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Beyond Words: Notes on the 'Irrelevance' of Language to Mental Health Services in South Africa

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Abstract South Africa's political history has led to a marginalizing of all languages except for English and Afrikaans. Many clinicians cannot speak the languages spoken by patients. We attempt to understand the slow progress towards achieving greater access to mental health services on the basis of language. The administrative constraints of an overburdened and bureaucratized health system lead to language and communication playing a relatively small part in clinical practice. Resistance to learning other languages may relate to the emotional risks involved in this learning. A psychological understanding of the barriers to linguistic change may help us develop further changes.

Key words institutional change • language • psychiatry • South Africa • Xhosa

South Africa is a multilingual country, with a total of 11 official languages. Different provinces have different official languages, depending on what is spoken in the region. For example, the Western Cape (of which Cape Town is the capital city) has three official languages – English, Afrikaans and Xhosa. Other provinces have up to five official languages, with English and Afrikaans continuing to be official languages in all provinces. The apartheid and earlier colonial regimes led to a situation in which English and Afrikaans were formerly the only official languages, and very little

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provision in social services was made for other languages. In the health system, for example, and partly for a host of reasons clustered around racial privilege, most practitioners in the higher echelons (medical practitioners and other health service providers, apart from nurses) speak only English and/or Afrikaans. There are no designated posts for interpreters in the health system (Crawford, 1999).

The issue of the politics of language is not something that is new to South Africa, or to health care in South Africa in particular. The apartheid government systematically advanced the interests of Afrikaans by making it a requirement that persons working in the public service be able to speak the language. The Soweto uprising of 1976, a key event in the struggle leading to democracy in South Africa, was ignited over black schoolchildren's objections to learning Afrikaans, which was seen as the language of the oppressor. As far back as 1889, English-speaking nurses came into conflict with administrations that required them to demonstrate some proficiency in Dutch, the forerunner of Afrikaans (Marks, 1994). Throughout South Africa's history, issues of language have been intertwined with political questions (Mesthrie, 1995), as is the case in other parts of the world. Five years ago, the major turning point of South Africa's first democratic elections took place, marking an ostensible shift in all areas of South African life, including in language policy. For the first time, indigenous languages (apart from Afrikaans)[1] are officially recognized, and these languages have, in constitutional terms, equal value with English and Afrikaans.

Research in transcultural psychiatry and related disciplines in South Africa has been remarkably silent on the issue of language (Swartz & Foster, 1984). This relative lack of attention to the language issue is not unique to South African research (Swartz, Drennan, & Crawford, 1997). For example, the *World mental health* report (Desjarlais, Eisenberg, Good, & Kleinman, 1995) does not directly address the issue of language policy and planning in mental health care. There are of course important exceptions to this relative lack of attention to language issues (see, for example Kaufert & Koolage, 1984; Kaufert, Koolage, Kaufert, & O'Neil, 1984; Kaufert, 1990; Westermeyer, 1990; Kaufert & O'Neil, 1995; Kaufert, Lavallee, Kaufert, & O' Neil, 1996; Kaufert & Putsch. 1997; Westermeyer & Janca, 1997), but the overriding picture remains. Against this backdrop, it is probably not surprising that changes in the access which non-native speakers of English and Afrikaans have to mental health care in South Africa have been slow and hesitant, as discussed below. Our aim in this article is to raise the question as to whether there are possible reasons for slow progress over and beyond an untheorized invisibility of language issues. We prepare the way for our discussion with the presentation of some very brief vignettes from South African health care. We then consider issues in the structure of

mental health care itself which may make the issue of language not just invisible, but also irrelevant to the care which is offered. We then move on to consider our own attempts to change language policy and access in educating mental health clinicians in Cape Town, before providing some brief concluding comments.

Some Brief Examples of Health Care in South Africa

All three of these examples are from health services for poor people in South Africa.

Case 1

The Western Cape has the highest incidence of tuberculosis (TB) in the world. In line with World Health Organization (WHO) suggested guidelines, the system of treatment known as directly observed treatment (DOTS) is undertaken. The particular method of DOTS varies somewhat from setting to setting, but in many cases it involves known TB patients attending a clinic every day from Monday to Friday, waiting in a queue, and taking medication under the direct supervision of a nurse. According to ethnographic research by van der Walt (1998), a scene at a clinic, may be very bleak. The only verbal interaction between nurse and patient could be the words:

> *Fill your glass with water.*
> *Take your pill*[2]

There are clearly many features of this interaction and its dehumanizing qualities that could be commented on (see van der Walt & Swartz, in press, for a discussion); for the purposes of this article it is sufficient to note the impoverished communication in the interaction.

Case 2

Psychiatric epidemiologists throughout the world have shown that primary health care practitioners do not always detect minor psychiatric morbidity among their patients. South African research confirms this international trend, which suggests that over half of psychiatric morbidity presenting to primary care facilities may be overlooked (Zung, Magill, Moore, & George, 1983; Casey, Dillon, & Tyrer, 1984; Von Korff et al., 1987; Ormel, Koeter, Van den Brink, & Van den Willige, 1991; Gelman, 1999).

Some years ago, we conducted a study of psychiatric morbidity in a semi-rural area close to Cape Town (Miller, Swartz, & Rumble, 1991; Rumble, Swartz, Zwarenstein, & Parry, 1996). Preparatory interviews with

primary care personnel indicated that some of these were well aware of the issue of non-detection. One interviewee, however, pointed out that it was of very little value to him to find out about the psychosocial problems of his patients as he had neither the time nor the expertise to attend to these difficulties, nor were there social work or similar services which could take referrals. He commented:

It's just me and my pills[3]

CASE 3

Lentegeur Hospital is a busy psychiatric hospital in Mitchells Plain, a former 'Coloured' area near Cape Town, where the dominant spoken languages are Afrikaans and English. Khayelitsha, a large settlement where most of the people are Xhosa-speaking, many of them migrants to Cape Town and able to speak little or no Afrikaans or English, falls within the hospital catchment area. Drennan (1999) found that on occasion (for periods up to a month) there would be no staff on the ward who could communicate with the patients. He describes a situation in which staff would sit in the nurses' station and observe patients through glass. On the basis of these observations, decisions were made about medication and discharge. One doctor commented: 'one might as well be practising veterinary science' (Drennan, 1999: 12).

LANGUAGE AND THE STRUCTURE OF MENTAL HEALTH CARE

The above three examples give some sense of the context within which we are working on issues of language and mental health services in South Africa. In this section we raise and attempt to answer a very simple question: 'Why is the fact that most practitioners in the upper echelons of public sector mental health care in South Africa (particularly psychiatrists and psychologists) cannot speak the languages of many of their patients unimportant?' An audience interested in cultural aspects of mental health may find this question offensive. To people whose business is culture, it is evident that language is very important. There is an enormous literature on the importance of language in clinical communication. Within the mental health field in particular, there are strong research traditions emphasizing the role of language in psychotherapy. Lacanians, structuralists more generally, and postmodernists, many of whom work in language departments at universities, have devoted entire careers to exploring how the unconscious is structured like a language, to the discursive nature of all interaction including (and especially) psychotherapy.

In the post-Freudian world, the idea that strange behaviour has

meaning, and if interpreted correctly can be understood has become commonplace. A further commonplace idea is that if this meaning is correctly understood or interpreted, this may lead to an improvement in symptoms (however that may be defined) and the alleviation of distress – hence the 'talking cure'. This view, especially when we think about serious mental disorder, is at odds with much of the history of mental health care and with some dominant contemporary developments in the way people think about this care. It is easy to forget that the major tranquilliser revolution, which is only about 50 years old, dramatically changed thinking about whether recovery from serious mental illness was possible. Following these developments in psychopharmacology it was possible in the 1960s to begin a movement towards deinstitutionalization of seriously mentally ill people. This movement, which began with great hopes for the civil rights of the mentally ill, is now regarded by some as a failure, as it is clear that without a substantial infrastructure in place in the community it is not possible simply to empty mental hospitals (Leff, 1997). Together with deinstitutionalization there has been an increase worldwide in homelessness, and, indeed, epidemiological research has shown that a proportion of homeless people in countries such as the U.S.A. and the U.K. are mentally ill and would probably have been institutionalized in another era (Leff, 1997; Susser et al., 1997). Mossman (1997) has tried to understand the cultural construction of what he terms a 'myth' that psychiatry has abandoned the mentally ill. This 'myth' of abandonment is related to the idea that psychiatry, in particular, and mental health care practice, in general, should be able to solve the problem of mental illness.

On all fronts, it is increasingly clear that *cure* of mental disorder may not be possible. Furthermore, dramatic changes, often owe rather more to pharmacology than some proponents of the 'talking cure' may feel comfortable admitting. There is a burgeoning literature on the social effects of psychopharmacology, some of it laudatory to the point of worship of panacea drugs, some of it branding psychotropic drugs as simply a sinister form of mind control (Kramer, 1993; Wurtzel, 1994; Lyon, 1996; Diller, 1998; De Grandpre, 1999). It is significant for this discussion that a popular book by a psychiatrist on the most-prescribed psychotropic drug in history, is somewhat satirically entitled *Listening to Prozac* (Kramer, 1993). In the Prozac world, it is the Prozac rather than the patient that is listened to, and we may safely assume that Prozac is multilingual![4]

Over 30 years ago, in the early days of the behaviour therapy revolution, Storr (1968), a psychoanalyst, wrote:

> . . . the evidence that psychoanalysis cures anybody of anything is so shaky as to be practically non-existent. (p. 57)

Subsequent research has been more positive about the impact of psychoanalysis on people's lives (Roth & Fonagy, 1996), but this research is costly and detailed – it is easier (and less controversial) to measure the impact of less complex interventions than psychoanalysis and its various therapeutic offshoots. In the case of both serious mental disorder and what are termed 'disorders of the self' – difficulties with identity very prominent in psychotherapeutic practice in these postmodern times (Wolf, 1988; Kuipers, 1996) – there is at present a recognition of the value of some forms of psychotherapeutic intervention, but at the same time a sense that human difficulties are to be managed rather than put right.

In this context, the focus on what mental health care is and does to some extent moves away from both the notion of cure and from the therapeutic theory and method, which is most deeply concerned with meaning and its complexity – psychoanalysis. In the context of Britain in 1968, a country in which there still existed a vibrant national health system, Storr (1968) described psychoanalysis in the following way:

> . . . the process of analysis becomes an end in itself, a journey of exploration which is undertaken for its own sake; not so much a treatment, more a way of life. (p. 53)

In the Mpumalanga province in a democratic South Africa, there are one psychiatrist, two psychologists and 12 social workers for a population of 2.4 million people. Other provinces are similarly under-resourced (Freeman & Pillay, 1997: 46–48). Psychoanalysis (and, by extension, the clinical making of meaning more generally) as a lifestyle choice is hardly likely to make a strong first claim on the public purse in this context. This is even more true when we consider the impact of existing diseases, such as TB and the frightening AIDS epidemic, on the health budget.

If we can make no great claims for the role of language in the cure of mental disorder and distress, perhaps it is more modest and more accurate to think about the role of language as crucial for the *care* of people in emotional turmoil. Many claims, some of them backed by empirical evidence, have been made for the positive impact of a caring and respectful attitude towards patients (Kleinman, 1988; Helman, 1994). If we cannot cure patients, then at least through being able to communicate with them adequately, we can care for them and offer them an improved quality of life. The ideal of humane care is an implicit value underlying much of our own work (Drennan, 1998, 1999; Swartz, 1998a, 1998b), and in the new South African human rights culture. But care, as mediated through language, especially in the context of under-resourced mental health services in South Africa, can be related only with difficulty to 'hard', measurable outcomes. One of the bases on which arguments for adequate access to services for people from all linguistic communities are made is

that if clinicians cannot understand what their patients are saying, they may misdiagnose their patients and offer the wrong treatment (Malady, Rogler, & Constantino, 1987; Mezzich, Kleinman, Fabrega, & Parron, 1996). In psychiatry internationally, however, there is not always a one-to-one correspondence between any diagnosis and a treatment specific to that diagnosis, with the result that some diagnostic errors have minor clinical consequences. For example, the pharmacological treatment for affective disorder and for schizophrenia may in many cases be the same, and pharmacological or behavioural treatments for anxiety and depression overlap to a large extent. It is not always very important, in reality, to be able to make fine-grained diagnostic decisions. The unimportance of accurate diagnosis comes even more sharply into focus in the context of overstretched services that offer very little other than custodial or instrumental interventions.

A number of authors have highlighted the tensions between the caring and the administrative functions of health care in general and mental health care in particular (Mizrahi, 1987; Rhodes, 1991). Furthermore, with large numbers of service users and professional differentiation of caring functions (Abbott, 1988), health care has become increasingly bureaucratized. The administrative functions can be prioritized, creating notions of minimum standards of care, reductive understandings of access to services, rather than access to care. If it is difficult to demonstrate the importance of linguistic access to the administrative functions of health care, then ideas about the importance of language become devalued in themselves. If care in itself and of itself is not valued, or cannot readily be shown to be valuable, then the administrative or social *control* functions of mental health care become foregrounded.

Versed though many mental health workers may be in Foucauldian and similar theories, it is likely that very few became involved in this work with the desire to act simply as custodians or agents of social control. What linguistic means, therefore, can we use to reframe our control functions into something more palatable? Ironically, perhaps, some research completed ten years ago (Swartz, 1989) showed that the language of psychoanalysis played an important role in practitioners' talk about the unacceptable coercive nature of their work. At that time, the research focused on in how practitioners understood and used the concept of culture in their clinical work. Psychiatrists in training were interviewed about their work and were also asked to respond to clinical vignettes. All the vignettes dealt with serious mental illness and implicitly with the possibility of being admitted to a psychiatric hospital. Without exception, every respondent in the study spoke of the need for patients with certain difficulties to be contained. *Containment* was frequently said to be 'needed' by patients (Swartz, 1989: 264). Some respondents spoke of seriously mentally

ill patients as 'wanting' or 'asking for' containment. In the context of this study, containment literally meant incarceration in a psychiatric hospital, with one respondent speaking, for example, of a patient who 'might require further containment' in a locked as opposed to an open ward. There was also talk about whether patients were 'containable at home' or could be 'contained on oral medication'. Clearly, much of this talk has to do with the question of the social disruptiveness of patients. Containment of the patient in this sense may be 'needed' more immediately by people other than the patient.

None of this is necessarily a problem. Part of the function of mental health care is to protect the public from potentially disruptive people. But this is the aspect that gives mental health care a bad name, is attacked by the antipsychiatry movement (Szasz, 1961, 1971; Ingleby, 1981) and flies in the face of traditions of 'moral treatment' (Foucault, 1973a, 1973b) which go back centuries. The word 'containment' is a cornerstone of some important psychoanalytic theories. For example, it is said that children need to be in environments in which their anxieties are contained, and that psychotherapy patients have similar important needs (Winnicott, 1984). Use of the term when incarceration or sedation of patients, often involuntary, is being discussed, immediately links these acts with the image of benign care of the Winnicottian 'good enough mothering' (Winnicott, 1984) type. This is in spite of the fact that, from certain perspectives, the provision of 'containment' could be viewed as a potential infringement of patients' rights.[5] A further example of how the psychoanalytic term 'containment' comes to serve as a gloss for incarceration in the context of service provision in a multilingual context can be seen from the following statement by a clinician working in such an environment:

> I think if you are treating a psychiatric patient with whom you cannot communicate you are violating them in a way. You [just] contain them, people don't know what's going on. (Drennan, 1998: 156)

Given the continuing pervasive influence of psychoanalytic ideas on theories of mental health and illness (even on theories that object stridently to many aspects of psychoanalysis), it is perhaps a banal observation to note that practitioners use psychoanalytic terms to describe their work. More important here is the probability that psychoanalytic terminology helps practitioners justify to themselves and others the less palatable parts of their work. Psychoanalysis was constructed as a method of uncovering the unconscious or the unacceptable; psychoanalytic terminology may also be used to obscure the unconscious or the unacceptable. There has been much discussion, both in South Africa and elsewhere, of the elitism of psychoanalysis (Phillips, 1995; Swartz, 1998b). It is a difficult reality that in the context of few and shrinking resources the role of mental health care

as a means of protecting the public from the bizarre or the dangerous will be maintained longer than the role of mental health care as a semantic system of elaborating meaning. Psychological theories about what motivates human behaviour are ostensibly systems of meaning, but in an increasingly bureaucratized health care system they become vehicles for accomplishing more mundane 'management' tasks. Rhodes (1991) describes how psychological theories are used selectively to justify the central task of 'emptying a bed'. Clearly, this issue is not confined to health care in South Africa, but language barriers make it more likely that the administration and care functions may not coincide.

A study conducted in poorly resourced communities in Cape Town has shown that perceptions of mental health problems and mental health care even among community health workers focused largely on the social difficulties of disruptive behaviour (Binedell, 1993). In this study, depression was said not to exist, or to exist very rarely, in African townships in Cape Town. Epidemiological evidence consistently shows that there are in fact high rates of depression (Gillis, 1992; Swartz, 1998a). This disjunction between perceptions and reality is important for the present argument for at least three reasons. First, depression often causes more difficulty for the depressed person than for others, and it may often be hidden. Second, in spite of the fact that there is ample evidence that antidepressant therapies can have a dramatic impact on depression, to recognize that another person is depressed implicitly requires some degree of empathy with – and the opportunity to be affected by – that person's emotional pain. Third, there is a long and ignominious history in racist transcultural psychiatry which has argued that black people, being childlike, carefree and generally prelapsarian in their lifestyle, lack the intellectual insight and sophistication necessary for depression (see Littlewood and Lipsedge, 1997 for a review).

Even where there are strong and strident attempts to combat racism of the past, institutional racism may still exist and be reproduced (Swartz, 1991). The prospect for the monolingual, white clinician to understand fully the situation of patients for whom there is in reality very little available in terms of mental health care may simply be too overwhelming. Better, in this context, not to understand patients than to risk being overwhelmed by their needs and by the gap between their needs and what help can be offered. 'Veterinary science', as spoken about in the vignettes that opened this article, is a shocking metaphor for the operation of mental health care, but perhaps acting in a veterinary way also provides clinicians with some degree of protection from what they have to deal with.

In making some of the above comments on the defensive use of psychoanalytic language to obscure rather than reveal difficulties, we are implicitly suggesting, of course, that psychoanalytic theory (or any theory of

meaning) may well be helpful in our understanding not of patients' problems, but of how practitioners defend themselves against the unbearability of these problems. Psychoanalytic theory allows us to ask further questions about why multilingualism is so seldom achieved by non-native speakers of indigenous languages in South Africa.

Struggles on the Road to Changing Language Practices

In attempting to improve access, on the basis of language, to mental health services in South Africa we have suggested a number of changes, including deploying mental health care personnel differently, and training native speakers of a wider variety of languages (Swartz et al., 1997). In this section we focus only on attempts to improve English and Afrikaans speakers' proficiency in other local languages.

Why is it frequently said that it is difficult for South African clinicians (and, by extension, other South Africans) to learn these languages? We shall consider this question by examining an example from our own experience. In 1993, the Department of Psychology at the University of Cape Town introduced a staged system whereby potential applicants for professional training in psychology would at first be strongly encouraged, and in later years required, to demonstrate a basic proficiency in an indigenous language apart from Afrikaans. There is no doubt that as a result of this requirement we are having more and more applicants who have taken courses in indigenous languages; we have also seen an increase in applications from native speakers of indigenous languages. At the same time, however, the policy remains contested and is applied only in the context of one of our professional degrees (the training in clinical psychology). Many potential applicants complain vociferously about the requirement, and selection panels struggle with how to apply it. A number of applicants simply ignore the requirement. Not a year has gone by without some unpleasant discussion about the language issue, with some selectors feeling it is tokenism and others feeling it is an unnecessary requirement.

It should be obvious by this point that our department's own lack of clarity and unified will on the language issue must contribute to some of the confusion about it, and to some of the objections from applicants. This lack of unity, however, was not present at the time the rule was introduced in the early 1990s. LS joined the Department of Psychology in 1986, and shortly after his arrival as a junior staff member he suggested that a language requirement be put in place. At that time, senior staff, who have since left the university, argued that knowledge of an indigenous language was 'irrelevant' to clinical training. By the early 1990s, a time of great political uncertainty and turmoil, but also hope about change, there was unanimous support for the introduction of the language requirement. We went

ahead, taking great trouble to warn in advance all potential future applicants for professional training in psychology that the requirement would be effected.

Applicants' complaints about the requirement almost invariably centre around how difficult it is to learn Xhosa (this is the language candidates most commonly attempt to learn as it is spoken in the Western Cape). It is indeed true that Xhosa is a difficult language to learn for an English speaker, and it is also true that English speakers have a reputation worldwide for resisting multilingualism. It is also the case, however, that English speakers are capable of learning other 'difficult' languages if they have to, and that in certain areas of South Africa, such as the rural Eastern Cape and KwaZulu/Natal, English speakers quite commonly speak Xhosa or Zulu, a language closely related to Xhosa. The 'difficulty' issue cannot fully explain the situation. Applicants rightly observe that few of the staff have made meaningful efforts to learn indigenous languages, and their resentment at this extra burden on them may be part of the explanation. Furthermore, applicants were raised in the context of particular language politics, and they had not expected the indigenous language issue to be a stumbling block in their careers. Second-language teaching in indigenous languages apart from Afrikaans in schools and elsewhere is often non-existent or extremely poor. Many students have been socialized to expect a training that will equip them for work in countries such as Britain (we are in fact lamentably good at preparing trainees for work abroad) and do not see their future in South Africa. There are very few public sector and non-governmental organization (NGO) jobs for psychologists, and the number of clients with the means to consult private practitioners who are not fluent in English is very small. These are all important realities.

We wish to suggest, however, that there is something else at work, something which underpins many of the above issues and adds to them. Many of the people who apply to become clinical psychologists are determined to reverse some of the racist practices in which they have grown up in South Africa. People who choose clinical psychology as a career commonly have as part of their motivation (conscious or otherwise) the desire to put right hurts from their own past (Cushway, 1997; Dale, 1997). The burden of being able fully to understand black South African clients is likely to be enormous for these candidates – to understand the need is potentially to be affected by it, as we have suggested earlier. There are further issues which may be at stake. If a white South African clinician is fluent in, say, Xhosa, and has a Xhosa-speaking client in psychotherapy, what if the clinician still does not understand this person's experience? It has often been said (defensively, we believe) that because language and culture are so strongly intertwined there is little point in learning the language of others as we will still not understand the culture. What, though, if we take this statement and

turn it on its head? Is it worth risking learning a language only to find out what South African socialization has made us feel is all too true – that no matter what white clinicians do they will never understand black people? Perhaps it is better not to take this risk.

Yet another complicating factor in this issue is the way in which knowledge of an indigenous language apart from Afrikaans gives mother-tongue speakers of such languages an inviolable position of power over other students. The language issue throws up the reality of racialized knowledges, in a particular way. Students who are not native speakers of these languages in general perform better at tertiary institutions such as the University of Cape Town than do native speakers. The pattern may be changing, but for a host of reasons related largely to the appalling legacy of apartheid education, it remains true at present. The area of indigenous language knowledge inverts the usual pattern. It may be difficult in this context for trainees who do very well in other spheres to accept their serious deficiency in the language arena. Similarly, those who can speak the languages may wish to protect an area of exclusive strength (cf. Swartz, 1991).

Concluding Comments

Historically, the racist reasons for the dominance of Afrikaans and English in South Africa are easy to see. The movement towards greater inclusivity would understandably be resisted as all change is resisted to a degree. It is also hard to give up power. Psychological thinking may help us change the discourse about resistance to language change from a moral discourse to a more psychological-based understanding. This, in turn, could help us support professionals and service providers to have a better sense of how difficult this change may be psychologically. The South Africa of the post-1994 era is the era of integration. Integration is easy to speak about but often difficult to implement. Because of the political necessity of integration, it becomes hard to speak of the difficulties. A study we conducted on the racial integration of two psychotherapeutic units some years ago found that staff did not talk of difficulties at all (Roth & Swartz, 1992). When one thinks about people who point out the difficulties with integration one thinks of racists and reactionaries. Perhaps it is easier to complain that Xhosa is so hard to learn than to admit to the fears, losses and discomfort that integration inevitably brings, however much that integration is good and wanted (Swartz, 1996).

It is not enough simply to decree that accessibility to mental health services on the basis of language must be improved dramatically. Nor is it enough to develop incentives for people to learn more languages. We also need to think about what the difficulties may be in doing this, and about

how to help overcome these difficulties. A major problem is that the institutional wheels of psychiatric practice continue as they must do. As a result, the investments we need to make in effecting language change in mental health care need to go beyond an idealistic view of language as obviously essential for continuing institutional and professional practice. Some of these investments lie not only in technical questions about language competence, but also in psychological questions about personal and institutional transformation.

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Notes

1. The question of how to define what constitutes an 'indigenous' language is open to debate. The standard version of Afrikaans is based to a large extent on Dutch (with admittedly significant local influence). Dutch, like English, was a settler language. It may be argued similarly that local appropriations of English may be regarded as 'indigenising' the language. What is important for the present discussion, however, is simply the fact that only English and Afrikaans have been official languages in the past, and this has changed.
2. Our translation of the Afrikaans: *Tap maar vir jou water. Drink jou pilletjie.*
3. Our translation of the Afrikaans: *Dis net ek en my pille.*
4. There is an important literature that shows that response to medication depends not only on the pharmacological properties of the medication but also on cultural, interpersonal and intrapsychic factors (Helman, 1994; Littlewood, 1994; McDonald, 1994; Swartz, 1998a), but the central issue for the current argument is the extent of the influence of pharmacological care on how we think about mental disorder and its treatment.
5. We make no implication here that patients' rights are in fact routinely infringed; there is indeed a widespread awareness of patients' rights within contemporary South African human rights culture. But an important and enduring image of mental health care, and one with which mental health practitioners have to grapple, is that of this care as a form of coercive physical or chemical incarceration.

References

Abbott, A. (1988). *The system of the professions: An essay on the division of expert labor*. Chicago, IL: Chicago University Press.

Binedell, J. (1993). *Methods and madness: Researching community health workers'*

perceptions of mental illness in Khayelitsha and Nyanga. Unpublished masters dissertation, University of Cape Town, Cape Town.

Casey, P. R., Dillon, S., & Tyrer P. J. (1984). The diagnostic status of patients with conspicuous psychiatric morbidity in primary care. *Psychological Medicine*, *14*, 673–683.

Crawford, A. (1999). 'We can't all understand the whites' language': An analysis of monolingual health services in a multilingual society. *International Journal of the Sociology of Language*, *136*, 27–45.

Cushway, D. (1997). Stress in trainee psychotherapists. In V. P. Varma (Ed.), *Stress in psychotherapists* (pp. 24–43). London: Routledge.

Dale, F. (1997). Stress and the personality of the psychotherapist. In V. P. Varma (Ed.), *Stress in psychotherapists* (pp. 11–23). London: Routledge.

De Grandpre, R. J. (1999). *Ritalin nation: Rapid-fire culture and the transformation of human consciousness*. New York: Norton.

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World mental health: Problems and priorities in low-income countries*. New York: Oxford University Press.

Diller, L. H. (1998). *Running on Ritalin: A physician reflects on children, society and performance in a pill*. New York: Bantam Doubleday Dell.

Drennan, G. (1998). *Language and the role of interpreting in South African psychiatry: A study of institutional practice in the Western Cape*. Unpublished doctoral thesis, University of Cape Town, 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.

Foucault, M. (1973a). *Madness and civilization*. New York: Vintage.

Foucault, M. (1973b). *The birth of the clinic: An archaeology of medical perception*. New York: Vintage.

Freeman, M., & Pillay, Y. (1997). Mental health policy – plans and funding. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa* (pp. 32–54). Cape Town: MASA Multimedia.

Gelman, T. (1999). *The prevalence and detection of possible minor psychiatric morbidity in students attending the student health services at the University of Cape Town. A pilot study*. Unpublished masters dissertation, University of Cape Town, Cape Town.

Gillis, L. S. (1992). Depression in newly-urbanised elderly South Africans. *Southern African Journal of Gerontology*, *1*, 20–24.

Helman, C. (1994). *Culture, health and illness: An introduction for health professionals* (3rd ed.). Oxford, UK: Butterworth-Heinemann.

Ingleby, D. (Ed.). (1981). *Critical psychiatry*. Harmondsworth, UK: Penguin.

Kaufert, J. M. (1990). Sociological and anthropological perspectives on the impact of interpreters on clinician/client communication. *Sante Culture Health*, *7*, 209–235.

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

Kaufert, J. M., Koolage, W. W., Kaufert, P. L., & O'Neil, J. O. (1984). The use of 'trouble case' examples in teaching the impact of sociocultural and political factors in clinical communication. *Medical Anthropology, 8*, 36–46.

Kaufert, J. M., Lavallee, M., Koolage, W., & O'Neil, J. (1996). Culture and informed consent: The role of aboriginal interpreters in patient advocacy in urban hospitals. *Issues in the North, 1*, 89–93.

Kaufert, J. M., & O'Neil, J. (1995). Cultural mediation of dying and grieving among native Canadian patients in urban hospitals. In L. A. DeSpelder & A. L. Strickland (Eds.), *The path ahead: Readings in death and dying* (pp. 59–74). Mountain View, CA: Mayfield.

Kaufert, J. M., & Putsch, R. W. (1997). Communication through interpreters in health care: Ethical dilemmas arising from differences in class, culture, language and power. *The Journal of Clinical Ethics, 8*, 71–87.

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York: Free Press.

Kramer, P. (1993). *Listening to Prozac: A psychiatrist explores antidepressant drugs and the remaking of the self*. New York: Viking

Kuipers, E. (1996). The management of difficult to treat patients with schizophrenia, using non-drug therapies. *British Journal of Psychiatry, 169* (Suppl. 31), 41–51.

Leff, J. (Ed.). (1997). *Care in the community: Illusion or reality?* Chichester, UK: Wiley.

Littlewood, R. (1994). Symptoms, struggles and functions: What does the overdose represent? In M. McDonald (Ed.), *Gender, drink and drugs* (pp. 77–98). Oxford, UK: Berg.

Littlewood, R., & Lipsedge, M. (1997). *Aliens and alienists: Ethnic minorities and psychiatry* (3rd ed.). London: Routledge.

Lyon, M. L. (1996). C. Wright Mills meets Prozac: The relevance of 'social emotion' to the sociology of health and illness. In V. James & J. Gabe (Eds.), *Health and the sociology of emotions* (pp. 55–78). Oxford, UK: Blackwell.

Malady, R. G., Rogler, L. H., & Constantino, G. (1987). Ethnocultural and linguistic bias in mental health evaluation of Hispanics. *American Psychologist, 42*, 228–234.

Marks, S. (1994). *Divided sisterhood: Race, class and gender in the South African nursing profession*. New York: St Martin's Press.

McDonald, M. (1994). Introduction: A social–anthropological view of gender, drink and drugs. In M. McDonald (Ed.), *Gender, drink and drugs* (pp. 1–31). Oxford, UK: Berg.

Mesthrie, R. (Ed.). (1995). *Language and social history: Studies in South African sociolinguistics*. Cape Town: David Philip.

Mezzich, J. E., Kleinman, A., Fabrega, H. Jr, & Parron, D. L. (Eds.). (1996). *Culture and diagnosis: A DSM-IV perspective*. Washington, DC: American Psychiatric Press.

Miller, T., Swartz, L., & Rumble, S. (1991). *Psychological factors in primary health care in Mamre*. Paper presented at the Epidemiological Society of South Africa Conference, University of the Western Cape, July.

Mizrahi, T. (1987). Getting rid of patients: Contradictions in the socialization of internists to the doctor–patient relationship. *Sociology of Health and Illness*, *7*, 214–235.

Mossman, D. (1997). Deinstitutionalization, homelessness and the myth of psychiatric abandonment: A structural anthropology perspective. *Social Science & Medicine*, *44*, 71–83.

Ormel, J., Koeter, M. W. J., Van den Brink, W., & Van de Willige, G. (1991). Recognition, management and course of anxiety and depression in general practice. *Archives of General Psychiatry*, *48*, 700–706.

Phillips, A. (1995). *Terrors and experts*. London: Faber and Faber.

Rhodes, L. A. (1991). *Emptying beds: The work of a psychiatric emergency psychiatric unit*. Berkeley: University of California Press.

Roth, A., & Fonagy, P. (1996). *What works for whom: A critical review of psychotherapy research*. New York: Guilford.

Roth, L., & Swartz, L. (1992). The integration of two psychotherapeutic units: Staff experiences of the first six months. *South African Journal of Occupational Therapy*, *22(2)*, 6–11.

Rumble, S., Swartz, L., Parry, C., & Zwarenstein, M. (1996). Prevalence of psychiatric morbidity in the adult population of a rural South African village. *Psychological Medicine*, *26*, 997–1007.

Storr, A. (1968). The concept of cure. In C. Rycroft (Ed.), *Psychoanalysis observed* (pp. 48–68). Harmondsworth, UK: Penguin.

Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W. Y., & Wyatt, R. J. (1997). Preventing recurrent homelessness among mentally ill men: A 'critical time' intervention after discharge from a shelter. *American Journal of Public Health*, *87*, 256–262.

Swartz, L. (1989). *Aspects of culture in South African psychiatry*. Unpublished doctoral thesis, University of Cape Town, Cape Town.

Swartz, L. (1991). The reproduction of racism in South African mental health care. *South African Journal of Psychology*, *21*, 240–246.

Swartz, L. (1996). Culture and mental health in the rainbow nation: Transcultural psychiatry in a changing South Africa. *Transcultural Psychiatric Research Review, 33*, 119–136.

Swartz, L. (1998a). *Culture and mental health: A southern African view*. Cape Town: Oxford University Press.

Swartz, L. (1998b). *Mental health in South Africa*. Paper presented at the Conference Change: Psycho-Analytic Perspectives, Cape Town, 2–5 April.

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 in South Africa* (pp. 166–180). Cape Town: MASA Multimedia.

Swartz, L., & Foster, D. (1984). Images of culture and mental illness: South African psychiatric approaches. *Social Dynamics*, *10*, 17–25.

Szasz, T. (1961). *The myth of mental illness*. New York: Hoeber and Harper.

Szasz, T. (1971). *The manufacture of madness*. London: Routledge and Kegan Paul.

Van der Walt, H. (1998). *Nurses and their work in the tuberculosis control*

programme in the Western Cape: Too close for comfort. Unpublished doctoral dissertation, University of Cape Town, Cape Town.

Van der Walt, H., & Swartz, L. (in press). Isabel Menzies Lyth revisited: Institutional defenses in public health nursing in South Africa during the nineties. *Psychodynamic Counselling*.

Von Korff, M., Shapiro, S., Burke, J. D., Teitlebaum, M., Skinner, E. A., German, P., Turner, R. W., Klein, L., & Burns, B. (1987). Anxiety and depression in a primary care clinic: Comparison of DIS, GHQ and practitioner assessment. *Archives of General Psychiatry*, *44*, 152–156.

Westermeyer, J. (1990). Working with an interpreter in psychiatric assessment and treatment. *Journal of Nervous and Mental Disease*, *178*, 745–749.

Westermeyer, J., & Janca, A. (1997). Language, culture and psychopathology: Conceptual and methodological issues. *Transcultural Psychiatry*, *34*, 291–311.

Winnicott, D. (1984). *Playing and reality*. Harmondsworth, UK: Penguin.

Wolf, E. S. (1988). *Treating the self: Elements of clinical self psychology*. New York: Guilford.

Wurtzel, E. (1994). *Prozac nation*. Boston: Houghton Mifflin.

Zung, L. S., Magill, M., Moore, J. T., & George, T. (1983). Recognition and treatment of depression in a family medicine practice. *Journal of Clinical Psychiatry*, *44*, 1–3.

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