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Article

# Psychiatry, Post-Apartheid Integration and the Neglected Role of Language in South African Institutional Contexts

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**Abstract** This study examined the use of interpreters with patients who are speakers of African languages at a recently integrated psychiatric institution in post-apartheid South Africa. The research process itself reflected important aspects of the institutional dynamics around the issues of language and ethnicity. The impact of inadequate language resources on service provision was profound. Interpreters have a role in alleviating the difficulties described, but routine organizational strategies for managing speakers of African languages are powerful obstacles to change. Complex institutional and societal discourses to do with race, identity, community, alienation and the practice of public psychiatry constellate around the language issue. Without sufficient recognition of the centrality of language in service provision, integration and institutional transformation will be impeded.

**Key words** interpreters • language • psychiatry • South Africa • Xhosa

> It may be worth considering, then, a glib Freudian paradox: That some of the most efficient forms of censorship are those that render themselves invisible. (Phillips, 1993, p. 55)

The absence of a common language between doctors and patients and, by implication, the use of interpreters, is so much a part of the everyday experience of health care provision in South Africa as to make it almost

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invisible. Part of this invisibility is the way in which the struggle to speak with patients through interpreters or in broken English or Afrikaans has become a routine complication of clinical work in particular settings. It is also in the nature of institutions in general, and clinical work in particular, to generate routine solutions to such problems (Fisher & Todd, 1983; West, 1984). Thus the so-called 'language gap' and routinized strategies to work around it have become institutionalized, even ritualized, aspects of the everyday practice of health care.

This paper describes a study which was intended to simply document the routine management of Xhosa-speaking[1] patients at a large psychiatric hospital in the Western Cape. It was designed to replicate a similar study at a neighbouring hospital (Drennan, 1996a) by counting the number of times Xhosa-speaking patients are interviewed either with or without an interpreter. From the outset this task proved more complicated than in the first study and yet the problem of interpreter availability was curiously obscured. In order to clarify the quantitative data, a series of interviews was undertaken with staff who had assisted in the quantitative phase. This paper shows that any attempt to study language services in institutional contexts throws up issues around identity, ethnicity and practice. Interpreters and their work constitute a particular nexus for these factors and the cross-currents they generate illuminate the complexity of attempts to provide equitable health care in a racially divided society.

## Institutional Racism and Mental Health Care

During the apartheid era in South Africa's history, international reports documented gross inadequacies and inequalities in the provision of services for black patients arising out of legislated and enforced institutional racism (Stone, Pinderhughes, Spurlock, & Weinberg, 1979). It was noted in such reports that there were few medical practitioners and even fewer mental health specialists who spoke indigenous languages (O'Donaghue, 1989). Local reports focused on the fragmentation of services, restricted access to hospital beds for black patients, and attention to psychotic disorders and curative factors at the expense of prevention, promotion and rehabilitation (Freeman 1989a, 1989b). More recent local studies of psychiatric services have focused on dimensions of patient satisfaction (Ensink & Robertson, n.d.) and the integration of services (Freeman, Lee, & Vivian, 1994). This latter Centre for Health Policy study, evaluating psychiatric services in the Orange Free State (a province of South Africa), documented a levelling off in the discrepancy between the services available to black patients in comparison with their white counterparts. However, significant ways in which integration was incomplete due to differences in quality of care and access to services were noted. It is

unfortunate that the multilingual nature of the patient population in terms of access and equitability of the services is not referred to at all in this descriptive study.

The issues of race and prejudice in the practice of medicine and psychiatry in America and Britain have already generated a sizeable body of research and writing. In the absence of legislated inequality in the US, writers have identified areas in which black service users and members of ethnic minorities have different access and treatment in health care (Chung, Mahler, & Kakuma, 1995; Flaherty & Meagher, 1980; Sabshin, Diesenhaus, & Wilkerson, 1970; Segal, Bola, & Watson, 1996). Littlewood and Lipsedge (1989) and Fernando (1995) have explored institutional racism in Britain and psychiatry's role in the 'alienation' of ethnic minorities. Fernando (1995) differentiates between racial prejudice, which has to do with individual attitudes and generalizations, and racism, which has more to do with ideology as it is expressed in institutional structures. These structures and their strategies, techniques and procedures then represent, in Foucaultian terms, discursive means by which inequality is generated independent of any particular individual's attitude. Language as a factor in inequality has been on the agenda in Britain for some time as it has been recognized that a monolingual service in a multilingual society is discriminatory (Shackman, 1985). Other countries, such as Belgium (Verrept & Louckx, 1994) and Australia (Price, 1975), have established programmes and structures recognizing the central role language has to play in providing non-discriminatory mental health services.

It is only with the abolition of apartheid legislation and the establishment of a new bill of rights and a new constitution that South African health services are in position to be subjected to studies and analyses of a comparable nature. Indeed, such studies will be an integral part of any attempt to radically transform health care institutions.

## Language, Language Policy and Mental Health Care

Even though South Africa has always been a multilingual society this has not been reflected in national policies or in health care institutions. In the late 19th century it was Afrikaans, ironically, that was to struggle with having the status of an official language with inferior social standing. Marks (1994), in her history of nursing in South Africa, points out that as early as 1889 there were clashes between English-speaking nurses and administrations that insisted on a degree of proficiency in the Dutch language. She also observes that no one insisted that a black language be learnt. From 1948, proficiency in English and Afrikaans has been a requirement of state employees, although in practice a degree of proficiency in one language was usually sufficient for a professional person. As a consequence,

interpreting from black African languages for doctors and other professionals in state service has always been an aspect of the health system (Campbell, 1961, 1994). Hospitals and regions differ in terms of the unwritten conventions as to how the work of interpreting will be accomplished but most seem to rely upon the haphazard availability of anyone who speaks even a smattering of the patient's language (Crawford, 1994; Drennan, 1996a; Ngqakayi, 1994). While interpreting has been recognized as a fundamental aspect of providing mental health services to black patients, at best it has been left to nurses to fulfil this role, at worst to fellow patients. Even in areas where there are few whites and the patients are almost exclusively black, the black nursing staff view interpreting as an incidental, although daily, aspect of their work (de Villiers, 1993).

In 1994, 11 languages were made official at a national level, although each of nine provinces could prioritize which languages would be emphasized in their region. Plans to meet this expectation are not yet in place and there are no official interpreter posts in health care in the entire country (Beukes, 1996).

## International and South African Perspectives on Interpreting

Little of the substantial body of work on doctor–patient interactions has been applied to the position of the interpreter in these interchanges (Wood, 1993). It is perhaps because interpreters have been expected to function as a 'black box' (Westermeyer, 1990) or naive language machine (Pergnier, 1978) in the process of bridging disparate discourses, that their role in accomplishing and enabling communication has been somewhat taken for granted. Only with the consideration of the social and cultural dimension of interpreter function has their position in relation to linguistic, medical and cultural bodies of knowledge begun to be re-examined and problematized (Kaufert & Koolage, 1984; O'Neil, 1989).

Swartz (1989, 1991b) has raised the interpreter issue as a complex and problematic aspect of clinical practice in psychiatry in South Africa. Ritualized introductions to interviews demonstrate how discourses of race and culture contribute to the subordination of the position of interpreter in ward rounds, even when the interpreter is a clinician. Through a detailed transcript of a single interpreter-mediated interview, Muller (1994) has shown how clinical pressures compel interpreters to manage and control interviews in ways that contradict accepted standards of practice in other settings. She also demonstrated graphically how the routinized cultural and biomedical accomplishments of the interpreter are made consistent with clinical and institutional objectives. Thus, the employment of interpreters may be seen as an attempt to provide the patient with a voice

in clinical assessment. However, institutional imperatives to 'manage' patients efficiently (Fisher & Todd, 1986; Mizrahi, 1987; Rhodes, 1991) may encourage forms of interpreter exploitation. In addition, language is sometimes seen as part of the cultural gap between doctors and patients, and so interpreters are often expected to fulfil the role of culture broker for both parties. This has led Herselman (1994) to suggest that this more inclusive concept of 'culture brokerage' be introduced as an official part of nursing duties, with clear delineations as to what this would entail. This is a controversial suggestion that would not necessarily meet with unanimous support, even amongst nurses, for a range of professional, personal and organizational reasons (Holdsworth, 1994; Mgoduso & Butchart, 1992).

## Contextualizing the Issue of Language

### *The Hospital Context*

The hospital referred to in this study is situated approximately 25 km from Cape Town in the historically coloured[2] area of Mitchell's Plain and borders on Khayelitsha ('new home'), a sprawling township estimated to have half a million inhabitants. Lentegeur Hospital (LGH) opened in 1986 under the control of the House of Representatives, the government body set up under the tricameral parliament to serve the coloured community of the country. LGH was therefore, in the crass terms of the apartheid era, a 'coloured hospital' for the Western Cape, and the only one of its kind in the country. However, from the outset the management of the hospital made a commitment to providing a non-racial mental health service. It had approximately 1500 beds and was divided into a rehabilitation centre for mentally handicapped people and wards for acute and chronic psychiatric illness. Specialist units attracted patients from all race groups but blacks and whites in much smaller numbers.

When the psychiatric health services were integrated, the Cape peninsula and inland areas were divided up amongst the three psychiatric hospitals in greater Cape Town. A number of townships, including Khayelitsha, fell within the LGH catchment area and so patients who had previously been accommodated at a neighbouring hospital were admitted to LGH from April 1992. Prior to the integration, LGH had allocated catchment areas to particular wards. This policy continued with the allocation of black areas to a particular ward in the new dispensation.

At the time of initiating the study there was no one employed as an interpreter at LGH. Earlier in the year of the study there had been labour unrest at LGH and one of the issues high on a list of nursing staff grievances was the situation of the hospital being without interpreters. A

number of negotiations had taken place and the local government had approved the appointment of a full-time interpreter against the post of a cleaner (general assistant) in May 1994. The new interpreter began work 2 weeks before the end of the study. He is a coloured person formerly employed as a security guard in the hospital.

### *The Quantitative Study*

The quantitative data gathering required clinicians and nursing staff to complete a questionnaire each time they used someone as an interpreter, or would have, had someone been available. A senior nursing staff member indicated that interpreters were required so often by nurses that they would not complete questionnaires, thus under-representing the need for interpreting. Consequently, a separate questionnaire for nurses was drawn up. The study took place over 8 calendar weeks from September until October 1994.

Both questionnaires yielded returns far below what was expected given the number of patients involved, and indicated two main points (see Drennan, 1996b, for a more detailed discussion). First, that clinicians were completely dependent on the availability of nursing staff to interpret and that the availability varied enormously from ward to ward. Second, that the availability of nurses to interpret, and indeed much of the nursing service, was dependent on the single Xhosa-speaking professional nurse allocated to duty in each of the two main wards serving the Khayelitsha catchment area. In accordance with a shift system, the Xhosa-speaking nurses were available in each ward for approximately 50% of time. On one ward there were nine consecutive days without an Xhosa-speaking staff member.

The reasons for the poor compliance with the study can in part be attributed to the same factors that dog the service as a whole: structural inadequacies and serious staffing shortages. However, as Venuti (1992), writing in the area of literary translation, has observed, 'to make translation visible today is necessarily a political gesture' (p. 10). The historical and clinical context of identifying the language issue at LGH may have complicated the simplistic assumption that participants would wholeheartedly comply with the demands of a questionnaire study. For whatever reasons, the nature and extent of the problem was not clear from the quantitative study and a qualitative study was undertaken.

### *The Qualitative Study*

This involved interviews (tape-recorded where possible) with 12 staff members. There were interviews with five doctors, two Xhosa-speaking

professional nurses, three non-Xhosa-speaking professional nurses, one social worker and two with the interpreter.

The extent to which the language problem pervaded clinical and organizational functioning was more far-reaching than anticipated, and as is shown later, this even had implications for the study itself. In a sense my experience of the unfolding insight gained through the interviews reproduced something of the experience of the people working in this system. One of the interviewees conveyed a rich sense of how painful it had been to acknowledge the extent of the problem when he said that at LGH it had been difficult to say that the emperor has no clothes. This provided an organizing metaphor for the interview data and a perspective on the possible dynamics of confronting this issue.

## Historical Development of 'The Problem' as a Problem

What emerged from the interviews was a sense of the historical development of the difficulties around integration. There seems to have been an initial unhappiness regarding a lack of consultation in the allocation of catchment areas. But in spite of this there was an effort to cope with the crisis. This enthusiasm could not last when the crisis seemed interminable. Initially perhaps staff did not realize the full implications of the change and tried at first to continue with a 'business as usual' approach. However, a mounting sense of failure, fatigue and despondency eventually emerged.

Almost everyone interviewed said that language as a barrier was the biggest single problem in the two main wards studied. Interviewees spoke of burn-out and high nursing turnover. Non-Xhosa-speaking nursing staff found that they were having to manage psychosis with patients they could not talk to. One interviewee said that he could see in the way the staff said the patient was Xhosa-speaking that this was a source of irritation and aggression. Xhosa-speaking staff were thought to have role overload through performing functions associated with social work: accompanying patients home, doing interviews, etc. As the only Xhosa-speaking nurse had to do everything for a particular group of patients, the wards were paralysed without that person. In essence, the old divisions of labour in the system had collapsed. This placed tremendous organizational burdens on all sectors of the multidisciplinary team.

### *Implications for Patients*

Xhosa-speaking patients were considered to be multiply disadvantaged. It was felt that the rehabilitation programmes available in the two Khayelitsha wards were significantly compromised in comparison with that of other wards. One element of this was the perceived absence of occupational

therapy in these units as a result of the problems of running groups in three languages simultaneously without an interpreter.[3] It was felt that Xhosa-speaking patients who were recovering from psychotic illnesses had less access to the appropriate neuroclinic. Even more disquieting was the perception that non-psychotic Xhosa-speaking patients did not have access to the appropriate neuroclinic or drug rehabilitation unit. Interviewees were of the opinion that these patients were either not admitted or were housed in the wards for psychotic patients. Staff described a re-admission rate for the female ward serving Khayelitsha twice that of the equivalent ward for Mitchell's Plain. This was attributed directly to the impact upon the service that could be offered to these patients in the absence of adequate language services.

Doctors described conducting only short interviews during which mental state examinations were carried out and some features of the presenting problem were elicited. Communication could be so impeded that occasionally it was not possible to find out where the patient lived. Doctors and nurses alike lamented that there was no attempt to educate or even inform the patient's family of their relative being admitted. One doctor characterized the management they were able to offer as a 'surrealistic' caricature of what psychiatry should be.

Prior to the study there had been periods of up to 1 month without any Xhosa-speaking nursing staff in a particular ward. During these times assessment was reduced to observing the patients through the glass partition which separated their common room area from the nursing station. There was a focus on 'observables,' i.e. the level of aggression, whether the patient was mute, not eating, showing bizarre behaviour or extra-pyramidal side-effects to the neuroleptic medication. As one doctor expressed it, without language as the tool or instrument of psychiatry 'one might as well be practising veterinary science.'

The absence of language services impacted upon the nursing duties in the following way. The nurses prepared for ward rounds by having some insight into each patient's mental state. If they were not able to discern this through English, Afrikaans or observing the patient, the nurses would undertake to interview the patient in Xhosa. Usually a fellow patient would be enlisted, occasionally a staff member. The pressure on the doctors' time often meant that they would only see problem cases, for which nursing staff said they would always have an interpreter. However, doctors felt that nurses did not bother them with the patients they could not speak to.

The Xhosa nurses interviewed both preferred to interpret in their ward; and usually refused to go to other wards for this. Similarly, non-Xhosa-speaking nurses and clinical staff preferred to have nurses interpret, but wished to avoid being exploitative. It appeared that conflict around who was responsible for interpreting cast it as being outside of the nurses' role

and that institutional obstacles to doing interpreting arose, even when the nurse was willing.

## Discursive Themes and Institutional Obstacles

The preceding description of how the hospital functions as a mental health care institution for Xhosa-speaking patients in the absence of language services indicates how overt obstacles to accessing mental health services constellate around the language issue. They are overt obstacles in so far as they constitute routine institutional strategies for managing Xhosa-speaking patients. In so far as they indicate that Xhosa speakers have a restricted range of interventions available to them, and that the management of non-Xhosa-speaking patients is substantially different, this demonstrates contradiction and inconsistency with the apparent racially integrated status of the hospital, and the mental health services as a whole. The hospital itself has an explicit commitment to non-racial care but the implications of inadequate language resources create a contradictory practical reality. While only one interviewee felt that the hospital should refuse to operate the Khayelitsha wards at all under these circumstances, the majority that continue would not be able to avoid reproducing racial inequality despite all intentions to the contrary. An interviewee described an occasion on which another ward had requested interpreting which this person was happy to provide. A senior colleague had been unsupportive of the request, saying that if the person left their own ward in order to interpret they would be held responsible if anything untoward happened in their absence from their own post. While it would be easy to label the senior colleague pejoratively for depriving an individual patient of an interpreter, it is also possible to see that this person was prioritizing a different set of institutional imperatives and that within the logic of the institution and its history this may have been a defensible position to take. While the rationale of the senior colleague is not known, it is possible that they were attempting in a small way to challenge the invisibility of the difficulties faced.

While there were clearly substantial overt attempts at integration, the residual overt obstacles inevitably co-exist with covert impediments to equitable care and integration. The covert obstacles to integration are a combination of discourses that may be unique to the practice of psychiatry in South Africa but may also be found elsewhere.

### *Alienation, Community and Access to Services*

The first and most striking of these discursive themes was the palpable sense in which Xhosa patients could be seen to be aliens in mental health

care. In a letter to the *South African Medical Journal*, Dr G. Campbell (1961) lamented that there was no pressure on South African doctors to learn an African language to practice, and likened this to the absurd situation of a foreign doctor in Britain being unable to speak English and having no intention to learn. Three and a half decades later local institutions still operate on the premise that either English or Afrikaans is normative. British writings dealing with the obstacles for immigrants to equitable mental health care are remarkably similar to those confronting indigenous people here (Fernando, 1995; Littlewood & Lipsedge, 1989). With the exception of psychiatric nurses, mental health professionals are overwhelmingly white and do not speak the home language of most black patients or share similar experiential backgrounds. In so far as LGH is a western psychiatric hospital, Xhosa patients have the status of immigrants or members of a minority group, and they are therefore 'other' and alien. Swartz (1989) has suggested that the discourse of 'otherness' in western psychiatry in southern Africa constellated around notions of culture. But more recently he has argued that culture may have been subsumed as an organizing metaphor by the idea of community (Swartz, 1996). In the broader socio-political discourses of the day, 'linguistic communities' are the new lines of identity and boundedness which must be simultaneously maintained and transcended. However, in institutional contexts where particular languages and world-views are so dominant, patients who have specific needs but who have the status of a minority group may be subsumed rather than accommodated. Daubenton (1994) and Swartz (1996) have highlighted the irony of the loss of specific types of services to black patients through integration.

The partitioning of wards by catchment area at LGH was a strategy in place before official integration and was explicitly intended to maintain continuity of care between the hospital staff and community resources. As this was retained with the addition of new catchment areas the risk of reproducing the apartheid structures and marginalizing Xhosa-speaking patients was considerable. However, given the small number of Xhosa-speaking staff and the even more limited language resources, the strategy may have served to contain 'the language problem'. Implicit assumptions around the notion of community may also have been instrumental in the implementation of this system.

It was interesting to note that the Xhosa-speaking nurses interviewed resisted the use of the interpreter. There was some disagreement amongst the interviewees, both those that spoke Xhosa and those that did not, as to whether interpreting was part of nurses' work. One Xhosa-speaking nurse felt that interpreting was not part of nursing duties but chose to do it out of concern for misunderstood patients. This suggests that interpreting could be something black staff do, not as an identification with a nursing

role, but as an identification with a community of Xhosa speakers. There was no question, however, that nurses should not interpret for a doctor who could not speak Afrikaans to patients. These apparent contradictions in what nurses should do in hospitals are not unique to LGH. Nationally there is a lack of clarity as to whether the diversity of languages spoken by nurses automatically extends to nurses acting as interpreters in doctor–patient interviews.

The 'language problem' at state hospitals can, therefore, be seen to have two facets. In so far as the hospital cannot function as it did prior to integration there may be a recognition that communication difficulties were a significant factor. One interviewee remarked that on the days on which the single Xhosa-speaking nurse was not in the unit there was 'a real problem'. However, when the institution generates routine solutions to the problem of communication such that service users are able to be viewed as patients who can be admitted, managed and discharged, the language issue ceases to be the institution's problem. One informant remarked on the ease with which a patient can be managed in the outpatients department if there is no interpreter because one can just write: 'patient can't communicate.' The patient is then transferred to a ward for black patients. This constructs the problem of communication as the patient's; it is the patient's lack or deficit that results in non-communication. I wish to take up here in more detail the question of how such a mental health care system constructs patients that are able to be managed, if necessary, without reference to language at all.

## *Veterinary Psychiatry*

Rhodes (1993a) outlined two levels at which one can look at the field of action in psychiatry. One is that of the caring professionals using the techniques and technology at their disposal to ameliorate human suffering and the consequences of social pathology. The second characterizes the practice of psychiatry itself as a social pathology, with psychiatrists as agents of social control. Elsewhere she draws on Gordon's (1988) analogy to illustrate the practice of psychiatry in an emergency service as a swamp of action, with distant and sometimes tenuous connections to the theoretical high ground. In the everyday realities of clinical practice a range of interventions may be available but which of these is selected will often depend upon pragmatic institutional imperatives (Rhodes, 1993b). Swartz (1991a) also highlights the contradictions that arise when ostensibly non-racist, liberal psychiatrists reproduce racist discourses when working with particular patients. Patients who are difficult to manage or categorize by virtue of the language they speak or their social class are most likely to generate the use of diagnostic approaches which do not require engagement with the patient's illness narrative and the use of primarily biological

interventions. Swartz identifies these strategies as a type of 'veterinary psychiatry', using Kleinman's (1977) term, partly because they emphasize the behavioural control of patients, but also because they are accomplished without much likelihood that patients will object or challenge their treatment in any coherent or systematic manner.

There was anger, anxiety and resignation in the voices of the clinicians I interviewed who literally spoke of having to practice 'veterinary psychiatry'. The example of observing patients through the glass panes of the nursing station serves as a metaphor for the situation of patients (cf. Foucault, 1977). While they may occupy the same physical spaces through racial integration, without meaningful communication they occupy different discursive spaces which impact profoundly upon the meaning of those physical spaces. Besides obvious issues of material access to services, questions of psychological access, alienation, identification and connectedness are not addressed through the powerful but invisible barrier of impeded communication. These sorts of issues are faced by all who must negotiate patienthood in institutional contexts but the weight of this burden and the implications for failure are that much greater without ready access to the medium of language to communicate.

While of a completely different order, staff are also compromised in their access to patients, when biology and medication are the primary interventions. All categories of staff adopted a motto of 'treat first, ask questions later' and the main reason given for using interpreters was to ensure that patients got the right medication. The presence of a single interpreter may thus serve to facilitate biological interventions but obscure the need for additional forms of treatment.

While it would be absurd to suggest that nothing had changed or improved with the employment of an interpreter at the hospital studied here, there were preliminary indications that the extent of the changes that would be effected through this would be restricted by institutional routines and discourses such as those articulated above. Powerful features of these discourses are also the silences and gaps that were again made visible in the research process.

## Language, Race and Identity

At the outset of the research, I had hoped to help put the role of interpreters, and language issues generally, higher on the agendas of local policy makers and service providers. As a clinician working within the state health care system, I was well aware of the frustrations of staff and patients, and felt that I identified personally with this struggle. It was therefore distressing to find that an initial draft of this paper met with a negative response from hospital authorities. While I was aware that the paper

quoted interviewees' most strongly worded statements and that it drew challenging conclusions regarding race, I naively assumed that it could be of benefit to a hospital that desperately requires more substantial state support. Some issues with the draft referred to inaccurate historical detail, but the main thrust was the feeling that the hospital had been misrepresented with respect to the question of race and racism. It was felt that the identity of the hospital as a non-racial institution, an identity adopted years before integration became the macro-health policy, was lost through not adequately situating it in the general health care system. These comments were most certainly valid. The practices in any particular institution are strategies developed to deal with the pressure of reflecting larger social forces and paradoxes in their work. The position of the researcher commenting on the practices of a particular institution as an exemplar of the effects of certain types of social pathology is, however, a complex one (Rhodes, 1986). Conflicting loyalties and identifications on the part of the researcher may result in over-simplification and even misinterpretation.

The consequences of such errors, where one is at serious risk of betraying the trust of colleagues in a relatively small professional community, are serious. This is a moral and ethical dilemma that anthropologists have struggled with in relation to studying professional elites (Harrel-Bond, 1976), but most particularly when conducting research with people who will read the texts that are produced, with whom one has an on-going relationship and direct accountability, and for whom there may be negative effects (Cheater, 1987). Even if anonymity to a wider audience for the researched group were possible, this cannot protect the more important intimate relationships from these implications. However, I am attempting to be explicit about this dilemma precisely because I believe it to be a fundamental component to understanding the complexity of language issues, and the integration process, in local institutional contexts.

Roth and Swartz (1992) noted that the integration process at a different hospital was remarkable for its silence on issues of race. They hypothesized that talk of race can slip very easily into racist talk and so this was avoided. It appeared that what was unacceptable for the hospital studied here, by virtue of its challenge to its identity, was the inference that the problems it experienced with respect to language could be interpreted as evidence of racism. In response, I considered all sorts of changes including attempting to make a distinction between language and race in an effort to avoid having to name racial discrimination. It is possible, however, that similar pressures exist within this hospital, and indeed all the local hospitals like it, to being explicit on this fraught subject. An issue omitted from the draft of this paper was the question of blame. This was an important theme in the talk of interviewees and each had a theory as to who was responsible. By omitting to address this specifically in a draft of a paper for wider

consumption it is possible that the hospital administration would seem the most likely to be implicated without regard for the multiplicity of factors that impact upon what can and cannot be said in public spaces. Local academic writing during the apartheid era was subject to particular internal and external pressures (Swartz, 1985). During this period of transition, the gradual permeation of change into institutional contexts, a type of working through with its attendant anxieties, may create types of self-censorship which are not easily overcome. The enormous social and emotional consequences for exploring questions of race and racism create a climate in which this is an uncomfortable experience for everyone and which make meaningful engagement with our history and social transformation less likely.

## Conclusion

The process of racial and ethnic integration of mental health care services in South Africa begun in the late 1980s and early 1990s was a significant advance in providing equitable health care to all the country's citizens. While the principle has been that everyone should receive the same service, the practical implementation of this has been slow and uneven. Often the impediment has been the shortage of material or personnel resources. Certainly these obstacles apply within psychiatry, and nowhere could this be more apparent than at the hospital studied here. However, it would seem that an unrecognized stumbling block has been the focus on narrowly defined equitable health services. This study on interpreter utilization has highlighted that beyond equal housing and nutrition, for example, lies the question of equal communication and access. By neglecting to sufficiently recognize the psychosocial dimension of psychiatric interventions and focusing on material and biological dimensions, bureaucratic alterations to mental health services have fallen short of their intended goal. I would argue that the shortcomings of integration identified by Freeman et al. (1994) in the Orange Free State are very similar to those apparent here and that language issues contribute centrally to the discrepancies in both instances. The language issue at the hospital in this study was particularly exposed because inadequate staffing and overt organizational conflict did not permit the degree of invisibility achieved in other institutional settings. It is not, however, sufficiently different to disqualify it as a microcosm of the impact upon mental health care that a neglect of the language issue gives rise to. Adequate communication is not simply desirable but is an essential part of the service, a *sine qua non* of mental health care delivery. Without such recognition a type of functional apartheid (Heggenhougen, 1995) will have replaced gross apartheid inequalities.

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## Notes

1. *isiXhosa* is the predominant African language spoken in the region. The prefix *isi* is a part of speech and only the root is employed here.
2. During the apartheid era the term 'so-called coloured' was used to indicate a rejection of the racist classification system in place at the time, which distinguished between whites, blacks, coloureds and Asians. Since the election of a democratic African-National-Congress-led government in 1994, the prefix 'so-called' appears to have been dropped from common usage of the term 'coloured'.
3. Hospital reviewers of an earlier draft of this paper challenged the perception that occupational therapists were absent from these wards, but acknowledged that there were problems with running occupational therapy programmes there. It was felt that the psychopathology of the patient population, and not only language, contributed. Since this study, the hospital has initiated programmes to increase occupational therapy involvement in both in-patient and out-patient settings for Xhosa-speaking patients.

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