ENGLISH AND AFRIKAANS SPEAKING CLINICAL PSYCHOLOGY INTERNS’ EXPERIENCES OF USING INTERPRETERS IN A MULTILINGUAL SETTING IN DR GEORGE MUKHARI HOSPITAL, SOUTH AFRICA

Submitted in accordance with the requirement for the degree of

MASTER IN CLINICAL PSYCHOLOGY (MSc Clinical Psychology)

At the

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

By:

Lauren de Ricquebourg

SUPERVISOR: KGADI THOBEJANE

June 2015
Table of Contents

DECLARATION ........................................................................................................................................... v
ACKNOWLEDGMENTS ................................................................................................................................. vi
ABSTRACT .................................................................................................................................................... vii

CHAPTER 1 .................................................................................................................................................... 1
  1.1 Background ........................................................................................................................................... 1
  1.2 Aims and objectives of the study ........................................................................................................ 3
  1.3 Goals .................................................................................................................................................... 4
    1.3.1 Specific Goals .................................................................................................................................. 4
  1.4 Motivation.............................................................................................................................................. 4
    1.4.1 Academic Motivation .................................................................................................................... 4
    1.4.2 Research Motivation ..................................................................................................................... 5
  1.5 Structure .............................................................................................................................................. 5
  1.6 Conclusion............................................................................................................................................ 7
  1.7 Preview of the following chapter ....................................................................................................... 7

CHAPTER 2 .................................................................................................................................................... 8
  2.1 Introduction ......................................................................................................................................... 8
  2.2 The interpreter in the South African context ....................................................................................... 9
  2.3 Interpreters in the health and mental health care settings ................................................................. 12
  2.4 Working with an interpreter ............................................................................................................... 14
    2.4.1 Assessing the need for an interpreter ............................................................................................ 15
    2.4.2 The accredited interpreter ........................................................................................................... 16
    2.4.3 The unaccredited interpreter ........................................................................................................ 17
  2.5 Ethical considerations when working with an interpreter ................................................................. 18
  2.6 Other important considerations when working with an interpreter ................................................. 19
    2.6.1 Pre-existing and non-professional relationships ......................................................................... 19
    2.6.2 Continuity of services .................................................................................................................... 20
    2.6.3 Pre-consultation meetings ............................................................................................................ 20
    2.6.4 Collaboration .................................................................................................................................. 20
    2.6.5 Communication ............................................................................................................................. 21
    2.6.6 Accuracy of information ................................................................................................................. 22
  2.7 Considerations in psychometric assessment ....................................................................................... 23
    2.7.1 Psychometric norms ....................................................................................................................... 23
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.7.2</td>
<td>Administration of psychometric assessments</td>
<td>25</td>
</tr>
<tr>
<td>2.8</td>
<td>Expectations of the interpreter</td>
<td>26</td>
</tr>
<tr>
<td>2.9</td>
<td>Challenges experienced by interpreters in South Africa</td>
<td>27</td>
</tr>
<tr>
<td>2.10</td>
<td>Conclusion</td>
<td>28</td>
</tr>
<tr>
<td>2.11</td>
<td>Preview of the contents of the following chapter</td>
<td>29</td>
</tr>
<tr>
<td>CHAPTER 3</td>
<td>Preview of the contents of the following chapter</td>
<td>30</td>
</tr>
<tr>
<td>3.1</td>
<td>The therapeutic relationship</td>
<td>30</td>
</tr>
<tr>
<td>3.2</td>
<td>Definitions of the therapeutic relationship</td>
<td>30</td>
</tr>
<tr>
<td>3.3</td>
<td>Humanist views on the therapeutic relationship</td>
<td>32</td>
</tr>
<tr>
<td>3.4</td>
<td>Psychodynamic views on the therapeutic relationship</td>
<td>33</td>
</tr>
<tr>
<td>3.5</td>
<td>The interpreter and the therapeutic relationship</td>
<td>34</td>
</tr>
<tr>
<td>3.6</td>
<td>Challenges to the therapeutic relationship when using an interpreter</td>
<td>36</td>
</tr>
<tr>
<td>3.6.1</td>
<td>Therapeutic Taboos</td>
<td>37</td>
</tr>
<tr>
<td>3.6.2</td>
<td>The interpreter’s experience</td>
<td>37</td>
</tr>
<tr>
<td>3.6.3</td>
<td>The client’s experience</td>
<td>38</td>
</tr>
<tr>
<td>3.6.4</td>
<td>The psychologist’s experience</td>
<td>39</td>
</tr>
<tr>
<td>3.6.5</td>
<td>Alliance formation</td>
<td>40</td>
</tr>
<tr>
<td>3.6.6</td>
<td>The triadic relationship</td>
<td>41</td>
</tr>
<tr>
<td>3.7</td>
<td>Methods of addressing challenges when working with an interpreter</td>
<td>42</td>
</tr>
<tr>
<td>3.8</td>
<td>Conclusion</td>
<td>44</td>
</tr>
<tr>
<td>3.9</td>
<td>Preview of the contents of the following chapter</td>
<td>45</td>
</tr>
<tr>
<td>CHAPTER 4</td>
<td>Cultural competence and multiculturalism when using an interpreter</td>
<td>46</td>
</tr>
<tr>
<td>4.1</td>
<td>Cultural competence and multiculturalism when using an interpreter</td>
<td>46</td>
</tr>
<tr>
<td>4.1.1</td>
<td>Cultural competence</td>
<td>46</td>
</tr>
<tr>
<td>4.1.2</td>
<td>Definition of cultural competence</td>
<td>47</td>
</tr>
<tr>
<td>4.1.3</td>
<td>Components of cultural competence</td>
<td>47</td>
</tr>
<tr>
<td>4.1.4</td>
<td>Table 1: Components of cultural competence</td>
<td>47</td>
</tr>
<tr>
<td>4.1.4</td>
<td>Cultural competence and working with an interpreter</td>
<td>50</td>
</tr>
<tr>
<td>4.2</td>
<td>Multiculturalism</td>
<td>50</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Definition of multiculturalism</td>
<td>50</td>
</tr>
<tr>
<td>4.2.2</td>
<td>The MDCC applied to multiculturalism within South Africa</td>
<td>51</td>
</tr>
<tr>
<td>4.3</td>
<td>The African perspective and multiculturalism</td>
<td>52</td>
</tr>
<tr>
<td>4.3.1</td>
<td>History of the African perspective</td>
<td>53</td>
</tr>
<tr>
<td>4.3.2</td>
<td>The African perspective on psychology</td>
<td>55</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
<td>Page</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>4.3.3</td>
<td>The African perspective and mental health</td>
<td>56</td>
</tr>
<tr>
<td>4.3.4</td>
<td>The African perspective and the therapeutic process</td>
<td>57</td>
</tr>
<tr>
<td>4.3.5</td>
<td>The African perspective, psychologists and interpreters in South Africa</td>
<td>58</td>
</tr>
<tr>
<td>4.4</td>
<td>Conclusion</td>
<td>59</td>
</tr>
<tr>
<td>4.5</td>
<td>Preview of the contents of the following chapter</td>
<td>60</td>
</tr>
<tr>
<td>5.1</td>
<td>Aims/objectives of the study</td>
<td>61</td>
</tr>
<tr>
<td>5.2</td>
<td>Qualitative research</td>
<td>61</td>
</tr>
<tr>
<td>5.3</td>
<td>Research design</td>
<td>62</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Phenomenology</td>
<td>63</td>
</tr>
<tr>
<td>5.4</td>
<td>Method of enquiry</td>
<td>64</td>
</tr>
<tr>
<td>5.4.1</td>
<td>Participants</td>
<td>64</td>
</tr>
<tr>
<td>5.5</td>
<td>Data-collection</td>
<td>66</td>
</tr>
<tr>
<td>5.6</td>
<td>Data analysis</td>
<td>69</td>
</tr>
<tr>
<td>5.7</td>
<td>Trustworthiness</td>
<td>71</td>
</tr>
<tr>
<td>5.7.1</td>
<td>Credibility</td>
<td>71</td>
</tr>
<tr>
<td>5.7.2</td>
<td>Transferability</td>
<td>72</td>
</tr>
<tr>
<td>5.7.3</td>
<td>Dependability</td>
<td>72</td>
</tr>
<tr>
<td>5.7.4</td>
<td>Confirmability</td>
<td>72</td>
</tr>
<tr>
<td>5.8</td>
<td>Ethical considerations</td>
<td>73</td>
</tr>
<tr>
<td>5.8.1</td>
<td>Ethical clearance</td>
<td>74</td>
</tr>
<tr>
<td>5.8.2</td>
<td>Ethical codes</td>
<td>74</td>
</tr>
<tr>
<td>5.8.3</td>
<td>Informed consent</td>
<td>75</td>
</tr>
<tr>
<td>5.8.4</td>
<td>Confidentiality</td>
<td>75</td>
</tr>
<tr>
<td>5.8.5</td>
<td>Debriefing</td>
<td>75</td>
</tr>
<tr>
<td>5.9</td>
<td>Bias</td>
<td>76</td>
</tr>
<tr>
<td>5.9.1</td>
<td>Selection bias</td>
<td>76</td>
</tr>
<tr>
<td>5.9.2</td>
<td>Researcher Bias</td>
<td>76</td>
</tr>
<tr>
<td>5.10</td>
<td>Challenges</td>
<td>77</td>
</tr>
<tr>
<td>5.11</td>
<td>Preview of the following chapter</td>
<td>78</td>
</tr>
<tr>
<td>6.1</td>
<td>The experiences of working with an interpreter</td>
<td>79</td>
</tr>
<tr>
<td>6.1.1</td>
<td>Theme 1: Psychologist’s Frustration</td>
<td>79</td>
</tr>
<tr>
<td>6.1.2</td>
<td>Theme 2: Superficial Therapy</td>
<td>81</td>
</tr>
</tbody>
</table>
DECLARATION

I, Lauren de Ricquebourg, declare that ‘English and Afrikaans speaking clinical psychology interns’ experiences of using interpreters in a multilingual setting in Dr George Mukhari hospital, South Africa’ is my own work and that all the sources I used or quoted have been indicated and acknowledged by means of complex citation and references.

.............................................. ..............................................

Lauren de Ricquebourg
ACKNOWLEDGMENTS

There are many people who have helped me along the way:

Thank you to my supervisor Kgadi Thobejane for guiding me through this process and helping me to understand all that is required in completing this dissertation.

Thank you to my parents for your endless love and support. You never gave up on me, you always believed in me and for everything I have achieved I have you both to thank.

To my husband, Graham. You have been there for me every step of the way, you have loved me and taken care of me and it is through you that I have found the strength to complete this dissertation. Thank you, I love you.

To all my friends and family who have supported me, dealt with my frustrations, kept me calm and made me laugh throughout this process, thank you.
ABSTRACT

The current study aimed to explore and describe the experiences of clinical psychology interns when working with interpreters in a multilingual environment in Dr George Mukhari hospital. Semi-structured interviews were conducted with seven conveniently and purposively sampled participants using an interview guide as a tool to guide the interviews. The results were analysed using thematic analysis.

The results indicated that the intern psychologists experienced frustration and they felt therapy became superficial. However, they also reported positive contributions when working with interpreters that resulted in successful therapy. There were a number of challenges they experienced with regard to untrained interpreters, intellectually disabled patients, psychotic patients as well as the administration psychometric assessments. The results further indicated the impact on the relationship dynamics when an interpreter is involved in therapy namely; difficulty in building rapport and the formation of alliances between the interpreter and the patient. Cultural competence was also an implication when working with an interpreter as well as insufficient training with regards to the African perspective. Although the results of the current study cannot be generalised, its strength lies in creating awareness and guiding future interns in the challenges of working with interpreters and to guide future research in the development of training programmes for interpreters and mental health practitioners.

Key words: interpreters, psychologists, equality, language diversity, mental health
CHAPTER 1

Introduction

In this chapter I will briefly discuss the context of the study and then proceed with a discussion of the research questions, the motivation for the research study, and its goals. Finally, the structure of the study will be explained.

1.1 Background

In 1993, nine indigenous African languages were granted status equal to that of English and Afrikaans in South Africa. It was also proclaimed that education and governmental documentation would be available in all languages. This resulted in changes in the health care sector and, in particular, in the mental health care sector, which is the focus of this study. In addition, the Mental Health Care Act No.17 of 2002 aimed to increase the availability and accessibility of mental health care services and to prevent unnecessary referrals to psychiatric hospitals (Mkhize & Khometsi, 2008; Peterson & Lund, 2011).

However, even though some progress has been made in decentralising the care of severe mental health disorders, there are still insufficient resources to provide adequate support to community-based services, involving cultural and language barriers in particular (Peterson & Lund, 2011). The challenge becomes apparent in situations where there is no colleague to whom a mental health practitioner (MHP) may refer a patient who does not speak the MHP’s home language. Therefore, health care accessibility cannot be improved if MHPs are not able to communicate with their patients. In order to ensure equality, mental health services need to be provided in all official languages. However, the language diversity
challenge has not been adequately addressed in the mental health care setting (Peterson & Lund, 2011).

For this reason, interpreters are used in the mental health setting. An interpreter will be defined for the purposes of this study as “a person who works between the spoken forms of two languages providing communication facilitation between speakers of those languages” (Hamerdinger & Karlin, 2002 p.1).

The use of interpreters may contribute to greater accessibility for all South Africans, regardless of culture, race or language, in the mental health setting. In South Africa, MHPs are ethically required to use interpreters in providing professional services (Form 233, HPCSA, 2004). However, it appears that interpreters are largely untrained and may provide unsatisfactory services, which results in a number of challenges (Killian, Swartz & Joska, 2010; Mkhize & Khometsi, 2008; Peterson & Lund, 2011).

Among these challenges, those that pertain to psychological services in particular are the following: therapeutic taboos, including certain culture-bound therapeutic taboos present in the definition of the helping role; the interpreter’s experience of working with the client and psychologist; the manner in which the client may experience the inclusion of an interpreter in therapy; the psychologist’s experience of working with an interpreter; and the impact that the inclusion of an interpreter has on alliance formation within the therapeutic relationship (Hill & McGrath, 2008; Miller, Martell, Pazdirek, Caruth & Lopez 2005; Sue, 2001; Tribe & Morrissey, 2004).

Given the above, the use of an interpreter may impact on the therapeutic process and be challenging for the psychologist, the interpreter and the patient (Corey, 2009). There are numerous research studies and a substantial body of literature pertaining to working with an interpreter (American Psychological Association, 2010; Australian Psychological Society, 2013; Killian et al., 2010; Lee, Batal, Masselli & Kutner, 2002; Morales, Cunningham,
Brown, Lin & Hays, 1999, cited in Tribe & Morrissey). However, the majority of these studies were conducted in the United Kingdom (UK), Australia and the United States of America (USA). On the other hand, there are only a limited number of research studies on the personal experiences of psychologists who use the services of interpreters in SA. In the democratic SA, equality is valued, and there is an obligation to provide equal access to health care services for all people, regardless of their language (de Kadt, 2005).

This study posits that, although the South African government has shown an unprecedented commitment to ensuring equality in services provided by the mental health sector, the language diversity dilemma has not been resolved. Therefore, the use of an interpreter holds the promise of providing greater accessibility and more competent services to all South Africans, regardless of culture, race or language, in the mental health setting.

1.2 Aims and objectives of the study

This qualitative study aims to explore and describe the experiences clinical psychology interns when working with interpreters in a multilingual environment in Dr George Mukhari Hospital.

The objectives of the study were to:

- gather information, using the interview guide, about the experiences of clinical psychology interns when working with interpreters;
- understand challenges that arise when using an interpreter; and
- explore the relationship dynamics when an interpreter is involved.
1.3 Goals

1.3.1 Specific Goals

This project has the following specific goals as guidelines for achieving the three primary goals:

1. to conduct a literature review on the role of interpreters in the health care setting (see Chapters 2, 3 and 4);
2. to describe the research inquiry of this research project, with reference to the research context, research participants, research process and research ethics (see Chapter 5); and
3. to report the findings of this research project in the form of a mini-thesis (see Chapters 1 to 7), as well as a scholarly article.

1.4 Motivation

There were two areas of motivation for the current study, namely academic and research motivation.

1.4.1 Academic Motivation

This study was conducted in fulfilment of the requirements of the MSc degree in the Department of Clinical Psychology at Sefako Makgatho Health Sciences University. This degree is based on the researcher-practitioner training model. Thus, the research project contributes 50% of the programme. The requirement of the mini-thesis for completion of the MSc degree therefore served as the academic motivation for the study.
1.4.2 Research Motivation

In conducting this qualitative study I aim to explore the experiences of intern psychologists working with interpreters in the mental health care setting. I accordingly conducted semi-structured interviews. I was motivated to explore the subjective experiences of each participant in order to gain an understanding of their experiences in working with an interpreter.

I therefore hope that this study will create awareness about the inequalities that exist in the mental health sector and the challenges involved when working with interpreters. In addition, I hope that the findings of this study will encourage future research in the development of training programmes for interpreters and mental health practitioners.

1.5 Structure

The structure of this study is as follows:

Chapter 1

This chapter provides an introduction to the study, and briefly discusses its context, the research questions, the motivation for the research study, and its goals. Finally, the structure of the study is explained.

Chapter 2

This chapter provides a background to the mental health care setting in South Africa and the role of the interpreter. Guidelines and ethical considerations when working with an interpreter are also discussed.
Chapter 3

This chapter explores the therapeutic relationship as well as the impact of interpreters on this therapeutic alliance. A strong therapeutic relationship is viewed as essential for the therapeutic process. Hence, the impact of an interpreter on this relationship is also discussed.

Chapter 4

In this chapter, cultural competence and multiculturalism are discussed. The researcher also explores the African perspective on psychology that underpins this study. The African perspective takes into consideration aspects such as language, culture, traditions, family, society and others, all of which are relevant in working with an interpreter.

Chapter 5

This chapter focuses on the aims and objectives, and the research methodology and design. The demographics of the participants are elaborated on, and the data collection method is discussed. This is followed by a discussion of the measures which the researcher took in order to maintain the quality of the research study, as well as the ethical considerations.

Chapter 6

In this chapter, the results of the study are discussed by focusing on the questions posed in its objectives, namely:

- How did the psychology interns experience working with an interpreter?
- What were the challenges that arose when working with an interpreter?
- How did working with an interpreter impact on the relationship dynamics?

Chapter 7

In the last chapter, the findings of this research study are discussed as they relate to the primary research questions. The findings are divided into the central themes, which arose
repeatedly in the accounts of the participants. The chapter also explores the limitations of the study, as well as recommendations for future research.

1.6 Conclusion

The focus of this chapter was on the research context. The research questions, the motivation for the current study and the research goals were also discussed. In the final section, the structure of the research study was outlined.

1.7 Preview of the following chapter

The following chapter focuses on the mental health care setting within South Africa. Furthermore, it highlights the role of the interpreter within this mental health care setting. There is also a discussion on the guidelines for and implications of working with an interpreter.
CHAPTER 2
The Interpreter in the Mental Health Care Setting in South Africa

2.1 Introduction

In South Africa (SA) there is a unique combination of cultures and, consequently, of languages. Prior to 1994, SA had two official languages, namely English and Afrikaans. However, the introduction of democracy and the coming to power of the African National Congress (ANC) brought about a change in the official language situation of South Africa. As a result, in 1993, nine indigenous African languages were granted equal status to English and Afrikaans: these were isiZulu, isiXhosa, isiNdebele, Xitsonga, Tshivenda, siSwati, Setswana, Sesotho and Sepedi. Furthermore, when South Africa’s new interim constitution was adopted in 1993, it guaranteed equality to all SA citizens on the basis of race, gender, and language (de Kadt, 2005).

The introduction of democracy in SA also entailed changes to the health care sector and to the mental health care sector in particular. There has since been a movement towards increased provision of, and access to, mental health care services for all South Africans (Mkhize & Khometsi, 2008; Peterson & Lund, 2011). However, Peterson & Lund (2011) maintained that, although some progress had been made in the decentralised care of severe mental health disorders in SA, there were still insufficient resources to provide adequate support to community-based services. In addition, Peterson & Lund (2011) indicated that there was a need to promote cultural and language equality in the mental health care sector. In SA, many government hospitals and clinics may have only one Mental Health Professional (MHP) or none at all. The challenge becomes apparent in situations where there is no colleague to whom a practitioner may refer a patient who does not speak the practitioner’s language. Furthermore, a practitioner is ethically required to provide professional services,
yet lack of resources creates a situation where a practitioner is faced with the dilemma of deciding whether a flawed therapeutic intervention is preferable to no intervention at all (Tribe & Morrissey, 2004). In order to address this problem, the use of interpreters is recommended. However, the use of an interpreter to improve access to mental health care services also has certain implications. Given the sensitive nature of the content in a mental health care setting, interpreters need to be qualified to perform the services required of them within the mental healthcare setting.

In a study conducted by Killian et al (2010) on determining the competence of interpreters in a South African psychiatric hospital in translating key psychiatric terms, it was found that the competence level of the interpreters was not conducive to optimal care. The results of the study further indicated that none of the interpreters had any formal training, that they had a limited understanding of English and were unfamiliar with key psychiatric terms. The study concluded that the shortage of formally trained interpreters in South Africa could lead to the misdiagnosis of patients and could compromise therapeutic interventions (Killian et al., 2010).

2.2 The interpreter in the South African context

According to the ethical rules of conduct for practitioners registered under the Health Professions Act 56, 1974, a psychologist shall suggest the use of an interpreter when the psychologist feels that a client is not fluent in the psychologist’s language. The interpreter used shall be fluent in at least two languages. In particular, the interpreter shall be fluent in the client’s language of preference. A psychologist who works with an interpreter shall take all necessary steps to ensure that the interpreter does not have a multiple relationship with the client concerned could lead to exploitation or loss of objectivity. The psychologist must also
ensure that the interpreter performs the interpretation tasks competently (Health Professions Act 56, 1974).

Furthermore, Form 223 of the Health Professions Council of South Africa (HPCSA, 2004), which outlines the rules of conduct pertaining specifically to psychology, includes a section on working with interpreters. The Act states that a psychologist who engages the services of an interpreter shall take steps to ensure that:

a. such interpreter is, at a minimum, bilingually fluent and is particularly conversant in the language of the client’s preference;

b. the interpreter preferably holds a qualification in interpretation approved by the council;

c. where it is clear that a client is not fluent in the psychologist’s language, at a minimum the services of an interpreter be proposed to such client;

d. the interpreter does not have a multiple relationship with a client being served that would likely lead to exploitation or loss of objectivity; and

e. the interpreter performs the delegated tasks competently (Form 223, HPCSA, 2004).

In South Africa there are no officially employed interpreters in the state mental health care sector (Tribe & Morrissey, 2004). As a result, mental health care institutions making use of interpreters have either hired them independently or make use of volunteer interpreters. However, the government in South Africa does not pay for these interpreters to receive formal training and, furthermore, it is not an official requirement of the Department of Health, National Health Bill, 2003 to provide such training. If a mental health care institution wishes its interpreters to receive training, it becomes their responsibility to fund the training. Yet, many mental health care institutions or mental health clinics are situated in previously disadvantaged communities and are unable to provide interpreters with formal training.
Therefore, although clinics require interpreters, the interpreters have not been professionally trained to provide an appropriate service. A study by Elderkin-Thompson, Cohen Silver and Waitzkin (2001) noted that when bilingual nurses who had not received formal training in interpreting acted as medical interpreters, there were more interpretation errors. This study stressed the need for skills training in interpretation.

Drennan and Swartz (1999) conducted a study at Valkenberg Hospital in Cape Town during the racial integration of the hospital during the post-apartheid era. The hospital admitted approximately 300 patients a month, and between one-third and one-fifth of these patients required interpreting services. The results of the study revealed that interpreting was needed in multiple contexts in the hospital. These included; ward rounds, clinical interviews and patient therapeutic groups. Therefore, if patients are not to be excluded from the full range of services on the basis of their language needs, interpreters are required. However, the study furthermore determined that the promise of improved lines of communication through the use of interpreter’s may give rise to unreasonable expectations as, within the South African context and given the limited resources available, formally trained interpreters are not always available (Drennan & Swartz, 1999; Eagle, 2005; Miller et al., 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004; Quinn, 2009).

Given the above, the difficulties faced by MHPs with regard to the use of interpreters in the mental health setting in South Africa are the following: ethically they are required to use interpreters in order to provide professional services; however, it appears that interpreters are not available or that those who are, are untrained and hence may provide incompetent services which may result in a number of negative implications, such as misdiagnosis and poor standards of therapeutic interventions (Killian et al, 2010).
2.3 Interpreters in the health and mental health care settings

The acceptance of diversity and the promise of equality for all individuals in South Africa have had a particular influence on the use of interpreters in the mental health care setting. The use of an interpreter holds the promise of providing greater accessibility to all South Africans, regardless of culture, race or language in the mental health setting. Given that there are eleven official languages, in order to ensure equality mental health services need to be provided in all these languages. Nonetheless, the language diversity challenge has not been adequately addressed in the mental health care setting (Mkhize & Khometsi, 2008; Peterson, & Lund, 2011).

Numerous studies have been conducted which indicate that when a health care worker and patient speak the same language, this leads to higher quality of services for patients (Bischoff, Bovier, Isah, Francoise, Ariel & Louis, 2002; Lee, et al, 2002; Manson, 1988; Morales, et al, 2004; Perez-Stable, Napoles-Springer & Miramontes, 1997; Riddick, 1998; Stolk, Ziguras, Saunders, Garlick, Stuart & Coffey, 1998).

In a study conducted by Morales et al. (1999) on access to and quality of health care for Hispanic Americans, it was found that communication is fundamental to the process of health care delivery and has significant effects on patient-practitioner relationships as well as on the quality of the health care patients receive. Furthermore, the study concluded that there was often unnecessary ordering of medical tests, lack of understanding of the side effects of medication and provider instructions, inadequate follow-up appointments and general poorer quality of care for patients when there was a language barrier between practitioners and patients.

Lee et al. (2002) conducted a study whose objective was to examine the effect of Spanish interpretation methods on satisfaction with health care received. The researchers concluded that those receiving service with language-concordant providers were more
satisfied with the quality of care they received than those who were provided a service through the use of an ad hoc or unqualified interpreter.

Schlemmer and Mash (2006) aimed at exploring the effects of a language barrier on health workers and patients at the Hottentots Holland Hospital in the Western Cape. It was found that the language barrier interfered with efficient working, created uncertainty about the accuracy of interpretation, indicated lack of education or training of health workers and contributed to significant ethical dilemmas. Furthermore, language barriers influenced the attitudes of patients and staff negatively towards each other, decreased the quality of and satisfaction with care, and caused cross-cultural misunderstandings. Despite the findings of these studies, there are not always healthcare workers or psychologists available who speak the same language as the client. Consequently, it is necessary to use an interpreter (Eagle, 2005; Miller et al., 2005; Tribe & Lane, 2009; Tribe & Thompson, 2008).

Flores (2005) conducted a study on the impact of interpreter services on quality of care in a psychiatric hospital setting. The findings were that more interpreting errors occurred with untrained interpreters, and that these inadequate interpreter services may have serious negative implications for patients with mental disorders. Furthermore, Karliner, Jacobs, Chen and Mutha (2007) found that the use of professional, qualified interpreters is associated with improved clinical care. Professional interpreters also appeared to increase the quality of clinical care for limited English proficiency patients so as to equal that for patients without language barriers (Karliner et al., 2007). The aforementioned studies all concluded that working with a qualified interpreter was more favourable than working with an untrained interpreter.

Additionally, studies have indicated that it is also favourable if the psychologist receives training in working with an interpreter (Eagle, 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004). It is also important that the psychologist is culturally competent in order to
understand culturally embedded information, is able to recognise when alliances are being formed within the triadic relationship, and is able to draw on salient observations made by the interpreter and use these to support or reassess their own observations and conclusions (Eagle, 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004).

2.4 Working with an interpreter

Interpreting is a specialised skill involving accurate, appropriate, effective and well-timed translation of information from one language to another. An interpreter would be used in a psychological setting such as therapy or psychometric assessment at the client’s request or if it is clear to the psychologist that the patient is more fluent in a language other than the psychologist’s first language. In order to ensure accurate and ethical assessment and treatment, an accurate understanding of what the client is communicating is important. It would be impossible to provide valuable, ethical psychological services without effective communication between the psychologist and the client (Eagle, 2005; Karliner et al., 2007; Miller et al., 2005; Tribe & Lane, 2009; Tribe & Thompson, 2008). Therefore, working with an interpreter is often necessary in order to address the client-psychologist language barrier.

In South Africa, the only official guidelines available for working with an interpreter in the mental health setting are those mentioned above in the Health Professions Act (1974) and Form 223 of the HPCSA (2004). However, the Australian Psychological Society (2013) provides extensive guidelines and considerations for working with interpreters. These considerations include the following:

a. that it is important to work with an accredited interpreter who is trained to be impartial;
b. that the interpreter needs to respect confidentiality and is accountable and strives for accuracy;

c. that the MHP must also bear in mind the significant ethical, professional and legal consequences involved when working with an unaccredited interpreter; and

d. in selecting an interpreter, the MHP needs to consider the client’s ethnicity, religion, education and level of literacy, and the language or dialect of the interpreter.

The above-mentioned points are important in order for communication to be effective. For example, a patient who has an educational level of Grade Seven will not understand the same terminology as a patient who has received a tertiary education. Given the points mentioned above, the psychologist and interpreter should adjust their language and communication style accordingly. Patel (2003) and Nijad (2003) report that it is often helpful to match interpreter and client for gender, age and religion. This is particularly relevant to the meeting or consultation, for example where it concerns a sexual assault or domestic violence. Furthermore, certain religions do not allow women to interact or be alone with a man who is not their husband, which would require a psychologist to consider gender and religion when working with an interpreter.

According to the Australian Psychological Society (2013), there are a number of practical considerations that need to be considered when working with an interpreter. These considerations will be discussed in the following section.

2.4.1 Assessing the need for an interpreter

At times a client will request for an interpreter if they are having difficulty understanding the psychologist, whilst other times it may be the psychologist who identifies the need for an interpreter. If the latter is the case, the psychologist will discuss this with the
client before arranging for an interpreter. Prior to arranging the interpreter, the psychologist may also provide information to the client regarding the role of the interpreter and what their services involve. Furthermore, they may also address any concerns or questions that the client may have about working with an interpreter (Australian Psychological Society, 2013).

When working with an interpreter, there are a number of things the psychologist needs to clarify prior to commencing work. The psychologist must ensure the interpreter knows the appropriate language and dialect of the client and take into consideration the client’s ethnicity and religion as discussed above. The psychologist should also establish whether the client needs a male or female interpreter, as the client may be bound by cultural or religious practice or may simply have a preference for an interpreter of a particular gender (Australian Psychological Society, 2013).

### 2.4.2 The accredited interpreter

An accredited interpreter is a trained bilingual professional, who is guided by a code of ethics. An interpreter is trained to be unbiased and to respect confidentiality (Australian Psychological Society, 2013; Hamerdinger & Karlin, 2002).

Furthermore, according to the South African Translators Institute (SATI), a qualified interpreter has a very high degree of linguistic proficiency, and a broad general knowledge. This includes knowledge about current affairs and a variety of technical subjects, insight into the cultural and political background of the speaker and the audience, a quick mind, analytical skills, a good short-term memory, the ability to stay calm under stressful conditions, note-taking skills (especially for consecutive interpreting) and knowledge of the subject matter (South African Translators Institute, 2007).
SATI states that written translating and interpreting require different skills. Translators may take their time to think about the best word or phrase required; however, interpreters are required to understand and respond almost immediately, and this requires specialised skills and training. Training courses for aspirant interpreters are available through SATI and they suggest that prospective interpreters should consider studying for a bachelor's degree with languages as major subjects. Some South African universities offer postgraduate qualifications in general and legal interpreting, and the Department of Justice provides training for its own court interpreters (South African Translators Institute, 2007)

Studies suggest that in order for therapy with the assistance of an interpreter to be effective, training and experience are essential for both the psychologist and interpreter (Drennan & Swartz, 1999; Eagle, 2005; Miller et al., 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004; Quinn, 2009). According to Tribe and Morrissey (2004), emphasis is always placed on the training of the interpreter, and slight emphasis on training for the MHP who will be requiring the services of an interpreter. Tribe and Morrissey (2004) found that difficulties may arise when both parties (interpreter and MHP) have not been formally trained.

2.4.3 The unaccredited interpreter

In South Africa there are limited resources and it is therefore not always possible to work with a trained interpreter or an MHP who has been trained to work with interpreters. Working with an unaccredited interpreter may entail a number of ethical, professional, and legal consequences, as well as other significant adverse outcomes, such as the following:

a. inaccurate translation of the psychologist’s or client’s communication, due to lack of knowledge of mental health terminology;
b. the possibility of information being withheld or distorted in translation because of family relationships or the emotional/sensitive nature of the issues;

c. inadequate communication due to lack of knowledge of interpreting techniques;

d. the undermining of hierarchical relationships in a family through the use of children as interpreters for their parents;

e. the undermining of the psychologist’s confidence that the necessary information is being communicated appropriately; and

f. the compromising of confidentiality (Australian Psychological Society, 2013).

The above implications may lead to inappropriate clinical decisions such as over- or under-estimating psychopathology, inappropriate therapeutic interventions or decisions that lead to complaints or litigation.

2.5 Ethical considerations when working with an interpreter

When the services of an interpreter are used, there are a number of ethical considerations. As mentioned previously, there are few official guidelines in South Africa for working with an interpreter in the mental health setting; hence the ethical considerations reviewed in the following section are guided by the American Psychological Association Code of Ethics (American Psychological Association, 2010). These state that psychologists who use interpreters should:

a. take reasonable steps to ensure that the interpreters are competent to work as interpreters in the relevant context;

b. take reasonable steps to ensure that the interpreter is not in a multiple relationship with the client that may impair the interpreter’s judgement;
c. take reasonable steps to ensure that the interpreter will keep confidential the existence and content of the psychological service;

d. take reasonable steps to ensure that the interpreter is aware of any other relevant provisions of this Code and

e. obtain informed consent from the client to use the selected interpreter.

2.6 Other important considerations when working with an interpreter

When using the services of an interpreter, there are a number of practical considerations. The practical considerations reviewed in the following section are guided by the Australian Psychological Society (2013).

2.6.1 Pre-existing and non-professional relationships

Pre-existing non-professional relationships need to be considered when working with an interpreter. The psychologist should determine whether there is a pre-existing non-professional relationship between the client and the interpreter prior to working with an interpreter. In smaller communities there is a greater likelihood of acquaintance between client and interpreter. As a result, there may be a risk of breach of confidentiality, which may impact seriously on the therapeutic process and also impose barriers to open and honest communication (Australian Psychological Society, 2013). Considering the collectivist nature of many South African communities, there may be a greater risk of pre-existing relationships, and the implications of this should be taken into account by the psychologist.

Form 223 of the HPCSA (2004) also states that the interpreter cannot have a multiple relationship with a client being served that would likely lead to exploitation or loss of
objectivity. Furthermore the Health Professions Act (1974) emphasises that psychologists are to take all reasonable steps to ensure that the interpreter with whom they are working does not have a multiple relationship with the client or patient.

2.6.2 Continuity of services

Another aspect to consider is continuity of care. If a psychologist consults with a client for a number of sessions, the same interpreter should be used for the following consultations with the client. Having to repeatedly establish rapport with new interpreters will hamper the therapeutic process. By retaining the same interpreter the psychologist is more likely to provide competent services to the client (Australian Psychological Society, 2013).

2.6.3 Pre-consultation meetings

A psychologist should always include a pre-consultation meeting before working with an interpreter. This will enable all parties to form a clear understanding of the purpose of the meeting and the role of all involved. In order to provide the interpreter with an outline of the session, the psychologist may arrange a pre-consultation meeting with the interpreter (Australian Psychological Society, 2013).

2.6.4 Collaboration

Collaboration is an important factor when working with an interpreter. Building a relationship with the interpreter and deciding together how they will work with one another is important. For example, this may include setting rules on how both psychologist and interpreter prefer to and are comfortable working. It is helpful if the psychologist provides the
interpreter with any important information that may provide an understanding of the context of the situation. Even if the psychologist and interpreter are only working together on a once-off arrangement, collaboration is recommended (Australian Psychological Society, 2013).

2.6.5 Communication

Effective communication is another consideration when working with an interpreter. A key feature of psychotherapy is that clients are required to communicate about difficult and personal experiences, emotions and interpersonal relationships. When using a language in which they are not fluent, this may become an even more difficult process. Additionally, when considering a psychiatric context, such as the presence of a thought disorder, delirium, dementia, anxiety or depression, the capacity to communicate in a second language is further impaired.

Without effective communication between the client and the psychologist, there will be limitations to the psychologist’s capacity in the following areas: the development of a therapeutic relationship, understanding the client’s point of view, understanding the cultural context of the client, conducting an assessment, formulating a diagnosis, reaching an agreement on an appropriate psychological intervention plan, providing psychological intervention, and evaluating the effectiveness and any adverse effects of the psychological intervention (Australian Psychological Society, 2013). Thus, working with an interpreter who is able to facilitate effective communication between a psychologist and a patient is beneficial to the patient and the quality of service they receive.

A limitation that may arise without effective communication between a psychologist and interpreter is that a patient’s cultural context may be misunderstood. It is not possible to discuss communication as comprising language only; other aspects of culture need to be
included in order to understand what is being communicated by a person. According to Bischoff et al (2002), cross-cultural communication is becoming increasingly important in the mental health care setting, considering the government’s attempts to provide equal access to mental health care for all South Africans.

The question whether interpreters should merely translate the spoken word or play a role in interpreting cultural and contextual variables that may be relevant to the mental health issues in question is a complex one (Tribe & Morrissey, 2004). Languages are not interchangeable. Words in one particular language may not exist in another, and certain adjectives, metaphors, colloquialisms and idioms cannot be directly translated, as they would not make sense. Translating between languages means, in effect, translating between two separate world views. Language is multi-faceted, dynamic, and constantly changing to incorporate new words or societal changes. Many theorists argue that language not only transmits meaning but also constructs and shapes it at the individual and societal level (Anderson & Goolishian, 1992 & Burr, 2003).

In considering the above, language then bears a close relation to particular ways of construing meaning that may not be shared across cultures (Mudakiri, 2003), and may both reflect and shape how the world is interpreted. The implications of the aforesaid for mental health care is that cross-cultural communication becomes essential in assuring that certain groups are not denied access to mental health care (Tribe & Thompson, 2008).

2.6.6 Accuracy of information

Another aspect of importance when using an interpreter is accuracy of information. It is necessary that the psychologist portray to the interpreter in pre-consultation meetings, the importance of accurate communication. An exact interpretation of what the client is
conveying is the ideal. The interpreter is also required to repeat the questions and responses of the psychologist and attempt to maintain the same meaning as the original message (Australian Psychological Society, 2013).

However, psychologists need to take into consideration that some words, phrases, idioms and expressions often have no direct translation in another language. Therefore, interpreters may need to be forewarned that clients presenting with a thought disorder, flight of ideas, dysphasia or mania may have difficulty expressing themselves in a clear manner. In these circumstances, it is necessary for the interpreter to attempt direct translation without applying their own meaning or understanding, in order for the clinician to observe the effects of the disorder (Australian Psychological Society, 2013).

2.7 Considerations in psychometric assessment

When conducting psychometric assessments, there are a number of considerations that must be taken into account when using the services of an interpreter. The considerations reviewed in the following section are guided by the Australian Psychological Society (2013), American Psychological Association (2010), and Foxcroft and Roodt (2005).

2.7.1 Psychometric norms

The adaptation of assessment measures is necessary in a multicultural and multilingual society such as South Africa if test results are to be reliable and valid for all test takers within the population. Practically this would imply that test takers from all language, cultural and socio-economic backgrounds should be given the same opportunity to respond to test items. The adaptation of assessments is a time-consuming and costly process that requires
high levels of expertise in translating and adapting measures. The same applies to the development of new assessment measures which are standardised to South African population groups. Given South Africa’s limited resources, the development of new assessment measures and/or adaptation of assessment measures are not always possible (Foxcroft & Roodt, 2005).

Given the above, an interpreter is often needed in the administration of psychometric assessments. Psychologists need to be cautious in the use and interpretation of psychometric tests when working with an interpreter and should take into consideration the norms and the population to which the assessment is standardised. Assessment instruments and their normative scores are often developed in English-speaking populations and they may not have been adapted for the population from which the client originates (Australian Psychological Society, 2013). Thus, using an interpreter would enhance fairness in assessment by allowing a person to be assessed in their language of choice. It would also decrease bias associated with assessing an individual in their second or third language and thus increase validity of the assessment results (Foxcroft & Roodt, 2005).

The informal translation of an instrument standardised to an English population is not recommended as it may change the meaning and difficulty of the items, possibly resulting in inaccurate scores. If a psychologist intends to use a psychometric assessment, it is recommended that this should be discussed with the interpreter during a pre-consultation meeting (Australian Psychological Society, 2013).
2.7.2 Administration of psychometric assessments

The HPCSA ethical code of professional conduct (Form 223, HPCSA, 2004) states that a psychologist who develops, administers, scores, interprets, or otherwise uses psychological assessment techniques, interviews, tests, instruments or other measures referred to in the Act shall:

a. do so in a manner and for purposes that are appropriate in the light of the research or evidence of the usefulness and proper application of such assessment methods, and
b. refrain from the misuse of assessment techniques, interventions, results and interpretations, and take reasonable steps to prevent others from misusing the information such methods provide.

The implication of this for working with an interpreter is to ensure that the application and administration of the assessment is conducted in the standardised manner. This means that the psychologist and the interpreter need to be adequately trained in administering an assessment and need to know the norms and standardised population of the assessment, what the assessment measures are, and what purpose the assessment is being used for (Foxcroft & Roodt, 2005).

Furthermore, there are a number of cultural considerations that need to be taken into account when administering psychometric assessments. The ethical principles provided by the American Psychological Association (2010) provide guidelines on the correct use of psychometric assessments. These principles recommend that a psychologist should use assessment methods that are appropriate to an individual’s language preference and competence, unless the use of an alternative language is relevant to the assessment issues.

Prior to administering an assessment, a psychologist must ensure that the assessment is valid and reliable (standardised) for the specific population being tested. When this
standardisation has not been established for the population, the psychologist needs to describe
the strengths and weaknesses of test results and interpretation (American Psychological
Association, 2010). Caution should be exercised when considering the use of translated
psychometric tests. The psychologist needs to record clearly on the client’s file and in the
assessment report that the instrument was translated by an interpreter and the psychologist
would need to provide his or her reasons for using an interpreter (Foxcroft & Roodt, 2005).

The psychologist also needs to describe the limitations that using an interpreter would
impose on the assessment results and interpretation. It may be necessary to seek supervision
from an expert in the area to assist in determining whether the results of an assessment are an
accurate representation of the client’s abilities (Australian Psychological Society, 2013;
Foxcroft & Roodt, 2005).

2.8 Expectations of the interpreter

There are different roles an interpreter is expected to perform, depending on the
theoretical orientation and preferences of the therapist they are working with (Drennan &
Swartz, 1999; Eagle, 2005; Miller et al., 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004;
Quinn, 2009). These roles differ with regard to the extent of the interpreter’s participation in
the process. Some therapists expect the interpreter to translate word for word. Other
psychologists want the interpreter to provide the cultural meaning behind the words, whilst
yet others expect the interpreter to supply relevant and valuable cultural or contextual
information throughout the therapy process. Working from an African perspective, it would
be impossible to view the interpreter as a linguist or as a machine (Hamerdinger & Karlin,
2002) that merely translates words. Therefore, the interpreter is viewed as an integral part of
the therapeutic process.
2.9 Challenges experienced by interpreters in South Africa

Interpreters may be constrained in the therapeutic process, as they are often given a low status within the health care setting. Interpreting is a complex skill, but this is not always acknowledged in practice (Drennan & Swartz, 1999).

The National Language Project conducted a study in Cape Town that involved the training of individuals to become interpreters and then placing them in hospitals and institutions (Drennan & Swartz, 1999). The study focused on Valkenberg hospital in Cape Town. The results indicated that there were a number of problems arising from lack of training and language issues. There were also previous expectations of what role an interpreter should perform within the hospital setting. Furthermore, there was resistance from psychologists and psychiatrists to viewing the interpreter as a team member due to their lack of training in interpreting but also in the field of psychology. However, there was an agreement that an interpreter was important and valuable in the provision of cultural knowledge (Drennan & Swartz, 1999).

In South Africa there are limited programmes offering formal training as an interpreter, particularly within the mental health sector. It is therefore difficult for interpreters to know what is required of them if this has not been communicated by the MHP (Tribe & Morrissey, 2004). Furthermore, emphasis is placed on the need for formal training on the part of the interpreter, not of the MHP working with the interpreter. This may become a challenge for the interpreter when expectations are not made clear by the MHP.

There are four models of interpretation in which an interpreter may be trained. The first is the linguistic model, where the interpreter attempts to interpret word for word as far as possible and adopts a neutral and distanced position. The second is the psychotherapeutic/constructionist model where the meaning and feeling of the words is most important, and the interpreter is concerned with meaning conveyed rather than word-for-word
interpretation. The third model is the advocate or community model, where the interpreter takes the role of advocate for the client, either at the individual or community level, and represents their interests beyond interpreting language for them. The last model is the cultural broker/bicultural model, where the interpreter interprets not only the spoken word but also relevant cultural and contextual variables. If an MHP does not understand the framework within which an interpreter works, just as if an interpreter does not understand the framework within which the psychologist works, miscommunication may occur (Tribe & Morrissey, 2004).

2.10 Conclusion

The introduction of democracy in South Africa and the new constitution in 1994 brought about a number of significant changes to the country, including the declaration of South Africa’s eleven official languages. Furthermore, the introduction of democracy in SA also implied changes to the health care sector and particularly the mental health care sector. Consequently, there was a movement towards increasing provision of and access to mental health care services to all South Africans, which included the promotion of cultural and language equality.

However, within the South African context there are limited resources, and many government hospitals and clinics may only have one MHP providing a service to an entire community. Challenges thus arise when a MHP cannot speak the language of members of that community and the need for an interpreter becomes necessary. The difficulty that MHPs are currently facing with regard to using interpreters in the mental health setting in South Africa is that ethically they are required to use interpreters in order to provide professional services although it appears that interpreters are not available or are untrained. They may
therefore provide inadequate services, which may result in a number of negative implications such as misdiagnosis and poor standards of therapeutic interventions. Consequently, it appears that there are numerous challenges involved in the use of interpreters in the South African context.

2.11 Preview of the contents of the following chapter

The following chapter highlights the importance of the therapeutic relationship. This is followed by a discussion of the challenges to this therapeutic relationship when using an interpreter.
CHAPTER 3
The Therapeutic Relationship and the Interpreter

Regardless of the theoretical orientation of the psychologist, a strong therapeutic relationship is viewed as essential for the therapeutic process. In the following section, this relationship will be explored, as well as the impact of interpreters on this therapeutic alliance. For the purposes of this study, the terms therapeutic relationship and therapeutic alliance will be used interchangeably.

3.1 The therapeutic relationship

Therapy commences when the therapist and the patient create a positive alliance. The therapeutic relationship demands a collaborative and active working partnership between the therapist and the client. This process includes a trusting and empathetic stance towards the client, mutual agreement on the goals of therapy (what the client expects from therapy), the assignment of tasks (efforts that have to be made for effective collaborative therapy) and the development of a bond (interpersonal therapeutic connection between client and therapist) (Barber & Muran, 2010).

3.2 Definitions of the therapeutic relationship

Different terms are used for the therapeutic alliance, all of which are based on similar conceptualizations (Messer & Wolititzky, 2010). The different terms that have been developed and utilized are presented here, rather than an exact definition of building a therapeutic alliance. These terms are the following:
Bordin (1979) defined the therapeutic alliance as collaboration between therapist and patient. In this relationship, the patient and therapist engage in a number of tasks designed to lead towards mutually agreed-upon goals. During that process, a bond develops that supports the patient’s capacity to develop hope and trust. He also differentiated between three components of the therapeutic alliance, namely: agreement on goals, assignment of tasks and development of a bond (Bordin, 1979).

Strupp and Binder (1984, p. 33) described the basis of a therapeutic alliance, stating that “when a trusting relationship is formed, which is an important precondition, then the possibility for collaboration in the joint endeavour of psychotherapy has been created and this is at the basis of building the therapeutic alliance.”

Greenson’s (1978) concept of the working alliance implies that agreement on goals and taking on the responsibilities of being a patient presuppose a degree of trust in the therapist’s good intentions and a sense of common purpose, which is closer to the goals and task components identified by Bordin (1979).

Zetzel (1966) used the term therapeutic alliance. His definition focused on the development of a therapeutic bond and the role of “ego identification” and trust in that development.

Luborsky (1984, p. 79) uses the term “helping alliance” to refer to “the degree to which the patient experiences the relationship with the therapist as helpful or potentially helpful in achieving the patient’s goals in psychotherapy.”
3.3 Humanist views on the therapeutic relationship

According to Rogers (1961), the first condition necessary and sufficient for therapeutic change is that two people are in psychological contact with one another, and that a professional relationship exists between them. A crucial component of the therapeutic relationship according to Rogers (1961) is therapeutic rapport. Empathy and understanding are crucial in the development of rapport between patient and therapist. In order for the client to feel safe, the goal in therapy must be mutual trust and respect.

Rogers (1961) views the role of person-centred therapists as being rooted in their ways of being and their attitudes, and not in techniques which require a patient to do something. Research on person-centred therapy seems to indicate that it is not knowledge theories or techniques that facilitate change in a patient, but rather the attitude of the therapist. These attitudes are empathy, congruence and unconditional positive regard. Furthermore, the attitude of the therapist facilitates the development of the therapeutic relationship. Thus, therapists use themselves and the therapeutic relationship as instruments of change (Rogers, 1961). The therapeutic relationship between the therapist and client is viewed as the vehicle of change (Corey, 2009).

When clients commence with therapy, they often enter with doubts and uncertainties about the therapist and the therapeutic process. In addition to these uncertainties there are the personal concerns for which they are seeking help, and this may result in some discomfort and distress for the client. There will therefore be a power imbalance when the therapist and client begin therapy (Mearns & Thorne, 2007). The therapeutic relationship is based on quality, rather than on a hierarchical power imbalance. The process of change in the client depends to a large degree on the quality of this equal relationship (Corey, 2009).
3.4 Psychodynamic views on the therapeutic relationship

Psychodynamic theories also highlight the importance of a strong therapeutic alliance. Psychodynamic therapy helps patients to develop an understanding of their defensive structures through a verbal dialogue and, like traditional analysis, includes building a relationship between client and therapist. This relationship illuminates the protective stance the client has towards himself or herself and towards others (Barber & Muran, 2010).

The patient-therapist relationship was first seen by Freud (1961) as requiring an attitude of collaboration and cooperation between the patient and the therapist – locating this within the unobjectionable positive transference. According to Freud (1961), there are six factors involved in building a therapeutic alliance:

1. showing serious interest in the patient;
2. clearing away resistance;
3. counting on the patient’s associating the therapist with at least one affectionate, benign figure from their past;
4. maintaining an attitude of sympathetic understanding;
5. avoiding a moralistic stance, and
6. not advocating for some contending third party.

Sterba (1934) asserts that throughout the therapeutic process both therapist and patient should be able to oscillate flexibly between experiencing and reflecting on the experience that occurs within the relationship. This is described as a split in the ego between an “experiencing ego” and a “self-reflective ego” (Sterba, 1934). The therapist should be able to immerse himself or herself empathically in the patient’s psychic reality and also be able to step back on that stance and reflect on the possible meanings of the patient’s experiences. Viewed in this manner, in the context of mutual agreement on tasks and goals, this aspect of
analytic work contributes to the development of a therapeutic alliance, which facilitates the patient’s receptivity to the analyst’s insight-promoting interpretations (Sterba, 1934).

3.5 The interpreter and the therapeutic relationship

The theory and definitions of the therapeutic relationship have been discussed. What follows is a number of practical examples of the above. In a study conducted by Miller et al. (2005) on the role of interpreters in psychotherapy with refugees, it was found that two main themes arose regarding the impact of interpreters on the therapeutic process.

The first theme concerns the impact of interpreters on the development of the therapeutic alliance. The study found that, before one determines the impact an interpreter would have on a therapeutic alliance, it is necessary to determine how to conceptualize that alliance once an interpreter enters the traditional two-person therapy relationship. An important consideration is whether the critical alliance is still the dyadic relationship or whether the therapeutic alliance becomes a triadic set of relationships that develop among all three individuals.

The second consideration is whether it is necessary for the client and the interpreter to develop a therapeutic alliance, and how this alliance may differ from the one between the client and the therapist. Furthermore, Miller et al. (2005) found that the above considerations were viewed differently by the participants depending on the manner in which participants viewed the role of the interpreter in the therapeutic process.

The aforesaid implies that the model of interpretation that is agreed upon by the therapist and the interpreter will have an impact on the therapeutic process (Miller et al., 2005). For example, considering the linguistic model, where the interpreter assumes a neutral position and attempts to interpret word for word as far as possible, the translator may be
viewed as a machine. Therefore, the interpreter’s personality and relationship with the client are clinically insignificant unless they adversely interfere with the therapeutic process. Using this model, the interpreter would be aiming for invisibility and the focus would be on the traditional dyadic relationship. A challenge that may arise when adopting this model of interpretation is that by attempting to “eliminate the person of the interpreter”, genuine therapeutic contact with the client may be compromised (Miller et al., 2005, p. 30).

Conversely, if the therapist and interpreter understood the role of the interpreter in more relational terms, then the cultural/bicultural model might be adopted. From this perspective, the interpreter is viewed as an integral part of the therapeutic process, and a sense of trust between therapist, client and interpreter is important for the development of a relationship. When applying this model, it is recommended that working with the same interpreter for all the sessions is necessary for the maintenance and integrity of the triadic therapeutic alliance (Miller et al., 2005).

Furthermore, Tribe and Thompson (2008) hold that using an interpreter may result in the psychologist feeling anxious and excluded from the interaction. The therapist may also feel angered, annoyed and even self-conscious about how the interpreter will perceive them and their work, and about having what is normally a private session observed by someone else (Miller et al., 2005). Miller et al. (2005) established that, although most therapists reported a positive experience of using an interpreter, all had experienced some challenges as well. These challenges included an interpreter inappropriately interjecting his or her opinion into a session or directly intervening with the client in a manner which the therapist found to be unhelpful. Other experiences resulting in frustration for therapists occurred when an interpreter ridiculed or belittled what the therapist was saying to the client, or when an interpreter would selectively interpret, omit, or add certain remarks (Miller et al., 2005).
According to Tribe and Morrissey (2004), the therapeutic relationship may be altered when working with an interpreter, as it necessitates dependence on another person. This may change the dynamic of therapy in different ways. Psychologists who are inexperienced in working with interpreters may become frustrated at having to rely on another person to assist them. Furthermore, as everything is being mediated through the interpreter, the therapeutic process may take longer than usual.

However, a number of positive experiences have been reported by therapists. Some felt that it enabled them to be more reflective in their work. Raval (1996) found that once practitioners had worked with trained interpreters, they developed a greater respect for interpreters and felt more positively towards the use of interpreting services. Some therapists also find it useful when an interpreter provides cultural context and meaning for what the client is saying, as this helps the therapist to gain a holistic view of the client. It also helps the therapist to accurately understand what the client is saying and the context in which they are saying it (Miller et al, 2005).

3.6 Challenges to the therapeutic relationship when using an interpreter

There are a number of challenges to the therapeutic relationship that arise when using an interpreter. These challenges include culture-bound therapeutic taboos that may hamper the therapeutic relationship, the experience of the interpreter, the experience of the client, the formation of alliances and the triadic relationship. These challenges will be discussed in this section, followed by a discussion of ways of addressing challenges when working with an interpreter.
3.6.1 Therapeutic Taboos

Certain culture-bound therapeutic taboos are present in definitions of the helping role. Some of these taboos include the injunction that therapists do not give advice and suggestions (as this fosters dependency), that therapists do not self-disclose their thoughts and feelings (this is unprofessional), that therapists do not barter with clients (this changes the nature of the therapeutic relationship), that therapists do not serve dual-role relationships with clients (there is a potential loss of objectivity), and that therapists do not accept gifts from clients (this unduly obligates them) (Sue, 2001).

Although the abovementioned taboos are derived from the profession’s standards of practice and ethical codes of conduct, many of these taboos are intimate aspects of helping others in certain cultures. Thus, it is possible that different racial/ethnic groups, particularly Black African ethnic groups, may perceive the competence of the helping professional differently from other client groups. Therefore, clients from a Black African cultural group may see a clinician who exhibits primarily therapeutic skills associated with mainstream therapies as having less credibility (Sue, 2001).

3.6.2 The interpreter’s experience

Miller et al. (2005) conducted a study that focused not only on the therapist’s experiences when using an interpreter with refugees but also on the interpreter’s experiences. The study concluded that interpreters spoke mainly of the emotional impacts they experienced when listening to painful stories relayed by the clients in therapy. Some mentioned that, during therapy, this would sometimes trigger difficult and painful memories and emotions from their own lives. If interpreters are not formally trained, these emotional triggers may potentially be disruptive to the therapeutic process, both if they are unable to control their emotional responses and in terms of transference and countertransference. The
risk of using an unqualified interpreter lies not only in the possible disruption of therapy but also in the possibility of causing discomfort or distress to the interpreter (Miller et al., 2005).

Other experiences reported by interpreters include frustration and anger at working with therapists who are untrained in working with interpreters. Difficulties may arise if an interpreter is trained within a particular model of interpretation and a therapist has a different expectation of what they require from the interpreter (Tribe & Morrissey, 2004). Furthermore, interpreters sometimes also experience a certain amount of frustration when working within a multi-disciplinary team where they are excluded or not viewed as equal or valuable members of the team (Drennan & Swartz, 1999).

3.6.3 The client’s experience

As the nature of the relationship in therapy when working with an interpreter is that of a triad, the experiences of the client are important to consider. Tribe and Morrissey (2004) found that clients are sometimes uncomfortable when an interpreter is present in the room during therapy. The clients felt uncomfortable because they were concerned about confidentiality or about information reaching other family members or the community, or simply because they were embarrassed.

Furthermore, considering the South African context, there is still stigma associated with mental illness, and a lack of understanding about the reasons why one would consult a psychologist. Thus, some clients find it difficult to confide in others that they are seeing a psychologist for fear of being stigmatized, victimized or perceived as weak. Given the close community-oriented nature of many South African communities, this may leave clients feeling threatened that the interpreter may know someone that the client knows and thus may create fear of stigmatization (Mkhize & Kometsi, 2008). It is therefore essential that the
therapist is mindful when making the decision to work with an interpreter and ensures that the client fully understands the therapeutic agreement and confidentiality.

Miller et al. (2005) report that some clients have had negative experiences when working with an interpreter. The clients reported that an interpreter may paraphrase or selectively interpret what they have communicated, which leaves them feeling frustrated. Furthermore, they reported that interpreters might adopt a casual or dismissive tone when relaying their message, which leaves clients feeling that their painful experience has been minimized and that they are being judged. This perception resulted in clients distrusting the interpreters, and discouraged ongoing discussion of their experiences. Clients have also had negative experiences of interpreters being verbally abusive, telling them they are weak and giving advice (Miller et al., 2005).

However, some clients have reported that they find it easier to discuss their cultural and religious backgrounds when working with an interpreter who is of the same cultural or religious background as they are. Tribe and Morrissey (2004) suggest that clients feel more comfortable, understood and respected when there is an interpreter present who can translate their language, culture and religious beliefs if necessary.

3.6.4 The psychologist’s experience

The psychologist’s experience and perceptions of using an interpreter will also have an impact on the psychologist’s competence. If a psychologist’s experience is one of being uncomfortable in the presence of an interpreter, or if they feel judged at having their private work observed, this will have an impact on the therapeutic relationship (Eagle, 2005; Tribe & Morrissey, 2004; Tribe & Lane, 2009). There is scant research and literature, especially from
a South African perspective, on the psychologist’s experience when working with an interpreter.

3.6.5 Alliance formation

The most significant finding in the research on the triad is that of the alliance and how the flexible adaptation of alliances impacts on the outcomes of interpersonal relations (Hill & McGrath, 2008). Alliance formation is an important factor to consider when working with an interpreter, as the therapeutic alliance is fundamental to the therapeutic process (Corey, 2009). Thus, elements which become influential in the formation of an alliance within a triadic relation need to be considered. Demographic information, including age, gender, race and socio-economic status, may influence the way in which alliances are formed (Hill & McGrath, 2008).

Within the South African context, some of the factors that may have an influence on the formation of an alliance are language, race, home context and culture. As a result, working with an interpreter challenges the notion of a traditional dyadic relationship in therapy (Eagle, 2005; Miller et al., 2005; Quinn, 2009; Tribe & Lane, 2009; Tribe & Morrissey, 2004). Furthermore, if the interpreter is of the same culture as the patient and the therapist is from a different culture, this may result in the formation of an alliance between the patient and the interpreter.

The alliances that may form include the following: the client and the interpreter forming an alliance to the exclusion of the psychologist; the interpreter and the psychologist forming an alliance to the exclusion of the client and the psychologist and client forming an alliance to the exclusion of the interpreter (Australian Psychological Society, 2013; Drennan & Swartz 1999; Hamerdinger & Karlin, 2002; Quinn, 2009; Tribe & Thompson, 2008). Furthermore, if the therapist and the interpreter have different ‘helping styles’ or view their
‘helping role’ differently, this may cause misunderstanding within their relationship and may hinder the therapeutic process.

3.6.6 The triadic relationship

Working with an interpreter implies that theories focusing on a dyadic relationship are invalid, as the inclusion of an interpreter changes the relationship from a dyadic to a triadic one. Furthermore, there has also been a shift in attitudes towards interpreters. Interpreters are now seen as part of a team in the provision of mental health services (Drennan & Swartz, 1999; Eagle, 2005; Tribe & Morrissey, 2004; Tribe & Lane, 2009).

Traditionally, the focus is placed on dyadic or two-person interpersonal communication in the literature on human communication, and scant research has been conducted on the changes in communication patterns that occur when a third person is added to a situation or relationship. However, triadic communication became a topic of research as early as the beginning of the twentieth century. Simmel (1950) argued that the three-person association may be the central or foundational unit for considering society and the socialization process. In addition, Simmel (1950) suggested that the addition of a third party allows for a majority and shifts the emphasis from the individual to the collective. Simmel (1950) distinguished between three different roles that the intruding third party could play, namely “mediator, tertius gaudens, and oppressor” (Simmel, 1950, p. 145).

Established relationships and communication patterns in dyads change once the third party enters the scene, depending on the role that the third party assumes. Simmel (1950) described how conflict between two people could shift power to the third person or otherwise benefit the third person (tertius gaudens), and how two people in alliance would tend to view a third person as an intruder and disturber of solidarity.
Caplow (1956) set a primary trend in triadic research by stating that under most circumstances triads have a tendency to divide into a coalition of two members against the third. This view was supported by Vinacke and Arkoff (1957), who indicated that adding a third person to a dyadic relationship creates a common enemy or outsider to oppose. Although this was viewed as a means by which to make a dyadic relationship stronger, the influence this would have on the therapeutic process, as well as on the therapeutic relationship, needs to be considered. If a coalition formed between two people during therapy using an interpreter, it would mean that the therapist, patient or interpreter would be viewed as the ‘outsider’ or the ‘enemy’. The aforementioned scenarios are not conducive to an effective therapeutic process or environment.

According to Buchli and Pearce (1975), studies of communication and alliance should focus on what meanings various persons have within a triad. For example, it would be helpful to determine how each person felt about being excluded from or included in an alliance. This would have consequences for how a client perceives the inclusion of an interpreter in therapy, for example as an ally, enemy, intruder or as providing assistance.

3.7 Methods of addressing challenges when working with an interpreter

To ensure that the commencement of work is done so in a professional manner, it is recommended that a working agreement is established from the beginning. The contract between psychologist and interpreter will vary depending on the context, however it will generally include areas such as professional conduct, ethics, boundaries, roles, responsibilities and confidentiality (Tribe & Morrissey, 2004).

The contract will need to be an agreement between the psychologist, the interpreter and the client. Form 223 of the Health Professions Council of South Africa (HPCSA, 2004)
specifically states that a psychologist who engages the services of an interpreter shall take steps to ensure that:

a. such interpreter is, at a minimum, bilingually fluent and is particularly conversant in the client’s language preference;

b. the interpreter preferably holds a qualification in interpretation approved by the council;

c. where it is clear that a client is not fluent in the psychologist’s language, at a minimum, the services of an interpreter be proposed to such client;

d. the interpreter does not have a multiple relationship with a client being served that would likely lead to exploitation or loss of objectivity; and

e. the interpreter performs the delegated tasks competently (Form 223, HPCSA, 2004).

Given the abovementioned, no mention is made of confidentiality. Therefore, with regard to confidentiality, the triad will need to make a decision on whether the same limits of confidentiality apply to the interpreter as to the psychologist.

The Australian Psychological Society (2013) elaborates on the above ethical considerations by providing guidelines and considerations when working with interpreters. These considerations include the following:

a. that it is important to work with an accredited interpreter who is trained to be impartial;

b. that the interpreter needs to respect confidentiality and be accountable and strive for accuracy;

c. that the MHP must also bear in mind the significant ethical, professional and legal consequences involved when working with an unaccredited interpreter; and

d. in selecting an interpreter, the MHP needs to consider the client’s ethnicity, religion, education and level of literacy, and the language or dialect of the interpreter.
The American Psychological Association (American Psychological Association, 2010) also provides ethical considerations for working with an interpreter which include the following:

a. Take reasonable steps to ensure that the interpreters are competent to work as interpreters in the relevant context.

b. Take reasonable steps to ensure that the interpreter is not in a multiple relationship with the client that may impair the interpreter’s judgement.

c. Take reasonable steps to ensure that the interpreter will keep confidential the existence and content of the psychological service.

d. Take reasonable steps to ensure that the interpreter is aware of any other relevant provisions of this Code.

e. Obtain informed consent from the client to use the selected interpreter.

Given the abovementioned research findings, it appears that challenges arise when using an interpreter. However, competent and professional services to all clients will be ensured by following ethical guidelines, being cognisant of the impact of the interpreter on the therapeutic relationship, and applying certain methods when using an interpreter. The aforesaid will promote cultural and language equality in the mental healthcare sector.

3.8 Conclusion

Regardless of the theoretical orientation of the psychologist, a strong therapeutic relationship is viewed as essential for the therapeutic process. However, there are a number of challenges to the therapeutic relationship that arise when using an interpreter. These challenges include culture-bound therapeutic taboos that may hamper the therapeutic relationship, the experience of the interpreter, the experience of the client, the potential for
the formation of alliances and the triadic relationship. However, there are methods and recommendations provided by the HPCSA (2004) and the American Psychological Association (2010) to address the challenges when working with an interpreter.

Furthermore, before working with an interpreter, one needs to consider the models of interpretation. The psychologist and interpreter must agree upon the model that is suitable for all parties involved. When working with an interpreter, it becomes clear that planning and contracting with an interpreter before therapy commences is essential to ensure the success of the collaboration.

3.9 Preview of the contents of the following chapter

In the following chapter, cultural competence and multiculturalism will be discussed. The researcher will also explore the African perspective on psychology that underpins this study. The African perspective will take into consideration aspects such as language, culture, traditions, family and society, all of which are relevant in working with an interpreter.
CHAPTER 4

Cultural Competence, Multiculturalism and the African Perspective on Psychology

In this chapter, cultural competence and multiculturalism will be discussed. The researcher will also explore the African perspective on psychology that underpins this study.

4.1 Cultural competence and multiculturalism when using an interpreter

In order to understand culturally embedded information that a client may bring to therapy, knowledge of the client’s culture is important. According to Sue (2001), if multicultural therapy using an interpreter is addressed using a holistic approach, therapy may be successful and meaningful. In the following section cultural competence and multiculturalism will be discussed.

4.1.1 Cultural competence

Cultural competence is an important factor in ensuring that the patient or client receives professional treatment. Sue (2001) states that mental health services are often not available to minority populations, or are inappropriate for them or even oppressive. Social justice is therefore an essential aspect of multicultural therapy competence. This means that multicultural therapy should provide equal access and opportunity, it should be inclusive, and should remove individual and systemic barriers to mental health services.
4.1.2 Definition of cultural competence

Sue (2001, p.12) proposed the following definition of cultural competence:

Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counselling competence is defined as the counsellor’s acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups.

A number of factors have hampered the incorporation of cultural competence into psychology. These include the belief in the universality of psychological laws and theories, the invisibility of mono-cultural policies and practices, disagreements about the definition of cultural competence, and the lack of a conceptual framework for organizing its multifaceted dimensions (Sue, 2001).

4.1.3 Components of cultural competence

A proposed model for cultural competence is the Multiple Dimensions of Cultural Competence (MDCC) proposed by Sue (2001). The MDCC functions from a set of shared core principles considered to be the foundation of a democratic society. These principles are inclusion, fairness, collaboration, cooperation, and equal access and opportunity (Sue et al., 1998). The MDCC allows for the systematic identification of cultural competence in a number of different areas (Sue, 2001). If an interpreter needs to be culturally competent, then
it may be assumed that there are guidelines for cultural competence, and a means of assessing it.

In South Africa, there are no official guidelines outlining or assessing cultural competence. Hanley (1999) describes cultural competence from a South African perspective and holds that culturally competent individuals accept and respect cultural differences. Furthermore, to have cultural competence is to continuously self-assess for cultural awareness, and to ensure that careful attention is paid to the dynamics of cultural differences, that there is the continual expansion of cultural knowledge and resources and that culturally relevant practices and service models are adopted in order to better meet the needs of the population.

Futter (2007) describes cultural competence as the ability of individuals and systems to work or respond effectively across cultures in a way that acknowledges and respects the culture of the person or organization being served. The emphasis is on the collective efforts of all involved in the system to provide a consistently high standard in cross cultural situations.

Despite differences in definitions, a core component of cultural competence is that of cultural sensitivity. Cultural sensitivity implies knowledge of culture and differences, awareness of one’s own cultural assumptions, skills necessary for successful cultural intervention, levels of worldview, universal healing conditions moderated by culture-specific contexts, the inclusive or exclusive nature of multiculturalism, and/or some combination of these factors (Sue, 2001).

The following table provides a summary of the core components of cultural competence according to the MDCC.


<table>
<thead>
<tr>
<th>Belief/Attitude</th>
<th>Knowledge</th>
<th>Skill</th>
</tr>
</thead>
</table>
| Is aware of and sensitive to own heritage.                                    | Has knowledge of own racial/cultural heritage.                                              | Seeks out educational, consultative, and valuing/respecting differences and how they affect perceptions. 
|                                                                                |                                                                                             | Has multicultural training experiences.                                                    |
| Is aware of own background/experiences and biases and how they influence psychological processes. | Posesses knowledge about racial identity development.                                       | Seeks to understand self as racial/cultural being.                                         |
|                                                                                             | Is able to acknowledge own racist attitudes and beliefs.                                    |                                                                                           |
| Recognizes limits of competencies and expertise.                               | Is knowledgeable about own social impact and communication styles.                          | Familiarizes self with relevant research on racial/ethnic groups.                           |
|                                                                                             |                                                                                             |                                                                                           |
| Is comfortable with differences that exist between oneself and others.         | Is knowledgeable about the groups one works with or interacts with.                         | Is involved with minority groups outside of work role: community events, celebrations, neighbours etc. |
|                                                                                             |                                                                                             |                                                                                           |
| Is in touch with negative emotional reactions toward racial/ethnic groups and can be non-judgmental. | Understands how race/ethnicity affects personality formation, vocational choices, psychological disorders etc. | Is able to engage in a variety of verbal/nonverbal helping styles.                           |
|                                                                                             |                                                                                             |                                                                                           |
| Is aware of stereotypes and preconceived notions.                              | Knows about socio-political influences, immigration, poverty, powerlessness etc.            | Can exercise institutional intervention skills on behalf of clients.                          |
| Respects religious and/or spiritual beliefs of others.                        | Understands culture-bound, class-bound and linguistic features of psychological help.       | Can seek consultation with traditional healers.                                             |
|                                                                                             |                                                                                             |                                                                                           |
| Respects indigenous helping practices and community networks.                  | Knows the effect of institutional barriers.                                                  | Can take responsibility for providing linguistic competence for clients.                    |
| Values bilingualism.                                                           | Knows bias of assessments.                                                                  | Has expertise in cultural aspects of assessment.                                            |
|                                                                                             |                                                                                             | Works to eliminate bias, prejudice, and discrimination.                                    |
|                                                                                             |                                                                                             | Educates clients in the nature of one’s practice.                                         |
|                                                                                             |                                                                                             |                                                                                           |

NOTE: Adapted from D. W. Sue, Arredondo, & McDavis (1992).
4.1.4 Cultural competence and working with an interpreter

Considering the proposed components of cultural competence as it is depicted in Table 1, consequences need to be considered when working with an interpreter in a psychological setting. According to Sue (2001), both the therapist and the interpreter have to be culturally competent, incorporating all of the components of cultural competence.

Therefore, when administering a psychometric assessment, or in providing therapeutic services, both the therapist and interpreter need to be culturally competent. Qualified psychologists have undergone a number of years of study and training; however, it may be argued that there is not sufficient focus in this programme on the cultural aspects of psychology. Despite the development of African psychology, the training that psychologists receive in South Africa is still based on the western model. The applicability of western-focused theories and interventions to Black South Africans is questionable. Considering the components of cultural competence, a shift in training to an African perspective is therefore required (Baloyi, 2008). Furthermore, interpreters would also be required to receive training in order to ensure their cultural competence. However, given the limited availability of resources in South Africa, the aforesaid is not always possible (Tribe & Morrissey, 2004).

4.2 Multiculturalism

4.2.1 Definition of multiculturalism

Helms and Richardson (1997) state that multiculturalism involves integrating the dimensions of a client’s culture into appropriate counselling theories, techniques, and practices. The intention is to provide clients from all backgrounds with effective mental health services. This definition implies that the goal of multiculturalism in mental health care
is to provide professional treatment to all populations. Furthermore, providing a patient with relevant, effective service implies cultural competence. If consideration is given to this definition of multiculturalism and its implications for working with an interpreter in the mental health setting, then merely providing a service with an interpreter does not imply multiculturalism, as cultural competence is an essential aspect of multiculturalism.

4.2.2 The MDCC applied to multiculturalism within South Africa

Multiculturalism refers to the integration of dimensions of a client’s culture into counselling or psychological theories. As a result, the MDCC is a relevant model, given the South African context, in that it utilizes a holistic approach to understanding personal identity demands.

The model recognizes the three levels of being: the individual level, which is a person’s unique characteristics; the group level, which constitutes shared cultural values and beliefs; and the universal level, which is the shared characteristics of being human. Unfortunately, the focus within the field of psychology has generally been on the individual and universal levels of identity, while placing less importance on the group level (Sue, 2001). This is problematic within a South African setting, as many South African cultures are based upon the principles of collectivism and community (Baloyi, 2008).

Eaton and Louw (2000) describe collectivism as a tendency within a culture to promote sociability and group orientation. Evidence has been found that individualistic and collectivist cultures differ in a number of ways. These include their cognitions, behavioural and emotional motivation, styles of communicating, patterns of social behaviour and ethical codes (Triandis & Suh, 2002). With regard to cognitions, collectivists tend to view the norms, obligations and duties within a society as fixed, whereas they see their own attitudes and personality as changeable. Furthermore, collectivists base their sense of satisfaction with
life on the approval of others and make decisions based on social norms rather than emotions (Triandis & Suh, 2002).

Green, Deschamps and Páez, (2005) maintain that interdependence is emphasized within collectivist societies. Priority is given to group goals, and people’s behaviour is thus measured mainly by group norms rather than by personal attitudes. From this collectivist perspective, the field of psychology within South Africa is neglecting its duty, for in a discipline that strives to understand the human condition, no level of a person’s identity should be neglected. In psychology, group identities such as race and ethnicity have historically occupied a peripheral role. Thus, the focus of this model of cultural competence and multiculturalism operates from a group perspective that is ethnically based (Sue, 2001).

4.3 The African perspective and multiculturalism

According to the African perspective of psychology, schools and theories of counselling and psychotherapy have arisen from Western European contexts. The worldview they advocate may not be applicable to other racial or ethnic groups in the world, and are therefore not multicultural or universally applicable (Sue, 2001). Given the South African context, the minority group in South Africa are Whites. Yet, the focus in psychological training is still based on a western model as opposed to an African perspective.

Baloyi (2008) states that, within the context of South Africa, the use of western theories in psychology creates a distorted impression that positions psychology and psychotherapy as irreplaceable and irrefutable western discoveries. This perception creates a tendency in which psychologists apply westernised theories to explain African experiences. Psychologists working in Africa with Black Africans are finding it increasingly difficult to
communicate with and effectively treat clients using western concepts and theories; hence the movement towards the development of African-based psychological theories (Baloyi, 2008).

4.3.1 History of the African perspective

The Association of Black Psychologists (ABP) was established in America in 1968, in response to the dominance of Eurocentric psychology. The ABP aimed to establish the origins of African psychological thinking so that these might serve as the foundation for an African paradigm. Holdstock (2000) arguably provides the most comprehensive overview of the African perspective on psychology, asserting that Africa has its own psychological dimensions that are unique and valid and accusing mainstream psychologists of neglecting this. Holdstock (2000) considers that Africa’s colonial past is still hindering further development in psychology; “To what extent the ethnocentric approach to psychology can be modified remains an open question, for the power wielded by Western institutions and paradigms is undoubtedly very strong and very difficult to resist” (Holdstock, 2000, p. 158).

Holdstock (2000) also discusses the African worldview and describes it as involving a living holism based in the lived experience. This differs from the worldview of Westerners, who are more privacy-oriented. Holdstock (2000) claims that Africans have an “other-centeredness”, characterised by a dynamic intrapersonal dimension. The concept of Ubuntu involves humaneness, care, compassion, gentleness, respect and empathy, and expresses the African way of human relatedness (Holdstock, 2000). Holdstock (2000) compares and contrasts Carl Roger’s’ person-centred approach with the concept of Ubuntu. Ubuntu is a function of being. The ultimate goal of Rogers was similar to that of Ubuntu, but the means through which it was implemented ultimately became associated with and restricted to the professional sphere.
The expression of Ubuntu in daily behaviour is also apparent in a wider range of behaviour and attitudes than was originally intended by Rogers (Holdstock, 2000, p. 202).

Baloyi (2008) supports Holdstock’s view and adds that many western concepts such as the psyche hold no scientific basis and cannot be sustained within the African context. He asserts that African concepts such as Ubuntu are more relevant in describing the process of being and personhood within the African context (Baloyi, 2008). In addition, Holdstock (2000) believes that attaining a universal psychology is possible if the indigenous psychologies of Africa are incorporated, with the emphasis on the psychological uniqueness of each culture.

In post-apartheid South Africa, South Africans are exposed to both western and traditional African experiences and lifestyles. Thus, similarly to Baloyi, Dawes (1998) and Eagle (2005) argue that African psychology should focus on and draw from both indigenous and westernized knowledge systems. This is because in modern-day Africa, both of these cosmologies exist side by side.

According to Baloyi (2008), the standards in terms of which all behaviour of every person in the world is understood and explained are from western formulations and conceptualizations. Psychologists are still using Euro-American concepts and theories to look at Africa and are still gathering data on the behaviour of Africans using inappropriate principles from a western perspective that are devoid of insight into African life and worldviews.

Baloyi (2008) calls for an indigenous psychology separate from a western perspective and states that this should be generated from a purely African perspective. In addition, Nsamenang (1995) states that, in order for psychologists to avoid misunderstanding African reality, an indigenous understanding of the behaviour of Africans is necessary. It is maintained that, when scholars apply western concepts and categories to African systems,
these concepts and categories are not conducive to the healing process. Nsamenang (1995) also believes that the emergence and development of an indigenous body of psychological knowledge is the only manner in which progress in psychology in Africa will be made. An indigenous African psychology will enhance our understanding of local phenomena as well as expanding our vision of problems experienced by Africans (Nsamenang, 1995). Baloyi (2008) adds that it is necessary to create a unique and original African epistemology. He purports that Africans should cease attempts to understand, advance and develop the African knowledge base by using English or any other western language, as he maintains it is not possible to describe African ideas using non-African theories (Baloyi, 2008).

4.3.2 The African perspective on psychology

According to Baloyi (2008), there has been a shift in psychology, and multiculturalism and the African perspective are receiving more focus and attention. This is important, as each cultural/racial group has its own interpretation of reality and offers a different perspective on the nature of people, the origin of disorders, standards for judging normality and abnormality, and the therapeutic approach.

Baloyi (2008, p. 6) holds that it is imperative to rethink psychology and psychotherapy in order to “(i) affirm the validity of indigenous African ways of knowing and doing; (ii) show that the exclusion of the indigenous African ways of knowing and doing from the Western paradigm illustrates the tenuous and questionable character of its epistemological and methodological claims to neutrality, objectivity and universality”.

As in the western perspective, there are also different views and theories within the African perspective. The term African refers to a polymorphous grouping of indigenous peoples and includes geographical diversity as well as the human diversity of different population groups. Furthermore, it includes language and religious diversity, as well as the
diversity of ways of life that fall between traditional and modern as mentioned above. However, unlike the western perspective, there are similarities among the diversity of various African cultures and an all-encompassing African perspective. According to Sow (1980), these similarities lie in the realm of spirituality and in the way Africans represent and express themselves in works of art and behaviours shown in everyday life. African thought has a distinctive character, in which principles are derived from symbols and myths, merging the universe and society and integrating the African personality (Grills, 2004).

4.3.3 The African perspective and mental health

Toldson and Pasteur (1982) believe that, because of traditional Africans’ connectedness with their physical and spiritual environments, they are better equipped to reach and sustain optimal development and psychological health than westerners. Toldson and Pasteur (1982) explain the difference in brain functioning between westerners and Africans. The westerner’s functioning is dominated by the left hemisphere of the brain in an attempt to investigate and analyse phenomena in order to understand and explain them logically. This results in an imbalance between the right and left hemispheres and results in tension and stress. This is one of the leading reasons why westerners seek help, in order to relieve this tension. By contrast, the holistic view of the person and the world from an African perspective yields the balanced use of both hemispheres. According to Toldson and Pasteur (1982, p. 25), “instead of one-sided dominance of the left hemisphere, the right hemisphere is not repressed in the African mind and is therefore allowed to freely interact with the left, infusing it with creative imperatives. This is how the wonderful blend known as harmony comes to reside in the personality”.

In addition, Toldson and Pasteur (1982) recognize collective existence as promoting optimal development and functioning among Africans. The stress and tension that westerners
experience can be attributed to the emphasis on individuals’ responsibility for themselves, which results in competitive relationships. In contrast, the selflessness of Africans associated with a collectivist existence offers security and safety that can counteract anxiety and tension. Responsibility is placed upon the community, and the emphasis is on helping and supporting one another as opposed to being in competition with one another.

Biko (1998) explains that music, dancing and rhythm play an important role in the daily lives of Africans, not only as a means of communication but also to attain emotional balance and mental health. Members of the community express their feelings through active participation in music and by dancing and singing. Holdstock (2000, p. 184) asserts that “rhythm brings purpose and meaning, enhances the understanding and the sense of being. It unites the individual with the great cosmic force. It lifts the spirits and in so doing, heals”. Music, dance and rhythm play an integral part in the attainment of a fulfilled life amongst Africans, and function as important psychological healing devices (Holdstock, 2000).

4.3.4 The African perspective and the therapeutic process

Western culture prioritises verbal language as a means of communication. In western-style psychotherapy, verbal communication seems to be the central means through which the therapeutic process occurs. However, according to Maiello (1999), within the African culture, music and rhythm are more valuable as a means of communication and words do not seem to have the same value. Therefore, what western people think and talk about, African people tend to act and represent in dancing and singing. This implies that psychotherapy, which is based mainly on verbal communication, might not have the same outcome in an African context.

Within the African context, the individual is seen as an integral part of the community and thus therapy or healing is grounded in the collective existence. Therefore, treatment is not
individualistic but requires the cooperation of the family and the community (Bührmann, 1984). Parle (2007, p. 9) concurs that African therapeutic systems emphasize “collective social responses to afflictions rather than individualistic diagnosis and treatment”.

4.3.5 The African perspective, psychologists and interpreters in South Africa

Baloyi (2008, p. 94) states that African psychology should be central to curriculum development and teaching in South African institutions. Furthermore, he maintains that, if western psychology continues to be the focus for psychological training in South Africa, “psychology will continue to be perceived as a theoretical subject that bears no practical and healing relevance to African communities”. Other researchers namely Grills (2004), Baloyi (2008), Mkhize & Kometsi (2008), Obasi (2002), Parham (2002), and Ka Sigogo and Modipa (2004) also argue for the recognition of African healing practices within psychology.

The cultural context of mental health theories shapes the definition of the problem and influences the appropriate therapeutic response. Race, culture, ethnicity, and gender may influence and shape worldviews. Furthermore, the theoretical orientation of mental health professionals, including interpreters, may also influence their conceptions of the world and the manner in which they relate to the client. Therefore, one would need to consider the impact it would have on the therapeutic process if the therapist, client and interpreter were from different cultures (Dumas, Rollock, Prinz, Hops, & Blechman, 1999; Fraga, Atkinson & Wampold, 2004; Sue, 2001).

Considering the African perspective with its own views on mental health, psychology, psychopathology and the helping relationship, it is important to consider the impact that the inclusion of an interpreter would have on therapy. If an interpreter is not familiar with the African perspective, or if the psychologist is not familiar with the African perspective or a particular culture, there would be implications for the understanding of or meaning attached
to the interpretations. Furthermore, an interpreter who has an understanding of a client’s culture may be beneficial in helping the psychologist understand certain culture-bound statements or experiences.

Furthermore, multiculturalism is based on the premise that race, ethnicity, and culture are powerful variables in influencing how people think, make decisions, behave, and define events. It is therefore plausible to conclude that such variables may also affect how different groups or cultures would define a helping relationship (Dumas et al., 1999; Fraga et al., 2004; Sue & Sue, 1999 cited in Sue, 2001). Therefore, different theories of counselling and psychotherapy represent different worldviews, each with its own values, biases, and assumptions about human behaviour (Ivey, A., Ivey, M., & Simek-Morgan, 2002; Katz, 1985; Sue, 2001).

4.4 Conclusion

Cultural competence is an important aspect in ensuring that the patient or client receives professional treatment. Thus, social justice is a necessity of multicultural therapy competence. This means multicultural therapy should provide equal access and opportunity, it should be inclusive, and remove individual and systemic barriers to mental health services.

In South Africa, there are no official guidelines outlining or assessing cultural competence. Hanley (1999) describes cultural competence from a South African perspective and holds that culturally competent individuals accept and respect cultural differences, continue to self-assessment their cultural awareness, pay careful attention to the dynamics of cultural differences, continually expand their cultural knowledge and resources and adopt culturally relevant service models in order to better meet the needs of the population.
The goal of multiculturalism in mental health care is to provide relevant treatment to all populations. Multiculturalism refers to the integration of dimensions of a client’s culture into counselling or psychological theories. The MDCC is accordingly a relevant model, given the South African context, in that it utilizes a holistic approach to understanding personal identity demands. The model recognizes the three levels of being: individual (uniqueness), group (shared cultural values and beliefs), and universal (common features of being human). Unfortunately, within the field of psychology, the focus has generally been on the individual and universal levels of identity while placing less importance on the group level. This is problematic within a South African setting, as many South African cultures are based upon the principles of collectivism and community.

In light of the above, the western-trained therapist must be cognizant of the influence of social structures on behaviour and mechanisms that form an intricate part in the attainment of a fulfilled life amongst Africans, and this also plays an important role in the healing process. Therefore, psychologists and interpreters should be given training to enable them to offer appropriate services to all South Africans.

4.5 Preview of the contents of the following chapter

The following chapter will focus on the research methodology, research design and aims and objectives, and will explore the research context of the study. The demographics of the participants will be elaborated on and the data collection method will be discussed. This will be followed by a discussion of the measures which the researcher adopted in order to maintain the quality of the research study, as well as the ethical considerations.
CHAPTER 5

Methodology

In this chapter, the research methodology will be discussed. This includes the aims and objectives of the study, the choice of qualitative research, the research design, the method of enquiry, the participants, sampling, data collection, data analysis, trustworthiness and ethical considerations.

5.1 Aims/objectives of the study

This study aimed to explore and describe the experiences of clinical psychology interns when working with interpreters in a multicultural environment in Dr George Mukhari hospital. This was done through a qualitative phenomenological investigation.

The objectives of the study were to

- gather information, using the interview guide, on the experiences of clinical psychology interns when working with interpreters;
- understand challenges that arise when using an interpreter; and
- explore the relationship dynamics when an interpreter is involved.

5.2 Qualitative research

The method of investigation was a qualitative study. Qualitative research is primarily exploratory. It is used to gain an understanding of underlying reasons, opinions and
motivations. It provides insights into the problem or helps to develop ideas or hypotheses for further potential research (Wyse, 2011). Similarly, Willig (2008) maintains that qualitative research involves exploring how people make sense of their world and how they interpret and understand certain events and experiences. Qualitative research involves exploring people’s subjective experiences and discovering what is real for them. Qualitative also means that the research is studied in a great deal of depth and detail in order to attempt to understand human and social phenomena from the perspectives of the participants (Babbie & Mouton, 2010; Terre Blanche, Durrheim & Painter, 2006). Furthermore qualitative research is concerned with the quality and depth of experience rather than focusing on cause-effect relationships. The objective of qualitative research is to describe and possibly understand and explain events, but never to predict events (Willig, 2008).

Qualitative research was appropriate for this study as the aims of the study were to explore and describe the experiences psychology interns when working with interpreters. The study was interested in the subjective experiences of the participants in an attempt to understand and explain the experiences they had. The study was not aimed at proving a hypothesis or determining a cause-effect relationship but rather at understanding a social phenomenon from the participants’ perspectives. The study also aimed at developing ideas and hypotheses for further research.

5.3 Research design

The study was explorative and descriptive, as the researcher was discovering the participants’ lived experiences and opinions in the context in which they occurred (Babbie & Mouton, 2010; Terre Blanche et al., 2006). Descriptive research can be concrete or abstract. Descriptive research aims to give accurate and valid depictions of the variables that are of
concern to the research question (van Wyk, 2012). Good description provokes the ‘why’ questions of explanatory research. A disadvantage of descriptive research is that it can result in mindless fact gathering, unfocused surveys and case studies that report irrelevant information that is of no consequence. Furthermore it may fail to provoke any ‘why’ questions or provide any basis for generalization. However, this is more a result of inconsequential descriptions on the part of the researcher than a disadvantage of descriptive research itself (van Wyk, 2012). The researcher used a descriptive research design as she hoped to provide in-depth, detailed descriptions of the participants’ experiences when working with an interpreter. Furthermore, she hoped to explore the reasons why these experiences occurred.

5.3.1 Phenomenology

The study is rooted within phenomenology. Phenomenology is concerned with the ways in which human beings gain knowledge of the world around them. Phenomenology identifies different methods for human understanding and it argues that certain forms are more constructive than others. Phenomenology is interested in the world as it is experienced by human beings within particular contexts and at particular times. It does not focus on abstract statements about the nature of the world in general. From the phenomenological perspective, it is not possible to think of the world of objects and subjects as separate from our experience of it, as all objects or subjects must present themselves to us as something. This something then constitutes their reality at any given time (Willig, 2008). Phenomenologists urge researchers to return to ‘the phenomena themselves’ as they are revealed in consciousness and lived experience, rather than to impose previously derived theories in the search to understand human behaviour and experiences (Terre Blanche et al., 2006). Attempting to explore a person’s phenomenology involves in-depth, comprehensive
descriptions of their lived experiences in the context of particular phenomena (Groenewald, 2004).

A phenomenological investigation design was utilized for this study. This was appropriate because the researcher was exploring and describing intern psychologists’ personal perspectives on using an interpreter in the therapeutic setting. The researcher attempted to explore the lived experiences of the participants rather than impose previous theories or hypotheses in attempting to understand their experience.

5.4 Method of enquiry

In this section, a description of the research process will be presented. The description will include the selection of participants, the process of gathering data using semi-structured interviews and an explanation of the method of the data analysis process.

5.4.1 Participants

5.4.1.1 Inclusion/Exclusion criteria

The participants who participated in this study were English and Afrikaans-speaking clinical psychology interns who could not speak an African language. The participants were of various ages and there were five females and two males. The research setting was Dr George Mukhari Hospital. The participants had experience of working with interpreters in therapy and assessment settings.

5.4.1.2 Sampling

The sampling methods used for this study were convenience and purposive sampling (Terre Blanche et al., 2006). Purposive sampling occurs by grouping participants according to a number of preselected criteria relevant to the research question. The size of the sample depends on the objectives of the study as well as the time and resources available to the
researcher. The sample sizes may or may not be fixed prior to data collection. Purposive sample sizes are often determined when new data no longer brings additional information or insights to the research question. This is known as theoretical saturation. Purposive sampling is therefore most successful when data review and analysis are done concurrently with data collection (Denzin & Lincoln, 2000). Participants are selected using purposive sampling when the researcher believes they are likely to generate useful data for the project. Purposive sampling consists in selecting a sample on the basis of the researcher’s knowledge of the population, as well as the nature of the research aims (Babbie & Mouton, 2010). The individual characteristics are selected to answer necessary and specific questions about a certain matter or experience (MacNealy, 1999). Based on this, the researcher is then able to select participants for the study on the basis of internal knowledge of said characteristics. This method is useful if a researcher wants to study a small group or sample of a larger population in which many members of the group are easily identified, but where to work with or include all in the study would be impossible (Babbie & Mouton, 2010). In this study the sample of English or Afrikaans-speaking interns was selected as they represented the population who could not speak another African language and who therefore had to make use of interpreters when doing therapy or assessment.

Convenience sampling was used in an effort to save time and money. Convenience sampling includes participants who are readily available and agree to participate in a study (Fink, 1995; Frey, Botan, & Kreps, 2000; Henry, 1990; MacNealy, 1999). Convenience sampling was chosen for this study as the researcher was herself an intern psychologist at Dr George Mukhari Academic Hospital (DGMAH) and thus had knowledge of and access to the participants for the study. The researcher was aware that many of her colleagues had worked with interpreters at the hospital and at other clinics and institutions. A disadvantage of convenience sampling is that, if participants are only obtained by the convenience method,
the findings will be, at best, only inferences and the researcher will be unable to make any stronger assertions. Thus both purposive and convenience sampling methods were used for this study.

Convenience and purposive techniques do not always facilitate the generalization of findings (Terre Blanche et. al, 2006); however; that was not the focus of this study. Participants were chosen in an attempt to represent the population group of English/Afrikaans speaking interns at DGMAH. Interviews and therefore sampling continued until data saturation had occurred. A sample of seven participants was used.

5.5 Data-collection

The main form of data collection for this study was semi-structured interviews (Babbie & Mouton, 2010; Terre Blanche et al, 2006; Willig, 2008). In a semi-structured interview, the interviewer and participants engage in a formal interview. In semi-structured interviewing, an interview guide is used. This is to ensure that all questions and topics necessary for the study are covered. The interviewer has some flexibility regarding the order in which questions are asked; however, the questions are standardized. A researcher may probe a participant to ensure the interview covers sufficient and appropriate material. This kind of interview allows for detailed information to be collected in a manner that is somewhat conversational. Semi-structured interviews are often used when the researcher wants to enquire deeply into a topic and to understand thoroughly the answers provided.

To begin with, the interviewer develops and uses the interview guide, which is a list of questions and topics, in a particular order, that are necessary to answer the research question and thus need to be covered during the conversation. The interviewer mostly follows the guide, but is able to follow other topics and points of interest which the interviewer deems
important as they arise in the conversation. The semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable, comparable qualitative data. Cohen and Crabtree (2006) are of the opinion that prior to the use of semi-structured interviews, researchers should observe and participate in informal and unstructured interviewing so as to develop a thorough understanding of their topic of interest. This is so that they may develop questions that are relevant to their topic and will provide them with meaningful responses. A researcher who is well trained and makes use of open-ended questions may follow topics that stray from the interview guide if they believe this will provide an opportunity to view their topic in a new and insightful way. Typically, with a semi-structured interview, the interviewer has a paper-based interview guide that they follow. Since semi-structured interviews often contain open-ended questions and discussions may deviate from the interview guide, it is generally best to tape-record interviews and later transcribe these tapes for analysis. Furthermore, to ensure that a participant feels comfortable and is able to speak openly, the development of rapport and dialogue is essential in semi-structured interviews. Semi-structured interviews also allow participants the freedom to express themselves, their views and their experiences in their own manner. Semi-structured interviews can provide reliable, comparable qualitative data (Cohen & Crabtree, 2006).

This study was interested in the interns’ personal experiences of working with interpreters. Therefore, interviews were an effective and appropriate method to gather this information. The semi-structured interview provides an opportunity for the researcher to hear the participant talk about a particular experience. The interviewer asks questions and steers the interview to obtain data that will answer the research question. The interviewer needs to find an optimal balance between maintaining control and leading the interview on one hand and, on the other, allowing the participant space to redefine the topic, make sense of it and provide the researcher with original insights into the topic. The researcher needs to consider
certain aspects that will impact on the interview process, such as their own social identity, linguistic variety and rapport (Willig, 2008).

The interview agenda for a semi-structured interview consists of a relatively small number of open-ended questions (Willig, 2008). The interviews in this study were open-ended in an attempt to gauge an accurate representative response without leading the participant. The interview was designed in an attempt to determine how the participants had experienced working with an interpreter and what experiences had led them to feel this way. Semi-structured interviews were suitable for the research design as they allowed a detailed descriptive picture of the personal experiences that interns had when working with interpreters (Willig, 2008). In this study the interview began with an open-ended introductory question followed by a number of further probing questions in an attempt to gather enough information to answer the research question. Willig (2008) also states that at times it may be a good idea to restate interviewees’ comments and to incorporate them into further questions throughout the interview. This affirms that the interviewer is indeed listening and allows the interviewer to check with the participant that they have understood correctly what has been said.

The interviews were recorded and then transcribed. Qualitative methods of analysis often require that interviews are transcribed verbatim or near-verbatim (Willig, 2008). The researcher asked for consent to use a tape recorder to record the interviews to be transcribed later. The reason for recording the interview is that it allows the researcher to gain a more detailed, accurate record of the interviews and allows the researcher to focus on the participant and interview process rather than on writing notes (Greef, 2005:298).

An interpretive approach was used, meaning that the interviewer attempted to create an environment of openness and trust in order for the interviewee to feel sufficiently comfortable to provide honest and authentic responses (Terre Blanche et al., 2006).
5.6 Data analysis

Thematic analysis was used to analyse data for this study. Having collected all the data, the researcher adopted the manual analysis method. The audiotapes were transcribed, coded, and sorted according to salient themes that emerged inductively from the data. The themes were issues that arose consistently across the data. The resultant transcripts were read and re-read alongside the accompanying field notes that were taken during the interviews (Potter & Hepburn, 2005).

According to Patton and Cochran (2002), thematic analysis is a method in qualitative research which involves searching through data to identify any recurrent patterns. A theme is a group of similar linked categories portraying similar meanings. The themes usually emerge through the inductive analytic process which characterises the qualitative paradigm. An advantage of this technique is its exploratory power which is enhanced when the researcher lacks any previous knowledge of the research topic. This would ensure that the researcher is not guided by any preconceptions. Thus, the researcher does not have to be an expert in the research topic in order to conduct their study. However, in order to begin analysis, a researcher must have at least some conceptual understanding to guide the insight processes (Patton, 2002; Zhang & Wildemuth, 2009).

The first step in thematic analysis is to prepare the data for analysis. This was done by transcribing the interviews into text and formatting the document so that the margin could be used for identifying individual bits of data. The next step was to read the text and note items of interest. The researcher began with the initial reading of the text. As mentioned above, an inductive approach to thematic analysis allows themes to emerge from the data, rather than searching for pre-defined themes. During the first reading of the data, the researcher made notes of major issues as they emerged in order to develop a sense of the various topics rooted in the data. As a third step the researcher re-read the text and wrote any thoughts in the
margin. The researcher examined the text line by line, to facilitate a micro-analysis of the data. This process also promoted open coding which helped to identify any new information by de-contextualising bits of data embedded within the primary material (Patton, 2002; Green & Thorogood, 2004; Zhang & Wildemuth, 2009).

The fourth step in the process is where coding begins. The researcher began by sorting items of interest into proto-themes. This is the step where themes begin to emerge through the organizing of items relating to similar topics into categories. This should be a fluid process so that categories can be modified and developed and new ones allowed to emerge freely. At this stage, keeping the themes as simple as possible assists flexibility in the categorization process whereby any re-ordering of the clusters of categories can help create and re-define the initial themes. The following step is to examine the proto-themes which have been identified and to attempt to form initial definitions. A provisional name and working definition was created for every emerging theme. Next the researcher re-examined the text carefully for relevant occurrences of data for each proto-theme. This second process of searching back through the data is also called axial coding. As human perception is selective, relevant data can at times be overlooked. Thus, it was necessary at this stage to look at each theme separately and re-examine the original data to ensure relevant information relating to each theme was not overlooked. Furthermore, pieces of data previously assigned to a theme may have been misunderstood and in fact be contradictory. Finally the researcher constructed the final form of each theme. Again, the name, definition and supporting data of each theme were re-examined by means of working through all the material relating to it. This stage of re-contextualisation focuses more closely upon the underlying meaning of each theme (Patton & Cochran, 2002; Green & Thorogood, 2004; Zhang & Wildemuth, 2009).

The last step in the analysis process is to report each theme. This was done by deciding and finalising the name of each theme, writing its description and illustrating it with
a few quotations from the original text to help communicate its meaning to the reader (Patton & Cochran, 2002; Green & Thorogood, 2004; Zhang & Wildemuth, 2009). The findings are reported in chapter 6.

The study adopted the stance of Van Manen (1997; 2002) who argues that phenomenological data is interpretative and should occur through the deliberate act of describing experiences. In describing the experiences of the interns, whole cases were compared with other whole cases in order to identify the central themes of the research. When documenting these themes, one is describing a theory that describes the shared nature of the phenomena under investigation (Forbes, 1999). The interpretation of experiences of intern psychologists working with an interpreter involved closely scrutinizing the transcripts, studying other sources of literature and self-reflection of personal experience.

5.7 Trustworthiness

Trustworthiness helps to persuade others that the findings of a study are worth taking note of. Trustworthiness is based on four concepts: credibility, transferability, dependability and confirmability (Babbie & Mouton, 2010).

5.7.1 Credibility

Credibility is similar to the concept of internal validity in that it helps to answer the question “How congruent are the findings with reality?” (Shenton, 2004:64). To increase credibility for this particular study, the researcher engaged in prolonged exposure to the research material and field of research, triangulation, and negative case analysis, checked her interpretations against the raw data, and carried out peer debriefing and member checks where necessary. Owing to the researcher’s limited experience of coding, she needed to
design transparent processes for coding and drawing conclusions from the raw data (Babbie & Mouton, 2010).

### 5.7.2 Transferability

Transferability refers to the extent to which the research can be applied to other contexts. The researcher took pains to provide data sets and descriptions of the data that were rich and thorough enough to allow other researchers to make judgements about the transferability of the data. In making use of content analysis, the researcher’s own way of thinking, preconceptions and assumptions were not necessarily viewed as biases but were rather seen as necessary for making interpretations and understanding another person’s experience. For this reason the transferability of the study may be questioned. Phenomenological investigation is also questionable in terms of transferability, as there were only a relatively small number of participants in the study (Shenton, 2004; Babbie & Mouton, 2010).

### 5.7.3 Dependability

Dependability refers to the coherence of the internal process and the way the researcher accounts for changing conditions in the phenomena. It also refers to the fact that, if the study were to be repeated with the same or similar subjects in the same or similar context, the findings would be similar. If the techniques identified to ensure credibility are followed, this should establish the study’s dependability (Shenton, 2004; Babbie & Mouton, 2010).

### 5.7.4 Confirmability

Confirmability refers to the extent to which the characteristics of the data, as posited by the researcher, can be confirmed by others who read or review the research results (Zhang & Wildemuth, 2009). This means that the findings are in fact the product of the data and are
not influenced by the biases of the researcher (Babbie & Mouton, 2010). To ensure confirmability the researcher left an “audit trail” which would mean that an auditor would be able to trace all conclusions, interpretations, findings etc. to their sources. The researcher was sure to supply and record accurately all raw data, data reduction and analysis products (including field notes, theoretical notes, working hypotheses etc.), data reconstruction and synthesis products (themes, findings, conclusions), process notes, material relating to intentions and dispositions as well as instrument development information (Shenton, 2004; Babbie & Mouton, 2010).

5.8 Ethical considerations

Ethics, also known as moral philosophy, is a branch of philosophy that involves systematizing, defending, and recommending concepts of right and wrong behaviour. The aim of ethics is to help people decide what is right and what the correct means are to achieve the right result (Jones, Sontag, Beckner & Fogelin, 1969). Ethics is also not about making a decision that will make someone feel good, as doing the right thing may sometimes be distressing, but rather involves adhering to a set of codes or guidelines to ensure that principles such as autonomy, beneficence, non-maleficence and justice are maintained (Allan, 2008).

Psychologists are committed to increasing scientific and professional knowledge of behaviour and people’s understanding of themselves and others. Psychologists are also committed to the use of such knowledge to improve the condition of individuals, organizations and society. Psychologists respect and protect civil and human rights and the central importance of freedom of inquiry and expression in research, teaching, and publication (American Psychological Association, 2010). Psychologists perform a number of
roles, such as researcher, in striving to help the public to develop informed judgments and choices concerning human behaviour. Due to the nature of psychologists’ work and the role they play in their interaction with people, certain guidelines, principles and standards were constructed for the protection of the client, or of participants in the case of research, and of the psychologist (American Psychological Association, 2010). Particularly with regard to this study, the following ethical considerations were adhered to:

5.8.1 Ethical clearance

Prior to commencement of this study, the researcher first obtained a clearance certificate from the Medunsa Research Ethics Committee (MREC). The researcher also obtained permission from Dr George Mukhari Hospital in order to conduct her research there.

5.8.2 Ethical codes

The study required the researcher to work with and interview a number of participants. This required her, as a researcher, to promote values that are essential for collaborative work. These included aspects such as fairness, trust, accountability and mutual respect. The researcher considered ethical norms such as human rights, health and safety issues, and following the law (David & Resnick, 2008). She also needed to ensure that the ethical codes, principles, standards and guidelines outlined by the American Psychological Association (2010) were followed so as to ensure scientific validity and a favourable risk/benefit ratio (American Psychological Association, 2010; Terre Blanch et al., 2006). A number of guidelines provided by the Health Professions Council of South Africa (HPCSA) (2004) and pertaining to the rules of professional conduct for psychologists, particularly with regard to research, were also adhered to.
5.8.3 Informed consent

For the purpose of this study the researcher needed to consider the issue of informed consent. She informed the participants about the overall purpose of the investigation, any possible risks or benefits, and confidentiality (Babbie & Mouton, 2010). The participants were informed about the nature of the study and informed that they were free to participate or decline to participate as well as withdraw from the research at any point (HPCSA, 2004). The researcher also obtained informed consent to record the interviews and ensured participants that the recordings would be used in such a manner that personal identification would not occur.

5.8.4 Confidentiality

Confidentiality is an important factor in this study. The participants' and interpreters’ identities needed to be protected to ensure that no negative consequences arose from the study. Confidentiality means the researcher can identify a participant by their responses, but promises not to do so publicly. A number of methods were employed to ensure confidentiality, such as names and any other identifying information being removed from interview guides and replaced with letters and numbers (Babbie & Mouton, 2010).

5.8.5 Debriefing

The researcher provided the opportunity for the participants to receive debriefing if necessary. An opportunity for the participants to obtain appropriate information about the nature, results and conclusions of the study was also provided.
5.9 Bias

Bias is defined as any affinity which helps to prevent unprejudiced consideration of a question (Babbie & Mouton, 2010). During sampling or testing, systematic error is introduced when one outcome is encouraged above others: this is bias. Bias can occur at any phase of research, including study design or data collection, as well as in the process of data analysis and publication.

5.9.1 Selection bias

When identifying the participants for the study, selection bias might have occurred. When a study population is identified, selection bias occurs when the criteria used to recruit participants into separate study units are fundamentally different (Pannucci & Wilkins, 2011). The researcher attempted to reduce selection bias by clearly defining her population group and ensuring they adhered to the inclusion/exclusion criteria mentioned above. The researcher was aware that the members of the sample population differed in terms of age and gender; however, this was unavoidable given the limited access to participants available to the researcher at the hospital. The researcher felt that despite these differences, the study was still valid.

5.9.2 Researcher Bias

Researcher or interviewer bias refers to systematic differences in the ways information is solicited, recorded, or interpreted (Pannucci & Wilkins, 2011). The researcher needed to be aware of her own bias and predispositions towards the topic of study, as she was also an intern psychologist who worked with interpreters at DGMAH. This was addressed by having another trained clinical psychologist review the data and analyse it. The data was then
compared and reported. This process was explained to participants and consent was obtained. Additionally, to ensure the researcher did not exclude or misinterpret any information during the interview, the interview was recorded using a tape recorder.

Furthermore, in an attempt to reduce interviewer bias, the researcher also attempted to ask open-ended, non-leading questions within the interview (see Appendix A: Interview Guide) so as to avoid encouraging participants to respond in a particular way (Babbie & Mouton, 2010). The interview guide was reviewed by the researcher’s supervisor prior to commencement of the interviews to ensure the questions were satisfactory.

5.10 Challenges

A number of challenges were experienced when conducting this research. The first challenge was collecting appropriate and sufficient literature for the study. The researcher found that there was insufficient literature on the topic of working with interpreters, particularly within the South African context and particularly recent literature or studies.

The second challenge was with regard to data collection. As the study was limited to English and Afrikaans-speaking clinical psychology interns at DGMAH, the sampling population to which the researcher had access was small. Furthermore, the researcher experienced challenges when attempting to interview participants so as to not disrupt their working schedules. Interviews were thus conducted outside of working hours and attempting to recruit participants then became a challenge. Finding a time to do the interviews that was convenient for both the researcher and the participant was challenging at times, and the researcher found she needed to be very flexible in order to ensure data collection was completed.
5.11 Preview of the following chapter

In the following chapter the results will be discussed.
CHAPTER 6

Results

In this chapter, the results of the study will be discussed by focusing on its objectives, which were to establish the following:

- How did the interns experience working with an interpreter?
- What were the challenges that arose when working with an interpreter?
- How did working with an interpreter impact on the relationship dynamics?

6.1 The experiences of working with an interpreter

In the following section I will provide a summary of the research findings of the seven participants with regard to their experiences of working with an interpreter. The findings are divided into the central themes, which arose repeatedly in the accounts of the participants. The following themes appeared to be central regarding their experiences:

6.1.1 Theme 1: Psychologist’s Frustration

The participants reported that their experiences of working with an interpreter resulted in the therapeutic process becoming more complicated, which then resulted in frustration. P1 described his experience of working with an interpreter in the following manner:

“It is a bit challenging seeing that you don’t know what the interpreter is saying to the client first of all and what the interpreter makes of what you are saying. So there is constant misunderstanding I might say and confusion for the client and for me.”
Similarly P2, P3, and P5 all described their experiences as “challenging”, “confusing”, “complicated” and “frustrating”. P2 further stated the following:

“It’s the indirect way of speaking with someone where a lot of it gets lost in the time that you wait for the translation to happen. So it’s a very complicated process.”

It appears that the constant confusion and the misunderstanding of what the interpreter is relaying both to the therapist and to the client results in frustration and complication. The participants reported becoming frustrated at not knowing what was being translated and unsure if the translation was correct. P3 reported the aforesaid in the following manner:

“You ended up just asking a lot of questions and you never knew if the questions were asked in the way you needed or whether the responses you received were a true reflection of what the patient was saying.”

Similarly, P1 stated:

“There is confusion on the side of the client and on my side by not knowing what was said and not knowing how it was said.”

Furthermore, the participants reported that the delay while they waited for the translation to occur complicated the process and resulted in frustration. P6 correspondingly expressed the following:

“It is so frustrating while you wait for the interpreter to translate to the patient and then you have to wait again for them to translate the response. It isn’t straightforward how you would normally have a session with the patient and I think all three, the interpreter, myself and the patient get frustrated which isn’t conducive to effective therapy.”
6.1.2 Theme 2: Superficial Therapy

The participants reported commonly that when working with an interpreter, therapy becomes superficial and that it was no longer therapeutic. P1 expressed the aforesaid in the following manner:

“It wasn’t therapeutic and it wasn’t what a therapy session was meant to be.”

P2 and P3 both experienced the therapy as “superficial”, “basic therapy” and “not real therapy”. P1 further elaborated on the aforementioned in the following way:

“It made me feel quite distracted because I was constantly thinking about what the nurse was saying and so I was not with the client, I was not in their frame of reference.”

It would appear from the participant’s responses that therapy when working with an interpreter did not feel therapeutic. They felt distanced from their patients and that resulted in the therapy feeling superficial. P7 expressed this in the following manner:

“I think you lose a lot of the therapy and the relationship because the nurse or whoever you are using is in-between the whole time and you are not speaking directly to the patient.”

P5 expressed the view that working through an interpreter for therapy as opposed to working directly with the patient impacted negatively on the relationship between therapist and patient (to be discussed further on) and on the therapeutic process. She described this as follows:

“As I was not working directly with the client, it gave the therapy an inauthentic feel.”

P2 agreed and described her experience as follows:

“It [therapy] is quite superficial. Very basic therapy with a very basic outcome.”
6.1.3 Theme 3: Positive Interpreter Contribution

Some of the participants reported that therapy with an interpreter can be successful and they have had some positive experiences where this occurred. Although none of the participants have ever worked with a formally trained interpreter, there have been particular instances where they have had success in therapy. These instances have occurred when the participants worked with the same interpreter for an extended period of time, when they had a good working relationship with the interpreter and when the interpreter had some knowledge of or background in psychology. P1 expressed the aforesaid in the following manner:

“I think when you use a colleague, someone who is trained in our profession; they know more or less to stick to what was said exactly, to stick to being client-centred.”

Similarly, P3 stated:

“The interpreters I worked with at the clinic were honours students in psychology. I think this made a big difference in the sessions when they had some understanding of the concepts of psychology. It helped for them to know they need to stay client-centred, non-judgemental, to have empathy and to know that what they say can influence the patient.”

P3 elaborated on the abovementioned:

“I think with a trained interpreter with whom you have a good working relationship it can be successful.”

The participants commented that when they worked with the same interpreter for an extended period and when they had a good working relationship with that interpreter they felt therapy was more effective, less complicated and less frustrating. The reason for the aforementioned is that they were able to discuss their expectations with the interpreter, hear
the interpreter’s expectations of them and decide as a team how they could improve the sessions. P5 described her experience in the following manner:

“I had some success when I worked with the same interpreter on numerous occasions; we developed a good relationship and were able to discuss with one another what our expectations were.”

Similarly, P3 expressed the following:

“I would say it can be successful and when I was working at the clinic and the interpreters and I were on the same page and we could discuss things before and after the sessions on how we would like to do things differently and how we could improve the session then I would say the therapy became more successful but not perfect.”

Additionally, when P2 was asked if she believed that therapy could be successful with an interpreter she responded:

“Perhaps if you work with one interpreter that you develop a relationship with and if the two of you can work closely as a team over a long period, then yes I think it is possible.”

6.2 Challenges when working with an interpreter

6.2.1 Theme 1: Untrained interpreters

All the participants expressed the view that one of the biggest challenges when working with an interpreter was that the interpreters were untrained. Not one of the participants had ever worked with a trained interpreter, nor had they, the intern psychologists, been trained in how to work with an interpreter. P1 reported:
“In my entire year, year-and-a-half of working with an interpreter, not one was formally trained. It was quite on-the-spot, either a nurse that was available or a friend or colleague.”

When the participants were asked directly if they had ever worked with a trained interpreter, all of them indicated that they had never worked with a formally trained interpreter. P3 responded:

“No, not one of them was formally trained.”

Similarly, P5 stated:

“No, I have never worked with a trained interpreter.”

Working with untrained interpreters resulted in a number of challenges as described by the participants. These challenges included the fact that the interpreter had little or no knowledge of psychology and its concepts and principles. The participants all agreed that despite their not having formal training in interpreting, working with a colleague who has knowledge of and a background in psychology is more beneficial and more successful than working with someone who does not. P6 expressed this in the following manner:

“They do not understand the importance of 100 percent accurate reflections so that the patient can feel someone understands them and that if we as psychologists do not accurately understand the patient’s problem, we cannot implement an effective treatment plan.”

Similarly, P1 said:

“When you are in a therapeutic setting, to use the exact words that was [sic] used by the patient in the exact emotions is very important and I think when you work with colleagues that are trained in your profession and who know the principles, it makes a huge difference. Um, it brings across that sense of
empathy and the basic principles that I would have used if it was in my language.”

Another challenge described by the participants is that the untrained interpreters would not translate directly or ‘word for word’ and they would attach their own meaning to what the client or psychologist said. P7 relayed this in the following manner:

“This was frustrating, as you could tell they didn’t know the importance of translating word for word. Without a background in psychology, they didn’t understand that the way things are said or phrased holds importance or that we do not try to lead our patients or give them advice.”

P1 further described his experience of working with nurses instead of a trained interpreter:

“They took what I said and changed it into something that made better sense for them, and gave that over to the client.”

Similarly, P2 indicated:

“I don’t know if my words are being interpreted and if I am again getting a true reflection of what the person is saying.”

Similarly P2, P4 and P5 all indicated that one of their frustrations with an untrained interpreter was that they did not translate: “word for word”.

A third challenge mentioned was that the untrained interpreters would sometimes begin to direct the session on their own and they would occasionally enter into the therapy session irritable or annoyed at being asked to do a task for which they were not trained and for which they did not have time. P1 described this in the following manner:

“When you ask for a nurse to help interpret, they are not always in the mood and they are also busy and have a hectic schedule. So for them to take time out
of their schedule is also inconveniencing them. So they go into the session with ambivalence, they feel agitated, irritated, they don’t want to be there.”

Similarly P7 stated:

“The nurses in the hospital are always so busy and they become annoyed when you ask them to take 45 minutes or an hour to interpret for you. Then often the older or more qualified nurses will tell a new or training nurse to do it which used to irritate them.”

6.2.2 Theme 2: Intellectually disabled and psychotic patients

All the participants, excluding P1 and P2, agreed that working with an interpreter when assessing or doing therapy with an intellectually disabled patient was difficult and even ineffective. They commented that the interpreters did not translate directly and were not professional within the session. P3 reported:

“With a cognitively challenged patient I found that the interpreter was unprofessional, would often laugh at their responses and give me a translation of what they think the patient should have said as opposed to what they actually did say.”

P4 agreed and further described the experience in the following manner:

“It was frustrating, it did not work at all as the interpreter would not give accurate interpretations and often make comments that what the patient was saying did not make sense or that the patient was stupid or mad.”

The interpreters would often not give direct translations or re-word what the patient had said, which did not allow the therapists to form an accurate understanding or representation of the patient. P6 reported:
“It was difficult to assess the level of cognitive impairment.”

Similarly, with psychotic patients, all the participants, excluding P2 who had never had the experience, agreed that therapy with a psychotic patient and an interpreter does not work. P1 explained:

“The nurse had already decided that the patient was psychotic, so before we even started she was making jokes and saying ‘This man is crazy’, and I didn’t find that effective at all so we ended quite shortly.”

P3 expressed the following:

“With a psychotic patient it was difficult to pick up delusions or thought and speech disorders, as the interpreter does not always interpret word for word. They also would laugh at the patients and openly call them crazy or comment that they are not making sense.”

P5 and P7 agreed, and both reported that the interpreters would comment that the patient was not making sense and comment that the patient was “mad” or “crazy”. All agreed that they did not find the experience effective; they found it difficult to accurately diagnosis a patient and would not willingly do it again.

6.2.3 Theme 3: Psychometric assessments

All the participants agree that doing psychometric assessment using an interpreter is “unethical”, and P3 and P4 state that it is “unreliable”.

P1 indicated:

“I don’t think it is possible to do assessments without a trained interpreter.”

P3 agreed and further elaborated:

“Psychometric assessments are standardized for specific populations and language groups. The instructions and words used are phrased in a specific
manner for a purpose, and if they are not given verbatim as they are instructed in the manual the assessment loses reliability and validity.”

Furthermore, all participants agreed that they were not able to apply and administer the assessment in a standardized manner when working with an interpreter. P4 stated this in the following way:

“The results will not be accurate or valid if the test is not administered in a standardized manner, and it is impossible, I believe, to administer an assessment in another language other than that for which it has been standardized without compromising the reliability and validity of the test.”

P2 agreed and commented:

“I have done it where I had to, but I think the test result is completely skewed because you lose the whole point of using those specific words for that instruction.”

All the participants further agreed that the results and the interpretation of the assessment were negatively impacted by working with an interpreter. P3 explained:

“If the instructions are not given correctly then the results will be skewed.”

P6 agreed and elaborated:

“If one cannot administer the test in a standardized manner, then one cannot expect reliable results that can be compared to the population for which the assessment is standardized.”
6.3 Impact on relationship dynamics

6.3.1 Theme 1: Alliance formation

All the participants, when describing the impact of the interpreter on the relationship dynamics in therapy, expressed the fact that they felt excluded from the interaction. P3 expressed this in the following way:

“When working with an untrained interpreter I have seen how time and again there is a relationship formed between interpreter and client to the exclusion of the therapist.”

P2, P4 and P5 described that they felt “outside” of the relationship and P1 expressed this:

“I felt quite left out of the session. It was like the conversation took place between the nurse and the client, like they were having their own conversation and I was being let into what they were discussing.”

When the participants were asked specifically if they felt an alliance was formed between the interpreter and the patient, all agreed. P3 described this as follows:

“That is exactly what I would call it and at times when you as the therapist try to speak, it feels like you are the one interrupting the session, like you become a burden and are unnecessary.”

The participants described similarly that the language and cultural barrier resulted in the interpreter and patient beginning a conversation on their own and that the therapist was on the outside. P4 explained:

“I mean what can one expect, of course if you speak the same language and are from the same cultural group you are going to form a bond, it is just easier to speak to that person.”
The participants also commented upon the implications of moving from a dyadic to a triadic relationship. P2 commented:

“That is purely how it works, the three-way relationship.”

P5 correspondingly stated:

“An alliance is inevitable in a triadic relationship, particularly when working with an untrained interpreter with little knowledge of relationship dynamics.”

6.3.2 Theme 2: Rapport

Throughout the interview, the participants all expressed concern about the impact that working with an interpreter had on rapport building. P3 stated this in the following manner:

“When we are trained, we are taught that therapy is not possible without a thread of a relationship. The relationship is the tool through which change occurs.”

When discussing the impact that working with an interpreter had on the therapeutic relationship, P3 expressed the following:

“It made it difficult to build a relationship at all”.

P1 agreed and stated similarly:

“The rapport is definitely not there, there is a lack of a relationship and that is what we have in psychology.”

P2 and P5 also spoke of a “lack of rapport”, while P7 said “rapport was difficult to establish”. It would appear that the alliance formation as discussed above results in rapport built between patient and interpreter and not between patient and therapist. P1 expressed this in detail:
“You can’t interact with the patient one on one; you have to give everything over to the interpreter.”

When the participants were asked to mention specifically the challenges they had experienced, all seven participants reiterated that building rapport was one of the main challenges they experienced.

6.4 Cultural competence and the African perspective

6.4.1 Theme 1: Cultural competence

All the participants expressed the sense that when interpreting across language and cultural barriers, information is easily misunderstood. It is not always possible for interpreters to translate directly what is said, as there are not always words or explanations for a given phrase in English or Afrikaans. The participants all understood this limitation and expressed the sense that it was always helpful to have some knowledge of the patient’s cultural background. P1 indicated:

“Given the nature of the hospital and where we live, and given South Africa and all the different languages and cultures, acknowledging everyone’s culture is important.”

P6 agreed and further elaborated:

“It is so important to understand the cultural meaning or significance of what a patient is saying; otherwise the whole point of therapy is lost.”

All participants agreed that cultural knowledge is necessary for all psychologists working in South Africa. This notion of cultural competence relates to interpreters, in that all the participants described that at one point in their experiences with interpreters certain
culturally embedded or culturally significant information was explained to them by the interpreters. P3 expressed this in the following manner:

“They [the interpreters] would try to explain cultural things especially when it came to, like, understanding relationships and beliefs about the dead and ancestors and witchcraft etc. The interpreter would say what the client said and then give an explanation like ‘us [sic] black people believe that when a person dies they join the ancestors’ or something like that. That I found helpful because although I have some knowledge on African cultures I obviously don’t know nearly everything, so it helps give perspective, as long as the interpreter is giving the correct perspective.”

Similarly P2 stated:

“They would kind of, um, extend their understanding of the patient from a cultural perspective to make sure that you also understand, which is helpful.”

P1, P4 and P5 all similarly agreed that at times the interpreter had been “helpful” in relaying culturally embedded information, and P7 indicated:

“Since the interpreter is from the same culture, or –wait – rather I should say has more knowledge of Black African cultures, it was often helpful for me to ask if what the patient was describing is ‘normal’ in their culture, and I found it helped me to understand the patient better at times.”

6.4.2 Theme 2: Training in the African perspective

All seven participants reported that, although they had received some training in the African perspective, they felt it was not adequate or sufficient, given that they were working in Africa with African patients. P4 stated:
“I feel many of the Western theories are irrelevant or even, um, inappropriate when doing therapy with African patients.”

P5 agreed and further elaborated:

“By being a White therapist, speaking English and applying western theories I feel one can easily lose, misunderstand and even fail to help a patient from a Black African culture.”

P3 explained when asked if she had received training in African psychology:

“Yes, we had some training but not nearly enough. I mean it is always stressed to us the importance of being culturally aware and sensitive, which I really do try to do, but my knowledge is so limited. I mean I don’t think it is possible to know everything about every culture, but a broad understanding on things like traditional marriages, ancestors, witchcraft etc. would have been so helpful.”

P1 and P2 also agreed that “more training” would have been beneficial to them. P6 further stated:

“I definitely think it would be helpful to have more knowledge and understanding of the African cultures we are exposed to on a daily basis.”

Conversely, some of the participants felt that although they would have liked to receive a more thorough training in African psychology, they still believed that they could be effective as therapists. P1 explained this in the following way:

“I think being there in the moment, spending time with another human being is more important and can give you more information than previous learning or knowledge.”

P4 similarly expressed:

“Relating to someone on a human level, having empathy and listening without judgement holds more weight for me than any theory.”
Furthermore, P3 explained:

“I believe as long as I am willing to learn and willing to try to understand the patient as best as I can, I can help them.”

6.5 Conclusion

This research project was aimed at exploring and describing the experiences of intern psychologists when working with an interpreter. A summary of the findings was presented with the purpose of addressing the three objectives of this study.

6.6 Preview of the following chapter

In the following chapter there will be a discussion of the results and how they compare with or differ from existing literature. Furthermore the chapter will discuss the limitations of the study and the recommendations.
CHAPTER 7

Discussion of Results and Conclusion

This qualitative research study comprised three primary research questions, namely: How did the interns experience working with an interpreter? What were the challenges that arose when working with an interpreter? How did working with an interpreter impact on the relationship dynamics in therapy?

The summary of the findings will be addressed in light of the existing literature on interpreters in the mental health setting. The findings will be explored as they relate to the primary research questions by considering the responses of the participants. The findings are divided into the central themes, which arose repeatedly in the accounts of all the participants. Additionally, the chapter will explore the limitations of this study, as well as making recommendations for future research.

7.1 Discussion of the Results

7.1.1 The experiences of working with an interpreter

In the following section, the findings relating to the experiences of working with an interpreter will be discussed.

7.1.1.1 Theme 1: Psychologist’s Frustration

The participants in the current study reported that their experiences of working with an interpreter resulted in the therapeutic process becoming more complicated, which resulted in frustration. This is consistent with previous research. Miller et al. (2005) found that when working with an interpreter, the therapist may feel angry, annoyed, frustrated and even self-conscious about how the interpreter will perceive them. Furthermore, therapists felt
uncomfortable about having what is normally a confidential session, observed by someone else. Furthermore, the participants in the current study reported being frustrated by not knowing what was being translated, and if the translation was correct.

According to Miller et al. (2005), there were other experiences that also resulted in frustration for therapists, such as when an interpreter ridiculed or belittled what the therapist was saying to the client, or when interpreters would selectively interpret, omit, or add certain remarks. The aforementioned findings also related with the findings from the current study.

The findings of this study are also consistent with Tribe and Morrissey (2004) in that the therapeutic relationship may be altered when working with an interpreter as it necessitates dependence on another person. This changes the dynamic of therapy and may also complicate the therapeutic process. The aforementioned study reported that intern psychologists who are inexperienced with working with interpreters may become frustrated at having to rely on another person to assist them. Furthermore, as everything is being mediated through the interpreter, the therapeutic process may take longer than usual (Tribe & Morrissey, 2004).

The participants in the current study also reported frustration in the delay that occurs whilst waiting for the translation to occur.

7.1.1.2 Theme 2: Superficial Therapy

According to the participants in the current study, therapy became superficial and no longer therapeutic when an interpreter was utilized. The participants reported that they felt distant from their patients and that working with an interpreter impacted negatively on the therapeutic relationship. This finding with regard to the word ‘superficial’ appears to be unique to this study; however, considering certain themes to follow (Rapport, Alliance Formation and Cultural Competence), this theme appears to relate and correspond to those particular themes.
The therapeutic relationship is central to the therapeutic process. Meaningful therapy cannot be achieved without the relationship (Barber & Muran, 2010; Corey, 2009; Rogers, 1961). The relationship is formed through building rapport with a patient. Without rapport there can be no relationship. Furthermore, if a patient forms an alliance with the interpreter to the exclusion of the therapist, this will negatively impact upon the therapeutic relationship. If a therapist is not culturally competent, this will have a negative impact on rapport and may possibly increase the risk of an alliance forming between the patient and the interpreter and thus negatively impact on the therapeutic relationship. Without rapport, if an alliance forms and if a therapist is not culturally competent, this will ultimately result in therapy which is superficial, as the foundation of a strong therapeutic relationship will be lacking. This theme can therefore be said to correspond with existing literature that highlights the importance of the therapeutic relationship (Barber & Muran, 2010; Corey, 2009; Rogers, 1961), that discusses the impact of the interpreter on building rapport with a patient (Corey, 2009; Rogers, 1961), that highlights the possibility of alliance formation (Corey, 2009; Hill & McGrath, 2008; Tribe & Morrissey, 2004), and lastly literature that discusses the importance of cultural competence (Baloyi, 2008; Miller et al., 2005; Sue, 2001).

7.1.1.3 Theme 3: Positive Interpreter Contribution

The participants in the current study reported that therapy with an interpreter has the potential to be successful. The participants provided examples of instances where they have had success working with an interpreter. This includes instances when they have worked with the same interpreter for an extended period of time, when they have a good working relationship with the interpreter and when the interpreter has some knowledge or background in psychology.

These findings are consistent with a study conducted by Tribe and Morrissey (2004), which found that establishing a working agreement from the onset and following recommended
practice could ensure that the work undertaken commences in a professional manner. Furthermore, the HPCSA form 223 (2004), Australian Psychological Society (2013) and American Psychological Association (2010) have set guidelines for working with an interpreter. These guidelines recommend working with an accredited interpreter, conducting pre-consultation meetings and drawing up a contract prior to commencing work.

7.1.2. Challenges when working with an interpreter

In the following section there will be a discussion of the findings relating to challenges when working with an interpreter.

7.1.2.1 Theme 1: Untrained interpreters

The participants in the current study expressed the view that one of the biggest challenges when working with an interpreter was that the interpreters were untrained. None of the participants had ever worked with a trained interpreter, nor had they, the intern psychologists, been trained in how to work with an interpreter. Studies suggest that in order for therapy to be effective, training and experience are essential for both the psychologist and the interpreter (Drennan & Swartz, 1999; Eagle, 2005; Miller et al., 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004; Quinn, 2009). Additionally, in South Africa, there are no officially employed interpreters in the state mental health care sector (Tribe & Morrissey, 2004), and many health care clinics in South Africa are situated in rural areas and cannot afford to employ trained interpreters. As a result, patients either do not receive proficient services or the clinics make use of volunteer or untrained interpreters (Tribe & Morrissey, 2004).

The participants in the current study reported that working with untrained interpreters resulted in a number of challenges. These challenges included:

- The interpreter had little or no knowledge of psychology.
• The interpreter could not translate verbatim.
• The interpreters would attach their own meaning to what the client or psychologist said.
• The interpreter would at times control the therapeutic process.
• The interpreter would occasionally enter into the therapy session irritable or annoyed at being requested to conduct a task for which they were not trained and for which they did not have time.

The abovementioned challenges correspond with a study conducted by Elderkin-Thompson et al. (2001). These researchers noted that errors in interpretation occur frequently when bilingual nurses who were untrained in interpreting acted as medical interpreters. This study stressed the need for skills training in interpretation. Furthermore, Drennan and Swartz (1999) also found a need for trained interpreters in South Africa and report a lack of resources to meet the demand. Similarly, Lee et al. (2002) concluded that patients receiving services with language-concordant providers were more satisfied with the quality of care they received than those who were provided a service through the use of a volunteer or unqualified interpreter. Numerous studies compare with the abovementioned research finding (Bischoff et al, 2002; Lee et al, 2002; Manson, 1988; Morales et al, 2004; Perez-Stable et al, 1997; Riddick, 1998; Stolk, et al, 1998).

The intern psychologists participating in the current study indicated that they believed they would have benefited from training in working with interpreters. This finding relates to a number of studies which indicate that it is favourable if the psychologist also receives training in working with an interpreter (Eagle, 2005; Tribe & Lane, 2009; Tribe & Morrissey, 2004).

7.1.2.2 Theme 2: Intellectually disabled and psychotic patients

The findings of this study indicate that working with an interpreter when conducting therapy with or assessing an intellectually disabled patient was difficult and ineffective. The participants commented that the interpreters did not translate directly and did not behave
professionally during the session. Similarly, when working with psychotic patients, the participants in this study agreed that therapy with an interpreter is not effective. The participants also reported that it was difficult to accurately diagnose a patient and would not willingly work with an interpreter when attempting to diagnose or conduct therapy with a psychotic patient.

In accordance with the abovementioned findings, Killian et al. (2010) found that the competence level of the interpreters was not conducive to optimal care. The study concluded that the lack of formally trained interpreters in South Africa could result in misdiagnosis of patients and could compromise therapeutic interventions (Killian et al. 2010).

Furthermore, Flores (2005) conducted a study on the impact of interpreter services on quality of care in a psychiatric hospital setting. The findings indicated that more interpreting errors occurred with untrained interpreters, and that these inadequate interpreter services may have negative implications for patients with mental health disorders. These findings therefore relate and compare with the findings from the current study.

7.1.2.3 Theme 3: Psychometric assessments

The participants in the current study expressed the view that conducting psychometric assessment using an interpreter is unethical and unreliable. Furthermore, all participants agreed that they were not able to apply, administer and interpret the assessment in a standardized manner when working with an interpreter.

There is limited literature on the administration of psychometric tests using an interpreter within the South African context. Form 223 of the HPCSA lays down guidelines for working with an interpreter when conducting psychometric assessment. These guidelines are to ensure that the application and administration of the assessment is conducted in the standardized manner (Foxcroft & Roodt, 2005).
The Australian Psychological Society (2013) states that psychologists need to be cautious in the use and interpretation of psychometric tests when working with an interpreter and take into consideration the norms and the population for which the assessment is standardized. Assessment instruments and their normative scores are often developed in English-speaking populations and may not have been adapted for the population from which the client originates. The Australian Psychological Society (2013) caution that informal translation of an instrument standardized to an English population may provide inaccurate scores. Formal translation to convey effective equivalence in meaning is a complex process involving interpreters with appropriate mental health training, which is not always an option within the South African context.

Given the abovementioned, it would appear that existing literature concurs with the findings of the current study. These findings concluded that psychometric assessment when working with an untrained interpreter impacts negatively on the reliability and validity of the application and interpretation of an assessment and that it is therefore not recommended.

7.1.3 Impact on relationship dynamics

In the following section there will be a discussion of the findings relating to the impact on relationship dynamics when working with an interpreter.

7.1.3.1 Theme 1: Alliance formation

All the participants, when describing the impact of the interpreter on the relationship dynamics in therapy, expressed the sense that they had felt excluded from the interaction. They reported that they felt ‘outside’ of the relationship and expressed the view that an alliance was formed between the interpreter and the patient.

These findings are in line with existing research on the triadic relationship. Hill and McGrath (2008) state that the most significant finding with regard to research on the triadic
relationship is that the alliance has an impact on the outcomes of interpersonal relations. Similarly, Corey (2009) reports that alliance formation is important to consider when working with an interpreter, as the therapeutic alliance is fundamental to the therapeutic process.

Tribe and Morrissey (2004) found that the therapeutic relationship may be altered when working with an interpreter as it necessitates dependence on another person, which changes the dynamic of therapy in different ways. Therefore, if a coalition was formed between two people during therapy using an interpreter, it would mean that the therapist, the patient or the interpreter would be viewed as the ‘outsider’ or the ‘enemy’. The aforementioned scenarios are not conducive to an effective therapeutic process or environment (Tribe & Morrissey, 2004).

The participants in the current study indicated that they felt the language and cultural barriers had an impact on the formation of an alliance between the interpreter and the patient. Similarly, Hill and McGrath (2008) described elements which become influential in the formation of an alliance within a triadic relationship. These were demographic information including age, gender, race and socio-economic status. Other studies report similar findings and elaborate that within the South African context, factors that may have an influence on an alliance forming are language, race, home context and culture. As a result, working with an interpreter challenges the notion of a traditional dyadic relationship in therapy (Eagle, 2005; Miller et al., 2005; Quinn, 2009; Tribe & Lane, 2009; Tribe & Morrissey, 2004).

The participants in the current study further commented upon the shift from a dyadic to a triadic relationship and the implications thereof. Simmel (1950), Caplow (1956), Vinacke and Arkoff (1957) conducted research on the triad. These authors found that once a third party enters into an existing dyadic relationship, two people would enter into an alliance. The third person would then be viewed as an intruder and a disturber of solidarity. Given the aforesaid,
the findings of the current study are consistent with literature stating that when working with an interpreter in therapy, the relationship dynamics are negatively impacted. Furthermore, the introduction of an interpreter into the therapeutic relationship changes the relationship from a dyadic to a triadic relationship and results in the formation of alliances.

7.1.3.2 Theme 2: Rapport

During the interview, the participants in the current study expressed concern regarding rapport building when working with an interpreter. The participants described ‘a lack of rapport’ and indicated that it was difficult to build a relationship with the patient when an interpreter was involved. Furthermore, it would appear that the alliance formation (as discussed above) results in rapport built between patient and interpreter and not between patient and therapist.

The concern expressed by the participants is consistent with literature describing the therapeutic relationship. According to Rogers (1961), the first condition necessary for therapeutic change is that two people are in psychological contact and that a professional relationship exists between them. Corey (2009) asserts that the therapeutic relationship between the therapist and client is viewed as the vehicle of change. The participants in the current study expressed difficulty in building rapport. The aforesaid implies that effective therapy is not possible without a strong therapeutic relationship.

Miller et al. (2005) reported that working with interpreters had an impact on the development of the therapeutic alliance. This study established that an important consideration is whether the critical alliance is still the dyadic relationship or whether the therapeutic alliance becomes a triadic set of relationships that develop among all three individuals (Miller et al., 2005). The findings of the current study are hence consistent with the literature that was reviewed.

7.1.4 Cultural competence and the African perspective
The following section provides a discussion of the findings relating to cultural competence and the African perspective.

7.1.4.1 Theme 1: Cultural competence and the use of interpreters

The participants in the current study agreed that when interpreting occurs across language and cultural barriers, information may be misunderstood. It is not always possible for interpreters to translate verbatim, as there are not always words or explanations for a given phrase in English or Afrikaans. The participants all understood this limitation and reported that it was helpful to have knowledge of the patient’s cultural background.

This is consistent with the discussion on cultural competence in Chapter 4. Additionally, according to Sue (2001), both the therapist and the interpreter have to be culturally competent, incorporating all of the components of cultural competence. Qualified psychologists have undergone a number of years of study and training; however, it may be argued that there is not sufficient focus on the cultural aspects of psychology. Despite the development of African psychology, the training that psychologists receive in SA is still based on the western model (Baloyi, 2008). The implications of the applicability of western-focused theories and interventions on Black South Africans are questionable. Therefore, if the components of cultural competence are considered, a shift in training to an African perspective is required (Baloyi, 2008).

The participants from the current study agreed that cultural knowledge is necessary for all psychologists working in South Africa. The participants explained that at one point in their experiences when working with interpreters, certain culturally embedded or culturally significant information was explained to them by the interpreters. According to the participants this information was beneficial to the therapeutic process.

In accordance, Miller et al. (2005) outline the different roles an interpreter might assume. One of the models that may be adopted is the cultural/bicultural model in which the
interpreter is viewed as an integral part of the therapeutic process. From this perspective the interpreter’s role is not only to translate what the patient is saying but also to provide cultural perspective and information. Furthermore, Miller et al. (2005) hold that psychologists find it useful when an interpreter provides cultural context and meaning to what the client is saying, as it helps the therapist to gain a holistic view of the client. It also helps the therapist to accurately understand what the client is saying and the context in which they are saying it. Therefore, the findings of the current study are consistent with the previous research studies. The participant’s responses regarding cultural competence are consistent with a number of the other themes namely; superficial therapy, rapport and alliance formation. As mentioned above, if a therapist cannot build adequate rapport with a patient and if the patient forms an alliance with the interpreter to the exclusion of the therapist, therapy is bound to be superficial. The ground upon which meaningful therapy is based is the therapeutic relationship (Barber & Muran, 2010; Corey, 2009; Rogers, 1961), and without that relationship nothing meaningful can be achieved in therapy, resulting in the superficiality of the therapeutic process. If a therapist is not culturally competent this will impact on building rapport with the patient, which will further negatively impact on the therapeutic relationship. Furthermore, if a therapist is not culturally competent and the interpreter is culturally competent, or the interpreter is from the same culture as the patient, this is likely to result in alliance formation to the exclusion of the therapist. As mentioned above, the participants reported that working with an interpreter was beneficial in helping them to understand culturally embedded information, and literature supported these findings (Miller et al., 2005). There is also the risk that when working with an interpreter, an alliance may be formed between the patient and the interpreter. Thus, despite the benefits of working with an interpreter, if English and Afrikaans-speaking therapists in
South Africa want to build meaningful relationships with their patients, it is also necessary for them to be culturally competent and adequately trained in the African perspective.

7.1.4.2 Training in the African perspective

The participants in the current study reported that although they had received some training in the African perspective, they felt it was not sufficient, given that they are working in Africa with African patients/clients.

According to the African perspective of psychology, schools and theories of counselling and psychotherapy have arisen from western European contexts. The worldview they advocate may not be applicable to other racial or ethnic groups in the world, and are thus not multicultural or universal (Sue, 2001). In the South African context, the minority group in South Africa are Whites. Yet the focus in psychological training is still based on a western model, as opposed to an African perspective.

According to Baloyi (2008), the use of western theories in psychology creates a distorted impression that positions psychology and psychotherapy as western discoveries. This perception creates a tendency in which psychologists apply westernised theories to explain African experiences. However, psychologists working in Africa with Black Africans are finding it increasingly difficult to communicate with and effectively treat clients using western concepts and theories; hence the movement towards the development of African-based psychological theories (Baloyi, 2008). Baloyi (2008) further elaborates that African psychology should be central to curriculum development and teaching in South African universities and other training institutions.

All the participants expressed the opinion that when interpreting across language and cultural barriers, information is easily misunderstood. Peterson and Lund (2011) indicated that there is a need to promote cultural and language equality in the mental health care sector. If a therapist constantly misunderstands a patient, the therapeutic relationship will be negatively
affected, and working with an interpreter therefore appears to be the logical solution. However, as this study has revealed, this is not always the case. When working with an interpreter there is the risk of alliance formation, difficulty in building rapport, untrained and unprofessional interpreters and ultimately non-meaningful and superficial therapy. This finding regarding the decision whether to work with an interpreter despite the possible negative impacts or to offer the patient no therapeutic intervention at all is a dilemma documented by Tribe and Morrissey, (2004).

Studies have indicated that when a health care worker and patient speak the same language, this leads to higher quality of services for patients (Bischoff et al, 2002; Lee et al, 2002; Manson, 1988; Morales et al, 2004; Perez-Stable et al, 1997; Riddick, 1998; Stolk et al, 1998). However, in South Africa we are aware that a lack of resources does not always allow for a patient to be seen by a health care professional who speaks their language, and interpreters are utilized as a result. English and Afrikaans-speaking psychologists do not always have the option of referring a patient and therefore have to make a choice between working with an interpreter and offering the patient no psychological help.

It is difficult enough that a therapist is not able to speak a client’s language without the added disadvantages of cultural incompetence and poor knowledge and training in the African perspective. All the participants reported that they were aware of the importance of being culturally competent and that this was something that had been repeatedly told to them throughout their training. The findings of this study, however, reveal that despite being told about the importance of cultural competence and the importance of understanding their Black African patients, little actual training in the African perspective and the cultures within South Africa was given.

In South Africa, given the lack of resources, there is still much that needs to be improved in the health care sector to ensure equality of services for all patients. Given the reality of this
situations in SA, working with an interpreter is a service that will still be used and necessary for many years. This study has highlighted some of the advantages and disadvantages of working with an interpreter. English and Afrikaans-speaking psychologists will still need to work with interpreters and, short of their learning all official 11 languages, certain measures will need to be put in place to ensure that working with an interpreter does not disadvantage a patient and allows them to receive the best possible health care. Cultural competence and adequate training in and knowledge of the African perspective may be the first step in improving a psychologist’s experience when working with an interpreter. If a psychologist is culturally sensitive and can culturally understand what a patient is saying to them, even if they cannot speak the same language, this will help positively with building rapport and may possibly help to prevent the formation of alliances with the exclusion of the therapist. If a patient feels understood by their therapist and a positive, trusting therapeutic relationship can be formed then meaningful therapy can be achieved.

7.2 Limitations of the study

The following section will discuss the limitations of this study. The researcher found limitations with regard to the sample, available literature, bias and language.

Firstly, the sample consisted of seven White English or Afrikaans-speaking participants. Two participants were male and five were female. Therefore, the study was not representative of the general population demographic of SA. The seven participants in this study worked at DGMAH as intern psychologists. Including participants from other hospitals might have improved the transferability of the study. The study consisted largely of female participants. Including more male participants might also have further improved the transferability of the
study. The researcher also relied on volunteer participants, which raises concerns about the representativeness of the research sample.

Secondly, most of the literature reviewed in the current study is from British, American and Australian sources. Although these research findings are relevant to the current study, caution needs to be applied so as not to imply that these studies are necessarily equally valid in the South African context.

Thirdly, there may be an element of bias in the research. The researcher has professional interest and experience in working with interpreters. Bias in the findings may have resulted from the researcher’s projecting her own subjective experiences onto the participants’ responses. This may have resulted in the researcher’s analyzing and interpreting the data as it corresponded to her own experience. However, this was addressed by having another trained clinical psychologist review the data.

Lastly, the interviews were conducted in English. Although all the participants were proficient in English, some of participants were Afrikaans-speaking and at times had difficulty in expressing their feelings and experiences accurately. Therefore, it is possible that the researcher might have misunderstood what a participant was expressing, or a participant might have expressed themselves incorrectly. Conducting the interviews in Afrikaans for the Afrikaans-speaking participants might have improved the dependability of the study.

7.3 Strengths

The strengths of this study are the following:

- The current study indicated the implications of working with an interpreter and helped to create awareness about how to address these challenges.
- The results of this study highlight the importance of implementing certain practices to improve the effectiveness of therapy when working with an interpreter.
Additionally, the study highlighted the importance of working with trained interpreters and advocates for the development of training programs for interpreters as well as psychologists.

The study further revealed the limited resources and literature on the topic of working with an interpreter in SA.

The study also highlighted the need for further and more training for students and interns in the African perspective and cultural competence.

Lastly, the study indicated the need for practical and ethical guidelines for psychologists who work with interpreters in a therapeutic or psychometric context.

7.4 Recommendations

Firstly, the researcher recommends that participants from other hospitals be incorporated and that more male participants be interviewed. In addition, the researcher recommends including Black psychologists who have worked with interpreters so as to ensure that the study is more representative of the general South African population.

Secondly, there is limited research available on this topic in SA. Further research is recommended to explore the themes and findings of this research and validate the findings.

Thirdly, the researcher recommends that training programs be implemented for both psychologists and interpreters. Teaching psychologists and interpreters to work collaboratively might address many of the challenges described by the participants in this study.

Fourthly, the researcher recommends that health care clinics, particularly within the rural areas of South Africa, employ trained interpreters in order to improve accessibility and ensure that patients receive professional services.

Fifthly, the researcher recommends a greater emphasis on training in the African perspective and cultural competence. The researcher recommends that universities include more in-depth
training in the African perspective in their curricula. Furthermore, it is recommended that this training in cultural competence be continued into the psychologists’ in-training internships. Lastly, South Africa does not have a formal set of guidelines for working with interpreters. Although there are guidelines available for American and Australian psychologists, it cannot be assumed that these same guidelines are relevant in the South African context. The researcher thus recommends that formal guidelines be implemented for both psychologists and interpreters to ensure competence in the health care setting.

7.5 Conclusion

This study posits that although the South African government has shown an unprecedented commitment to ensuring equality in services provided in the public mental health sector, the language diversity challenge has not been adequately addressed. The use of an interpreter holds the promise of providing greater access to all South Africans, regardless of culture, race or language, in the mental health setting. Therefore, the aim of this study was to inform others about the experiences of clinical psychology interns when working with interpreters, to explore the challenges that arise when working with an interpreter, and to understand the change in relationship dynamics when an interpreter is involved. The results indicated that the intern psychologists experienced frustration and felt that therapy had become superficial. However, they also reported positive contributions when working with interpreters that resulted in successful therapy. There were a number of challenges they experienced with regard to untrained interpreters, intellectually disabled patients and psychotic patients, as well as the administration of psychometric assessments. The results further indicated the impact on the relationship dynamics when an interpreter is involved in therapy namely difficulty in building rapport and the formation of alliances between the interpreter and the patient.
Cultural competence was also an implication when working with an interpreter as well as insufficient training with regard to the African perspective.

The above research findings correspond to existing literature and research findings. The researcher therefore concludes that the experiences of working with an interpreter result in a number of challenges as represented by the central themes of this research.
REFERENCES


Australian Psychological Society (2013). *APS code of ethics*. Melbourne


Cohen, D. J., & Crabtree, B. J. (2006). *Qualitative research guidelines project.* Retrieved from

http://www.qualres.org/


London: Routledge.

Ivey, A. E., D’Andrea, M., Ivey, M. B., & Simek-Morgan, L. (2002). *Counselling and

Jones, W. T., Sontag, F., Beckner, M. O., & Fogelin, R. J. (Eds.). (1969). *Approaches to

improve clinical care for patients with limited English proficiency? A systematic
review of the literature. *Health Services Research, 42*(2), 727-754.

in South Africa.* Cape Town: University of Cape Town Press.


method on patient satisfaction in an urban walk-in clinic. *Journal of General Internal
Medicine, 17*:641-646.


Wesley Longman.


APPENDICES

Appendix A: Interview Guide Interview

The interview will be a semi-structured interview in which one question will be asked to open the discussion and the rest of the interview will be guided by the participants’ responses.

Introductory question

1. How would you describe your experience of working with an interpreter?

Further probing questions:

1. What impact did working with an interpreter have on you?
2. What in your opinion was the outcome of therapy when working with an interpreter? (Would you say it was successful or unsuccessful – optional if person does not understand ‘outcome’)
3. Was the interpreter formally trained? If yes, where?
4. Was there a difference when working with a trained interpreter or an interpreter with a background in psychology as opposed to someone untrained or without a background in psychology? How?
5. How would you describe your experience of working with an interpreter when seeing an adult patient as opposed to a child patient?
6. How would you describe your experience of working with an interpreter when seeing a cognitively challenged patient?
7. How would you describe your experience of working with an interpreter when seeing a psychotic patient?
8. How would you describe your experience when working with an interpreter for psychometric assessment?
9. Do you feel you were still able to apply and administer the assessment in a standardised manner?
10. Did working with an interpreter impact the results and interpretation of the assessment in your opinion?
11. How did working with an interpreter impact your relationship with the client?
12. What challenges, if any, did you experience when working with an interpreter?
13. How did you attempt to deal with these challenges?
14. What benefits, if any did you experience?
15. Were you aware of any alliances forming?
16. Did the interpreter translate word for word what you were saying? If no how did they translate?
17. Did the interpreter translate to you any culturally embedded information during the session that you are aware of?
18. Did you have a pre-consultation meeting with the interpreter? If yes what did you discuss?
19. Was there a discussion before the session about your expectations of the interpreter and the interpreter’s expectations of you?
20. Did you the psychologist have any knowledge or understanding of the client’s culture? Did the interpreter have any knowledge or understanding of the client’s culture?
21. During your studies were you trained in African psychology?
22. Do you feel the training was sufficient and was it beneficial given the context in which you work?
Appendix B: Consent Form

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY ENGLISH CONSENT FORM

Statement concerning participation in a Research Project

Name of Study:

I have read the information on the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurised to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name is not revealed.

I understand that participation in this Study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Study has been approved by the Medunsa Research Ethics Committee (MREC), Sefako Makgatho Health Sciences University. I am fully aware that the results of this Study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study.

.............................................................................................................  .................................................................
Name of patient/volunteer  Signature of patient or guardian

Place. .................................  Date. .................................  Witness. .................................

Statement by the Researcher

I provided verbal and written information regarding this Study
I agree to answer any future questions concerning the Study as best as I am able.
I will adhere to the approved protocol.

.............................................................................................................  .................................................................
Name of Researcher  Signature  Date  Place
SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY AFRIKAANS
CONSENT FORM

Verklaring ten opsigte van deelname aan 'n Navorsingsprojek

Naam van Studie:

Ek het die inligting in verband met die beoogde studie gelees en is die geleentheid gegun om vrae te stel asook voldoende tyd toegelaat om oor die aangeleentheid te besin. Die doelwit en oogmerke van die studie is duidelik genoeg vir my. Ek is geensins onder enige druk geplaas om deel te neem nie.

Ek verstaan dat deelname aan hierdie Studie geheel en al vrywillig is en dat ek te eniger tyd daarvan kan onttrek sonder om enige redes aan te voer. Dit sal geen invloed hê op die gereelde behandeling van my toestand nie, en sal ook nie die behandeling wat ek van my eie dokter ontvang, beïnvloed nie.

Ek is bewus daarvan dat hierdie Studie goedgekeur is deur die 'Medunsa Research Ethics Committee (MREC)', Sefako Makgatho Health Sciences University. Ek is bewus daarvan dat n opname van die onderhoude geneem sal word. Ek is ook ten volle bewus daarvan dat die uitslae van hierdie Studie aangewend sal word vir wetenskaplike doeleinde, en gepubliseer mag word. Ek stem daartoe in, met dien verstande dat my privaatheid gewaarborg is.

Hiermee verleen ek toestemming om deel te neem aan hierdie Studie.

........................................................... ..............................................................
Naam van pasiënt/vrywilliger Handtekening van pasiënt of voog

Plek. ........................................ Datum. ........................................ Getuie. ........................................

___________________________________________________________________________

Verklaring deur Navorser

Ek het mondelingse en skriftelike inligting ten opsigte van hierdie Studie voorsien. Ek verklaar myself bereid om enige toekomstige vrae ten opsigte van die Studie na die beste van my vermoë te beantwoord. Ek sal myself onderwerp aan die goedgekeurde protokol.

........................................................... .............................................................. ................................................ ..............................................................
Naam van Navorser Handtekening Datum Plek
Appendix C: MREC Certificate

Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)
Moltotegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/3698 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 163 Medunsna 0204

APPROVAL NOTICE - NEW APPLICATION

05 March 2015

Miss L de Riquebourg
Department of Clinical Psychology
P.O Box 110
MEDUNSA, 0204

MEETING: 02/2015

SMUREC Ethics Reference Number: SMUREC/M/45/2015: PG

The New Application received on 12 February 2015, was reviewed by members of Sefako Makgatho University Research Ethics Committee on 05 March 2015 and was approved on 05 March 2015.

Title: English and Afrikaans speaking clinical psychologists and clinical psychology interns experiences of using interpreters in a multilingual setting in Dr George Mukhari Hospital, South Africa

Researcher: Miss L de Riquebourg
Supervisor: Ms RK Thobejane
Department: Clinical Psychological
School: Medicine
Degree: MSc Clinical Psychology

Please note the following information about your approved research protocol:

Protocol Approval Period: 05 March 2015 – 05 March 2016

Please remember to use your protocol number (SMUREC/M/45/2015: PG) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modification, or monitor the conduct of your research and the consent process.

After Ethical Review: Please note a template of the progress report is obtainable in the Research Office and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit. Translation of the consent document in the language applicable to the study participants should be submitted.

International Organisation (IORG0004319), Institutional Review Board (IRB00005122), Federal Wide Assurance (FWA00009419)
Expiry date: 11 October 2016 and NHREC No: REC 210408-003

Sincerely

PROF. S. GUNBABANJO
CHAIRPERSON-SMUREC

Members of the Interim Council:
Prof O Shisana (Chairperson), Ms SA Mchunu, Mr P Slack, Dr N Simelela, Prof AM Segone, Dr E van Staden

127
Appendix D: Editing Certificate

To Whom It May Concern

This is to certify that I, Glenda Holcroft, have carried out the language editing of the Master’s thesis submitted by Lauren de Ricquebourg.

Glenda Holcroft, BA (Hons.) (English) University of Pretoria

MA (Linguistics) University of Stellenbosch

27/06/2015
Appendix E: Permission Letter

See next page.