusion is based.

### 7.1.1. Context of the research

The contextual setting within which translation occurs emerged as highly influential on the process of translation. Firstly, translation services are based on the 'add-in approach' (Swartz, 1998) to translation practices where any bilingual/multilingual staff member can be approached and expected to translate. Nurses were found to be the most commonly approached individuals for translating as they are deemed to be convenient candidates. This is because they more often than not share the same language and cultural orientation with patients and they are clinically required to be present during patient assessment. As translation services emerged as 'ad hoc', nurses who double as translators do not receive remuneration or any other additional benefits for providing translation services.

Secondly, a lack of structure and emphasis on the complexity of translation processes on a daily basis within the institution facilitated perceptions of translation as unacknowledged and amateur in nature. This was found to further complicate the translation process as such perceptions of translation

influences participant behaviour during the translated assessment sessions. For, if clinicians and nurses acting as translators do not share pragmatic and culturally sensitive views of translation processes then differing expectations create additional confusion and tension. This may account for poor resolution of systematic and/or surprising problems that arise during translated assessment sessions.

### 7.1.2. Language, Meaning and Reality

Two important influential concerns emerged within the global theme of language, meaning and reality. Firstly, clinicians' perceptions of translation were found to be based on empiricist views of language and conduit models of translation. Clinicians' expectations of the translation process emerged as impractical and not aligned with current translation theory and practice. In contrast to this, nurse's perceptions of translation seemed to be based predominantly on the practical experiential working knowledge they obtain and the felt need to meet clinicians' expectations of translator role performance and the outcomes of the translation process. Therefore, the mismatch between clinicians' ideas relating to role performance of translation processes and the nurses' practical and expectation-based perceptions emerged as highly influential on communication within the triad and the level of service provision for patients.

Secondly, two specific limitations relating to translation processes during patient assessment sessions were evident. First, systematic errors unique to the process of translation, such as the translation of emotions, emerged as negatively influencing communication within the triad. Second, the implications of the cross-cultural adaptation of western psychiatric nosology within patient assessment were highlighted.

It is important to note that both of these concerns emerged as influencing one another. If participant perceptions of role performance and expected outcomes of the translation process are not aligned, the two specific limitations inherent in the use of translation in patient assessment are further compounded. This means that if participants do not communicate confusion or misunderstanding that stems from the systematic errors unique to translation and the complications that may arise from the cross-cultural adaptation of psychiatric nosology, misunderstanding, confusion and tension may result.

### 7.1.3. Culture

In the global theme of culture it emerged that not only are linguistic concerns important for the process of translation, but specific cultural discourses and individual, culturally-informed sub-systems which are intrinsically linked with language are influential in meaning generation as well. As nurses were often found to share their cultural heritage with patients and have understanding of both cultural and

biomedical discourses, this further compounded unrealistic assumptions and expectations held by clinicians concerning role performance. Evidence of ambivalence emerged here, as the expectation that linguistic translation includes translation of culture, contradicts clinicians' ideas of translation along the lines of the conduit model mentioned in point 7.1.2 above. Although there is evidence that nurses are aware of this ambivalence, clinicians' perceptions and role expectations seem distorted. Furthermore, there were implications for clinicians' assumptions regarding nurses' linguistic and cultural understanding of the patients. This was highlighted by specific differences inherent within dialects of the isiXhosa language and the heterogeneity of amaXhosa culture.

## 7.1.4. Translator's Role

Three important interrelated concerns emerged within the global theme of Translator's Role. Firstly, a sense of duality emerged relating to the visibility of the nurses' roles within translated patient assessment. Through participant perceptions, it emerged that nurses assume two particular roles: a visible role as professional nurse and an invisible role as translator. Clinicians' perceptions of these dual roles emerged as being informed by their unrealistic expectations of verbatim translation which is influenced by the institutional context in which translation occurs on an 'ad hoc' basis. Furthermore, this influenced clinicians' understanding of their position and role/s within the translation process. Where, as mentioned above, if translators and clinicians had shared (pragmatically/culturally sensitive) views of translation processes and the roles translators assume, this would contribute to more nuanced understandings of what is happening during translated interactions. This means that both clinicians and nurses will be more aware of misunderstandings when they occur and how they each both influence, and are influenced by, these misunderstandings as well as how they are both able to develop solutions to problems as they occur.

Secondly, it emerged that nurses expressed resistance to their role as translators. Four particular interpretations emerged concerning translator role resistance, namely: the practical difficulties that arise for nurses in assuming dual roles; the contextual influences that do not facilitate these dual roles; the imposition of nurses' presence and their need to communicate their presence to clinicians; and ideas relating to race, class and gender. It is important to note that a positive association emerged in relation to nurses' dual roles in terms of the elicitation of clinically relevant patient information.

Lastly, several practical limitations which result from nurses' assuming dual roles during translated patient assessment emerged, highlighting concerns about confusion resulting from role overlap.

## 7.1.5 Clinician's Role

Three important concerns emerged within the global theme of clinician's role. Firstly, clinicians expressed limited awareness and recognition of their role/s and influence on the translation process during patient assessment. This was linked to the clinicians' empiricist views of language and conduit models of translation, which are informed by the contextual setting of the hospital. Clinicians' limited awareness and recognition of their role/s were significant as nurses are placed in a position where they become solely responsible and accountable for problems in the translation process.

Secondly, an important concern that emerged is related to the nurses' resistance to answering questions that required reflection on the clinicians' position. Three particular interpretations emerged as reasons to why nurses did not respond to these questions. First, their limited proficiency in English may have influenced their understanding of the questions posed. Second, nurses' perceptions of my presence as an outsider to the hospital may have influenced their lack of response. Third, tensions relating to hierarchical dynamics between clinicians' and nurses may have influenced nurses' lack of response, as nurses may have been concerned over repercussions for their working conditions and professional relationships.

Lastly, two practical illustrations of how the clinicians' presence or role/s influences translated patient assessment emerged. The first example concerns the clinicians' use of first/third person referral and the second related to the ways in which clinicians formulate and execute psychiatric assessment questions. It is important to note that a contradiction emerged here, where clinicians' perceptions of their presence does not align with what they do in practice. Furthermore, this may account for tension between translator and clinician roles and the perception that each individual has of the others' role/s.

## 7.1.6. Dimensions of Exclusion, Influence and Control.

Three important concerns emerged within the global theme of dimensions of exclusion, influence and control. Firstly, participant expressed feelings of exclusion relating to differences in language. An interesting concern that emerged here related to the nurses' feelings of exclusion in the absence of language differences between clinicians and patients. This was interpreted as being linked to the dual roles nurses are expected to fulfil and the tensions that may arise from nurses wanting to assume a more visible position within the institutional hierarchy. This leads to the second important concern relating to evidence of institutional hierarchies. It was found that there were clear perceptions of differences in status amongst participants in terms of the level of institutional and disciplinary influence held by psychiatrists, psychologists and nurses. In examining participants' perceptions of who has more influence and control within translated patient assessment, it emerged that clinicians believe that nurses

have more influence and control in relation to their role as translator. Furthermore, the institutional context in which translation occurs on an unacknowledged and 'ad hoc' basis, together with the apparent tug-of-war between role expectations and performance are both influenced by hierarchical tensions evident within the hospital.

Lastly, it emerged that only the clinicians commented on issues of influence and control during patient assessment and institutional hierarchies within the hospital. This was interpreted as being related to the nurses' awareness of their low status within the hierarchies.

### 7.1.7. Strategies and Skills

Two important suggestions emerged within the global theme of strategies and skills. Firstly, specific contextual strategies relating to the 'add-on approach' to translation (Swartz, 1998) were suggested by participants. Specifically, this included the employment of both independent translators and bilingual/multilingual clinicians. Moreover, training was suggested as a strategy for the current 'add-in approach' to translation (Swartz, 1998). Secondly, specific skills that participants require when working within translated processes were highlighted in terms of training. This included, sensitivity towards linguistic and cultural heterogeneity, clinical knowledge and application, practical experience and awareness, communication and the use of briefing and de-briefing sessions.

In terms of the findings of this study, problems relating to translation processes based on the abovementioned strategies, skills and capabilities of participants can be looked at in terms a circular relationship of influence between the contextual setting within which translation occurs and participant perception and behaviour.

### 7.2. Recommendations

Translation, as a complex process, needs to be better acknowledged within mental health care institutional settings. This includes contextual structuring in the form of room allocation and privacy which would not only increase the acknowledgement of translation, but will allow the translation process to flow in an uninterrupted manner. Translation schedules stipulating who translates, when and where they translate and for whom they are translating should be implemented to provide a supportive context in which translation can occur.

Training in translation and collaboration within the translation triad needs to focus on the difficulties that surround linguistic and cultural sensitivity for both nurses working as translators and for clinicians working with translators. Training should also focus on providing participants with knowledge regarding the limitations of the empiricist views of language and conduit models of translation as a

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verbatim activity. In transforming participant views in terms of current theory on translation as a form of interpretation and its influence on practice, more pragmatic ideas of role expectations, role capabilities and awareness of how each individual influences the translation process will be facilitated. Moreover, training should also include relevant clinical knowledge which is applicable to mental health care hospital settings.

The importance of experience in translation processes should also be stressed during training. Moreover, in order to implement more realistic views of translation, personal experiences and problems, specific to the use of translation in assessment sessions, should be verbally expressed or shared between clinicians and between nurses, as well as between clinicians and nurses. As the availability of resources within institutional settings is strained, this could possibly be facilitated with the use of workshops or informal discussions during training and/or with the use of briefing and de-briefing sessions within daily practices. Practical problems that are experienced frequently and/or repeatedly could be included as reflective examples during such discussions. Some examples that emerged in this study that could be discussed in this manner include: instances where clinical exercises (and their cross-cultural application) are problematic; instances of linguistic and cultural heterogeneity, such as the translation of emotions; instances where the translation of rapport is omitted; and instances of lengthy or double-barrelled assessment questioning.

In sharing experiences, awareness will be increased. This is specifically relevant for those individuals who are inexperienced in translation practices. Such awareness includes cognisance of unrealistic role expectation, participant's awareness of their and others' individual positioning and influence on the translation process. Additionally, increasing individual awareness of the translation process will better equip individual participants to identify and address practical problems which may negatively influence communication.

In order to make the dual roles that individuals assume as clinical nurse and translator more visible and better acknowledged, these roles need to be defined and organized in relation to the context within which they are assumed. This is related to the clinical roles performed by both clinicians and nurses as well as the roles assumed within the process of translation. Following from this, participants also need to be aware of specific practical problems that stem from unrealistic views of translation relating to role expectations, overlap, confusion, resistance and hierarchical conflict during the assessment process. If roles assumed by both clinicians and translators are re-defined, this will allow participant perceptions to be aligned with what is practically possible during translation. This may alleviate or prevent the occurrence of the abovementioned problems associated with contradictory ideas concerning translation theory and practice. It is important for clinicians and nurses acting as translators to recognise and

engage with current developments in translation theory and practice. This will facilitate good communication for the valid assessment and diagnosis of patients. Gadamer (2006, p. 50) emphasises that it is important to remember that:

a conversation is not possible if one of the partners believes himself or herself to be in a clearly superior position in comparison with the other person, and assumes that he or she possesses a prior knowledge of the erroneous pre-judgments in which the other is tangled. But if one does this, one actually locks oneself into the circle of one's own prejudices.

Following from this and closely linked to concerns about the roles clinicians and translators assume during the assessment sessions, are ideas relating to institutional hierarchical tensions between clinicians and nurses. Therefore, it is important that individuals remain open and willing to communicate and address tensions that may already exist or arise during practice and within the institutional setting. This is particularly relevant regarding role expectation and the practical constraints on role performance. Although totally eradicating institutional hierarchies between clinicians and nurses may not be a realistic possibility, reducing role confusion and unrealistic role expectations may diminish the opportunity for tensions to arise between clinicians and nurses. This will ultimately work towards facilitating a *'fusion of participant horizons'* instantiated within constructive conversation between clinicians and nurses. Moreover, by reducing existing tensions or the formation of tensions through communication, awareness and understanding will help facilitate improved working relationships between nurses and clinicians.

So, if the communicative behaviour of the clinician, patient and nurse (translator) is enhanced and the acknowledgement of translation processes within the broader contextual setting is likewise improved, this will ultimately better the level of communication achieved and the level of service provision for patient assessment.

## 7.3. Reflexivity

My initial intentions for wanting to study translation practices were informed by concerns I had regarding what actually happens in clinical practice within the South African context which is dynamic, multi-lingual and multi-cultural. By placing myself in the position of a clinician within this context, questions arose concerning what sort of clinical practices are associated with good assessment, diagnoses and treatment of patients who are suffering and who, in most cases, do not understand why. Who is there to assist these patients and help them understand their experiences if not mental health

care clinicians? Literature on translation within the South African context is highly critical of clinicians working with patients who are linguistically and culturally different, as well as of nurses who are attempting to assist clinicians in communicating with their patients. Moreover, translation practices are portrayed as inadequate, ineffective and unhelpful, whilst strategies for improving these practices fall predominantly on a bureaucracy that clearly does not wish to prioritise translation practices within institutional settings. This slow transformation of translation practices within mental health care is despite more than 15 years of democracy, majority rule and governance.

As a white, middle class student who has future intentions to practice as a clinical psychologist in South Africa, I was greatly concerned about how I would be able to do so without being able to communicate with a number of my patients and with limited help from individuals who receive no benefits for doing so. Consequently, the aims of this study were informed by my need, as an individual wanting to practice psychology, to examine translation processes and to address the concerns that emerged. This means that the lens with which I analysed the study material was informed both personally and theoretically by the desire to identify where the problems lie concerning translation practices and why these current practices do not seem to be beneficial within the South African context? Although the findings of this study were supportive of the literature, the picture that emerged concerning translation processes was not as gloomy as I had previously expected or perceived it to be. Whilst the majority of the systematic problems related to translation practices identified in the literature were supported by the findings of this study, it also emerged that there are many positive and helpful aspects regarding translation practices within this particular setting. This challenged my pre-conceived ideas regarding translation and its purpose within the clinical realm of mental health care and opened avenues where participants as individuals working together could assist in the process of determining recommendations that may change these practices for the better.

In qualitative research it is important to highlight and acknowledge the inter-personal and intra-personal dynamics that emerged through interactions between researcher and participants. As a researcher engaging with people on, what is for them a real-life issue, in the context in which it occurs, one of the expectations I had of my participants (besides the devotion of their limited time and effort to participation) was sincerity, co-operation and for them to use the interview space to reflect on their experiences of translation practices. This was at times easier said than done. As expected, both clinicians and nurses were very busy and could only spare limited time for the individual interviews. Secondly, one particular nurse was resistant to the notion of the individual interview and stated that she was 'nervous' about the interview. In this instance I felt that the nurse was afraid to be involved in the study as she may have had preconceived perceptions and concerns over the purposes of my research

(i.e. my intentions were to assess and critique her job performance). Some nurses were also reluctant in their responses to particular questions, predominantly those relating to the clinicians' positions within the assessment sessions and translation processes. This was interpreted as relating to both their limited fluency in English and their possible views regarding my presence as researcher, which could have reproduced relational dynamics associated with their working relationships with clinicians. This was particularly important during the analysis and interpretation of material, as nurses resistance to my position as researcher could have been read as resistance to the translation process, or as a result of tensions between nurses' and clinicians'.

My experiences of the individual interviews with the nurses were different to that with the clinicians. Some of the nurses expected me to merely listen to their stories and give them a voice; others stated that they wanted more. Specifically, they wanted me to help them by physically intervening and providing training and/or recommendations for practice. Furthermore, I felt that some of the nurses were more concerned with financial remuneration and the need to be more recognised for what they do in terms of translation within the institution. I felt that the clinicians on the other hand did not expect much from me and were more concerned with giving me relevant information for my study by critically examining and reflecting on translation processes and the ways in which nurses practice as translators. This may have influenced my interpretation, as I may have been more critical and sceptical of clinicians' responses during the interviews compared to nurses' responses. The establishment of rapport with participants was more prominent with the nurses than with the clinicians. I was aware that nurses may have wished to establish more of a rapport with me as the researcher in order for me to fulfil their expectations regarding potential changes to their working conditions. Consequently, the possibility for bias or skewed findings obtained from nurses is identified here.

In terms of the interviews and recommendations made, I wanted both nurses and clinicians to be heard equally. Regarding participant expectations, I am obligated to give my participants a voice and provide written recommendations for practice as stipulated within the aims of this study. Ethically, I was not able to directly intervene within the hospital setting as some of the nurses expected and I was not able to assist nurses financially, or to provide them with training in translation practice myself. However, with respect to my intended future career in clinical psychology, the findings of this study will contribute towards my professional practice in clinical assessment of patients in a multilingual and multi-cultural context in an ethically informed manner. Furthermore, the possibilities for future research into this aspect of mental health service provision in South Africa mentioned below may also provide avenues through which the difficulties with the current state of translation practices in mental health care can be addressed.

Finally, I do feel that the nurses and clinicians who participated in this study did receive recognition for their willingness to participate and the time and effort they devoted to doing so. What is more, all the participants demonstrated a real sense of dedication to the welfare of the patients and a commitment to improving the level of mental health care they provide. I sincerely hope that participants will be satisfied with the outcomes of this study and that the recommendations made will not only help them in their daily execution of duties, but that they will also raise particular questions concerning the need for language and communication to be prioritised within mental health institutions for the betterment of service provision regarding patient assessment in mental health care.

## 7.4. Legitimisation of the Study

Following from considerations of the role of the researcher in this study, important strengths of this qualitative study are evident. Firstly, my position as researcher and the influence this had on the findings of the study was constantly acknowledged and reflected upon. This is epistemologically relevant in qualitative research and is known as the 'double hermeneutic' (Rennie, 1999). My pre-conceived ideas concerning assumptions of participant responses to questions were challenged by the positive associations that participants described relating to specific instances of translation in their daily work. So, although my initial assumptions concerning the institutional and assessment setting within which translation occurs were confirmed by the findings of this study, evidence of clinicians and nurses showing true commitment and dedication to improving translation for the benefit of patients helped re-structure my ideas concerning the process of translation. This demonstrates a *'fusion of horizons'*, where my prejudices as researcher were abandoned. Thus, reflexivity is important for the legitimisation of this study as it provided a clear representation of the interpretations upon which the findings of this study are based.

Secondly, clear and concise descriptions of the social contexts and the active acknowledgment of how these influence participant behaviour as well as the findings of this study were provided. This included background information about the overall structures, settings and frameworks within which participants were situated. An examination of how the findings of this study in turn contributed to sense-making within the larger context of translation practices was provided. This is represented by the recommendations, where a conceptual framework of the relationship between text and context was acted upon. This highlights the pragmatic rationale for this particular study and is supportive of the critical approach and methods used, as the aims of this study were appropriately addressed.

The variety of the sample used in this study is based on a range of individuals who had different levels of experience in the translation process. This is important, as material collected for analysis

represents a relatively wide scope of experience regarding translation practices. This further informs the findings of the study as it highlights the significance of, and need for, practical working experience and knowledge in terms of translation processes for better communication and mental health service provision. Consequently, although the findings of this study can only be moderately generalized in terms of their applicability to the experiences of individuals in comparable situations, the participant sample size, although small in scale, was seen as adequate for the attainment of material to answer the aims of the study. Furthermore, the small sample size, in accordance with the use of triangulation (the use of two sources of material: observations and interviews), enhanced the legitimisation of this study by allowing for the cross-checking of material during the analysis, where the conclusions of observations and interviews were supportive of one another. This illustrates the consistency and coherence of the findings of this study.

Thus, the findings of this study were deemed to be of a sufficiently rich and detailed nature and were regarded as representative of participants' experiences of translation in the hospital setting. It is important to note here, that evidence of potential biases inherent in the process of qualitative research is acknowledged, both in terms of the researcher's position (discussed in section 7.3 above), and the position of the independent translators of this study (Chapter 4, above).

It is important to note that this study provided a platform for reflection, where participants were able to explore their thoughts, feelings and experiences of the process of translation. Most of the participants of this study expressed gratitude for the researcher taking an interest in what they do and for allowing them to participate and talk about their experiences. This highlighted the unacknowledged nature of the work participants' do on a daily basis regarding translation practices within the hospital setting and provided the space for those involved in translation to become visible.

No serious harm was anticipated for individuals participating in this study, but specific acknowledgement of the potentially fragile mental functioning of patients was acknowledged throughout the study. This included awareness of how patients' ability to provide informed consent and be clear and honest during the research may be compromised by their mental functioning. Through established professional relations with the principal psychiatrists at the hospital, it was determined that the patients participating in the research were experiencing high levels of functioning at the time of interview and observation material collection, allowing for patient informed consent.

Through discussion with the principal psychiatrists, and due to the time and financial constraints on this study, the decision was made to not individually interview patients, but rather to observe them during the assessment sessions. Consequently, one of the main limitations of this study is that the experiences of the patients' who participated in the research were not looked at. This means that the lay

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knowledge of the mental health care institutional service users was excluded from this study. A second limitation of this study relates to a lack of the implementation of follow-up interviews with participants. This precluded the opportunity for further in-depth exploration of participants' experiences and perceptions of the translation process, as well as placed limits on the extent of the rapport that could be established with them. Moreover, a lack of follow-up interview sessions also removed the possibility for checking my interpretations of material with participants. Both of these aforementioned limitations were due to a lack of overall resources available for the study and the limited nature of the study.

An important concern within this study relates to my experience as researcher in working with independent translators for the isiXhosa transcriptions of the recorded assessment sessions. Difficulties arose as a level of trust was needed regarding the meanings generated within these particular findings. Furthermore, due to the time and financial limitations of this study, use was made of cross-checking rather than back-translation. This raises some minor questions concerning the verifiability of the initial translated transcriptions of the observed clinical assessment sessions. Nevertheless, it is important to note that no major discrepancies were found to exist between the two independently translated versions of the observations.

In the reflexive section above, resistance from nursing participants before the individual interviews was highlighted. In order to adequately address this resistance, participants were once again informed of their rights to withdraw from the research process and the intentions and aims of the research were once again clarified and assured. I was aware that participants may feel that their employment status may be at risk as certain questions did require a reflection on other clinicians and nurses working with the participants at the hospital. The high levels of confidentiality and anonymity maintained within this study ensured that the participants' work competency would not come under investigation. I remained sensitive and open to participants' feelings, and constantly reiterated the original intentions stipulated in the signed consent forms.

## 7.5. Suggestions for Future Research
Future studies relating to translation practices within the South African context could implement the use of more theoretically aligned sampling techniques where sampling should be based on the need for the development of a model for training in translation processes within the context of mental health practices. This includes both pre- and post- interventions and comparisons. Moreover, the development and evaluation of models for training in translation would also be beneficial. A replication of this study with the use of larger participant samples, or in different mental health care contexts, would be beneficial as it would provide more extensive material and findings for analysis. These findings could

then be compared either between mental health care hospitals or between institutional and/or private settings.

# References

Adler, P A., & Adler, P. (1998). Observational Techniques. In N. Denzin & V.S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials* (pp. 79-109). London: Sage.

Angelelli, C. V. (2004). *Medical interpreting and cross-cultural communication.* New York: Cambridge University Press,.

Angrosino, M.V., & Mays de Perez, K.A. (2000). Rethinking observation: From method to context. In N. Denzin & Y.S. Lincoln (Eds.), *The handbook of qualitative research.* (pp. 673-702). London: Sage.

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research, 1,* 385-405.

Banister, P. (1994). Observation. In P. Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), *Qualitiative methods in psychology: a research guide.* (pp. 17-33). Maidenhead, England: Open University Press.

Bantjes, M. (1999). *Translation in clinical practice: a hermeneutic enquiry.* Unpublished Honours Thesis, Rhodes University, Department of Psychology, Grahamstown.

Bantjes, M. (2006). *The construction of meaning by clinicians and translators in translated psychological interventions.* Unpublished Master's Thesis, University of the Witwatersrand, Johannesburg.

Baylav, A. (2003). Issues of language provision in health care services, In R. Tribe & T. Raval (Eds.), *Working with interpreters in mental health* (pp. 69-76). Hove and New York: Brunner-Routledge.

Bergman, M., & Coxon, A. (2005). The quality in qualitative methods. *Forum: Qualitative Social Research, 6(2),* 1-16.

Bjorn, R & Gjesdal, K. (2009). Hermeneutics. In E.N. Zalta (Ed.), The Stanford Encyclopaedia of Philosophy. Stanford: The Metaphysics Research Lab. Retrieved 20 August 2010, from:

Bolden, G. B. (2000). Toward understanding practices of medical interpreting: interpreters' involvement in history taking. *Discourse studies, 2,* 387-418.

Bradley, E.H., Curry, L.A., Devers, K.J. (2007). Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Research and Educational Trust, 42(4),* 1758-1770.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.

Buhrmann, M.V. (1977). Western Psychiatry and the Xhosa patient. *South African Medical Journal,* *51,* 464-466.

Burke, A. (2006). Mental health care during apartheid in South Africa: an illustration of how "science" can be abused. In J. T. Parry (Ed.), *Evil, law and the state: Perspectives on state power and violence* (pp. 87-101). Amsterdam and New York: Rodopi B. V.

Ceci, C., Limacher, L.H., & McLeod, D. (2002). Language and power: Ascribing legitimacy to interpretive research. *Qualitative Health Research, 12,* 713-720.

Ceramella, N. (2008). Linking theory with practice: the way to quality translation, In A. Ikcevic-Batricevic & M. Knezevic (Eds.), *Culture-Bound translation and language in the global era* (pp. 3-32). Cambridge: Cambridge Scholars Publishing.

Cheetham, R.W.S., & Griffiths, J.A. (1981). Errors in the diagnosis of schizophrenia in Black and Indian patients. *South African Medical Journal, 59,* 71-75.

Crawford, A. (1994). Black patients/white doctors: stories lost in translation. Cape Town, South Africa: National Language Project.

Dickerson, S. S. (2002). Redefining life while forestalling death: Living with an implantable cardioverter defibrillator after sudden cardiac death experience. *Qualitative Health Research, 12,* 360-364.

Dingwaney, A. (1995). Introduction: translating "Third World" cultures. In A. Dingwaney & C. Maier (Eds.), *Between languages and cultures: translation and cross-cultural texts.* Pittsburgh: University of Pittsburgh press.

Dlomo, T. (2009). *An investigation into cultural barriers in intercultural communication between blacks and Indians at Durban institute of technology.* Unpublished Master's Thesis, University of Kwa-Zulu Natal, Durban.

Drennan, G. (1999). Psychiatry, post-apartheid integration and the neglected role of language in South African institutional contexts. *Transcultural Psychiatry, 36,* 5-22.

Drennan, G., Levett, A., & Swartz, L. (1991). Hidden dimensions of power and resistance in the translation process: a South African study. *Culture, Medicine and Psychiatry, 15,* 361-381.

Drennan, G., & Swartz, L. (1999). A concept over-burdened: Institutional roles for psychiatric interpreters in post-apartheid South Africa. *Interpreting: International Journal of Research and Practice in Interpreting, 4,* 169-198.

Drennan, G., & Swartz, L. (2002). The paradoxical use of interpreting in psychiatry. *Social Science and Medicine, 54,* 1853-1866.

Eco, U. (2001). *Experiences in translation.* Toronto: University of Toronto Press.

Elderkin-Thompson, V., Silver, R. C., & Waitzkin, H. (2001). When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Social Science and Medicine, 52,* 1343-1358.

Erasmus, M. (2003). Community-based interpreting in South African health services. *Acta Academia Supplementum, 2,* 168-189.

Foster, D., & Swartz, S. (1997). Introduction: policy considerations. In D. Foster., M. Freeman & Y. Pillay. (Eds.). *Mental health policy issues for South Africa* (pp. 1-22). Cape Town: Eson-Clyde Press.

Foster, K E. (2005). Clinics, communities, and cost recovery: Primary Health Care and Neoliberalism in Post-apartheid South Africa. *Cultural Dynamics, 17,* 239-266.

Gadamer, H, (2006a). Language and Understanding. *Theory, Culture and Society, 23(1),* 13-27.

Gadamer, H. (2006b). Classical and Philosophical Hermeneutics. *Theory, Culture and Society, 23*(1), 29-56.

Gile, D. (1995). *Basic concepts and models for interpreter and translator training.* Philadelphia: John Benjamins Publishing Company.

Golofshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597-607.

Haider, K. (2008). *Hermeneutics and Dialects: (Hegel, Husserl, Heidegger and) Hans-George Gadamer.* Unpublished Essay, Graduate School of International Studies, University of Denver, Denver.

Herselman, S. (1994). Towards more effective patient care: the role of the nurse as cultural broker. *South African Journal of Ethnology, 17,* 83-93.

Herselman, S. (1996). Some problems in health communication in multi-cultural clinical setting: a South African experience. *Health Communication, 8,* 153-170.

Holloway, I. & Todres, L. (2003). The status of method: flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345-357.

Horsburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing, 12,* 307-312.

Hsieh, E. (2006). Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science and Medicine, 62,* 721-730.

Iser, W. (2000). *The Range of Interpretation.* New York: Columbia University Press.

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 Research and Educational Trust, 42*(2), 727-754.

Kaufert, J. M. & Koolage, W.W. (1984). Role conflict among 'culture brokers': The experience of native Canadian medical interpreters. *Social Science and Medicine, 18*(3), 283-286.

Kelliher, F. (2005). Interpretivism and the pursuit of research legitimization: an integrated approach to single case design. *The Electronic Journal of Business Research Methodology 3*(2), 123-132.

Kinsella, E. A. (2006). Hermeneutics and Critical Hermeneutics: exploring possibilities within the art of interpretation. *Qualitative Social Research Journal 7*(3), 1-18.

Krauss, S. (2005). Research paradigms and meaning making: a primer. *The Qualitative Report, 10*(4), 758-770.

Kussmaul, P. (1995). *Training and translator.* Philadelphia: John Benjamins Publishing Company.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, California: Sage.

Leff, J. P., & Isaacs, A.D. (1990). *Psychiatric examination in clinical practice.* London: Blackwell Scientific Publications.

Levin, M. E. (2006). Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *South African Medical Journal, 96,* 1076-1079.

Louw, J. (2002). Psychology, history and society. *South African Journal of Psychology 32(1),* 1-8.

Malpas, J. (2003). *Hans-Georg Gadamer.* In E. Zalta (Ed.), The Stanford Encyclopedia of Philosophy. Retrieved 27 August 2010 from:

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice 13*(6), 522-525.

Mason, J. (2006). Mixing methods in a qualitatively driven way. *Qualitative Research 6*(9), 9-25.

May, T. (1993). *Social Research: Issues, methods and processes.* (pp. 111-132). Buckingham: Open University Press.

Maykut, P., & Morehouse, R. (1994). *Beginning qualitative research: a philosophical and practical guide.* London: Falmer Press.

McAfee, C. (2004). The linguistic relativity theory and Benjamin Lee Whorf. *The McMaster Journal of Communication, 1*(1), 1-9.

Meijer, P., Verloop, N., & Beijaard, D. (2002). Multi-method Triangulation in a qualititative study on teacher's practical knowledge: An attempt to increase internal validity. *Quality and Quantity, 36,* 145-167.

Merrick, E. (1999). An exploration of quality in qualitative research. In M. Kopala., & L. Suzuki. (Eds.), *Using Qualitative Methods in Psychology.* (pp. 25-36). London: *Sage Publications.*

Miller, K.E., Martell, Z.L., Caruth, M., & Lopez, D. (2005). The role of interpreters in Psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75*(1), 27-39.

Morini, M. (2008). *Outlining a new linguistic theory of translation.* Italy: John Benjamins Publishing Company.

Morse, J., Barrett, M., Mayan, M., Olsen, K., Spiers, J. (2002). Verification Strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1-19.

Painter, D., Terre Blanche, M., & Henderson, J. (2006). Critical psychology in South Africa: histories, themes, and prospects. *Annual Review of Critical Psychology, 5,* 1-24.

PanSALB. (2010). The Pan South African Board. Retrieved 15 October 2010 from

Peeters, J. (2005). *On the relationship between translation theory and translation practice.* Germany: Peter Long.

Petersen, I. (2000). Comprehensive integrated primary mental health care for South Africa. Pipedream or possibility? *Social Science & Medicine, 51,* 321-334.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: beyond attitudes and behaviour.* London: Sage Publications.

Prasad, A. (2002). The contest over meaning: hermeneutics as interpretive methodology for understanding texts. *Organizational Research Methods, 5,* 12-33.

Radford, G, P. (2002). *Hermeneutics: An intellectual tradition for communication studies.* Retrieved 3 June 2008 from

Raval, H. (2003). An overview of the issues in working with interpreters. In R. Tribe & T. Raval (Eds.), *Working with interpreters* (pp. 8-29). Hove and New York: Brunner-Routledge.

Richardson, B. (1998). Deitic features and the translator. In L. Hickey (Ed.). *The pragmatics of translation.* (pp. 124-142). Great Britain: Cromwell Press Ltd.

Richter, L. M., Griesel, R. D., Durrheim, K., Wilson, M., Surendorff, N., & Asafo-Agyei, L. (1998). Employment opportunities for psychology graduates in South Africa: A contemporary analysis. *South African Journal of Psychology, 28,* 1-7.

Rennie, D. (1999). Qualitative research: a matter of hermeneutics and sociology of knowledge. In M. Kopala & L. Suzuki (Eds.), *Using Qualitative Methods in Psychology.* (pp. 3-13). London: Sage Publications.

Rennie, D. (2007). Hermeneutics and humanistic psychology. *The Humanistic Psychologist, 1,* 1-25.

Robinson, D. (2003). *Becoming a translator: an introduction to the theory and practice of translation.* London: Routledge.

Roth, L., & Swartz, L. (1992). The integration of two psychotherapeutic units: staff experiences of the first six months. *South African Journal of Occupational Therapy, 22*, 6-11.

Sammel, A. (2003). An invitation to dialogue: Gadamer, hermeneutic phenomenology, and critical environmental education. *Canadian Journal of Environmental Education, 8*, 155-167.

Scheillerup, P. (2008). Stop making sense: the trials and tribulations of qualitative data analysis. *Area, 40*(2), 163-171.

Seidman, I. (1998). *Interviewing as qualitative research: a guide for researchers in education and the social sciences (2nd ed.)*. New York: Teacher's College Press.

Smit, J., van den Berg, C.E., Bekker, L.G., Seedat, S., & Stein, D.J. (2006). Translation and cross-cultural adaptation of a mental health battery in an African setting. *African Health Sciences, 6*, 215-222.

Smith, J.A. (2003). *Qualitative Psychology: a practical guide to research methods*. London: Sage Publications.

Stead, G. (2002). The transformation of psychology in a post-apartheid South Africa: an overview. *International Journal of Group Tensions, 31*(1), 79-102.

Steele, G.I. & Edwards, D.J.A. (2008). Development and validation of the Xhosa translations of the Beck Inventories: 1. Challenges of the translation process. *Journal of Psychology in Africa, 18*(2), 207-216.

Swartz, L. (1996). Culture and mental health in the rainbow nation: Transcultural psychiatry in a changing South Africa. *Transcultural Psychiatric Research Review, 33*, 119-133.

Swartz, L. (1998). *Culture and mental health*. London: Oxford University Press.

Swartz, L., Gibson, K., & Swartz, S. (1990). State violence in South African and the development of a progressive psychology. In C. Manganyi & A. du Toit (Eds.), *Political Violence and the struggle in South Africa* (pp. 234-261). London: MacMillan Academic and Professional Ltd.

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.

Swartz, L., & MacGregor, H. (2002). Integrating services, marginalizing patients: Psychiatric patients and primary health care in South Africa. *Transcultural Psychiatry, 39*, 155-172.

Swartz, L., Drennan, G., & Crawford, A. (1997). Changing language policy in mental health services-a matter of interpretation? In D. Foster., M. Freeman & Y. Pillay. (Eds.), *Mental health policy issues for South Africa* (pp. 166-180). Cape Town: Eson-Clyde Press.

Taylor, S.J., & Bogdan, R. (1998). *Introduction to qualitative research methods: a guidebook and resource*. New York: John Wiley & Sons Inc.

Temple, B & Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research, 4,* 161-178.

Terre Blanche, M., & Durrheim, K. (2006). Histories of the present: social science research in context. In M. Terre Blanche; K. Durrheim & D. Painter (2$^{nd}$ ed.). *Research in practice: Applied methods for the social sciences.* (pp. 2-17). Cape Town: University of Cape Town Press.

Thelen, M. (2005). Theory and practice in translation: co-operation or mere co-existence, In J. Peeters (Ed.), *On the relationship between translation theory and translation practice* (pp. 41-49). Germany: Peter Lang.

Tugushev, N. (2008). *Conditions in Translation.* Unpublished Master's Thesis, Graduate School of Stony Brook University, New York.

Turnbull, N. (2004). Making 'It' happen: Philosophy, hermeneutics and the truth of art. *Theory, Culture, Society, 21,* 171-178.

Venuti, L. (1992). *Rethinking translation: Discourse, subjectivity, ideology.* London: Routlege.

Wadensjö, C. (1998). *Interpreting as interaction.* New York: Addison Wesley Longman Ltd.

Weber, A. (2004). Editor's comments: The rhetoric of positivism versus interpretivism: A personal view. *Management information systems quarterly, 28*(1), 276-7783.

Westermeyer, J. (1990). Working with an interpreter in psychiatric assessment and treatment. *The Journal of Nervous and Mental Disease, 178*(12), 745-749.

Westereyer, J., & Janca, A. (1997). Language, culture and psychopathology: conceptual and methodological issues. *Transcultural Psychiatry, 34*(3), 291-311.

Zuidervaart, L. (2010). Introduction: critical hermeneutics, In L. Zuidervaart (Ed.), *Artistic truth-aesthetics, discourse and imaginative disclosure* (pp. 1-10). Toronto: Cambridge University Press.

# Appendices

## Appendix 1: PARTICIPANT CONSENT FORM

<div style="border:1px solid">

### MASTERS THESIS:
### RESEARCH PARTICIPANT CONSENT FORM

### Three's a crowd: the process of triadic translation in a South African psychiatric Institution.

</div>

I _____ hereby agree to take part in the research for a thesis in fulfillment of the requirements of the degree of Master of Social Science in Psychology, conducted by Meggan Slabbert.

This Thesis aims to identify and provide a clearer understanding of the social, political and psychological factors, as they occur in context, which inhibit and enhance effective communication during the interpretation/translation process in an institutional setting. The researcher will use the information obtained from the participants in conjunction with the existing theory to attain the above stipulated aim. Furthermore, intentions are to raise questions about institutional policies and the allocation of resources' for language and communication in South African mental health care services.

*I understand that:*

1. The researcher has discussed the research and consent form with me and, I understand and am aware of the above information concerning the nature of the Thesis.

2. My participation involves having one or more interviews audio-recorded and observed by the researcher. Furthermore, my participation will also involve responding to one or more interviews conducted by the researcher which will be audio-recorded.

3. The audio-recordings will be transcribed by one or more nominated third parties.

4. The researcher will use the information gathered throughout the research to compile a full thesis.

5. All personal information will remain anonymous and confidentiality will be of importance for all parties who have access to research material. All identifying information will be removed or changed with the use of pseudonyms in the Thesis.

6. Material obtained from the history taking interviews, the individual interviews as well as the tape-recordings will be destroyed once the final Thesis has been written.

7. This research is being supervised by Werner Böhmke a senior lecturer in the Psychology department at Rhodes University. This research has been cleared with the ethical committee at Rhodes University. This research requires the employment of an independent translator. Both the above-mentioned individuals will have access to the material obtained.

8. Both parties who will have access to the material obtained will be required to declare in writing that they will maintain anonymity as well as confidentiality.

9. I have the right to withdraw from the process if I believe it is no longer in my interests, but I undertake that I have committed myself to participating in the research at some level and to do this only under extreme circumstances and after discussing it fully with the researcher as I understand that my withdrawal will disrupt the researchers progress in an important component of the research process.

10. I have the right to voice any concerns about my participation in the research and the use of the material obtained at a later date and have these concerns addressed to my satisfaction.

11. I will have the final Thesis made available to me should I wish to read it once the research is complete.

<u>**NAME OF PARTICIPANT**</u>

<u>**SIGNED BY PARTICIPANT**</u>
<u>**Date:**</u>

<u>**RESEARCHER: M. SLABBERT**</u>

<u>**SIGNED BY RESEARCHER**</u>
<u>**Date:**</u>

<u>**SUPERVISOR: W. BÖHMKE**</u>

<u>**SIGNED BY SUPERVISOR**</u>
<u>**Date:**</u>

## Appendix 2: INDEPENDENT TRANSLATOR CONTRACT

<div style="border:1px solid">

### MASTERS THESIS
### INDEPENDENT TRANSLATOR CONTRACT

**Three's a crowd: the process of Translation in a South African psychiatric Institution.**

</div>

This document is a memorandum pertaining to an agreement between:

Researcher: _____     *and*

Third party translator: _____

*I understand that:*

1. Translator, as an independent contractor, will provide the following service(s):

    1.1 Translation of consent form for participants provided by researcher

    1.2 Translation of observation audio-recordings of approximately 10-15 minutes per recording

2. Translator shall make every effort to complete service(s) by the date indicated below, but shall not be responsible for delays in completion caused by events beyond Translator's control.

Date: _____

Method of delivery: _____

Format of delivery: _____

3. Fee for services. Researcher agrees to pay R_____ as Translator's fee for the above service(s). Payment is due as follows: CASH

4. The due dates for payment of fees and costs under this Agreement shall be the date(s) specified above in this Agreement.

5. Cancellation or withdrawal by Researcher. If Researcher cancels or withdraws any portion of the item(s) described in paragraph 1 above prior to Translator's completion of the service(s), then, in consideration of Translator's scheduling and/or performing said service(s) Researcher shall pay Translator the portion of the above fee represented by the percentage of total service(s) performed, but in any event not less than ___% of said fee.

6. Researcher's review of translation. Upon receipt of the translation from Translator, Researcher shall promptly review it, and within 30 working days after receipt shall notify Translator of any requested corrections or changes. Translator shall correct, at no cost to Researcher, any errors made by Translator.

7. Confidentiality. Due to the ethical nature of this research, all knowledge and information which Translator acquires during the term of this Agreement regarding all and any obtained material, shall be maintained in confidentiality and anonymity by Translator and, shall not be divulged or published by Translator and shall not be authorized by Translator to be divulged or published by others. Confidential information for purposes of this paragraph shall not include the following:

       a. Information which is or becomes available to the general public provided the disclosure of such information did not result from a breach by Translator of this paragraph.

       b. Terminological glossary entries compiled by Translator in the course of Translator's performance of the translation service(s) under this Agreement; provided, however, that Researcher and Translator may agree in writing that, upon payment by Researcher to Translator of an agreed-upon fee, such terminological glossary entries shall be the property of Researcher and shall be covered by the confidentiality provisions of this paragraph.

9. Indemnification and hold-harmless by Researcher. Researcher agrees to indemnify and hold Translator harmless from any and all losses, claims, damages, expenses or liabilities (including reasonable attorneys' fees) which Translator may incur based on information, representations, reports, data or product specifications furnished, prepared or approved by Researcher for use by Translator in the work performed under this Agreement.

10. Changes by others. Translator shall have no responsibility whatever as to any changes in the translation made by persons other than Translator.

13. Complete agreement. This is the complete agreement of the parties as to the subject matter hereof. Any changes in this Agreement must be in writing signed by both parties. This Agreement becomes a binding contract only upon signature by both parties and the delivery of fully signed copies to each party.

Independent     translator     signature: _____

Researcher signature: _____

Signed Date: _____

## Interview One (N1)

Researcher: Can you please just keep your name or anything about your family confidential ok.

Nurse 1: Ok.

Researcher: Ok. Do you want to maybe just start by telling me a bit about yourself, um if you could just maybe tell me your ethnicity your cultural group and your gender and your age?

Nurse 1: um 35 years old ok, um how long is this going to take?

Researcher: I am not sure, how long do you have?

Nurse 1: Cause I'm thinking 11

Researcher: 11, that's perfect

Nurse 1: ok, I'm a Xhosa, my family, got four brothers and one sister.

Researcher: and your gender?

Nurse 1: Male

Researcher: Aha.

(Both laugh)

Researcher: Can you just tell me, how many languages can you speak fluently?

Nurse 1: IsiXhosa and English

Researcher: oh ok and which one do you speak at home?

Nurse 1: Xhosa.

Researcher: Ok. Um, then can you tell me a bit about your current job?

Nurse 1: Ok, I am a professional nurse.

Researcher: Is that your official position at the hospital? Professional nurse?

Nurse 1: Ya.

Researcher: Ok. Um, do you want to tell me a bit about your experiences as working as a translator for the hospital?

Nurse 1: You know as a professional nurse we are not supposed to be interpreters because, of the problems that are in the institution. We find that many doctors are not speaking the language and most of the patients are Xhosa speaking so as a result, the doctors, they don't understand what the patients are saying, cause the patients, there are few of them that speak English and therefore we have to interpret for the doctors and also for the psychologists.

Researcher: Ok. So you say interpreter. Do you think that that you are a translator or an interpreter? What do you think is the difference between the two?

Nurse 1: Shoo

(Both Laugh)

Researcher: Ok well, if I say translator to you, what does that mean to you? What do you think that is?

Nurse 1: I think um, I don't know that difference between being an interpreter and translator. I am not quite sure, I have not thought about that one.

Researcher: Ok that's fine, that's perfect. Um ok so I take it, um which term would you rather use interpreter or translator? Or does it not really matter to you?

Nurse 1: Ah it doesn't really matter.

Researcher: Ok um so I take it translating or interpreting is not officially part of your job profile.

Nurse 1: mmm mmm (responding no by shaking his head)

Researcher: Ok, um but is it still seen as work at the hospital?

Nurse 1: It is seen, the problem which we normally encounter is that the doctors and the psychologists they always, they expect the nurses to be the translators and interpreters even though, the problem is we find that the patient, it becomes difficult at times for you to translate what the patient has said. It would have been better if the person whom you are translating was the one who was here, knew what the patient was saying because the patient will say many things but to listen to what he is saying, you end up saying, or you end up not understanding what he is trying to say. When you state to the doctor or whoever, that I cannot even be able to explain what the patient is saying, the doctor does not understand because he wanted you to say what the patient was saying, but you don't know what the patient was saying.

Researcher: So the doctor doesn't understand what you were saying because you don't understand what the patient was saying. Ok. So do you think that, do you think that translation should become part of your job? Do you think that, do you get any benefits from doing it, do you get paid for doing it?

Nurse 1: Aha.

Researcher: Do you think you should?

Nurse 1: I think they should employ people who are able to interpret.

Researcher: So do you think they should employ a separate person so that nurses don't have to

Nurse 1: Ya, at times we don't end up doing what we are supposed to as a nurse because we don't have the time, because it takes up most of your time when there were other things you should have done.

Researcher: well that was one of my next questions, is that I noticed that you are very busy and then you are kind of need to come and translate but you have other nurse duties to do as well. So, does it get in the way of your job then as a nurse?

Nurse 1: Well, it depends, it depends, at times the patient is here with the doctor and I also need to be here to report on the behavior of the patient. If the doctor is going to see the patient it is fine cause there should be a professional nurse around so that he can give a report about the patient, how is he doing in the ward and his behavior and also so that because the doctor may be able to ask questions from the about the behavior or he may order something or or some new treatment for, or maybe refer to some so this should be allowed.

Researcher: So, are you saying that there are some positive aspects to having nurses translate?

Nurse 1: Aha (responds no). Not our translating.

Researcher: Oh just being present?

Nurse 1: Ya

Researcher: Oh ok I see. Um ok what I wanted to ask you was so is there ever a set schedule for you to interpret or do you just do it as needed?

Nurse 1: In the ward, we know the doctor, let's say we do it as needed cause not all the patients cant speak English. Some of the... maybe the patient does not understand some of the questions that was asked by the doctor, there are patients who can speak language so...

Researcher: Ok. So basically so the doctor just or do you know when the doctor is coming to see that patient.

Nurse 1: Ya the doctor has a schedule for the whole week so we know when is he coming to see the patients.

Researcher: Ok so you follow the doctors schedule and then you just know when to come?

Nurse 1: Ya.

Researcher: Ok, lets stick with positives and negatives. Can you maybe tell me or isolate ok we have isolated one, some other problems that you find working, well, acting as a translator. So, do you think that translation is beneficial for the patient for assessment and diagnosis.

Nurse 1: It is beneficial in the sense that if no-one is able to translate for the patient the patient does not benefit because they will not know, if for an example, the patient if he states that he is hearing noises and the doctor does not know that, then he will not be able to prescribe the treatment which is going to assist the patient. So, the patient benefits.

Researcher: So do you think there is better understanding when someone is translating?

Nurse 1: Ya.

Researcher: Ok and then what are some of the negative things? Do you think it sometimes impacts negatively on the interview of the patient?

Nurse 1: I would say, I don't think, what I can say is that at I think at times there are patients who would prefer if the doctor understood what they were saying. You will find at times that certain patients prefer to speak to people who understand their language so that, cause you know that, when addressing himself or herself in that language, also knows the language, but I think em that the patients are benefiting in terms of the translating.

Researcher: Ok. What are some of the problems you find when translating? So say when I have read in the literature, in some books and whatever, that, um there is a problem, some things you can say in English but then translating it in Xhosa is a mission well or you can't even do it.

Nurse 1: Ya, that is true. Sometimes you will find a patient he will be talking um let's say he is talking round about for forty seconds now we will be able to say it in about five to ten sentences.

Researcher: You will be able to say it?

Nurse 1: Ya. Then you will find it confuses cause the doctor will ask what is he saying.

Researcher: Oh yes, I actually noticed that. So the patient will talk for long periods of time and then...

Nurse 1: Ya. Ya.

Researcher: So do you ever just summarize things that the patient is saying?

Nurse 1: No it depends on the doctors because the doctors prefer that you say what the patients said but at times it becomes difficult to say each and every word of what the patient has said when interpreting.

Researcher: Oh ok.

Nurse 1: It becomes difficult, you can't even remember what he said before, because of what he is talking about so, you know at the end of the day you know what he was trying to say.

Researcher: ok so are the periods that they speak too long and then you can't remember what they said?

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Nurse 1: Ya

Researcher: Ok, um. I also noticed that sometimes when you translate it sometimes overlaps with the doctor's questions. So do the doctors ever ask multiple questions or long questions that you can't remember same as with the patients.

Nurse 1: Ya. They do at times (mumbles) sometimes you find a doctor will ask a long question, and then even if you don't understand it is better to ask what the doctor said.

Researcher: ok, then do you ever finish the doctors question before he has actually asked the question?

Nurse 1: ha-ah I wait for him, sometimes since you know if you use a certain doctor then you know what he is going to ask about the dates, you know what day is it today. When they are asking that we also ask the month and the year cause we know they are going to ask that.

Researcher: So, are you quiet used to doing the translations and also the interviews, so do you know the questions that are going to come after...

Nurse 1: Ya sometimes we do know (mumble) why im saying when he is going to ask about the dates then the year and but otherwise then we just wait for her or him to ask.

(Interruption)

Researcher: Ok so we have highlighted some problems, do you think there are any solutions to these problems are there any personal strategies that you use to either prevent the problems from happening or to deal with these problems as they happen if they do happen?

Nurse 1: about translating?

Researcher: ya

Nurse 1: Ya, the thing is ne the doctors will tell you, he doesn't want you to summarize, he wants you to state the whole thing what the patient has said (mumbles). What some of the other nurses do is when a patient speaks for a long time, you must stop the patient so that you can interpret it in parts so that you finish up because if you don't stop the patient then you wont remember what to interpret so you must stop the patient to translate so that you can finish up.

Researcher: Do you think that ever affects what the patient is saying if you stop them in the middle of what they are saying?

Nurse 1: It does, I would say that it does affect some of the patient, maybe they are very ill, but at the same time maybe it helps to assess his, his mental illness.

Researcher: why?

Nurse 1: because you won't be able to see that this patient was talking about this now he has changed once you have finished (mumbles) you are able to see what the patient has said, to assist you when observing the patient.

Researcher: that is really interesting actually. Ok, when you are translating, can you try and describe to me what you are, what exactly you are doing?

Nurse 1: mmm you translate what the patient has, has said when he was being asked a question by the doctor

Researcher: okay what does that mean, to translate?

Nurse 1: that means if the patient is, lets say the doctor is asking the question 'what day is it today?' the patient doesn't know he cant speak the language so you will ask him in Xhosa 'what day is it?' and you will state it in English, if its in English then I wont have to translate because the doctor will understand it and if the patient says 'it's Monday' he may ask in Xhosa but I may answer in English.

Researcher: OK, ok um what do you think the doctor expects from you when translating

Nurse 1: The doctor expects you to say what they are saying

Researcher: and what do you think the patient is expecting from you?

Nurse 1: he is expecting the same thing I must translate what he has said, what he has said to the doctor.

Researcher: Do you think the patients ever notice that the doctor doesn't understand, that the process actually isn't working that what he wants to say isn't coming through?

Nurse 1: I have never experienced that.

Researcher: oh ok. Um I also noticed in the Ward round yesterday that you and the nurses were translating first but then the social worker took over does that happened often?

Nurse 1: Ya no you see there was a as I have said before we are not supposed to interpret, they should be having someone who should be interpreting or translating. The social worker is just assisting us because she knows

Researcher: Ok, but staying with the situation we are in now, what affect do you think that has on communication because you interpret and then I am not sure what the other nurses name is, if he interprets and then the social worker interprets do you think it affects, affects the type of communication? Because do you each have your own specific way of doing it?

Nurse 1: I don't understand.

Researcher: So, have you ever had any sort of training in translating?

Nurse 1: No never.

Researcher: Ok not outside the hospital

Nurse 1: mm mm (indicating no)

Researcher: Not outside the hospital?

Nurse 1: mm mm (indiciating no)

Researcher: Ok so now do you think that you translating it is a personal skill that you have.

Nurse 1: Ya

Researcher: so you have that personal skill, the other nurse has that personal skill and the social worker ok

Nurse 1: ya

Researcher: now do you think that the way you each interpret is the same?

Nurse 1: It is not the same because there are people who can explain better when interpreting. We can't express ourselves the same as others. There are people who can be able to translate exactly the same because it is a personal thing. If he has got talent to he knows. They are different people, that is, all I can say. People can express it better than others when it comes to interpreting.

Researcher: Ok now that was what I was asking you, is do you think it affects what is said then because you translating is different to the way he translate which is different to the way the social worker translates. So do you think what the patient says changes then with each person that translates?

Nurse 1: I don't think so.

Researcher: you don't think so? Mmm, ok.

(Interruption: forced to move from one room to another).

Researcher: Do you ever have a meeting with the doctor before you see the patient or after you see the patient about what happened during the interview?

Nurse 1: No

Researcher: Do you think that something like that would be beneficial? Do you think it would be something that would be useful?

Nurse 1: I think it would be useful if we were employed as translators. So at the moment there have not been any complaints.

Researcher: So you haven't had any complaints?

Nurse 1: aha.

Researcher: Um do you think that, ok so in your opinion, do you think that translation is more beneficial or more complicated for the patient?

Nurse 1: It is beneficial for the patient.

Researcher: More beneficial ok. But do you think it would be even more beneficial if there was a separate person to translate?

Nurse 1: Ya ya, I am sure the people would have to be trained to translate what is expected of them.

Researcher: Um do you think that translation is only a language problem or do you think that culture is also part of it?

Nurse 1: I think it is only a language problem

Researcher: Ok, do you ever not feel, well I assume that most of the patients here are Xhosa right?

Nurse 1:mmm

Researcher: Do you ever feel that you understand the patient better because you are from the same culture?

Nurse 1: Ya, at times I would agree with you because sometimes, ya. I think that ya, you know culture you will find that the patient will talk about things that are cultural and when you are translating whatever, the thing that he was stating we may also not understand because he is not from the same culture. Ya it does at times affect because the patient will talk about (?) or sangoma. Ya about, you see we are twasa you see that means that it is stating that you must go for training for to be trained as a traditional healer em we will talk about rituals. Some of the doctors now at least they know our, a bit about our culture Xhosa.

Researcher: SO back to the first question do you still think it is only a language thing??

Nurse 1: Ahaha, culture culture

(Both laugh)

Researcher: ok when you are translating ok what they say in books, it is called a triad, so when there is just a doctor and patient it is just two in the relationship ok, but when you are here translating there are three people. Who out of those three people understands each other better? So do you think the doctor understands you better or do you think you understand the patient better or do you think the doctor understands the patient better?

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Nurse 1: the problem with translation is that the person does not get the same information from the other person as they are supposed to get. So you will find that I understand the patient better, and then when I translate it to you, you won't understand it better than what I understood what the patient said. It does happen at times.

Researcher: Oh ok and then do you, do you actually tell the doctor that when it happens?

Nurse 1: Ya

Researcher: and then what do you do then?

Nurse 1: you mean when I say don't understand?

Researcher: No when you say the doctor won't understand it because you understand it better because you cannot bring it back into English, it that right?

Nurse 1: Ya it could be, it becomes difficult to explain, I can't even say what he is saying but I understand what he saying but I cant explain it.

Researcher: Is that, how often is that because he is ill and he is just rambling, or because it is the language think because you cant put what he is saying into English?

Nurse 1: Most of the time it is when the patient is very ill

Researcher: Is it?

Nurse 1: Ya

Researcher: ok um, ok, the reason I was asking this question was because I saw, well do you ever find, say now the doctor gives the patient an exercise to do and you see the patient is battling do you ever want to help the patient or encourage them.

Nurse 1: Ya you feel at times we help the patient even though we are not supposed to help because in a way he is being assessed when he is given a task to do to see whether he is going to be able to do the task that he has been asked to do to see whether he is, how far he is, assessing his mental illness.

Researcher: mmm so do you think it would be problematic if you did help him?

Nurse 1: Ya it is problematic because you know it is part of assessing whether he is ill or not so you don't have to help him even though at times you find you want to help him.

Researcher: mmm mmm ya I even found that I wanted to help him as well. Ok um how do most of the doctors or psychiatrists or psychologists react when you tell them I don't, I just, I can't explain it? Like when we were saying before when you cant translate it straight from one language to another.

Nurse 1: In my experience I have not had any bad experience because they do understand that at times it is difficult, they know at times that even the patient when they are speaking, it becomes difficult if you can interpret it in Xhosa what the patient was saying even for someone who can speak Xhosa (mumbles).

Researcher: and how often to patients I know Xhosa as a language. How often do they have slang in there as well? You know what slang is hey?

Nurse 1: Ya

Researcher: So how often do they use slang that you don't know how to or you just don't know as a person.

Nurse 1: If I don't know the slang I will always ask the patients what does that mean? If I don't know then I will tell them the patient used this slang and I don't know what that means.

Researcher: ok what type of relations do you have with the doctors? Is it good relations or do you ever fight with them over the translations?

Nurse 1: in this unit, I would say that it is good relations. I haven't had any problems with regards to translation.

Researcher: Ok well lets speak hypothetically, and make a scenario, what if that had to happen, what if you couldn't translate and the doctor got angry with you, what would you do? How would you deal with that?

Nurse 1: In that case we would have to talk so that we can sort it out because at the end of the day we are not translators we are just assisting for the benefit of the patient so that the patient can go out of the hospital because they are here and they need to be assisted so that they can also go home just as any other patient so for the benefit of the patient it is better to just sit down and iron out the problems.

Researcher: ok.

Nurse 1: Then the recommendations should even come that we need to employ a translator, if we don't have a solution or...

Researcher: How confident do you feel when you are translating that you are representing the patient well enough

Nurse 1: can you please repeat the question?

Researcher: ok when you translating do you ever worry that you are not saying what patient said well enough?

Nurse 1: a I don't even worry about that because if I don't understand what the patient is saying then I just say ' I don't understand what the patient is saying' because it was difficult to translate what the patient was saying.

Researcher: ok I noticed there were times when, the doctor would ask you a questions and then it wasn't a straight answer back sometimes you would talk to the patient for longer periods of time that seemed longer than what the patient had answered. Do you ever think the doctor or psychologist or whoever feels left out of the interaction...

Nurse 1: ya ya ya at times they feel that they are left out because even with us, sometimes they will speak Afrikaans and we don't know Afrikaans and then you don't know what they are saying and you feel left out. It is better, since then I have learnt a bit of Afrikaans so it is better but if you don't know Afrikaans you feel left out so I am sure it is the same thing when we speak to the patient we speak Xhosa. You'll find at times that the patient will not say what is being asked ad then you must say don't talk about this talk about this and then he will end up answering what you have asked and then you state that the patient first answered this but they said this instead of answering whatever was asked (mumbles).

Researcher: So is it most of the time when you are talking to the patient it is asking them to rephrase or answer the exact question, cause I noticed that often happens when the doctor will be like I didn't ask you that, what did I ask you?

Nurse 1: At times we would prefer to, the reason I am repeating the question is that the patient didn't understand the question so I will re-phrase the question so that he can answer what I have asked (mumbles) so you repeat the same thing no I didn't ask you that I asked you this question so you must answer so you end up saying to the doctor what the patient has said and then the doctor says no I didn't ask this, why are you answering this.

Researcher: Do you think that you now have some training or experience in translation because you know what happens, you know what the problems are and you try and work around that? Ok it is very interesting. Well, those are all my main questions, is there anything else you would like to say about it?

Nurse 1:What I would say ne, I think the best thing is to have a translator that has been trained to be a translator because the thing is ne, we as nurses have a lot of work that we must do but then we end up interpreting (mumbles) as nurses for patient. At this case we must be there for the doctors to report on behavior but when it is a psychologist there is a problem because the psychologist is there to assess the patient but you will find they all need an interpreter so an interpreter will be needed so in that case it is because the time that we are supposed to spend with one patient takes time from another patient so I feel that there should be an interpreter.

Researcher: so are you saying that the time for one patient goes to another patient because you need to interpret for the patient. Mmm, is there anything else?

Nurse 1: No I think that is all.

Researcher: Great thank you so much for helping me you have been a great help. Did you enjoy the experience?

Nurse 1: it is scary

Researcher: is it scary?

Nurse 1: ya