

UNIVERSITY OF ZULULAND

**THE DYNAMICS OF CULTURE AND
LANGUAGE AMONGST ENGLISH
SPEAKING PSYCHOLOGISTS IN
KWAZULU NATAL**

2013

CONSTANCE NTOMBIFUTHI MKHIZE

**THE DYNAMICS OF CULTURE AND LANGUAGE AMONGST
ENGLISH SPEAKING PSYCHOLOGISTS IN KWAZULU NATAL**

C.N. Mkhize

Thesis submitted in partial fulfilment of the requirements for
the degree of PhD (Community Psychology)
in the Department of Psychology,
University of Zululand.

April 2013

DECLARATION

I hereby declare that this dissertation is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

C.N. Mkhize

Signature

Date:

DEDICATION

I dedicate this work to:

1. My husband, my children Mawande, Siyavuya and Athembele
2. All my family members.
3. My late friend and Colleague Thandi Mambi.

ACKNOWLEDGEMENTS

Firstly, acknowledgement is due to Professor J.D. Thwala, my supervisor for his valuable guidance, critical comments, insight, constant encouragement, supportive attitude and patience during the difficult times of producing this work.

To all friends and family, old and new, whose encouragement and assistance has been indispensable throughout this process, my thanks and appreciation.

To my husband and my children, thank you for believing in me always and for the unwavering support.

Finally, I am grateful to God whose faithfulness has been my strength.

ABSTRACT

The purpose of this presentation is to share some ideas on the continuing challenges facing English speaking psychologists in the province of KwaZulu Natal working interracially and how it affects the therapeutic relationship as a whole. A convenient sample of five psychologists was drawn from general and psychiatric hospitals as well as those working in private practice. The target population for this study included White and Indian psychologists. Eight participants were selected for this study. The transcripts of three participants were eventually abandoned due to poor quality of the taped interview. All the participants had experience in working with diverse cultures and people who are speaking isiZulu.

A discourse analytic approach was employed to understand the complicated language phenomenon in sharing sensitive and confidential material. The rationale of the study was to look at the extent to which psychologists from different cultural and diverse language backgrounds make sense of language and cultural diversity in their therapeutic relationship. There were interesting dynamics that came up from the data collected as follows: From the results it was identified that patients are disadvantaged of the psychological services because of the language they do and do not speak. In general, the study found that English speaking psychologists experience serious challenges when they have to conduct psychotherapy and other related activities with non-English speaking patients or clients.

The study found that the issue of working with interpreters continues to be faced with many uncertainties. While the interpretation process is by no means ideal for carrying out psychotherapeutic work, however, it can go a long way in creating access to psychological services. This study has demonstrated that psychotherapy can be implemented successfully through using interpreters, until such time that the system is able to produce psychologists that are adequately proficient in different indigenous languages spoken in South Africa.

Finally, the researcher hopes that this study will offer suggestions to psychology as a profession and find means to deal with the cultural and language challenges that psychology is faced with in order for psychologists to have efficient psychotherapy and subsequent to that work interracially. It was hoped that the study would play a positive role in increasing psychologist's sensitivity to issues of racism. Furthermore, it was hoped that the findings of this study would help promote culturally respectful programmes and strategies among psychologists and other health-care professionals in KZN.

TABLE OF CONTENTS

Chapter	Page
 CHAPTER ONE: INTRODUCTION	
1.1 Introduction	1-2
1.2 Motivation of the study	2
1.3 Aim of the study	2-3
1.4 Statement of the problem	3
1.5 Value of the study	3
 CHAPTER TWO: LITERATURE REVIEW	
2.1 Introduction	4
2.2 Dynamics of culture and Language	4-5
2.3 Psychology in African People	5-7
2.4 Counsellors' response to multicultural counselling	7-9
2.5 Cultural diversity and differences within the South African context	9-11
2.6. Cultural diversity and differences within the field of psychology	11
2.6.1 Cultural competence versus cross-cultural competence	11
2.6.2 Cultural diversity	11-12
2.6.3 Differences in psychology	12-13
2.7 Counselling perspective	13-14
2.8 The role of culture in counselling	15-16
 2.9 Multicultural competence (MCC)	 16-17
2.9.1 Awareness/attitudes	17-19
2.9.2 Knowledge	19-20
2.9.3 Skills	20

2.10 Maintaining competence	20-21
2.11 Measures to deal effectively with cultural diversity and differences	21
2.11.1 Treatment options and interventions	21

vii

2.11.2 Communication patterns	22
2.11.3 Developing African consciousness	22
2.11.4 Focus of Education and Training	23-24
2.12 The politics of language in mental health care	24-25
2.13 Language in the health care system	25-26
2.14 Working through an interpreter	26
2.15 Different models of translator roles	26-28
2.16 Conclusion	28-29

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction	30
3.1.1 Sample	30
3.1.2 Data collection	30-31
3.1.3 Data analysis	31-32
3.1.4 Practical and ethical considerations	32

CHAPTER FOUR: RESULTS ANALYSIS

4.1 Introduction	33-34
4.2 Dynamics of language and culture	34
A. Interview #1	34-37
B. Interview#2	37-40
C. Interview#3	40-43
D. Interview#4	43-48
E. Interview#5	48-50
4.3 Summary of Findings	51

CHAPTER FIVE: DISCUSSION

5.1 Introduction	52
-------------------------	-----------

5.2 Interpreters as culture mediators	52-53
5.3 Establishing trust in a therapeutic relationship	53-55
5.4 Communicating through the interpreter	55-57

viii

5.5 Language dynamics	57-62
5.6 Lack of self-confidence	62-64
5.7 Confusion with role ambiguity	64-68
5.8 Accommodating other people's culture	68-69
5.9 Lack of spontaneity	70-71

CHAPTER SIX: CONCLUSIONS, LIMITATIONS, SUMMARY AND RECOMMENDATIONS

6.1 Introduction	72
6.2 Conclusions	72-77
6.3 Limitations	77-78
6.4 Summary	78-79
6.5 Recommendations	79-80

7. REFERENCES	81-88
----------------------	--------------

8. APPENDICES

A: Informed consent	89
B: Questionnaires	90
C: Transcription symbols	91

CHAPTER ONE: INTRODUCTION

1. 1 Introduction

In South Africa, white psychologists have been exposed to the values of transitional era from apartheid to democratic ideologies, racism, human rights and humanist based forms of counselling (Strous & Eagle, 2004). There is a general increase in cross-cultural counselling and psychotherapy where the client or patient communicates in one of the black African languages while the counsellor or therapist is white. Bearing in mind that psychology in general, is based on the Western principles and ideologies, the present study specifically, addresses the complexities associated with such a situation. Interracial psychotherapy challenges are likely to cause ambivalent feelings, attitudes and uncertainties in a therapeutic relationship. Awareness of transferences, counter-transferences and personal issues that may interfere with the progress of psychotherapy is very important to note. South Africa has so many different ethnic groups and races that it makes it even more important to recognize and accept diversity.

Historical, political and class factors that result in racism have been ignored in South African psychology (Strous & Eagle, 2004). The counselling profession during its early years of development ignored issues of cultural diversity. Focus has been on ethical issues. Maintenance of multicultural counselling competence may be one of the most important ethical issue the counselling profession faces in today's diverse society (Harper & McFadden, 2003). These issues need to be considered because they have a huge impact in counselling relationships. Therapist training is not sufficient enough to handle issues of race and racism, and this may unwillingly cause therapists to be influenced by racist ideologies (Strous & Eagle, 2004). The training of psychologists has for the past few decades been Eurocentric in nature and there is therefore a strong need to make a shift in order not to estrange the indigenous in their own context (Strouse & Eagle, 2004).

Most therapeutic interventions take little interest of the dynamics of relationships in the extended family of the client. They usually focus on the self, which does not

recognize the importance of the family and culture. Culture is known as one of the most important and perhaps most misunderstood constructs in modern social theories. Culture may be defined narrowly as limited to ethnicity and nationality. Western or non-western approaches represent different worldviews.

Health-care professionals working with ethnic, linguistic, and culturally diverse populations have to follow certain guidelines to work effectively. These guidelines include: knowledge about diversity, client's culture, religion, beliefs, language, economic and political conditions and cultural identity (Pope & Reynolds, 1997).

It is unethical for counsellors to offer counselling to culturally diverse clients when the counsellors are not competent in working with such clients. Lack of competence among health care professionals in counselling diverse clients is a major ethical dilemma. Good and successful therapeutic relationship is often overshadowed by racial and cultural background. This study tried to explore the facilitating and hindering factors to good and successful therapeutic relationship among English-speaking psychologists in Kwa-Zulu Natal (KZN).

1.2 Motivation of the study

The study is influenced by the claims that health professionals have convinced themselves that language is not a problem in the way of appropriate care (Strous & Eagle, 2004) and that many individuals deny being prejudiced, yet they can recognise the impact of racism on other peoples lives, but failing to accept its influence on their own lives (Mashne, as cited in Pope & Reynolds, 1997). Psychotherapy is often found to be influenced by white-centric (individualistic) notions and tend to ignore underlying issues that result from different cultural contexts (holistic/collective). Lack of psychological services and the dynamics of language and culture in interracial psychotherapy, particularly in the rural areas, lead to psychological services being perceived as irrelevant or inappropriate. Due to this, people with mental health problems only seek services if available and affordable.

1.3 Aim of the study

Psychologists bring their personal qualities, ideologies and or what is usually referred to as “counsellors self” in therapy (Reupert, 2006). Therefore, the aim of the study was to investigate:

- How psychologists from different cultural and language background make sense of language and cultural diversity in their therapeutic relationship.
- The continuing challenges facing English psychologists working interracially and how it affects the therapeutic relationship

1.4 Statement of the problem

Psychology is still a relatively new thing to African people. All mental health interventions have paid little attention to the issue of language and culture. There are few psychologists in South Africa who speak indigenous languages. The fact that a language issue is not important in mental health care is unbecoming. The point of concern is that everyday people in South Africa are deprived from psychological vintervention simply because of the language they do, or do not, speak (Seedat, Duncan & Lazarus, 2001).

1.5 Research problem

This study has arisen out of the need for more psychotherapeutically focused and theoretically informed research in this field, and the need to develop an understanding of what it is like for English speaking psychologists to work in a multilingual setting that is socially dynamic which reflects the typical South African public health setting. It therefore provided an investigation exploring the dynamics of language and culture amongst English speaking psychologists. It attempted to answer the question of how the psychologists deal with the challenges they face when working interracially.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

South Africa has been a democratic country for 12 years, but according to Painter and Baldwin (2004) racism remains a reality in many areas even in societies where discrimination is illegal. The old and the long era of apartheid has left the legacy of selfishness, jingoistic approaches as well as racial prejudice's legacy of the interracial psychotherapy which seeks to promote the class prejudice, and this cannot be seen as a catalyst for interracial psychotherapy. In fact, one may be tempted to believe that democracy in South Africa is still not practiced accordingly; hence very minimal interracial education, training and psychotherapy can be realized. Interracial psychotherapy is a process, which encapsulates the frame of mind of the people and the level of development of the people. It is supposed to promote cultural tolerance in diversity. In South Africa interracial psychotherapy is distorted and wrongly projected utilised to denote multiracialism.

Race has been seen as a taboo topic for discussion, especially in multicultural settings or work place. According to Pope & Reynolds (1997), many individuals deny being prejudiced, yet they can recognize the impact of racism on other people's lives, but failing to accept its influence on their own lives. Acknowledging ones prejudice about one's own race or ethnic origin is a peaceful way to self-discovery (Pope & Reynolds, 1997). These authors further stated that this form of prejudice is usually repressed and stored at a preconscious or unconscious mind. These repressed issues eventually show as projections in different ways and this may have an impact on the counselling relationship.

2.2 Dynamics of culture and language

Dynamics of culture and language, in particular, remain a reality in multicultural counselling. For these reasons, psychologists need to have multicultural competent skills in order to carry out their duties effectively and efficiently. Psychologists' training leads to tension, which emanates from conflicts between continuous sense of selfhood, a position in a social order in terms of class, gender, sexuality, race and culture, demands and prohibitions of the profession about how relationships should be conducted (Kottler & Swartz, 2004). This process challenges personal identity, self

and how one views the world. For example, a study done by Kottler and Swartz (2004), investigating the clinical psychology training experience shows that psychology training is likely to become a form of identity transformation. Identity transformation may include awareness of one's self, counter-transferences and other people's cultures and behaviours.

The findings from the study done by Holcomb-McCoy (2001) where he investigated culturally competent counselling and challenges faced by school counsellors revealed the importance of ensuring that information on racial identity development and development of multicultural knowledge are included in multicultural training.

The results further showed that achieving a certain comfort level and competency in working with the families of linguistically and culturally diverse students and understanding cultural differences in students across a variety of cultures were the two areas that counsellors indicated were most challenging in their counselling work in diverse elementary and secondary schools. Working with diverse cultures requires specific understanding of language, family dynamics and family structure across different cultures.

2.3 Psychology in African people

Psychology is a new concept to most African people. Most of the mental health interventions have paid little attention to the issue of language and culture. Psychological intervention allows space and involves exploring painful issues in a safe environment. The importance of this process and relationship cannot be ignored. It is important to note that debates about appropriate psychology in South Africa have paid little attention on the issue of language. This is ironic, given the role that language plays in mental health and that South Africa is a multilingual country. According to Strous and Eagle (2004) health professionals have convinced themselves that language is not a problem in the way of appropriate care and that many individuals deny being prejudiced, yet they can recognise the impact of racism on other people's lives, but failing to accept its influence on their own lives (Pope & Raynolds, 1997). However, there are very few psychologists in South Africa who speak indigenous languages apart from Afrikaans. The fact that a language issue is not important in mental health care is bizarre and perhaps unbelievable.

The study done by Strous and Eagle (2004) investigating thoughts, feelings and fantasies of White South African therapists working interracially demonstrated that psychologists explain reality according to their own world view, to which they expect their clients to adopt. This could be due to the westernised form of training they have since been exposed to, which does not accommodate other forms of cultural beliefs (e.g., indigenous cultures). The assumption that Black clients need to accommodate the Western practices implies that they have to know English. Non- Black therapists rarely show commitment to learn Black languages. These results further showed issues such as white centrism, therapeutic complication, white ethnocentric, blacks' lack humanity, hierarchical relations and see therapists as victims.

The paper done by Pillay and Petersen (1996) reviewing clinical psychology training in the post apartheid period shows that 68.9% of English speaking psychologists are willing to learn indigenous languages, of that number only a marginal proportion of that number is able to consult in other languages either than English. The lack of competence of non-Black therapists to communicate in black languages means that therapists need to learn more about other languages and that mental health services are limited to the advantaged, educated, and middle class groups. The survey done by Pillay and Petersen (1996) shows that 92.4% of the participants were mainly white and 91.2% were English or Afrikaans speaking and their clients were 75% mainly white. Given that the vast majority of psychologists in South Africa speak no indigenous language, almost every day, people are excluded from specific forms of psychological interventions, simply on the basis of language they do, or do not speak.

The results further showed that this view makes the construction of White/Western culture to be seen as superior and black cultures as different and inferior. This results to African languages remaining a taboo so much so that African clients tend to look down upon their culture and language. This raises a problem because clients come for therapy if they have problems and have high expectations from psychologists, believing that their problems will be solved or understood immediately. The psychologist has to treat a client holistically and accommodate language and cultural dynamics without prejudice. Different cultural dynamics make it difficult for a therapeutic process to be effective. Counselling in a multicultural environment comes with challenges and these challenges are diverse in nature. The resources available to

help therapists/counsellors to overcome these challenges are limited. This calls for more multicultural trained therapists/counsellors, especially therapists who speak indigenous language.

According to Rogers (1951), counsellor empathy involves being sensitively involved in another individual's subjective world. Moreover, understanding another person's experiential world requires an active and continuous process in which attention is focused solely on the feeling of the other, to the exclusion of all other stimuli. Negative emotions need to be acknowledged and resolved by the therapist in order for facilitative multicultural counselling relationship to develop.

2.4 Counsellors' response to multicultural counselling

Unrecognised counsellor emotions include internalised racist reactions that are acquired throughout life, as well as unintentional individual racist behaviours need to be recognised. Counsellors who are not sensitive to their own reactions or who are resistant to critical self-examination may superficially process these emotions and may as a result remain unaware of their cultural self. Previous research has shown that therapist is generally more critical of their interventions and helpfulness than are clients (Ivey, Ivey & Simek-Morgan, 1997). Such counsellors may not develop the competency to form a multicultural counselling relationship. Further research also shows that therapists do not always accurately perceive their clients' reaction, especially the negative reaction. Therapists usually focus on their self-evaluation rather than on their clients' reaction.

According to Carter, (1995 as cited in Strous & Eagle (2004) self-awareness and insight are traditional goals of counselling and psychotherapy. However, due to insufficient theories on race, the development of racial identity and the impact it has on psychotherapy has created lack of insight among mental health practitioners as to the therapeutic implications of their racial and identities and assumptions. The study done by Strous and Eagle (2004) evaluating thoughts, feelings and fantasies of white South African therapists showed that therapists usually define reality according to their own worldviews, to which they expect their client to accommodate and conform. The results further showed that this view makes the construction of white/western culture to be seen as superior and black cultures as different and inferior. Such that

African language remains in semi taboo such that African clients tend to look down upon their culture and language.

The study done by Nutt-Williams and Hill (1996), investigating the effect and focus of therapists' self-talk in relation to other therapy process variables, specifically their perceptions of their own helpfulness and clients' negative reactions, after taking into consideration the perceived strength of the working alliance shows that self-talk is related to perceptions of the therapy process such that when therapists think negatively about themselves, they perceive themselves as less helpful and think their clients are reacting more negatively. This suggests that awareness and management of the therapists self-talk in relation to the way that they view themselves and the clients is important. Therapists entering therapy with own perceptions and without conscious awareness give rise to biased perceptions involving racial, ethnic and cultural issues. Culturally, competent psychologists/counsellors must have knowledge, awareness, and skills that enable them to interact successfully with people of different backgrounds, viewpoints, and values. It can be argued that too much self awareness could make psychologists feel paralysed and unable to perform or draw the therapist focus away from the client (Nutt-Williams & Hill, 1996). Multicultural competent psychologists/counsellors show understanding of diverse cultural issues. Pope and Reynolds (1997) postulate that cultural competence is never achieved completely, but one continues to acquire it throughout individual's lifetime. It is important for psychologists to become aware of their racially informed attitudes and the assumptions they make about their clients. Failure to do this will reflect negatively on the profession because the major reason for clients to use the service depends on the therapist's professional competence and attitudes, and not just culture, race and linguistic compatibility.

Culture is complex and dynamic in each given context. Much of what most people believe is that competence is very subjective. Counselling process focuses on things that matter to people, personal feelings about, and things that affect their lives. Based on the fact that counsellors/therapists are human beings, one cannot deny that their human feelings often influence their professional lives. This makes it difficult to view counselling as purely objective. Although multicultural competencies are an ongoing process, one cannot deny that cultural issues will always exist. Perhaps, one may say

that the period of democracy in South Africa is still not practiced accordingly so much so that out of it, very little multicultural counselling can be realized. Multicultural counselling is a process that encapsulates the frame of mind of the people and the level of development of the people.

The study done by Holcomb-McCoy (2001) demonstrated that counsellors conveyed some discomfort in their work with students from different cultures and language. The findings show that most of their discomfort stemmed from feeling unsure about whether certain actions, mannerisms, questioning behaviours, and interventions were culturally appropriate.

The study done by Holcomb-McCoy (2001) further shows that at times, counsellors were dependent upon the child to translate for them which they felt was inappropriate. The counsellors expressed a need to learn another language or to become more proficient in a second language; however, they also expressed concern that learning another language would not alleviate the need for translators.

The change for psychology as a profession lies in re-evaluation and reformulating the theory and models that are relevant to the South African context. Psychology further needs multi-skilled psychologists who will offer psychological services to diverse cultures. We argue that while there are constraints to transforming psychology as profession, social conditions and relevant discourses will always exist.

2.5 Cultural diversity and differences within the South African context

As a large country populated by people from different ethnic origins, South Africa represents diversity of cultures and traditions and prompts many challenges for those who want to adopt a uniform approach that is uniquely African perspective to issues confronting the country. South Africa, like many other African countries has been colonized and due to its diversity of ethnic groups, does not have a single cultural identity, which is why it is commonly known as “the rainbow nation (Edwards, 2000). According to our indigenous African culture, each individual is a tradition possessor of the past generations and of those who are yet to come. South African indigenous people have lived for many years as organised communities with common bonds of language, customs, traditions, and other distinct cultural traits (Edwards, 2000).

The cultural mind, that individuals adopt as they grow, has become so polluted that the South African individuals have virtually lost their own original identity (Edwards, 2000). Psychology is frequently considered to be a liberal humanity whilst within the South African context it has a long racist past considering the fact that issues of culture have been ignored and the training is westernised. Seedat, Duncan and Lazarus (2001), argued that South African psychology has viewed its society through the distorted lens of racial pathology and how often lent skills and talents in the actualization of racist visions. In South Africa psychology as a profession does not provide culturally appropriate mental health care to all South African citizens. Most psychologists were and still are English speaking and their training did not cater for differences among multicultural groups within the South African society. According to Tjale (2004) during the apartheid regime Verwoed proposed a system of racial classification for the South Africans which contended that blacks were culturally, intellectually genetically and physically inferior to whites which led to opposed race mixing. This perception convinced both black and white individuals to the extent that blacks saw themselves as inferior and whites saw themselves as superior. According to Edwards (2000) culturally encapsulated therapists contribute to cultural oppression because of their ignorance of cultural norms and failure to acknowledge diverse client groups needs. Most black groups are not exposed to psychology as a field and some of those who know about it avoid it as a way of avoiding erosion of their own values and cultural identity (Seedat et al., 2001). Most psychologists do not acknowledge their own weaknesses related to their poor understanding of languages, religion and other indigenous African cultural practices. They tend to impose their worldviews and theories without understanding the client's cultural background. This leads to psychology being viewed as culturally irrelevant and meaningless by most African individuals.

According to Pedersen, Dragun, Lonner & Trimble (1996), language is a fundamental tool in all therapeutic relations as it has the intra-psychic, interpersonal and trans-subjective meaning, which is often overlooked as only English and Afrikaans are still realistically recognized as the official languages. Those attending counselling and therapy have to strive to express themselves in the language suitable and better understood by the therapist or counsellor. Pedersen et al. (1996) postulates that

language is a very important cultural element that represents the essence of culture which distorted the process of counselling. Duffy and Wong (2003) see language differences, different ways of communicating and adopting a colour blind approach as some of the attitudes that hinder effective counselling relationship within the South African context. The study done by Snyman and Fasser (2004) shows that white psychologists think that they are forced to speak other peoples' language and see it as a threat and violation of individuals' rights. Furthermore, they see it unnecessary for white people to learn Xhosa or other languages because black people are presented as capable of speaking other languages. Although we cannot generalize about this, this may suggest that white people will not learn to speak other languages either than theirs.

2.6 Cultural diversity and differences within the field of psychology

2.6.1 Cultural Competence versus Cross-cultural Competence

Without cross- cultural competence, psychologists cannot be expected to effectively engage into psychological services, or do psychotherapy effectively to patients of different ethnic and racial backgrounds. According to Leong & Santiago (1998) to be culturally competent is to be able to adapt and function effectively in one's culture. He further states that counsellors and therapists are culturally competent with reference to their cultural heritage. Therefore, he postulates that the problem is not with cultural competence but with limited cross-cultural competence, i.e., the knowledge and skills to relate and communicate effectively with someone from another culture different from your own.

2.6.2 Cultural diversity

It is important to remain aware of specific cultural issues that apply to clients and their level of awareness concerning these issues. Failure of the counsellor or therapist to recognize these cultural differences can pose a serious setback to psychological interventions and therapeutic relationship. According to Pedersen et al. (1996) the greater the cultural differences between the counsellor and the client, the more noticeable and obtrusive is the role of culture in the counselling experience. The

potential is increased for clash of expectations, misunderstanding of intentions and meanings, and entanglements in counselling relationships.

Traditionally, psychologists and counsellors accepted culturally different people if they were willing to become acculturated and reject their cultural values. According to Gibson (2003) the western methods were, dehumanizing, culturally biased, full of stereotypes and accepted white culture as more valid and superior to other cultures. This made most black South Africans to see themselves as inferior, devalued, uninvited and misunderstood. Despite living in the new South Africa these views still exist and have a negative impact to most black South Africans. This leads to negative racial and ethnic attitudes, and limits the counsellors' understanding of ethics in other cultures. Edwards (2000) indicates that lack of documentation and research on indigenous African knowledge makes white South Africans impose all their approaches and methods to be based on objectivity and universality.

2.6.3 Differences in psychology

Diversity and differences are experienced in different fields of knowledge and studies and in the field of psychology (Diller, 1999). According to Strous and Eagle (2004) therapists define reality according to their own worldviews to which they expect their clients to accommodate. Practitioners often find their culturally different clients unmotivated, resistant, and lacking in ability to think through and to communicate their problems and experiences meaningfully. The study done by Strous and Eagle (2004) showed that psychologists view black clients as reluctant to trust community outsider, culturally encapsulated, hostile to white therapists, no-facilitative, different and inferior. In return clients see their counsellors as remote, uninterested and their comments, questions and suggestions as baffling and irrelevant (Pedersen et al, 1996). Language is one powerful means of communication yet often ignored in cultural diversity as good language skills are usually essential for social and economic success. South Africa embraced multilingualism by accommodating nine previously neglected African languages as official that also includes English and Afrikaans (Painter & Baldwin, 2004). However the general proficiency in African languages is still low.

Within the South African context English is often taken as a common language that most people can use, yet in different ways restricts those who use it as a second language in expressing their feelings. One can see that under these circumstances English has become the barrier in many areas. That includes psychotherapy and counselling. Emotions and other psychological constructs cannot be directly translated into a lot of indigenous languages.

It is important to always note that what is cultural appropriate to one culture in expressing empathy, therapeutic skills and other dimensions might not be culturally appropriate to a client from a different cultural background.

Verbal expression and self disclosure by clients are critical parts of the psychotherapy or counselling, while some cultures do not share and feel comfortable talking about themselves or disclosing personal issues to strangers (Diller, 1999). Dana (1998) states that disclosing intimate or personal issues to strangers is seen as bringing shame to one's family and is experienced as "loosing face". The mistake that is done by counsellors and therapists is that they tend to focus on verbal communication and fail to understand the importance of non verbal communication, which is seen as a barrier to genuine interaction with the client. According to Sue and Sue (1977), non-verbal communication within a therapeutic setting plays a pivotal role as failure to observe and interpret these in a more meaningful way. This often leads to negative perception on psychology as a profession and is seen as a useless and irrelevant process that can only deal with white people's problems and situations.

According to Dana (1998) mental illnesses markedly differ across racial/ethnic groups because they can signify moral, religious, political, or social crises. Therefore, it is important to know that the cultural beliefs of clients concerning psychological health and illness are part- and- parcel of a worldview that shapes their expectations for services and willingness to receive available resources.

2.7 Counselling perspective

According to Pedersen, Draguns, Lonner, and Trimble, (2002) the process of indigenous psychology has become a powerful force for psychological change in culture-centred counselling. Counselling is based on the understanding of the self.

Western psychology focuses on the separated self as the healthy prototype across cultures, making counselling and psychology as part of the problem rather than part of the solution through their emphasis on selfishness and lack of commitment to the group. According to the western psychology the self is defined in terms of its internal attributes such as thoughts and emotions. Interpersonal relationships are developed through individuals' own choice (Shweder, 1982 in Mook et al., 2004). According to (Markus & Kitayama, 1991, 1994 as cited in Mook et al., 2004), the view of selfhood is also known as the independent view of self. On the other hand indigenous psychology and non-western cultures view self in terms of relationships with others. This view of selfhood is also called the collectivist or interdependent self (Markus & Kitayama, 1991, 1994 in Mook et al., 2004). This may suggest that you cannot separate the self from the environment.

To a certain extent, Western psychology sees collectivist approach as a threat to individualism and freedom. The individual (self) is seen as independent of customs, traditions and social knowledge and neglects the dimensions of selfhood (Seedat et al., 2001). The western psychology does not take into account the socio-cultural context of people in developing societies. This approach can be viewed as a capitalist system, which is individual-oriented, and opposed to collective ideas (Seedat et al., 2001). Psychologists see culture as a barrier to psychological process.

Traditional Western approaches to science are based on facts/evidence and they are not influenced by the individual's personal feelings and beliefs. Conclusions can be reached (objective knowledge) through engaging in the necessary thought processes or experimental procedures (Mook, Mkhize, Kiguwa & Collins, 2004). Natural science methods are seen as the only way of collecting data and constructing new knowledge.

Counsellors have the responsibility to oblige by the ethical issues. Even then, these ethical issues cannot encompass/satisfy/be suitable for all the diverse clients. Counselling client of the opposite culture could lead to premature termination. This could happen when the client suspects incompetence to cultural issues or where the counsellor lacks sensitivity to issues of gender, race and class.

2.8 The role of culture in counselling

Cultural diversity encompasses so many issues, which are, language, gender, ethnicity, religion/spirituality, and socio-economic status. South Africa has so many different ethnic groups and races that it makes it even more important to accept diversity. The interesting thing about cultural diversity is that none of the cultural groups are exactly the same. Most peoples meet and interact with people from other cultures throughout their lives.

Individuals become aware of their own culture through numerous ways. Psychologists become aware of their culture throughout their lifetime experiences and counselling. Through culturally learned rules and principles, culture informs a psychologist's daily life, willingly and unwillingly. Historically, White institutions, as they claim to be the nozzle through which multicultural counselling can be realized have to undergo a process of transformation. Historically, most previously so-called "White institutions", that became multicultural in the 1980's claim to be multicultural training institutions which may not be a true reflection of the real situation. What is evident in these institutions is that they apply the old apartheid system which is based on the euro-centric approach.

Every single individual has multiple cultural identities. As individuals, people live in a context of family, group, and community; professions. Education exposes people to different racial groups and communities. According to Pedersen, Draguns, Lonner and Trimble (2002) all behaviours are learned and displayed within cultural contexts. Everyone has varying levels of understanding about their cultural identities.

Individuals become aware of their own culture through numerous ways. People become aware of their culture throughout their life experiences and counselling. Through culturally learned rules and principles culture controls one's daily life willingly and unwillingly. In the study done by Strous and Eagle (2004) as shown above, results show that awareness as a result of guilt feelings by therapists makes them realise that they might not challenge black clients where they would normally challenge white clients. This indicates the importance of being multicultural competent, more importantly to be aware of one's own cultural issues.

Culturally competent individuals must have knowledge, awareness, and skills that enable them to interact successfully with people of different backgrounds, viewpoints, and values. Multicultural competent individuals show understanding of diverse cultural issues. Pope and Reynolds (1997) postulate that cultural competence is never achieved completely, but one continues to acquire throughout individual's lifetime.

Health care professionals working with ethnic, linguistic, and culturally diverse populations have to follow certain guidelines to work effectively. These guidelines include knowledge about diversity, client's culture, religion, beliefs, language, economic and political conditions and cultural identity (Pope & Reynolds, 1997).

It is unethical for counsellors to offer counselling to culturally diverse clients when the counsellors are not competent in working with such clients. Lack of competence among health care professionals in counselling diverse clients is a major ethical issue.

2.9 Multicultural competence (MCC)

Developing multicultural counselling competence is an ongoing and complex task. MCC's aim is to increase clinicians' multicultural awareness and enhance their skills in working with culturally diverse patient. In mental health practitioners are repeatedly encouraged to become multicultural competent clinicians. Hansen, Randazzo, Schwartz, Marshall, Kalis, Frazier, Burke, Kershner-rice and Norvig (2006) conducted a study where they investigated multicultural psychologist competencies-to determine if psychologists practice what they preach, the study found that clinicians did not practice they preached. They found that professional and personal experiences were the most influential in their development of multicultural competence. Sue and Sue (1990) identify three primary areas of multicultural competence: awareness, understanding, and skills. Other writers have included the dimensions of nonbiased beliefs and attitudes, knowledge of diverse cultures, sensitivity, respect and tolerance for differences, appreciation of the ongoing problems of oppression and discrimination, expertise in using assessment tools appropriately, and psychological. These multicultural competencies have become recognised in the field of psychology and counselling. This study focuses on the three areas of MCC, which are, awareness, knowledge and skills. It is important for therapists to understand the impact of racial attitudes and the assumptions they make

about the clients of different culture to theirs. One cannot only see the good or the strength the therapists have in the realization of multiculturalism. However, there are threats and weaknesses, which in turn overshadow the good potential they have, hence critical analysis becomes essential if one is to analyse counselling within the context of multiculturalism. Psychology profession has a huge percentage of English speaking therapists and little percentage of African language speakers. This discrepancy causes frustration to clients who do not speak English.

Mental health services are frequently held to be insensitive to culture, psychiatrists and psychologists are said to be culturally incompetent and psychiatric and psychological therapies appear to be inappropriate for many people from non-Western cultures, (Fernandos, 2003). The important role of identifying cultural barriers for effective counselling and intervention need to be identified before an intervention is regarded as effective and appropriate. This makes it possible to remove identified barriers and a culturally appropriate solution like multicultural interventions can be implemented (Pedersen, Dragun, Lonner & Trimble, 1996).

2.9.1 Awareness/attitudes

Cultural self-exploration enables one the opportunity to develop awareness of one's collective-self, which is of particular importance in facilitating the process of multicultural counselling relationship. It also demands that trainee psychologist examine their own lives and find their own professional identity that will allow them to simultaneously solve clients' difficult issues in a meaningful way (Kottler & Swartz, 2004). Clinical training is likely to remain in a form of identity transformation. Individuals are socialised in different cultural, racial and ethnic backgrounds. Understanding of cultural diversity and differences begin with awareness of these differences among psychologists and within clients. The first step is to gain awareness of one's own biases, values, and assumption about human behaviour. The study done by Holcomb-McCoy (2001) shows that awareness was one of the challenges that faced counsellors who were working interracially and they realized that a first step in understanding other cultures was awareness of their own cultural values and biases. The psychologist must be able to "step outside" their own cultures.

American Counselling Association (ACA) states that the counsellors must be aware of their own values, attitudes, beliefs and behaviours and how these apply in a diverse society and also to refrain from imposing their own values on clients. It is the ethical responsibility of the counsellor to gain self-awareness as stipulated by the ACA code of ethics. Pope-Davis and Coleman (1997) define multicultural awareness as the process of examining the content and validity of personal and societal attitudes, opinions, and assumptions about societal racial and cultural groups, including one's own.

Self-awareness helps counsellors learn how cultural/racial/ethnic identity, affect their values and beliefs in the counselling process (Harper & McFadden, 2003).

Counsellors must be aware of their counter-transferences and personal values that may either facilitate or hinder counselling (Harper & McFadden, 2003). Burn (1992), postulated that counsellors must work from a foundation of self-awareness and continue to evaluate their held worldviews and personal biases. Through self-evaluation (awareness) counsellors discover their self and by accepting other people's socialization, they increase their level of comfort with clients' belief system, which is different from them.

Unrecognised counsellor emotions include internalised racist reactions that are acquired throughout one's lifetime, as well as unintentional individual racist behaviours need to be recognised. Counsellors who are not sensitive to their own reactions or who are resistant to critical self-examination may superficially process these emotions and may as a result remain unaware of their cultural self. Such counsellors may not develop the competency to form a multicultural counselling relationship.

An important aspect for counsellor is to develop sensitivity to cultural differences if they hope to make interventions that are congruent with the values of the clients. The social and cultural context of the clients should be taken into consideration and counsellors need to determine whether the assumptions they have made about the nature and functioning of therapy are appropriate to culturally diverse populations.

Multicultural differences leave counsellors with choices of either attending to culture as a construct that have significance towards the wellbeing or healing process of human beings or to totally ignore it in one's interventions, Pedersen et al. (1996). Whatever choice one makes, culture still has a significant impact on the helping process. Focus must be on understanding culturally learned assumptions and culturally relevant facts.

2.9.2 Knowledge

Pope-Davis and Coleman (1997), defines knowledge as the acquisition and precise understanding of facts and information about the relevant racial and cultural groups. This implies having an informed understanding of cultures that are different from ones' own culture, including knowledge of their histories, traditions, values, practices, etc. The result of the study done by Strous and Eagle (2004) evaluating thoughts, feelings and fantasies of white South African therapists working interracially shows that white therapists assume that it is the black clients' responsibility to accommodate western practices and they distance themselves from the responsibility to accommodate the needs of black clients. They assume that black clients lack knowledge to engage in therapy and do not have time to educate clients who do not understand the nature of psychotherapy. The assumption that black clients need to accommodate western practices implies that they have to know English. Non-black therapists rarely show commitment to learn black languages. Given that the vast majority of psychologists in South Africa speak no indigenous language, everyday people are excluded from specific forms of psychological interventions, simply on the basis of language they do, or do not, speak. The lack of competence of non-black therapists to communicate in black languages means that therapists need to learn more about other languages and that mental health services are limited to the advantaged, educated, middle class groups.

Counsellors have to gain knowledge and understanding of the worldviews of culturally diverse clients. This competency is reflected on the standard that requires counsellors to actively attempt to understand the diverse cultural background of the client with whom they work. Counsellors are trained to increase their skills so that they can efficiently assess their needs, explain behaviours in other cultures, and

manage diverse cultures in counselling. Knowledge is also a continuing process and it helps facilitate multicultural counselling process.

2.9.3 Skills

According to Pope-Davis and Coleman (1997) by skills he means application of the acquired self-awareness and knowledge into skills for multicultural practice. Counsellors have ethical responsibility to show willingness to gain knowledge, personal awareness and skills relevant to working with a diverse client population. The skills will equip them with culturally appropriate interventions. To create a culturally competent counselling profession one has to determine what skills counsellors' possess to function effectively in, and contribute to, sustaining a diverse community. Harper and McFadden (2003), defines skills as the ability to use awareness and knowledge to interact effectively with clients and colleagues regardless of their racial classification or cultural origins. Individuals use their skills to engage in an effective and meaningful interaction with those who are from different cultural backgrounds than their own.

2.10 Maintaining competence

The development of multicultural counselling competence is an ongoing process. Practitioners have to keep on maintaining their multicultural standard and to be updated with current cultural issues. The APA has ethical guidelines that compel counsellors to act within the boundaries of their competence. According Harper & McFadden, (2003) not all counsellors can be competent to offer therapeutic services to every client who comes for help since counselling is a broad profession. Counsellors cannot possibly know all the diverse cultural values, beliefs and behaviour of every client who comes for counselling. However, counsellors have an obligation to do their job within the boundaries of competence and guidelines set by APA and work effectively with a diverse number of clients. Counsellors can feel tempted and sometimes they are tempted to refer clients who are culturally different from them. This could be due to fear of harming the client or have own personal issues (Harper & McFadden, 2003). This may indicate lack of competence. Counsellors who do this may not develop/grow professionally. Counsellors should develop their knowledge and skills for working with diverse client populations. Whilst practicing that, they

must be careful not to harm clients while they are doing so. When clients seek counselling, they invest a great deal of trust in their counsellors to be capable of assisting them in resolving their problems. They make themselves vulnerable and rely on having a safe environment in which to confront their fears and concerns. They have the fundamental right to expect that their counsellors will be competent.

2.11 Measures to deal effectively with cultural diversity and differences

Differences occur as a result of the different roles, status and responsibilities that individuals have in their societies. The greater the number of cultural differences within society, the greater the extent to which the ideas and behaviour of its member differs (cultural heterogeneity).

2.11.1 Treatment options and interventions

According to Diller (1999) it is important to use treatment modalities that will suit the cultural needs of the clients. British/American models of clinical psychology training have been previously accepted as the applicable models but do not hold all the answers for psychologist working in Africa (Kottler & Swarts, 2004). These models increase demands and challenges facing South African practitioners who work with multilingual communities.

Professionals must be aware of theories that are culture bound and of different cultural definitions of health and illness as well as the existence of traditional cultural healing methods. Pedersen et al. (1996) supports this by stating that one needs to consider the client's unique frame of reference and psychosocial background before deciding whether to work with him or her to avoid harm of misdiagnosis and biased attitudes in the therapeutic relationship. This will help in preventing labelling or misjudging of clients. According to Gibson (2003) this makes counsellors to be alert to possible abuses of authority that violates human rights that culturally different clients are often exposed to, despite numerous laws and regulations prohibiting discrimination against minority groups.

Health professionals should understand what multicultural counselling is and the value it places when each individual is treated uniquely based on their culture, ethnicity and race.

2.11.2 Communication patterns

Ivey et al. (1997) suggests that both the counsellor and the client need to communicate within their own culture and learn the ability to understand other cultures as well.

It is important that the professional attending to clients speaking different language from theirs must encourage them to particularly discuss important issues and feelings in their own language, even if it may be a challenge for the counsellor to understand them. The counsellor can ask the client to translate them after they have expressed them as according (Ivey, Ivey & Simek- Morgan, 1997). Clients become in touch with their deeper experiences when expressing themselves in their own language.

Counsellors must be sensitive to non – verbal cues, have the ability to recognize direct and indirect communication styles as linguistic diversity may pose serious threats to multicultural competency.

2.11.3 Developing African consciousness

South African mental health practitioners should focus on cultural renewal so as to ensure the development of genuine African cultural forces that will drive social and psychological development (Sue & Sue, 1977).

African culture consciousness should also focus on the colonials who believe that the African indigenous experts are illiterate and not certified and should not be involved in colonially prescribed school education (Edwards, 2000). Counsellors/Psychologist need to acknowledge their own language and cultural limitations and get empowered by acknowledging their limited or no understanding of the language and culture by asking the client to explain and teach them the meaning of what they said in their own culture/language. Leadership must develop the cultural capital and mindset of organizations and institutions using cultural strategies that are rooted in African cultural belief systems and thoughts, so as to ensure sustainable development and transformation.

2.11.4 Focus of education and training

The counselling profession during its early years of development ignored issues of cultural diversity. Focus has been on ethical issues such that psychologists have rejected their objectivity and boundaries. Training for psychologist need to be revised because they are faced with challenges of diversity of worldviews that clashes with what has been taught. Maintenance of multicultural counselling competence may be one of the most important ethical issues the counselling profession faces in today's diverse society (Harper & McFadden, 2003).

These issues need to be considered because they have a huge impact on counselling relationship. Therapist training is not sufficient enough to handle issues of race and racism, and this may unwillingly cause therapists to be influenced by racist (Strous & Eagle, 2004). The practice and style of socialization in psychology/counselling is more of euro-centric/westernised in nature than being multicultural. One cannot turn a blind eye on the good part of some of the training institutions, which try to introduce multicultural training. Rogers-Sirin (2008) postulates that most published literature on training psychologists has focused on graduate training programs rather than on training needs of practicing psychologists who are already working in mental health.

Most therapeutic interventions take little interest of the dynamics of relationships in the extended family of the client. Most therapeutic interventions focus on the self, which do not recognize the importance of the family and culture. Culture is known as one of the most important and perhaps most misunderstood constructs in modern social theories. Culture may be defined narrowly as limited to ethnicity and nationality. Western or non-western approaches represent different worldviews. Traditional Western approaches to counselling and psychotherapy limited the important contributions of clients. According to Snyman and Fasser (2004), psychologists training demands trainees to become intimately involved in their clients issues and hardships. This is would be difficult if the client is speaking the language which is different from theirs. This also raises conflict and tension between individuals' sense of selfhood and the demands of the profession.

Training institutions need to acknowledge the importance of adopting indigenous knowledge systems as a means of making students aware of their knowledge systems

and those of others. Indigenous knowledge system is described as knowledge that belongs to and is transmitted by a specific ethnic group and with common practices that are based on cultural identity. Education Curriculum should include programmes that provide learning experience which incorporates intercultural perspective and supports cultural diversity. Edwards (2000) postulates that exposing students to cultures different from theirs will help explore cross-cultural possibilities more fully, richly and critically.

According to Aponte (2000), students must learn to administer psychological testing and assessments using culturally acceptable styles of service delivery. Psychological tests that have been used and currently used are culture biased and are not suitable for non-English speaking people. Psychologists/psychometrics must learn to prepare cultural formulations to increase reliability and accuracy of their clinical diagnoses with ethnic groups (Aponte & Wohl 2000). Cross cultural counsellors must start with the training, experience, and sensitivity that they have accumulated within-cultural clientele, extend and modify it to suit their interventions with culturally different clients (Pedersen et al., 1996). Counsellors should appreciate how ideas concerning race facilitate or interfere with the therapeutic relationship.

Psychology in South Africa has developed processes and adopted structures that would align their selection criteria and procedures with developments taking place in the broader South African context (Mayekiso, Strydom, Jithoo & Katz, 2004). The psychology training programme has implications not only for the quality of psychological services provided, but also for the psychological wellbeing of the South African population (Mayekiso et al., 2004)

2.12 The politics of language in mental-health care

The South African constitution has eleven official languages since it is a multilingual country. Language in mental health care is the most obvious potential barrier to the delivery of good mental health services. Language diversity issues in South African health care services have been neglected in the international mental health research (Drennan & Swartz, 2002). Focus has been on psychiatric assessments or general health care services while little attention has been paid to language issues in psychological or psychotherapeutic work. (Drennan, 1999; Finchilescu, 2005; Levin,

2004; Swartz, 1989). Mayekiso et al. (2004) postulates that the effectiveness of psychological services in the post apartheid era in South Africa rests on who the universities train to become psychologist and this is important in embarking in the process of addressing the issues of relevance for a post apartheid South Africa. Professionals working in mental health service should acquire the vocabulary necessary for effective communications, including becoming informed about intricacies of meaning that may be peculiar to particular cultural settings.

2.13 Language in the mental health-care system

Language is used as the medium of communication when conducting assessments and treating patients in mental health care (Levin, 2004; Raval & Smith, 2003; Swartz, 1998; Swartz & Drennan, 2000; Swartz, Drennan & Crawford, 1997). Although language is seen as a medium of communication, it however becomes a problem when a mental health care practitioner speaks a language that is different from his or her patient. According to Burbano o’Leary, Federico & Hampers, (2003), the presence of different languages deprives people access to mental health care, and promotes inequality. Although the South African constitution has documented eleven official languages, the mental health care services still remain heavily Anglicised and many patients are still disempowered because of language dynamics. Language dynamics prevent patients from explaining their problems in-depth and from expressing themselves thoroughly to the mental health care practitioner. In KwaZulu Natal the majority of patients who make use of primary and secondary health care services are first language isiZulu speaking patients. On the other hand, the majority of health care practitioners in the public sector mental health care are first language English and Afrikaans speakers, and cannot speak the language of most of their patients (Schwartz, 2004). According to Drennan, 1998; Fisch, 2001, 9% of the country’s population speaks English as a first language, with only 32% of the country’s black population proficient in English while only 29% of the black population can speak Afrikaans.

Based on previous research and the shortage of qualified non-English speaking health care practitioners in mental health care, there is a huge ongoing need for people who must help with translation for non-English speaking patients. According to Drennan, 1998; Fisch, 2001; Schwartz, 2004 due to the shortage of health care practitioners

who speak indigenous languages the practitioners resort to using the nurses, patients, family members of patients and any other available person in order to help with translation. Translations have been used in mental health care system for many years (Drennan, 1999). This suggests that health care practitioners cannot work effectively without the help of translators.

2.14 Working through an interpreter

There has been little research done on the experiences of clinicians working through translators, researchers view this as a risk to exposing and challenging clinical work (Bolton, 2002). The inability to speak your patient's language stops the psychologist from connecting with the client if you use the translator and this leaves both the patient and the psychologist frustrated at the end. There is no doubt that the use of the translator impacts therapeutic relationship.

In the study done by Bolton (2002) where he investigated the therapeutic communication between patients and practitioners mediated by a translator, he found that the use of translators had a negative impacted in the therapeutic relationship. Bolton (2002) recommended a model that could be useful in a clinician/patient relationship. Clinicians need to achieve certain roles in their interaction with patients, namely, (i) to establish a basis of trust, (ii) to understand the patient's problem(s), and (iii) to try and make a difference (Bolton, 2002). Bolton (2002) in his study found that, the presence of a third person, in the intimate therapeutic process prevents the establishment of trust and a positive alliance between the clinician and the patient.

In the study done by Holcomb-McCoy (2001) language was found to be a challenge to counsellors who were working with students of different cultures and language. This challenge led the counsellors to using translators. The counsellors felt frustration at not being able to directly communicate in the native language. They described variations in how translators interacted with the counsellor and the client; the counsellors also felt that the translators took their roles

2.15 Different models of translator roles

Literature has shown different views about the expected roles which a translator should play in the clinical setting. The view that is disliked is the view that the

clinicians expect the translator to act as a silent channel through which communication can be facilitated between them and the patients (Swartz, 1998). This may suggest that the translator should have no influence and must be objective throughout the therapeutic process. Another view sees a translator acting as a team member and a junior colleague, working with the professional team (Swartz, 1998). It has been argued that this translator's role needs clinical knowledge and skills in translators who often make judgements about the clinical and cultural relevance of patients' stories (Swartz, 1998). This makes translators to have more power, through their skill to change questions asked and statements made, this changes the meaning of what the clinician stated (Swartz 1998).

This assumption highlights the importance of the role of the translation work, and may provide a good distinction between translation and interpretation (Bolton, 2002). Interpretation is said to be 'the formulation of a message expressed in a source language with the same meaning in a target language, to that the interpreted message has the same possibility to give the same response in the listener as the original message' (Bolton, 2002, p. 108). Swartz (1998) has proposed that the interpreter tries to give the same idea/meaning of a statement, in such a way that an additional idea/meaning, as opposed to merely an indication of the statement is communicated. This clearly suggests that translator communicates what he/she perceives to make sense of the statement from one language to another. The terms interpreter and translator are used interchangeably in this study.

Drennan (1998), Finchilescu, (2005) and Prince (2004) found that clinicians who use interpreters usually expect them to act as cultural brokers. This means, interpreters are expected to explain and clarify patients cultural context in their language, and the beliefs they hold, is constructed. This role may suggest that translators are well informed with the relevant culture. An alternative view suggests that translators act as patient advocate. This assumes that the translators' role empowers patients who are often deprived health care services because of the language do not speak. The translators' role is usually adopted in community based work and may include an ongoing relationship with the patient or client (Drennan, 1998; Swartz, 1998). However, given the lack of translators, such relationships are often not possible.

It is evident that the shortage of translators creates differences in service provision and is a huge problem. The lack of availability of translators and the unwillingness of those approached by clinicians to translate creates a problem (Drennan, 1998). Other researchers have also reported hesitance of the practitioners to use translators (Raval & Smith, 2003).

2.16 Conclusion

Culture is complex and dynamic in each context. Much of what therapists believe is that competence is very subjective. Counselling process focuses on things that matter to people, personal feelings about, and things that affect their lives. Based on the fact that counsellors or therapists are human beings, one may not deny that their human feelings often influence their professional lives. This makes it difficult to view counselling as purely objective. Although MCC is an ongoing process one cannot deny that cultural issues will always exist.

Creating fair and useful criteria for evaluation is very difficult in the counselling field (Palmer, 2000). This research has shown that mere knowledge is not enough to become a skilled and effective counsellor, and it is well known that having all the traditional counselling skills does not make one competent to work with culturally diverse clients.

Multicultural competences enable the individual to interact successfully and respectfully with people of different cultural background. Continuous professional development is perhaps the key to do away with mono-cultural therapeutic interventions and encourage cross-cultural diversity. Education needs to be done in a way that does not contribute to stereotypes, but to bring everyone together and not to separate. Counselling in a multicultural environment comes with challenges and these challenges are diverse. The resources available to help therapists/counsellors to overcome these challenges are limited. This calls for more multicultural trained therapists/counsellors, especially therapists who speak indigenous languages. Historically white institutions as they claim to be the nozzle through which multicultural counselling can be realized, have to undergo a process of transformation. There is disagreement as to whether counsellor and client should be

culturally similar. Minority clients prefer the counsellor of the same culture over opposite race counsellor.

Counsellors/therapists need to explore ways to work effectively with diverse cultures while maintaining respect for individual differences and beliefs. Failure to do this will reflect negatively on the profession. According to Palmer (2000) the major reason for clients to use the service depends on the therapist's professional competence and attitudes, not just culture, and race and linguistic compatibility.

Culture is no longer seen as a closed system that can be defined very clearly, nor something that is composed of traditional beliefs and practices that are passed on from generation to generation, but as something living, dynamic and changing – a flexible system of values and world values and world views that people live by and create and recreate continuously (Fernandos, 2003). Culture is now about the manifestation of what is valued, demonstrated through what people do rather than what they say. The more people act and behave in different ways, the challenge it becomes for those working with people to understand those diverse and different behaviours.

It is always necessary to be aware of one's own prejudices and how they may inadvertently be communicated to those who are culturally different from the therapist. Being aware of differences in cultural style, interactive patterns and values is important as these can lead to miscommunication. Ivey et al. (1997) suggests that those dealing with culturally different clients must have the ability to generate a maximum number of thoughts, words and behaviours to communicate with self and others within a given culture. They must have the ability to formulate plans, act on many possibilities existing in a culture, and reflect on these actions. They must have the ability to come up with culturally appropriate interventions strategies.

Psychology needs to correct the experience of historical, cultural and psychological dislocation and relocate what has historically been wrongly projected, with particular reference to interracial therapy in the South African context. Psychology as a profession may be conceived either retrospectively or prospectively. That is, to say, it may be dealt with as a process of accommodating the future to the past, or as a utilization of the past for a resource in a developing future.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology followed to collect and analyse the data.

3.1.1 Sample

The study focused on the KZN psychologists who are working interracially. The target population for this study included White and Indian psychologists. Eight participants were selected for this study. The transcripts of three participants were eventually abandoned due to poor quality of the taped interview. This meant therefore that the researcher selected to work with five transcripts. The sample consisted of five psychologists drawn from general and psychiatric hospitals and those working in private practice. All the participants had experience in working with diverse cultures and people who are speaking isiZulu. Three of the participants were females and two were males. The participants' ages ranged from 34 – 48 years. Two participants worked in private practice and three were in public service. A convenience sample was used. In this case, the researcher was guided by the accessibility and proximity of psychologists. Participation in this study was voluntary. The advantage of this sample was that, it entailed the selection of individuals who were easily available, and the disadvantage was that it could result to a biased sample (Babbie, 1992). It is, however important to note that the researcher was very careful in avoiding any form of biasness.

3.1.2 Data collection

In-depth semi-structured interviews were used, which allowed the participants to elaborate and introduce new aspects of experience, whilst still covering a set number of key areas. The interview lasted about one hour, and focused on the challenges faced by English speaking psychologists who are working interracially and overall feelings in regard to working interracially. Participants were interviewed at different times. The use of semi-structure interviews were considered beneficial for the aims of this study as they provide English speaking psychologists an opportunity to discuss other aspects of their experiences, in a flexible space and potentially open up new experiences, other than those directly addressed by the interview schedule itself.

The interviews were recorded verbatim on audiotapes and transcribed for analysis. The recorded interviews were later transcribed and the questionnaires can be found in APPENDIX B. Interviews were then transcribed using a technique by Potter & Wetherell, (1987) and Thompsons depth-hermeneutics' approach. Appendix C consists of transcript symbols used in the analysis

3.1.3 Data analysis

This was a qualitative study, which employed discourse analytic approach. Analytically, the study focused on how the English-speaking psychologists from different background of their clients made sense of cultural and language diversity in their therapeutic relationship. The analysis was developed within a social constructionist approach to discourse. Discourse analytic work is generally located within a social constructionist position. Social constructionist research is concerned with understanding the various ways in which people might construct their social reality (Bryman, 2004).

One of the reasons for using discourse analysis, is that it is a reflexive process which involves reading accounts and continuously reconsidering how each participant is making sense of, and accounts for, their experiences in interracial psychotherapy.

This is often done through understanding of the way in which language is used. Discourse analysis examines how people use language to construct versions of their experiences, and is based on the assumption that people draw on cultural and linguistic resources in order to construct their talk in certain ways to have certain effects (Bryman, 2004).

The discursive psychology analytical approach of Potter and Wetherell (1987) was used as it allows various levels of analysis: analysis of how speakers construct and negotiate meanings and discourses they draw to create and justify their actions. Discursive approach is interested in the outward activity rather than upon hypothetical, and essentially unobservable, inner states.

Taking a discursive approach, the researcher looked at how language and culture act as a facilitating or hindering factor to effective psychotherapy. A discursive approach

also provides an analytical tool to investigate the dynamics of language and culture facing English speaking psychologists. This approach does not force the researcher to generate conceptual categories and to apply a standardised measurement technique to analyse data. Discursive approach provides an empirical basis for studying the constitutive nature of forms of hindering and facilitating factors to psychotherapy.

The analysis of data began with repeated reading and re-reading of transcripts. This was done to develop in-depth familiarity with transcript in discourse analysis. After reading transcripts the coding was done, this process involved identifying all parts of transcripts that referred to the challenges/dynamics facing English speaking psychologists who are working interracially. Repeated and interesting themes of transcripts were categorized and formed basis for analysis.

3.1.4 Practical and ethical considerations

The information received during the interviews was treated with confidentiality and participants had the right to discontinue with the interviews should he/she felt uncomfortable, especially with the sensitive issues. Participants were reassured confidentiality since the study was sensitive in nature. Alternative methods could have been used to facilitate this study (e.g. focus groups), but interviews were used as to provide a safe confidential space for participants. Participants signed the consent form before the beginning of the study (see APPENDIX A).

CHAPTER FOUR: RESULTS

4.1 Introduction

Discourse analysis was employed to interpret the data from the transcribed interviews. Because of the transcription length, the data was first coded to highlight and structure the more relevant information to be used in the analysis. This process essentially involved the preliminary chunking of similar types of information into more manageable categories. It was from these categories that the actual discursive themes later emerged during the analysis phase. Thompsons depth-hermeneutics' approach for interpreting the meanings attributed to symbolic constructions (such as language), was used as the primary framework in which the actual analysis of discourse was undertaken. Discourse analysis is much more concerned with the subjective understandings conveyed through these themes, as well as their functions and ideological significance.

The findings of this research have been divided into seven main themes: interpreters as culture mediators, establishing trust in a therapeutic relationship, communicating through the interpreter, language dynamics, and confusion with role ambiguity, lack of self confidence and accommodating other people's culture.

Three participants did not feel comfortable responding to questions whilst the tape recorder was running. After the tape recorder was switched off they started reflecting their true feelings about the topic. They mentioned influence of apartheid, training, they have their own perceptions about black patients (they do not know nor understand English/psychotherapy), do not feel comfortable doing therapy with someone who does not understand their language. This is supported by Mayekiso et al, (2004) where he postulates that despite democracy, South Africa is still engaged in attempts to eradicate the deep inequalities resulting from the apartheid system. They think that black patients are inferior and have to listen to the therapist. They expect black clients to accommodate their own worldview. Sometimes, they are not certain about what the black client is relating, these makes them feel incompetent.

The presentation of the findings has been divided into seven sections as follows:

1. Interpreters as culture mediators
2. Establishing trust in a therapeutic relationship
3. Communicating through the interpreter
4. Language dynamics
5. Lack of self confidence
6. Confusion with role ambiguity
7. Accommodating other peoples culture

4.2 Dynamics of language and culture

A. INTERVIEW#1

Gender: Female

Age: 36

Place of work: Public hospital

Question 1

In your experience, please reflect on how interracial psychotherapy impacts on the therapeutic relationship

I can't say I have had problems with interpreters; I have had very good interpreters.

I can't really say, I think it is difficult to build a relationship if you are using an interpreter. Yah I guess it depends on the interpreter that you are using. Some interpreters do not do what you tell them to do.

I am not a fussy person such that it's very interesting I had a psychotic person I had aaa I think it was an HIV counsellor from where I was working (whom she used as interpreter). So interesting because I never realised that the lady presented well (the patient) so I did not realise she was psychotic. The information she was giving me was so confusing that it was only when she run away. (Laughter) Then I realised that it wasn't that. I didn't understand it was actually that this is her world it was very funny to see how it had affected him that he eventually run away he wasn't skilled in this psychological delusional thinking.

And then I called in another interpreter and we worked well together. When working with children you would tell them not to tell the children to play if they sit and do

nothing that's ok. Do you know why I asked her what she was doing? I knew what she was doing. I actually wanted the mother to hear that she had a dream. So it goes back to education that I can't use the interpreter over and over again its very tiring looking for them.

The issue of English sometimes, there are those psychological terms that are difficult to translate to simple English. It's kind of difficult...whether you are saying a statement that is easily translatable...I mean you don't know. You just worry about it...You ask yourself whether you've picked a psychological word that will complicate the translation process and give you what you do not want.

Question 2

To what extent does language and culture influence or hinder therapeutic relationship

When I do an MSE (mental state examination) there are all those fancy terms and I don't actually remember. I have the MSE written in English and Zulu. What I usually do I point to the sentence and he would read the Zulu word and he would answer me in English. There are times with translation where I get really stuck at least I try to read to them so that I do not feel alone. It is not ideal at all. You feel stupid and incompetent. In a way it depends on the type of person that you get. The respondent so to speak.

General assessment of a Therapeutic relationship, when I am doing therapy I sit in a triangle. I will be watching the patient and I will be living there and never minding that I have been sitting and chatting. After talking and sitting next to the translator and looking straight up I watch the non- verbal cues very much though. When you do that you get some information either way.

Thinking more of that especially when I use the translator she is helpful. It is amazing because she automatically transcribes the information and makes use of examples. I think I have a good relationship with the translator because we work together but with the patient its difficult because its like she is establishing the rapport with the translator not me.

Question 3

How would you reflect on dealing with social sensitivity?

I am ready to listen if I don't understand I go and check if I don't know I tell them that I don't understand because we do not follow ancestors. When I am forced to talk about it (ancestors and culture) and deal with the emotions if ever there is a case where I have to face the emotions I would rather try to do it but I first check how they understand it (their problem) and what is important for them.

To be honest, when working interracially you cannot totally separate culture and therapeutic relationship?

We have done years of training. What I am saying is that the way we are trained is intensive. That is why it takes so many years of training. If I am faced with a situation I will deal with that. I don't do that because of race but because I can do it. Some issues are really difficult to understand in your patients' culture. We were trained to accommodate other people's cultures but therapeutically it hinders therapy because as a therapist you have to understand all the dynamics of your clients' culture. With the help of the interpreter you get to understand part of the patients' problem. But you feel that so much is left out of the conversation between the patient and the interpreter.

Question 4

What do you think are the challenges facing English speaking psychologists?

I am so aware of what you are talking about such that there are arguments about the role of the psychologist in interracial psychotherapy. Especially when using the interpreter. When very powerful emotions are being communicated by the patient it's almost safe to be able to have that translated while the facilitator thinks and processes and holds on to what the emotion evokes in them before they actually understand what the actual content is. So you've got that time to process before the translator translates the content. And also hearing it then from, especially when it's very powerful emotions, getting to hear the content of those emotions through as safe medium of the translator.' What I am trying to say is that language is the biggest problem. For you to understand the patients' culture you have to understand their language first.

Lack of spontaneity, yes i think that is also a huge problem. You try so hard to build the relationship with the patient...you are deprived that intimate and meaningful interaction because of the language barrier and your own assumptions about what is the patient thinking.

Question 5

How have you transformed from your own belief system to meet the demands of multiculturalism?

There are things that English speaking psychologists cannot possibly understand. I believe black patients would feel comfortable talking to a person who understands their culture and language. This will always be a problem because we come different cultural backgrounds. I don't think I can change my belief system because of my work, but I can try and accommodate my patients' point of view.

B. INTERVIEW#2

Gender: Female

Age: 34

Place of work: Public hospital

Question 1

In your experience as a psychologist, please reflect on how interracial psychotherapy impact on the therapeutic relationship

I feel like it is still related to them and there is still a connection between them. What can be very difficult is communication and understanding working through a translator. You know ehm I would say that I may be working with Zulu speakers that I work with in this hospital. Mostly I would say the majority speak sufficiently English for us to communicate and we do have the connection to build rapport. They are able to establish the working relationship and to find the truth about the patient. Where I have to work without an interpreter and with the patient who does not understand english... It makes therapy a lot harder. I work in a rural clinic once a month. I would say that it doesn't destroy the relationship it is still possible to form a formal relationship. I also imagine that the err suppose that we are. To say something on that it so easier in some ways to trust this objective outcome. I would say I work

actively; there is staff which is alien to me, cultural beliefs that I find to be raised to be sub sufficient opinioned. That I find a lot harder. And I am really struggling with shame in front of the community. Shame of failing my patients and not giving them what they expect from me. I think I have reflected enough to work with my own urges. I really actively always try to understand their belief system. I struggle when it conflicts with my own. I try to be as much as I can I mean my bit that I do try reflect my own beliefs I really do try not to do that to separating out of my head and with the clients and what is asked to do eer I do grapple with it (laugh). And of course bewitchment and muthi are complicated issues.

I think some of that might be valid psychologically and I recently read a really interesting article by Gavin Ivy which helps to understand like any other defence mechanism in my own culture and understanding this I can really work with this. So yes it sometimes important to find er some connection

Question 2

To what extent does language and culture influence or hinder therapeutic relationship?

It has been difficult to get patients who speak English fluently. I probably should educate myself a little bit. I really feel that I don't give enough I know I should but I don't and I think to speak a different language is very important. I have seen wannabe psychologists coming through. In Cape Town one of the criteria for going to UCT is that you speak a Black African language. Personally I don't feel I can ever speak Zulu up to the efficiency that is required for psychotherapy probably that is why I don't bother but I also think I should. Same time I don't know if I get to the real depth of therapy with Zulu speaking. Whether its being done for assessment, for disability grant or doing in depth psychotherapy eer it is really setting to the dynamic of transference through a translator, I find it very difficult and I find that rapport ends up developing between a translator and a client. I feel left out of psychotherapy when they are having the conversation between them and I feel like (sad face) (laugh). And also a dynamic between me and the translator which is very difficult for me they hate me because I don't know Zulu and I think they resent me for asking them to translate

mostly is the nursing staff will say it's not their job. The psychiatric population can speak English.

It's very important for the therapist to explain to their patients the reasons for using the interpreter and to be heard in their own language. Sometimes I forget and I will find myself using words which are difficult to translate. It's because of my natural manner of speaking...sort of generally around the point and you forget that you are not talking to an English speaking person. That in itself is time consuming...trying to be concise and to the point so that the interpreter will understand what you are trying to say.

Question 3

How do you as an English-speaking psychologist reflect on and deal with social sensitivity?

It is really difficult you know, because black clients' belief system and cultural issues are totally different from our own. This also affects the therapeutic relationship because your client won't have faith in you. You feel forced to treat your client as a separate person from you. White people are taught to be independent and with the black community it's the opposite. Such issues affect psychotherapy and are difficult to work with. Anyway probably I have to work with that in the end of the session and after the session I really reflect as much as possible on that. I don't feel there are times where I have felt terribly despondent. What is required in therapy is not the hardest but, dealing with deep emotions is the hardest that is really hard. We find the way.

Question 4

What are the challenges that the English speaking psychologists are more likely to be faced with?

I think it goes without saying; yes language is the biggest challenge. Like I have said earlier on that translators are not the solution to the problem. Coming to think of it I never realised the impact that language has in therapy. I mean you have to understand and speak your clients' language for therapy to be effective. We can have extra Zulu lessons but it will never be enough to communicate fluently and it will take time. I believe that to be able to speak and understand another person's language you have to

live with them, and the chances of that happening are zero. I think this will always be a problem and I don't see myself taking zulu classes I would rather do research on something that is going to help me. It is better if you are working in private practice because you can always choose the type of clients you want to see and they come to you voluntarily. In public hospitals you do not have a choice you have to use the limited resources that are given to you, which the interpreter. Sometimes you can't even find the interpreter, which makes things more difficult for you.

Besides, there is no flow of therapy when using an interpreter. I don't feel comfortable in my own therapy as I am in other therapies, which is when I'm seeing patients from my own culture. It's not natural; you are always on guard, fear of being criticised.

Question 5

How have you transformed from your own belief system to meet the demands of multiculturalism?

I don't think an individual can transform from his/her belief system. What I do is to try and understand my clients' world and separate it from my world. Sometimes it is difficult when the client comes with a belief system that is totally different from your own. I believe in cultural diversity but imposing beliefs from the outside to your patient is not a good idea. Eer about meeting the demands of multiculturalism. I don't think one can completely meet the demands of multiculturalism. There will always be differences. But if you do research or get some help from your colleagues and ask for more information if you do not know... I think you can do better. I believe that in therapy you have to be yourself. Do not pretend to be something you are not.

C. INTERVIEW# 3

Gender: Female

Age: 38

Place of work: Public hospital

Question 1

In your experience as a psychologist, please reflect on how interracial psychotherapy impacts on the therapeutic relationship

It's kind of frustrating I mean because at one level I am a wacky sometimes feel useless and ineffective in therapy, such that it comes down to a point where you have to refer when you are seeing a patient of a different culture.

When working as a psychologist you follow a particular school of thought, which is what some of us do and it helps in understanding type of behaviours. But It is very difficult to understand a particular behaviour and to know what secondary gain is if you do not understand your patients' language and culture. Sometime you struggle to understand what the person is telling you, you know. It is very, very difficult when you are by yourself. There was an African patient who was telling me her story but I was caught along the way and I realised that her story was camouflaged. Basically she was talking from the African perspective that if you are women you have to behave in a certain way and it was her role as a woman to do that. I understood what was said but if I did not have a little of background of what was said it could have been transference. It would have been difficult if I did not have that background. I know I am not supposed to be judgemental. I tried to understand her story from her point of view. What I am trying to say is that this is ehh kind of a problem because if you believe in one school of thought therapeutic relationship could be affected. This also creates lack of confidence in you.

Question 2

To what extent does language and culture influence or hinder therapeutic relationship?

Eehm I think the two will always be a problem. Like I said earlier on, referring to a school of thought helps me to understand individuals' background and behaviour. Different races do not share the same culture and language, therefore it is difficult to expect a psychologist to neglect or separate him or her from his/her own culture.

It is very important to be in the same level of communication and understanding with your patient. Well, if you lack that your therapeutic relationship will be affected. I understand a little bit of Zulu, but I cannot say that I am perfect because I sometimes use an interpreter. Sometimes it is difficult to find an interpreter and you are forced to work without one. Nurses say it's not their job and sometimes they say they are busy. I don't like using interpreters because it feels like the patient is building that

rappot/relationship with the interpreter and u feel left out of the conversation. Yeh, that's true, its eeh sometimes it's frustrating, because you feel like you are not doing anything and this leads to feeling incompetent. It's like your power is taken away from you.

Language is very important in therapy...firstly it shapes meaning, discourse. It shapes the way they think, it shapes people's understandings, and most importantly who they are, and how other people see you. In therapy language facilitates the barrier between the therapist and the patient.

Its not that all patients can't speak English...what is important to also acknowledge is that there are patients who can actually speak English, but they prefer and they wish to speak their own home language those who can speak English, fail to express their emotions.

Question 3

How do you as an English-speaking psychologist reflect on and deal with social sensitivity?

I guess we do not have a choice but to deal with that situation and get help if necessary. We were trained to work with different cultures although we did not go to details with African cultures and language. I understand other universities compel students to learn African languages, which I think is good. But that takes time and you cannot learn everything and this goes back to the issues that language and culture will always be a problem amongst English speaking psychologists who are working interracially.

Question 4

What are the challenges that the English speaking psychologists are more likely to be faced with?

I think language and culture are the most common challenges. Translators are also the problem. Yes we use them but they cannot solve this dilemma. I guess those who are doing private practice can choose who they want to work with unfortunately those who are in public sectors have limited choices. I don't think I have time to learn Zulu even if I do they wont teach me everything about Zulu or any other African language. I mean you have to understand and speak your clients' language for therapy to be

effective. Sometimes we see patients who are educated and fluent in English, but because of cultural issues and psychological terms that are difficult to translate to simple English we experience some difficulties.

To me interpretation is much more than just interpreting the words. Interpreters play a very important role in mediating, in making sense of the meaning beyond the words, the cultural, relevance of things.

Sometimes it's difficult to know when to use a translator. I don't know the point at which to actually interrupt because I don't know what's being said at that point.' I think it would be useful for us as therapists to get an interpreter who is able to strike a balance between maintaining the free flow of conversation between me and the patient, and keep me informed of the therapeutic process, which is what's actually being said. Another challenge is that, when seeing a black patient you don't ask questions that you normally ask your white patients. Sometimes it's because you feel they won't understand you or give you what you want.

Question 5

How have you transformed from your own belief system to meet the demands of multiculturalism.

No no no, I don't think a person can transform from his/her own belief system. Yes I can learn about other people's cultures but that does not make me knowledgeable about them. In our training we were taught to meet the demands of multiculturalism and to work with diverse cultures. I don't think I can completely say I am confident when it comes to other peoples cultures. There will always be differences and misunderstanding during therapy. I just do what I can and if I am not sure I tell my patient and ask for help in that area. That displays lack of confidence in yourself but what can you do, you cannot lie to your patient and pretend to know something you know you do not know.

D. INTERVIEW#4

Gender: Female

Age: 40

Place of work: Private practice

Question 1

In your experience as a psychologist, please reflect on how interracial psychotherapy impacts on the therapeutic relationship

Hhm..well let me start with how I do therapy. My therapeutic approach is very very eclectic it s starts from before they come through the door so eeh the whole atmosphere of my office of the reception area of where they sit how they sit how comfortable they are that kind of thing. Once they walk in the door they generally are in a receptive mode. Usually they come in when they are still very severely depressed they haven't been receiving any form of treatment. So they are in that kind of state so they kind of the sense of comfort. They come in they greet you; we develop some kind of rapport and usually do develop some rapport. I cant really explain how you know develop that but with our training you know. Most of my patients are black so yah in fact I am have very very few white patients. I have had a few coloureds and I have ehh quite a bit of Indians but mainly black. Most of my patients are black ehmm I haven't had any difficulties when interacting. I find that ehmm a lot of times the man I know from cultural training, training cultural issues are suppose to be quite restraining and kind of conservative and for some reason or the other I haven't had that problem I find that they talk they open up they are able to understand concepts. I explain a lot of things in therapy. I don't live my patients wondering what's going on. I find that one of the main problems in treatment and especially with black patients in our communities is that nobody explains to them what is going on. They are kind of left in the dark. They don't know, they don't even know why they are here. The thing is I think they don't talk, they don't inform. I don't do that. I treat all my patients the same when it comes to that. I give them a lot of information I let them feel empowered, when they leave, they leave very happy and smiley and they feel like they got something. I always like patients to leave with the feeling like they have got something, because I believe that I may not see that patient again so I must give them what I have got now. Next time when they come there will be different things that they will need, unless we contract for long term therapy that I know we are doing the same things. But if I am seeing people just coming in like this

I treat each session as if that session and that what's going on is what we are dealing with at the moment and I find it works brilliantly. Ehmm the patients that I had the

psycho-education works brilliantly, I find that the patients, and this is across the board all races as well, tend to follow through they surprise me because when I speak to them about it they go and actually do it . They come back with this thing I did it I cant believe it, everything is changed. I find that they are very cooperative they tend to follow through ehhh I had one or two difficult ones again information has helped them stick to the programmes, so even those that are non-compliant with the medication and something like that when you explain to them and give them the time and give them respect ehhm they tend to open up and they listen its almost like you are speaking to a person heart to heart. So when it comes to the cultural thing its very difficult for me to define it as whatever it is because, ya because I treat everybody with that same kind of orah if you understand what I mean ehhh it just depends how that person responds to it. Because how that person responds to is then how I would then tailor my response back. I do go around with what ever it is that they say and they talking about I respect that and I work with it and have some kind of plan of what I want or what I try to get sometimes its small little things I give it just a shift in judgement or insight, just a small shift, because that small shift sometimes makes a big difference. So that is what I aim for with my patients. I find it that I am able to surpass cultural boundaries with that and patients come back and they keep coming back and they bring their families. I haven't had a problem with that because when parent bring their children they need to trust you as well. When you have what you need you know I have always been like that. I am not sure whether it is where you are or who you are or your approach. Even in government hospitals I did the same thing. If I could see that there is a problem somewhere that is affecting the process why I must not bring it out. The whole point of them coming to me is to iron out the wrinkles and find out where is the problem. If I know the problem is not lying here and that there is something else standing in the way why must I not bring it out. So its quite hands on you know.

Question 2

To what extent does language and culture influence or hinder therapeutic relationship?

I think the lack of understanding and the cultural background of the person hinders therapeutic interventions drastically. I think it very easy to offend somebody even subtly you know. Eehm and once you offend somebody already the relationship is

already damaged and if you are looking at the therapeutic relationship that's the end of that and developing the rapport is an uphill battle you know and eehm so I think it is very very important that people understand culture and you know where the person is coming from. The best way to do that is t sit back and listen you know. When you listen you are able to pick up what is it and where he is coming from and actually walk in their shoes, just actually just kind of subconsciously walk in their shoes. It's much easier to pick up where they are coming from and what they are doing what they feel when you do that. When you start thinking a lot more about it you start kind of analysing and it gets complicated and it becomes to theoretical you know and then its very hard to apply it but when you start to feel it and live it and just work with it as it goes when your intention at the back of your mind is to get a clear understanding of the person no matter what, that intention plays through and you find that you just pick up very easily what is going on but then again the background of actually being open to learning about culture. You know I mean if you react funny when somebody is saying something ehh like a "tolokoshe" and you say ahhh what? And they will immediately think you don't believe what they are saying and they will think of staying away from that topic you know what I mean.

Another thing when very powerful stories or very powerful emotions are being communicated by the patient, they communicate via the interpreter who contains them and the therapist misses out on that. (Participant no.4)

Question 3

How do you as an English-speaking psychologist reflect on and deal with social sensitivity?

I get a lot of patients with the ancestors' thing and I just work along with it. And I make sure that I do what needs to be done. It's not about what I believe in an ancestor or not the fact is when they believe in that it already has an impact on their own, Yah. So if they believe in it a change in that is going to cause a change in them. That is what is important. So that is about dynamics of that situation. So its not about what I believe in or whether I am trying to convince that person or what ever. So I don't ignore any of the dynamics in their relationships and their own scenario. If their ancestors play a part I tell them straight out sought it out what you need to do. Sometimes they come out with their own solutions and sometimes they don't know

what to do. I tell them find out, find out what to do. So with therapy I encourage them to do whatever needs to be done to put their environment right. So I am very much aware of the environment and culture that I work with my patients in all dynamics and always. You know the interesting thing is I have got mainly black patients eehm I think she is the only one so far that do not speak perfect English.

Question 4

What are the challenges that the English speaking psychologists are more likely to be faced with?

Obviously language and using interpreters are the main challenges. I am sure most English speaking psychologists have the same problem. All my black patients are highly educated. The government service, I was in Wentworth Hospital they were all Black patients and other Hospitals it was a mixture. When I work in Clinic where there were only Zulu speaking patients I actually bought a dictionary that has English, Xhosa and Zulu. I never had to use it. Old ladies who come from rural areas speak high Zulu even with my little Zulu I could not peak up what they were saying. The words are completely strange to me because their Zulu is of high level. It was also confusing to identify the cultural issues when they speak high Zulu. I can understand and speak Zulu in a normal level enough to make sense of the urban Zulu speaking people. There were cases where other patients could not understand nor speak English at all, and then I had to call the nurses to translate. Those interviews were very clinical. I had to do a lot diagnosing and I would refer. The nurses add their own things. I had the patient saying a short Zulu phrase and she gave me a long interpretation and that is not what the patient said. I couldn't argue that because once you fight with the nurses you are out. Quite a few nurses did not understand that they needed to translate straight to me instead they argued with the patient and instead of translating what the patient is saying. We talked about what the nurse was supposed to do very informally during sessions.

Question 5

How have you transformed from your own belief system to meet the demands of multiculturalism?

I think what is important is, when you enter psychotherapy you must separate your issues from those of your client. It is sometimes difficult because your clients might

talk about something that you do not understand or something that is against your belief system, but in that case you have to work hard to find more information about what the client said and that is time consuming as it delays therapy process. This also affects the therapeutic relationship because your client won't have faith in you.

E. INTERVIEW# 5

Gender: Female

Age 48

Place of work: Private school and Non Government Organisation (NGO)

Question 1

In your experience as a psychologist, please reflect on how interracial psychotherapy impacts on the therapeutic relationship

Ehh I think it is difficult to establish a relationship with someone who does not speak your language initially ehmm perhaps more difficult to understand the dynamics of culture that are connected to their own when your initial part of therapeutic relationship is, but I do believe that one can still establish a really good therapeutic relationship irrespective of culture or language differences there is an initial language. They do not understand you instantly with the recognition of concepts, the language. There might be elements of distrust from the patient for you as cultural alien. They might see you as a cultural alien. I still believe in a long term that one can establish an effective therapeutic relationship with none of these. Trust and building the relationship with the patient-yes, to be consistent in your work, using the same interpreter all the time, someone constant. Using someone constant helps you build up a therapeutic relationship, relieves the anxiety of using the interpreter.

Question 2

To what extent does language and culture influence or hinder therapeutic relationship?

I believe that with regards to language what is critical to establish in therapeutic relationship is that one hears and understands ones patient. Eehm they need to express themselves as comfortably, authentically and honestly as they can, which is easy to achieve in your mother tongue. The hindrance for me that the kind of questions that one is asking can be kind of personal and they might be understood by the patient

very clearly and then when the patient needs to express himself or herself they cannot express themselves in a way that fully explores the dilemma or the conflict what I am trying to say is that one can loose out of that authentic limitation because you want to communicate most effectively and most authentically in ones own language.

Interpreters? I have worked through interpreters. In my experience it depends on the interpreter. Some of them, I could see because I had a sputtering of the language to talk Zulu and I had enough to understand that some of my interpreters were interpreting my questions quite directly and others were not they would end up doing a little bit of therapy themselves a lot of masquering and they would go on and on and I would be excluded from process. Laugh quite frustrated and quite loss a sense of managing the situation and perhaps you don't know where you are going. But if the interpreter really really followed you exactly and gave the response back it would actually work very well. So I learned to use the interpreters that I knew were trying their hardest to follow the question and yet the same token those women cause they were all women who did their own thing as it were, were non the less I could see having some kind of impact.

I also feel because they were able perhaps to communicate some staff that might not have been relevant. In my approach might have not been relevant. So I was always very much happier using an interpreter than not using one. And I still believe that some things were achieved even if they were not following the process according to your definition of what the process means. It still think it is possible to explore the issue to even the through the medium of interpretation where things get lost. I still believe that really good therapy can be done through using the interpreter.

It's not right to stop the interpreter in the flow of therapy to allow for interpretation. It feels like you are going against the whole principle of natural flow of therapy. There is nothing that you can do but to take a back seat, especially when someone is speaking a different language. I think it shows disrespect to the patient and the interpreter.

Question 3

How do you as an English-speaking psychologist reflect on and deal with social sensitivity?

I believe that it's critical to reflect on and I think that was partly what drove my process when I was working in the community. I believe that you cannot work effectively with someone unless you understand their socio-cultural context in which they live and I also think if you do not understand those issues it might problematise where there is none and then miss the point and not understand what the question is trying to communicate. It's critical and fundamental to work interracially.

Question 4

What are the challenges that the English speaking psychologists are more likely to be faced with?

I think psychology is faced with...from a psychologist perspective I think there is quite a lot of frustration there is a fact that one might not be achieving what one wants or is suppose to achieve with the patient. From the patients perspective I think there could be a lot of resentment or distrust even of the therapist who does not speak their language and for him it's critical to establish trust. It kind of lowers the standard of work if you are English speaking and they are not. Be competent in the language with which the people you work with are. That's frustrating, competency and questions that are the main problem. I think you will be able to integrate far more above broader understand of what psychology actually means. I think I have been able to expand of narrow very narrow theory that I was taught I think it enriched the way I was taught I had to work a lot harder be very humbler be very open to reality that is not my own

Question 5

How have you transformed from your own belief system to meet the demands of multiculturalism?

Eehm, I think I had to distract my own system or suspend it I think I have to suspend my belief system and not to assume that its true. Maybe one does not totally suspend it you know a system of petty balancing yours with another I don't know if you can replace it. I think you can work in tangent with the other belief systems because you still use your own to understand and to order information but I think you can work alongside other belief systems. You must understand that your formulation of the problem might well not be accurate.

4.3 Summary of findings

The study found that many of the difficulties that were reported by the participants stemmed from a lack of fluency in using indigenous languages. It also found that the interpreter played a significant role, which overlapped with the functions of the psychologist. This made the psychologists feel insecure about their positions or roles.

In general, the study found that English speaking psychologists experience serious challenges when they have to conduct psychotherapy and other related activities with non-English speaking patients or clients.

The study found that the issue of working with interpreters continues to be faced with many uncertainties. While the interpretation process is by no means ideal for carrying out psychotherapeutic work, however, it can go a long way in creating access to psychological services. This study has demonstrated that psychotherapy can be implemented successfully through using interpreters, until such time that the system is able to produce psychologists that are adequately proficient in different indigenous languages spoken in South Africa.

CHAPTER FIVE: DISCUSSION

5.1 Introduction

This study's interview revealed a number of main themes, each of which included a few sub-categories. There were also a number of common themes, such as the use of interpreters and role confusion, which ran throughout the interview data, and formed important parts of the main themes. This section provides an outline of these themes and a discussion of their relationship with each other and with existing literature. Where applicable, findings from participant retrospection will also be included.

5.2 Interpreters as culture mediators

The study showed that interpreters played a dual role of being the interpreter and the culture mediator. This is supported by Drennan (1998) who found the same relationship between these two roles. He reported that in trying to help clients' access social services; translators felt compelled to intervene on behalf of clients in order to provide culturally nuanced information, and to stop discrimination and marginalisation.

Language is a part of a much larger cultural gap between clinician and patient (Drennan, 1999). There is often an implicit expectation of translators to act as culture brokers (Drennan, 1998; Drennan, 1999). The participants reported that the role of culture mediator was important in mediating conversation across languages. It was believed that this role would help the psychologists gain a better understanding of the cultural context and meaning of the patients' narratives (Drennan, 1998; Evans, 2001; Fisch, 2001; Swartz, 1998). The role of mediators also involved explaining aspects of psychotherapeutic culture to patients.

Understanding of your patients' illness, demands the incorporation of the patient's subjectivity of the illness and the psychologists' objective view.

“There are things that English speaking psychologists cannot possibly understand. I believe black patients would feel comfortable talking to a person who understands their culture and language”. (Participant no. 1)

“Sometimes it is difficult when the client comes with a belief system that is totally different from your own. I believe in cultural diversity but imposing beliefs from the outside to your patient is not a good idea” (Participant no. 2)

The patient’s illness may reflect cultural ideologies and disguise unfairness in the distribution of power, knowledge and privilege within the society of which the patient is part.

Pillay and Petersen (1996), postulates that given that discourse is embedded in language, an appropriate place to begin this process would be to challenge the use of the term ‘patients’ to refer to users of health care services.

The psychologist is required to understand firstly, the patient’s understanding of the causation of his/her illness, secondly the disease problems as well as illness related problems and thirdly that consensus be reached between the psychologist and the patient regarding the cause, diagnosis and optimal treatment for the problem. This is important where the patient holds traditional beliefs. Pope & Reynolds (1997) stipulated that the health care provider working with ethnic, linguistic, and culturally diverse populations have knowledge about diversity, client’s culture, religion, beliefs, language, economic and political conditions and cultural identity

5.3 Establishing trust in a therapeutic relationship

The development of a trusting relationship was another factor that emerged against the anxieties of using the interpreter. This is important in shaping how the patients experience the therapeutic process. Trust has been identified as an essential element of both clinical and translation work, without which is difficult to establish a good working relationship (Raval & Smith, 2003). The respondents felt that it would be better if they used the same person (interpreter) each time they conducted psychotherapy. This would have helped the interpreter to understand what is expected of her and to understand psychological jargon and to establish trust as they got to know both the interpreter and the psychologist. The fact that they will be using the same interpreter could provide something constant about the therapeutic relationship, and it could help to contain some anxieties about using an interpreter. This could help develop a sense of security in the therapeutic process.

‘Trust and building the relationship with the patient-yes, to be consistent in your work, using the same interpreter all the time, someone constant. Using someone constant helps you build up a therapeutic relationship, relieves the anxiety of using the interpreter. (Participant no.5)

The interpreter was seen as a safe source (someone to be trusted because he/she is the one seen as conveying the message and understanding the patients language), who’s translation or message could be relied upon. The possibility could be that the interpreter showed understanding and empathy over the patients presenting problem, and therefore gained credibility, as well as trust, respect and the confidence. This sense of trust in the interpreter created more anxieties with psychologists because it felt like the power or control of psychotherapy was taken away from them by the interpreter. The psychologists used the non-verbal cues to understand what was going on between the interpreter and the patient. The findings of this study are supported by literature where it stipulates that the presence of a third person, in the intimate therapeutic space has been found to hinder the establishment of trust and a positive alliance between the clinician and the patient (Bolton, 2002).

“From the patients perspective I think there could be a lot of resentment or distrust even of the therapist who does not speak their language and for him it’s critical to establish trust.(Participant no. 5)

I can’t really say, I think it is difficult to build a relationship if you are using an interpreter (Participant no.1)

The participants felt like they were building the relationship with the translator than the patient.

It is amazing because she automatically transcribes the information and makes use of examples. I think I have a good relationship with the translator because we work together but with the patient its difficult because its like she is establishing the rapport with the translator not me (Participant no. 1).

*There might be elements of distrust from the patient for you as cultural alien.
They might see you as a cultural alien. (Participant no.5)*

The patients established a strong relationship with the interpreter because it was their way of connecting with the interpreter. The respondents hoped for a better working relationship between interpreters and the patients to foster a smoother better communication. Duffy and Wong (2003) saw language differences, different ways of communicating and adopting a colour blind approach as some of the attitudes that hindered effective counselling relationship within the South African context.

5.4 Communicating through the interpreter

In mental health care settings effective communication depends in language diversity problems. According to Swartz, (1998) caring for people in emotional crisis requires adequate communication. Surprisingly in the health care setting psychologists are trying to care for people whom they cannot speak their language. While the patients could not speak directly to the psychologists, they still needed to communicate with them in order for their voices to be heard. Literature indicates that translation, in one form or another has always been part of mental health care provision (Drennan, 1999).

The translator was also initially identified as hugely important in the context of the psychotherapy, with respect to being able to sense when it was appropriate to stop and translate and when it was more sensitive to let the interpreter carry on talking. This was a particularly important role because the psychologists found it difficult to interrupt the interpreter in a sensitive and containing way, as they did not understand what was being said. They could not judge when it was best to interrupt. This may suggest that psychologist need to be on the look out for the best times to interrupt as this could help the therapy process to run smoothly. While limited research has been conducted on the experiences of clinicians working through translators, many researchers have referred to this exercise as a challenging clinical compromise (Bolton, 2002).

Sometimes I forget and I will find myself using words which are difficult to translate.

It's because of my natural manner of speaking...sort of generally around the point and you forget that you are not talking to an English speaking person. That in itself is time consuming...trying to be concise and to the point so that the interpreter will understand what you are trying to say. (Participant no.2)

It has been widely reported that the presence of the translator hindered the establishment of an emotional connection between patients and clinicians (Bolton, 2002). Bolton (2002) reported that indirect communication makes it difficult for the psychologists to create a trusting relationship and a positive therapeutic alliance with the patient. During the interviews respondents reported their concerns regarding the use of interpreters. They felt that the therapeutic relationship was established with the interpreter. Respondent reported that when they made use of the interpreters the patients are able to share their stories and they were able to express their emotions effectively.

Sometimes it's difficult to know when to use a translator. I don't know the point at which to actually interrupt because I don't know what's being said at that point.' I think it would be useful for us as therapists to get an interpreter who is able to strike a balance between maintaining the free flow of conversation between me and the patient, and keep me informed of the therapeutic process, which is what's actually being said.' (Participant no. 3)

This process was felt to be an extension of the facilitators' normal therapeutic techniques. Literature on cross-cultural work holds that non-verbal communication is a fundamental part of intercultural interaction, one which is often overlooked in the training of clinicians (Singelis, 1994).

General assessment of a Therapeutic relationship, when I am doing therapy I sit in a triangle. I will be watching the patient and I will be living there and never minding that I have been sitting and chatting. After talking and sitting next to the translator and looking straight up I watch the non- verbal cues very much though. When you do that you get some information either way. (Participant no. 1)

It is the practice of mental health clinicians, particularly those who work according to a psychodynamic perspective, to rely on their counter-transferential responses to a patient in order to understand the patient's problems better.

The nurses add their own things. I had the patient saying a short Zulu phrase and she gave me a long interpretation and that is not what the patient said. I couldn't argue that because once you fight with the nurses you are out.
(Participant no. 4)

As indicated in the literature, the importance of eye contact is an indication of acknowledgement in psychotherapeutic work has been identified by many authors (Prince, 2004). The lack of role clarification was therefore also confounded by uncertainties as to who the patients were to focus on during the therapeutic process. The eyes are an important tool of non-verbal communication through which patients convey meaning (Prince, 1994). It is also through eye contact that people acknowledge each other.

It is tricky you know having to get used to the fact that you will have to stop either the facilitator or the patient in the flow of therapy allow for translation. Mmm...you sometimes feel that it is going against the whole principle of natural flow of conversation. You never get used to taking a back sit. It is not easy, especially when someone is speaking a different language and you don't know the point at which to actually stop the interpreter because you don't know what's being said at that point. I think it shows disrespect...'
(Participant no.5).

Cultural relativism holds the view that there are many beliefs about the world and that no one has the single right answer to the world's problems. This means that people may want to respect other peoples' cultures but practically it is hard.

5.5 Language dynamics

Language is a powerful means of communication yet often ignored in cultural diversity as good language skills are usually essential in effective multicultural

psychotherapy. In South Africa English is often taken as a common language that most people use which makes it look more important than other languages. Yet it limits second language users in different ways. The 'language barrier' problem is embedded in issues of power and the power relations that contain relationships between clinicians and patients (Crawford, 1999). Therefore the introduction of the interpreter into a therapeutic relationship shifts the power dynamics within the psychologist and the interpreter. According to Burbano o'Leary, Federico and Hampers, (2003) the existence of language diversities and the resultant language barrier creates problems with access to mental health care, and also creates inequality.

"I believe that with regards to language what is critical to establish in therapeutic relationship is that one hears and understands ones patient. Eehm they need to express themselves as comfortably, authentically and honestly as they can, which is easy to achieve in your mother tongue."

Its not that all patients can't speak English...what is important to also acknowledge is that there are patients who can actually speak English, but they prefer and they wish to speak their own home language. Those who can speak English, fail to express their emotions ' (Participant no.3).

This was in line with literature on language theory. Different languages develop different systems of vocabulary for the expression of emotion, which gives the speakers of those languages access to the affective aspects of their experiences (Marcus, 1976; Swartz, 1998). Marcus (1976) also argued that speaking across the language barrier hinders the patient's ability to integrate experience with the affect associated with it. Patients may therefore have difficulty benefiting form therapeutic processes and experiences such as sharing experiences. This is an important part of the therapeutic process because the focus of the intervention is to create space in which patients could benefit from having the psychologist witnessing their experiences and emotions.

Old ladies who come from rural areas speak high Zulu even with my little Zulu I could not peak up what they were saying. The words are completely strange to me because their Zulu is of high level. It was also confusing to

identify the cultural issues when they speak high Zulu. I can understand and speak Zulu in a normal level enough to make sense of the urban Zulu speaking people. (Participant no.4)

The interviewees felt that the interpreter played an important role in psychotherapy. The respondents did not see themselves as the all knowing therapists, which was the position they occupied prior to engaging in psychotherapy. The use of interpreters enables black patients to speak in their home language, and to communicate their feelings in psychotherapy.

'...it's very important for the therapist to explain to their patients the reasons for using the interpreter and to be heard in their own language.' (Participant no. 2).

Patients often have to try and communicate in the language of the health professional which, in most cases is either English or Afrikaans (Drennan & Swartz, 2002). Speaking in your own language gives more freedom of expression around emotions. Language is a means of gaining access to knowledge. Therefore while English remains the dominant language of communication in the health care services, it gives it undisputed power. Ability to understand both indigenous languages, gives a psychologist a considerable amount of power in the therapeutic relationship.

I think there is quite a lot of frustration there is a fact that one might not be achieving what one wants or is suppose to achieve with the patient. From the patients perspective I think there could be a lot of resentment or distrust even of the therapist who does not speak their language and for him it's critical to establish trust. It kind of lowers the standard of work if you are English speaking and they are not.(Participant no. 5)

According to Pederson (1996) language is a fundamental tool in all therapeutic relations as it has the intra-psychic, interpersonal and trans-subjective meaning, was often overlooked as only English and Afrikaans were recognized as the official languages.

In a similar explanation, the participants highlighted the importance of language in mediating interaction between psychologist, interpreter and the patient.

“Language is very important in therapy...firstly it shapes meaning, discourse. It shapes the way they think; it shapes people’s understandings, and most importantly who they are, and how other people see you. in therapy language facilitates the barrier between the therapist and the patient.(Participant no. 3)

These understandings of language resonate with a constructionist understanding which holds that language “creates’ its own reality” (Swartz, 1998). It has also been established that different languages operate according to different systems of vocabulary, a fact that was supported by the perceptions held the facilitators (Swartz, 1998). It is important to recognize that different views and beliefs exist to all of us. The study emphasise the importance of speaking in your first language. It is felt that speaking in one’s mother tongue facilitates a better expression of the emotions associated with experiences. Better emotional expression is attributed to the fact that speaking your own first language may be a more emotive language in comparison to English.

“The words are completely strange to me because their Zulu is of high level. It was also confusing to identify the cultural issues when they speak high Zulu. I can understand and speak Zulu in a normal level enough to make sense of the urban Zulu speaking people. There were cases where other patients could not understand nor speak English at all, and then I had to call the nurses to translate.”(Participant no.4)

This experience is not a reflection of the experiences of most mental health practitioners in hospital settings. English speaking psychologists are often desperate for interpretation, which is not readily available (Crawford, 1999; Drennan, 1998).

“It is very important to be in the same level of communication and understanding with your patient. Well, if you lack that your therapeutic relationship will be affected. I understand a little bit of Zulu, but I cannot say that I am perfect because I sometimes use an interpreter.”(Participant no3)

The respondents also commented on the fact that it would be helpful if the translator was a psychology student as he/she had would have some knowledge and familiarity with work in this field. Clinical skills and knowledge has often been emphasised as an essential quality for translators working in mental health care settings (Drennan, 1998, Fisch, 2001; Marcos, 1979; Swartz, 1998; Swartz & Drennan, 2000).

A measure of attending to cultural diversity and differences start with awareness of these differences among and within patients and which makes it to be a person centered phenomenon.

I think it goes without saying; yes language is the biggest challenge. Like I have said earlier on that translators are not the solution to the problem. Coming to think of it I never realised the impact that language has in therapy. I mean you have to understand and speak your clients' language for therapy to be effective. We can have extra Zulu lessons but it will never be enough to communicate fluently and it will take time. I believe that to be able to speak and understand another person's language you have to live with them, and the chances of that happening are zero. (Participant no. 2)

This is supported by Pope and Reynolds (1997) where he postulate that cultural competence is never achieved completely, but one continues to acquire throughout individual's lifetime. Seedat (2001) also indicated that becoming an effective counsellor and a mental health practitioner involves learning how to recognize diversity and shaping your counselling practice to fit the client's world.

In Cape Town one of the criteria for going to UCT is that you speak a Black African language. Personally I don't feel I can ever speak Zulu up to the efficiency that is required for psychotherapy probably that is why I don't bother but I also think I should. Same time I don't know if I get to the real depth of therapy with Zulu speaking. Whether its being done for assessment, for disability grant or doing in depth psychotherapy eer it is really setting to the dynamic of transference through a translator. (Participant no. 2)

Language has often been referred to as the primary form of communication in psychotherapeutic work. Not only is it an important tool of assessment, but it is also the primary means of treating patients particularly. (Levin, 2004; Raval & Smith, 2003; Swartz, 1998; Swartz & Drennan, 2000; Swartz, Drennan & Crawford, 1997). The participants emphasised the importance of language in their work generally, and in the therapy process specifically, as it helped shape meaning. This reflects the analysis of Discourse analysis which stipulates that ascribing a name to something was a means through which one experiences that thing.

*Eehm they need to express themselves as comfortably, authentically and honestly as they can, which is easy to achieve in your mother tongue.
(Participant no.5)*

5.6 Lack of self confidence

The respondents reported limited interaction with their patients because in some cases they are forced to use interpreters. They presented with uncertainties as to the applicability and effectiveness of the therapeutic approach used. These uncertainties often lead to a lack of confidence in the psychologists' ability to work with an interpreter appropriately and a lack of confidence in the skills that the interpreter brings to the relationship (Drennan & Swartz, 1999). This may further erode feelings of doubt in patients. According to Palmer (2000) the major reason for clients to use the service depend on the therapist's professional competence and attitudes, not just culture, and race and linguistic compatibility.

“There are times with translation where I get really stuck at least I try to read to them so that I do not feel alone. It is not ideal at all. You wonder what the patient is thinking about you. You feel stupid and incompetent.”(Participant no.1)

The cultural differences between the race groups in South Africa emanate from vast customs, for example, language, food, and music preferences, and a variety of social practices. This leads to perceptions of dissimilarity and, in turn increases fear of norm conflicts (Finchilescu, 2005). Feelings of inadequacy in interracial psychotherapy may also be exacerbated by black cultural dynamics and belief systems.

Psychologist's consequences of fear are that they may fear confronting the black patient where they would normally challenge a white patient because they are not sure about their perceptions and they could be seen as judgmental.

“It's kind of frustrating I mean because at one level I am a wacky sometimes feel useless and ineffective in therapy, such that it comes down to a point where you have to refer when you are seeing a patient of a different culture.”

“When working as a psychologist you follow a particular school of thought, which is what some of us do and it helps in understanding type of behaviours. But It is very difficult to understand a particular behaviour and to know what secondary gain is if you do not understand your patients' language and culture”. (Participant no.3)

The psychologists may be seen as ineffective in interracial psychotherapy because of feelings of inadequacy, helplessness, and being consumed in their own social identities. Literature indicated that the basic need of being able to deal with cultural diversity and differences is to be culturally competent which is defined as a process in which people continuously strive to work effectively within the cultural context of an individual, family or community with a diverse cultural background (Tjale, 2004). Psychologists need to acquire cultural knowledge which will give sound foundation concerning various world views.

“I would say I work actively; there is staff which is alien to me, cultural beliefs that I find to be raised to be sub sufficient opinioned. That I find a lot harder. And I am really struggling with shame in front of the community, shame of failing my patients and not giving them what they expect from me”. (Participant no.2)

The psychologists may also be seen as not understanding the patients' world of view. Other research has reported that a lack of training and guidance often results in negative experiences for both clinicians and patients (Raval & Smith, 2003).

I don't think I can completely say I am confident when it comes to other peoples cultures. There will always be differences and misunderstanding

during therapy. I just do what I can and if I am not sure I tell my patient and ask for help in that area. That displays lack of confidence in yourself but what can you do, you cannot lie to your patient and pretend to know something you know you do not know.(Participant no. 3)

The findings of this study are supported by Fernandos (2003) where states that mental health services are frequently held to be insensitive to culture, psychiatrists and psychologists are said to be culturally incompetent and their therapy appear to be inappropriate for non-western cultures.

5.7 Confusion with role ambiguity

A sense of powerlessness was frequently identified during the interviews. The participants viewed themselves as powerless to engage in psychotherapy effectively because of language barriers. The participants assume their positions as in authority and those powers are taken away by factors beyond their control. This is in line with literature, where Swartz, (1998) views the translator as playing a more active part in the process where they act as team member and junior colleague, allied with the professional team.

“I find it very difficult and I find that rapport ends up developing between a translator and a client. I feel left out of psychotherapy when they are having the conversation between them and I feel like...sad.” (Participant no.3)

There were therefore a lot of uncertainties about how to go about doing psychotherapy through the use of an interpreter.

“I don't like using interpreters because it feels like the patient is building that rapport/relationship with the interpreter and u feel left out of the conversation. Yeh, that's true, its eeh sometimes it's frustrating, because you feel like you are not doing anything and this leads to feeling incompetent. It's like your power is taken away from you.” (Participant no.3)

The lack of clarity appears to have placed the participants in an uncomfortable position. This led to role ambiguity and power issues regarding who is the psychologist.

“Yah I guess it depends on the interpreter that you are using. Some interpreters do not do what you tell them to do”. (Participant no.1)

“Quite a few nurses did not understand that they needed to translate straight to me instead they argued with the patient and instead of translating what the patient is saying. The nurse became the part of the assessment. That was a big problem with interpretation”. (Participant no. 4)

As indicated in the literature, the process of translation often occurs in an ad hoc manner (Drennan, 1998; Drennan & Swartz, 2002; Erasmus, 1999; Prince, 2004). It seems as if not enough attention was given to thinking about how using an interpreter could impact the therapeutic relationship. The guidance to interpretation is usually given informally.

“To me it’s so much more than just translating the words. Translators play very important mediating part in helping to make sense of the meaning beyond the words, the cultural, relevance of things, so definitely a cultural broker in a lot of ways.” (Participant no. 5).

The lack of adequate information and understanding about psychotherapy is experienced as difficult by interpreters as they do not understand some of the psychological jargon. The participants expressed concerns about the many uncertainties that existed around using interpreters.

“Quite a few nurses did not understand that they needed to translate straight to me instead they argued with the patient and instead of translating what the patient is saying. The nurse became the part of the assessment. That was a big problem with interpretation”. We talked about what the nurse was supposed to do very informally during sessions.’ (Participant no.4)

What emerged from the interviews were a number of complex and sometimes contradictory expectations about what roles were to be played by the respondents and the interpreter. This uncertainty reflected the participants' inexperience in working with a translator which previous researchers on the topic have often attributed to insufficient thought and training in language issues and multicultural work (Drennan & Swartz, 1999, Raval & Smith, 2003).

Although using an interpreter created role ambiguity, therapist felt that the interpreter's role is very important in therapy.

I also feel because they were able perhaps to communicate some stuff that might not have been relevant. In my approach might have not been relevant. So I was always very much happier using an interpreter than not using one. And I still believe that some things were achieved even if they were not following the process according to your definition of what the process means. It still think it is possible to explore the issue to even the through the medium of interpretation where things get lost(Participant no5).

To me interpretation is much more than just interpreting the words. Interpreters play a very important role in mediating, in making sense of the meaning beyond the words, the cultural, relevance of things (participant no.3)

The functions of the interpreter determined the amount of power that the respondents held within the therapeutic relationship. Paradoxically, while both the translator and the respondents occupied positions of power, the participants felt disempowered. The respondents felt disempowered because they could not communicate directly with patients and relied upon the interpreter to understand what was being said. However these feelings were sometimes overshadowed by the positive impact that the presence of the interpreter was having on the success of the therapeutic session.

The interpreter acted as a container of patients' emotions through which information and emotions could be transported and communicated. The therapist does not get enough room and space in which to reflect on and process the emotions evoked by the

patient and to engaging with the actual content of what had been said by the patient. The therapists felt that this allowed the interpreter to control the therapy process.

'Another thing when very powerful stories or very powerful emotions are being communicated by the patient, they are communicate via the interpreter who contains them and the therapist misses out on that.(Participant no.4)

Therapeutic work requires containment from therapists (Raval & Smith, 2003). Where psychologists work through interpreters, their 'containing' role is therefore taken on by the interpreters. Interpreters get first hand information; they do not interpret only but also show empathy. They carry a lot of the emotional impact of the patients' stories. Furthermore, they hold their transference as well. This echoes findings in previous research in which it has been argued that acknowledge and work with this role in a supportive way, in order for them to maximise levels of containment (Raval & Smith, 2003). To work in this context you need to be 'caring' and 'supportive'. In order to naturally respond to emotions and want to comfort others who are hurting. This suggests that there is therefore a need for interpreters to be trained so that they can acquire certain innate qualities to interpret for psychologists.

I had a sputtering of the language to talk Zulu and I had enough to understand that some of my interpreters were interpreting my questions quite directly and others were not they would end up doing a little bit of therapy themselves a lot of masquering and they would go on and on. And I would be excluded from process.(Participant no.5)

This advocacy role seemed to be a problem for most participants. Past research has found that clinicians often feel that it is important to establish a close-knit working relationship with the translator in order to gain confidence in what the translator is doing (Drennan & Swartz, 1999). The participants did view the interpreters as member of the psychotherapy process.

The aspect that evoked the question as to who would be the therapist seemed to be the problem. The participants commented that their role played by the interpreter ended up being the facilitators of the process. This reflected that the function of the

interpreter in this context is multiple and often overlapped with the role played by the psychologist. Although the interpreters and the psychologists role, while appearing to conflict, they were in fact necessary in order to foster the kind of communication, between the patient and the psychologist.

5.8 Accommodating other people's culture

Respect for diversity was reflected by the participants. They also saw the need to learn other languages and about other cultures and racial groups. However, they acknowledged that although one can learn other languages that does not mean that the psychologist will know everything about that cultural group. Although therapists acknowledge patients social background and desire to be non-judgmental they still find it difficult to disregard their own world view when conducting therapy.

Although they have done years of training you can never separate your own culture from the patients.

I don't do that because of race but because I can do it. Some issues are really difficult to understand in your patients' culture. We were trained to accommodate other people's cultures but therapeutically it hinders therapy because as a therapist you have to understand all the dynamics of your clients' culture. (Participant no.1)

I also imagine that the err suppose that we are. To say something on that it so easier in some ways to trust this objective outcome. I would say I work actively; there is staff which is alien to me, cultural beliefs that I find to be raised to be sub sufficient opinioned. That I find a lot harder.

I really actively always try to understand their belief system. I struggle when it conflicts with my own. I try to be as much as I can I mean my bit that I do try reflect my own beliefs I really do try not to do that to separating out of my head and with the clients and what is asked to do eer I do grapple with it (laugh). And of course bewitchment and muthi are complicated issues. (Participant no.2)

Therapists who are working interracially must demonstrate flexibility and use approaches which match the worldview of the patient and accommodate their beliefs. This requires skills and knowledge that will accommodate patients' perspective.

I think what is important is, when you enter psychotherapy you must separate your issues from those of your client. It is sometimes difficult because your clients might talk about something that you do not understand or something that is against your belief system, but in that case you have to work hard to find more information about what the client said and that is time consuming as it delays therapy process. This also affects the therapeutic relationship because your client won't have faith in you. (Participant no. 2)

As acknowledged by most participants, interracial therapy has affected English speaking psychologists way of conducting therapy with black patients. This contradicts with their Eurocentric based training. This may suggest that mainstream psychology is unable to fully articulate the concerns and issues of the non-English speaking communities.

I don't think one can completely meet the demands of multiculturalism. There will be differences. (Participant no. 2)

Different races do not share the same culture and language, therefore it is difficult to expect a psychologist to neglect or separate him or her from his/her own culture. (Participant no.3)

No no no, I don't think a person can transform from his/her own belief system. Yes I can learn about other people's cultures but that does not make me knowledgeable about them. In our training we were taught to meet the demands of multiculturalism and to work with diverse cultures. (Participant no.3)

Maybe one does not totally suspend it you know a system of petty balancing yours with another I don't know if you can replace it. I think you can work in tangent with the other belief systems because you still use your own to understand and to order information but I think you can work alongside other belief systems. (Participant no. 5)

5.9 Lack of spontaneity

The challenges in interracial therapy may create negative transference from the patients and counter- transferences on the side of the therapist. Therapist may also anticipate disapproval from the patients. Furthermore, therapist displayed fear of being unable to connect emotionally with black patients.

“Lack of spontaneity, yes I think that is also a huge problem. You try so hard to build the relationship with the patient...you are deprived of that intimate and meaningful interaction because of the language barrier and your own assumptions about what is the patient thinking.” (Participant no. 1)

There may be fear of empathic failure on the therapist’s side. Many therapists hold the view that speaking a language that is different from your patient and holding on to your own world view creates difficulty in connecting and exploring intimate and sensitive issues with patients. This may lead to feelings of inadequacy and incompetence.

“I don’t feel comfortable in my own therapy as I am in other therapies, which is when I’m seeing patients from my own culture. It’s not natural; you are always on guard, fear of being criticised” (participant no. 2)

Themes that emerged may suggest that conducting therapy with a Black patient is different from an English speaking patient. Therapists feel compelled to therapy differently. Therapists’ fear of anticipated failure may prevent them from confronting their patients.

“When seeing a black patient you don’t ask questions that you normally ask your white patients. Sometimes it’s because you feel they won’t understand you or give you what you want” (participant no.3)

Such assumptions and fears tend to indirectly exclude black patients from participation in therapy and in expressing their feelings safely. It is evident that this is not about rendering similar services to different racial groups it also incorporates

questions about the appropriateness of psychotherapy for people from different cultural background. There were indications that lack of spontaneity, fear and lack of empathy interfere with the therapeutic process in interracial psychotherapy.

The social and cultural context of the patients should be taken into consideration and counsellors need to determine whether the assumptions they have made about the nature and functioning of therapy are appropriate to culturally diverse populations.

Focus must be on understanding culturally learned assumptions and culturally relevant facts.

CHAPTER SIX: CONCLUSIONS, LIMITATIONS, SUMMARY AND RECOMMENDATIONS

6.1 Introduction

The issue of language amongst English speaking psychologists who work interracially seems improbable. From the results it was identified that patients are disadvantaged of the psychological services because of the language they do and do not speak.

6.2 Conclusions

The study found that the issue of working with interpreters continues to be faced with many uncertainties. While the interpretation process is by no means ideal for carrying out psychotherapeutic work, however, it can go a long way in creating access to psychological services. This study has demonstrated that psychotherapy can be implemented successfully through using interpreters, until such time where we are able to produce psychologists that are sufficiently and adequately proficient in the different indigenous languages spoken in South Africa. The use of interpreters raises the ethical question as to why it is considered acceptable to offer psychological services using interpreters.

If we cannot produce psychologists who are fluent in indigenous languages, the best solution to the language problem is to improve the quality of interpretation work. It is surprising that the role of interpreters has not been explored in much detail in previous research, because it has such significance in reflecting the importance of interpreters in multilingual therapeutic work.

Although the participants can acknowledge patients' social and cultural background there are always dynamics of culture and language. The findings in this study suggest that language and culture are cause of concern in psychology service delivery. Whilst progress has been made in terms of selection programme to increase the number of African psychologists, this has not brought changes in terms of combating the issue of language and culture.

The participants see themselves as helpless when it comes to issues of culture and language. The therapists saw themselves as powerless to engage in effective therapy to deal with cultural issues. They stated that because of their cultural encapsulation they find it difficult to connect and explore pertinent issues with black clients. They stated that to understand culture you have to understand their language first. Language has played a significant role in racial exclusion in South Africa that includes ethnic mobilisation and practises of racial segregation (Mesthrie, 1995 in Painter and Baldwin, 2004). The participants do not see how psychology training can change this language and culture issue.

Most respondents think that the language issue will never be resolved. Despite taking Zulu classes, there will always be terms and concepts that are difficult to translate to IsiZulu and simple English. They also think that they do not have enough time to learn IsiZulu. They prefer developing themselves in psychology rather than learning something that is not going to help them. Others pretended that language was not the problem because they can use interpreters.

The results show that culture and language impact therapeutic relationship. The professional psychology is still a white dominated profession. There is an increasing number of African students who are selected for psychology training whilst there has been no decrease in the intake of white students. This is therefore a clear indication that while progress is being made on improving the situation, the issue of language and culture will still be a problem, provided that it is not addressed immediately, accordingly, and appropriately. It is interesting to note that psychology training programmes have revised the selection criteria to increase the number of African students. However, this has not translated to selection of psychologists who will be able to work cross culturally (diverse client population in diverse communities). Furthermore, training programmes do not assess the efficiency of languages spoken in community, including African languages. This is a cause of concern, considering the impact of language on service delivery (Pillay & Petersen, 1996). although much progressed has been made in developing models of training which are appropriate to south African needs, the issue of language and culture will always exist. According to Kottler and Swart, (2004) tension develops from conflicts between a continuous sense of selfhood, class, gender, sexuality, culture and about how relationships should be

conducted. Therefore, the psychologist has to interrogate the roles they have played in their families, communities and in life in general.

Patients often come to therapy because they have problems. They feel that things can change when undergoing psychotherapy. These dilemmas rely in the patterns of relating to other people and to themselves. Such dysfunctional forms of being and relating result in patients feeling that their relationships with others are difficult and stressful. Knight (2004) viewed therapeutic relationship in terms of object relation's model. According to object relations attachment to the object is important in the development of a sense of identity and belonging. He stated that patients choose to suppress their feelings; thoughts and other aspects of themselves that they think are unacceptable to others and to themselves to maintain the relationship. Hence psychotherapy is suppose to deal with such issues rather than re-enacting them. This has an impact in the therapeutic relationship.

This analysis suggests that patients may unconsciously (coach) prompt and guide their therapist in the direction that they most want need in order for therapeutic progress to occur. This may lead to empathic failure on the side of the therapist.

A therapist should adopt an attitude of empathic receptivity to these unconscious communications from patients, and to be attuned to how best to facilitate a new experience that could begin to break the old patterns of negative beliefs that result in problematic relations templates (Casement in Knight, 2004).

For psychotherapy to be successful both client and the therapist must be able to communicate in the language they both understand. English speaking therapists expect black clients to accommodate western practices and do not feel responsible to accommodate black clients' needs. Psychology training exposes most of the psychologists to interracial psychotherapy, which needs someone with a good background of African languages.

Incompetence, according to Rock and Hamber (1994) in Mayekiso et al., 2004 the credibility of the psychological profession depends on it being able to offer effective services to a broader spectrum of people in diverse circumstances. Hence, this has

become important for the profession of psychology to decentralise services to make them available and to meet the needs and demands of our communities

Although there are challenges in working interracially, some respondents reflected positive and constructive attitudes towards interracial psychotherapy. The positive themes that emerged were: using non-verbal cues, understanding clients' culture, research and flexibility. The respondents acknowledged the clients social and cultural background, non-judgemental and not imposing their values. There is a need for the approach that will match the worldview of clients and accommodate indigenous practices. Although white speaking psychologists are faced with these challenges, there is some receptivity and constructive attitudes noted in their responses. They try hard to be empathic without being judgemental, and not to stigmatise patients of different cultures and not to impose their own belief system.

Psychology is seen as lacking responsiveness to different cultures. It is criticised as being "Westocentric" (Holdstock, 2000); "individuocentrism" (Holdstock, 2000); and "irrelevance" (Berger & Lazarus, 1987). Its vocabulary and its frameworks are formulated in the western world. These critics of psychology have become very influential in the debate involving psychology and its position in different societies. From this study we have seen that expertise is not sufficient if you do not understand your patients' language.

To understand the relevance of psychology for indigenous societies, we will have to do much more. We will need to know why psychologists view themselves differently from their patients. Focus has been on African worldview, ideology, and cultural imperialism.

Asante (1999) advocates that in , there are political implications, because the issue of African politics throughout the world becomes one of securing a place from which to stand, unimpeded by the interventions of a decaying Europe that has lost its own moral way in its reach to enslave and dispossess other people. He further argues that this does not mean that all Europe is bad and all of Africa is good. Asante (1999) substantiates his view that a people's soul is, however dead when it can no longer breathe its own air or speak its own language, and when the air of another culture

smells sweeter. This probably suggests that the problem emanating in Africa, be it political, cultural, or economical, should be addressed from an African perspective in order for the remedy to be realistic. At the same time, may be attempting to correct the experience of dislocation and relocate what has historically been wrongly projected, and with particular reference to colonization by Europe. It applies with regard to multicultural psychotherapy in mental health. Psychology enhances our ability to free ourselves from imposed constraints but this may be difficult if you don't speak your own language because psychology installs its own language. One may be tempted to ask whether psychology is suitable for black South Africans.

South Africa is characterized by multiculturalism which can be traced back from the period of colonization in the 1800's. Different perceptions and interpretation of mental health problems can thus never go unnoticed since South Africa has got people from diverse cultural backgrounds. It is therefore significant that during psychology training indigenous languages should be taken into consideration.

It is thus significant that if psychology as a profession is serious about effective psychotherapy in the mental health fraternity, the realities based on multiculturalism be adhered to because South Africa is characterized as a multicultural society. Thus it would be imperative that all psychologists understand and speak the language of their patients. Such would also assist everyone having access to psychological services because people would have be talking in a language they understand and comfortable with. Notably there is no full support or interventions aimed at improving language dynamics in psychology.

Multiculturalism briefly refers to the existence, recognition and acceptance of cultural diversity in society. Embedded in the concept is a balance between conformity (sameness) and social diversity (otherness). While individuals need certain values, knowledge, and skills to operate effectively within the broad society, they do so without discarding their cultural baggage.

Multicultural psychotherapy in South Africa has been practiced, and has unleashed debates and criticism. Nevertheless it has become important in mental health fraternity especially in culturally diverse societies. In South Africa psychotherapy is

meant for people from diverse cultural backgrounds, hence it is recommended that when dealing with diverse cultures, the question of multiculturalism must be taken into cognizance in making sure that all cultural backgrounds are accommodated and considered in the process of psychotherapy.

With the need for multi-skilled psychologists, and for the development of psychology as a profession, effective psychotherapy in South Africa regardless of race, culture, ethnicity, class and sex, multicultural psychotherapy is gaining prominence. Numerous publications deal with the nature and functioning of the culture in general or with reference to particular societies, most largely homogeneous or non-specialized, and non-complex societies. However, although culture is approached as a comprehensive concept in such discussions, they frequently focus mainly on behaviour and material objects, and on people in apparently closed systems. They often pay little attention to culture in complex, culturally diverse societies. The same applies with language dynamics thus most English speaking psychologists are struggling and battling to do psychotherapy.

6.3 Limitations

This study reflects the findings that apply to this particular context and which may not be generalized to other therapeutic settings.

This study was focused at investigating the dynamics of language and culture among English speaking psychologists. There is limited research for discussion of the experience of the African psychologists in this context. Much of the South African literature that exists about translation work is limited to English speaking mental health care professionals.

Another limitation was the fact that I am a first language Zulu speaking psychologist. My anxiety was that I may not be a true reflection of the participants' feelings because they might fear how it could affect me. This may have created a barrier in my interviews with them, which could also explain why some of the participant did not feel comfortable having their views being recorded.

During the process of conducting this study, I performed the roles of both the interviewer and the psychologist. This dual involvement proved to be both a limitation and an advantage. The participants learnt some things from the interviewer since she is Zulu speaking. It served as a limitation because they thought that i will be judgmental and biased.

However, the study helped the researcher to gain insight into how it feels to be an African client and an African psychologist who works interracially. It broadened my frame of reference, such that I know what to expect when working with English speaking patients. Furthermore, it helped me to appreciate the complexities that accompany the role of a psychologist in the interracial context.

6.4 Summary

This study revealed that psychotherapy cannot be done effectively unless it is done in the same language as the patients.

If psychologists and patients do not understand each other appropriately, confusion and lack of trust is likely to take place between patients and psychologists. Thus, it is significant that indigenous languages be incorporated in the training which could be accommodated in the mental health setting so that there will be a universal understanding of all the stakeholders and effective psychotherapy. This may also ease the problem of dynamics of language and culture and other challenges faced by both psychologists and patients hence working towards quality and effective psychotherapy in the mental health.

The shortage of black psychologists in mental health today suggests the need to invite participation of all stakeholders in the progress and development of the psychology. It is thus, imperative that all universities, mental health institutions work together in order to ensure that language and cultural dynamics take their rightful place in accordance to the contextual cultural, religious, and cultural background of patients in order that language be used to benefit both the psychologist and the patient, and not to work against their progress and development of psychotherapy.

This study also revealed that it is hard for psychologists to work harmoniously with their interpreters where patients do not speak the same language as the psychologist. Fluency in indigenous languages could therefore result in effective psychotherapy.

Finally, the researcher hopes that this study will offer suggestions to psychology as a profession and find means to deal with the cultural and language problems that they are faced with in order for psychologists to have effective psychotherapy and be able to work interracially. It was hoped that the study would play a positive role in increasing psychologist's sensitivity to issues of race and racism. Furthermore, it was hoped that the findings of this study would help promote culturally respectful programmes and strategies among psychologists and other health-care professionals in KZN.

6.5 Recommendations

There is a need for greater investment in future empirical research that would determine if psychology is suitable for African patients. Furthermore, there is a need for a study that will focus on investigating the impact of interpreters in the therapy process. There is also a need to investigate the ethical considerations to the use of interpreters.

There is a need for training interpreters in the field of psychology. Such step will help the patients to access psychological services. Mental health professionals should be trained in indigenous languages. It will take time for professionals to be sufficiently proficient in another language. According to Drennan and Swartz (1999), training translators serves to address immediate needs of mental health care.

This study's findings highlight the importance of providing ongoing, in-depth professional development for psychologists on multicultural psychotherapy issues. Such professional development should focus on developing psychologists' knowledge and skill in working with diverse clients and on providing psychologists' with knowledge and skill in working with specific cultural groups. An important implication of this study is that those responsible for providing professional development for psychologists should conduct needs assessments to determine the

type of professional development most useful for psychologists who are working interracially.

Results also indicate that psychologists need ongoing opportunities to learn about the backgrounds, cultures, and language systems of their patients from different cultures.

REFERENCES

- Aponte, J.F., & Wohl, J. (2000). *Psychological Intervention and Cultural Diversity*. (2nd ed.). New Jersey: Allyn and Bacon.
- Asante, M.K. (1999). Afrocentricity Science & Techology: Implications for curriculum and Pedagogy. Reviewing Black Political Economy. *African Diaspora*, 27, 7-12.
- Babbie, E. (1992). *The practice of social research. Sixth edition*. California: Wadsworth Publishing Company.
- Berger, S. and Lazarus, S. (1987). The views of community organisers on the relevance of psychological practice in South Africa. *Psychology in Society*, 7, 2-6.
- Bolton, J. (2002). The third presence: A psychiatrist's experience working with non-English speaking patients and interpreters. *Transcultural Psychiatry*, 39, 94-114.
- Bryman, A. (2004). *Social Research Methods*. (2nd ed). New York: Oxford University Press.
- Burbano O'Leary, S. C., Federico, S., & Hampers, L. C. (2003). The truth about language barriers: One residency program. *Pediatrics*, 111(5), 569–573.
- Burn, D. (1992). Ethical implications in cross-cultural counseling and training. *Journal of Counseling and Development*, 70, 578-583.
- Crawford, A. (1999). "We can't all understand the whites' language": an analysis of monolingual services in a multilingual society. *International Journal of Language*, 136, 27-45.
- Dana, R.H. (1998). Problems with managed mental health care for multicultural problems. *Psychological Reports*, 83(1), 283-294.

- Diller, J.V. (1999). *Cultural Diversity: A primer for the human services*. Canada: Wadsworth Publishing Company.
- Drennan, G. (1998). *Language and the role of interpreters in South African psychiatry: a study of institutional practice in the Western Cape*. Unpublished doctoral thesis: University of Cape Town.
- Drennan, G. (1999). Psychiatry, post-apartheid integration and the neglected role of language in South African institutional contexts. *Transcultural Psychiatry*, 36, 5-22.
- Drennan, G., & Swartz, L. (1999). A concept over-burdened: institutional roles for psychiatric interpreters in post-apartheid South Africa. *Interpreting*, 4, 169-198.
- Drennan, G., & Swartz, L. (2002). The paradoxical use of interpreting in psychiatry. *Social Science & Medicine*, 54, 1853-1866.
- Duffy, K.G., & Wong, F.Y. (2003). *Community Psychology*. (3rd.ed). Pearson Education. Inc, Cape Town Oxford: Oxford University Press.
- Edwards, S.D. (2000). *The cultural context of counseling*. KwaDlangezwa: University of Zululand.
- Evans, M. (2001). *Towards culturally appropriate speech-language and hearing services: exploring the cultural narrative in initial consultations with Xhosa-speaking patients*. Unpublished masters thesis, University of Cape Town.
- Fernandos, S. (2003). *Cultural Diversity, Mental Health and Psychiatry: The struggle against racism*. New York: Bruner-Routledge.

- Finchilescu, G. (2005). Meta-stereotypes may hinder inter-racial contact. *South African Journal of Psychology*, 35(3), 460-472.
- Fisch, M (2001). *Interpreting practices in health care: an investigation of differences across trained and untrained interpreters in initial assessment interviews, within the field of speech-language and hearing therapy*. Unpublished masters thesis, University of Cape Town, South Africa.
- Frohmann, B. (1992). The power of images: a discourse analysis of the cognitive viewpoint. *Journal of Documentation*, 48(4), 365-386.
- Gibson, C. (2003). *Fanon- Post Colonial Imagination*. London: Bliddles Ltd.
- Hansen, N.D., Randazzo, V.K., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., Burke, C., Kershner-Rice, K. And Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychologist competencies. *Professional Psychology: Research and Practice*, 37 (1), 66-74.
- Harper, F.D., & Mc Fadden, J. (2003). *Culture and Counseling. New approaches*. New York: Pearson Education, Inc.
- Holdstock, T.L. (2000). Re-examining psychology: Critical perspectives and African insights. London: Routledge.
- Holcomb-McCoy, C. C. (2001). Exploring the self-perceived multicultural counseling competence of elementary schoolcounselors. *Professional School Counseling*, 4, 195-201.
- Ivey, A.E., Ivey, M.B., & Simek-Morgan, L. (1997). *Counseling and Psychotherapy: A multicultural perspective*. (4TH ed). Boston: Allan & Bacon.

- Kavanagh, K.H., & Kennedy, P.H. (1992). *Promoting Cultural Diversity*. London: Sage Publications.
- Knight, Z.G. (2004). Patients' coaching behaviours, transference testing and the corrective emotional experience: Tra-scending the self in psychotherapy. *South African Journal of Psychology*, 34 (1), 81-100.
- Kottler, A., & Swartz, S. (2004). Rites of passage: Identity and the training of clinical psychologists in the current South African context. *South African Journal of Psychology*, 34 (1), 55-71.
- Langdrige, D., & Butt, T. W. (2000). Self-deception and discursive psychology. Paper to be presented to British Psychological Society Social Psychology Annual Conference. Nottingham.
- Leong, F.T.L. (1994). Emergence of the cultural dimension: The role and impact of culture on counseling supervision. *Counselor Education and Supervision*, 34,115-116. (Introduction to special section: Cross-cultural counselin supervision).
- Levin, M. (2004). *Language differences as an access barrier for Xhosa speaking patients at a children's hospital in Cape Town*. Unpublished master's thesis, University of Cape Town.
- Manyoni, T. (1997). *Interpreting and translation services for local government in South Africa*. In M. Erasmus, L. Mathibela, E. Hertog & H. Antonissen (Eds), *Liaison interpreting in the community* (123-129). Pretoria: Van Schaik.
- Marcos, L. (1979). Effects of interpreters on evaluation of psychopathology in non-English speaking patients. *American Journal of Psychiatry*, 136, 171-174.

- Mayekiso, T., Strydom, F., Jithoo, V. And Katz, L. (2004). Creating new capacity through postgraduate selection. *South African Journal of Psychology*, 34 (4), 657-671.
- Mook, D., Mkhize, N., Kiguwa, P., & Collins, A. (2004). *Critical Psychology*. Lansdowne: UC.
- Mullavey-O'Byrne, C. (1994). Intercultural communication for health care professionals. In R. W. Brislin & T. Yoshida (Eds.), *Improving Intercultural Interaction: modules for cross-cultural training programs*. Thousand Oaks:Sage.
- Neuman, W.L. (2000). *Social research methods. Qualitative and quantitative approaches (4th ed.)*. Needham Heights, United States of America: Allyn and Bacon.
- Nutt-Williams, E., & Hill, C.E. (1996). The relationship between self-talk and therapy process variables for novice therapists. *Journal of Counseling Psychology*, 43(2), 170-177.
- O'Leary, A. (2004). *The Essential Guide to Doing Research*. London: SAGE Publications.
- Painter, D., & Baldwin, R. (2004). 'They all speak your language anyway....': Language and racism in a South African school. *South African Journal of Psychology*, 34(1), 1-24.
- Palmer, S. (2000). Developing an Individual Therapeutic Program Suitable for Use by Counselling Psychologist in a Multicultural Society: A Multimodal Perspective. *Counselling Psychology Review*, 15, 32-50.
- Pedersen, P.B., Dragun, J.G., Lonner, W.J., & Trimble, J.E. (1996). *Counseling Across Cultures(4th ed.)*. London: Sage Publications.

- Pedersen, P.B., Draguns, J.G., Lonner, W.J., & Trimble, J.E. (2002). *Counseling Across Cultures*. (5th ed.). London: SAGE.
- Pillay, T.G., & Petersen, I. (1996). Current practice patterns of clinical and counselling psychologists and their attitudes to transforming mental health policies in South Africa. *South African Journal of Psychology*, 26(2), 76-80.
- Pope-Davis, B.D., & Coleman, H.L.K. (1997). *Multicultural Counseling Competencies. Assessment, Education and Training, and Supervision*. London: SAGE.
- Pope, R., & Reynolds, A. (1997). Student affairs core competencies: Integrating multicultural awareness, knowledge, and skills. *Journal of College Student Development*, 38, 266-277.
- Potter, J., & Witherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: SAGE.
- Prince, L. (2004). *Interpreting and the clinician: a conversational analysis of the interpreted consultation in a paediatric hospital*. Unpublished master's thesis, University of Cape Town.
- Raval, H., & Smith, J. (2003). Therapists' experiences working with language interpreters. [Electronic version]. *International Journal of Mental Health*, 32, 6-31.
- Reupert, A. (2006). The counsellor's self in therapy: An inevitable presence. *International Journal for the Advancement of Counselling*, 28(1), 642-507.
- Rogers, C.R. (1951). *Client-centered therapy*. Boston: Houghton Mifflin.
- Rogers-Sirini, L., (2008). Approaches to multicultural training for professionals: A guide for choosing an appropriate program. *Professional Psychology: Research and Practice*, 39 (3), 313-319.

- Seedat, M., Duncan, N., & Lazarus, S. (2001). *Community Psychology. Theory, Method and Practice. South African and Other Perspectives*. Cape Town: Oxford University Press.
- Schwartz, T. (2004). *Communication in Health within the South African context: current practices employed across three levels of health care*. Unpublished master's thesis, University of Cape Town, South Africa.
- Singelis, T. (1994). Non-verbal communication in intercultural interactions. In R. W. Brislin & T. Yoshida (Eds.), *Improving Intercultural Interaction: modules for cross-cultural training programs*. Thousand Oaks: Sage.
- Snyman, S. & Fasser, R. (2004). Thoughts on ethics, psychotherapy and postmodernism. *South African Journal of Psychology*, 34, 72-83.
- Statistics South Africa. (2002). *Stats in brief*. Pretoria: Author.
- Strous, M., & Eagle, G. (2004). Anti-client and pro-client positions in interracial psychotherapy. *South African Journal of Psychology*, 34(1), 25-54.
- Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counselling. *Journal of Counseling Psychology*, 24(5), 420-429.
- Sue, D.W., & Sue, D. (1990). *Counseling the culturally different: Theory and Practice*. (2nd ed.). New York: John Wiley.
- Swartz, L. (1991). The politics of black patients' identity: ward-rounds on the 'black side' of a South African psychiatric hospital. *Culture, Medicine and Psychiatry*, 15, 217-244.

Swartz, L. (1998). *Culture and mental health: A South African view*. Cape Town: Oxford.

Swartz, L., Drennan, G., & Crawford, A. (1997). Changing language policy in mental health services: a matter of interpretation? In D. Foster, M. Freeman & Y. Pillay (Eds.), *Mental health policy issues in South Africa* (pp. 166-180). Cape Town: MASA.

Ting, S. (2003). Impact of language planning on language attitude: A case study in savawalc. *Journal of Multilingual and Multicultural Development*, 24(3), 318-331.

Tjale, A., & De Villiers, L. (Eds.), (2004). *Cultural Issues in health care and health Care*. Cape Town: Juta & Co Ltd

APPENDIX A
INFORMED CONSENT

I _____ undertake that this interview is part of a study that is being conducted with English speaking psychologists who are working interracially in the public hospitals and in private practice. The purpose of the study is to investigate how psychologists from different cultural and language background make sense of language and cultural diversity in their therapeutic relationship. Furthermore, to explore the continuing challenges facing English psychologists working interracially and how it affects the therapeutic relationship. I am working as a clinical psychologist in private practice. Currently I am doing a degree in doctor of philosophy. This study is part of the course requirements.

I am aware that the interview will be tape recorded. I understand that all information given in the interview will be strictly confidential and that I will not be identified at any stage in the study. I also understand that I can stop the interview at any point and not continue if I wish.

I am adequately informed about the study that is taking place and voluntarily take part in it.

Signature of participant

Ntombifuthi Mkhize
Department of Psychology
University of Zululand

APPENDIX B

QUESTIONNAIRES

1. In your experience, please reflect on how interracial psychotherapy impacts on the therapeutic relationship
2. To what extent does language and culture influence or hinder therapeutic relationship
3. How would you reflect on dealing with social sensitivity
4. What do you think are the challenges facing English speaking psychologists
5. How have you transformed from your own belief system to meet the demands of multiculturalism

APPENDIX C

TRANSCRIPTION SYMBOLS

A conventional system of symbols was used to transcribe text. A table of the symbols used in the transcription can often appear as an appendix, such as the following:

Symbol	Meaning
(.)	Short pause
(...)	Interruption