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SPEECH-LANGUAGE THERAPY CONSULTATION PRACTICES IN MULTILINGUAL AND MULTICULTURAL HEALTH CARE CONTEXTS

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By

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Abstract

This study explored the experiences of and interactions between speech-language therapists and interpreters in cross-linguistic mediated consultations with caregivers of children with severe disabilities within a health care setting. The objectives of the study included: to analyse the interactional characteristics and features of speech-language therapists and interpreters; and to identify speech therapists' and interpreters' perceptions of their competence and experiences in multicultural settings.

Patients who do not speak the same language as the health care professionals receive limited health services when compared with people who speak the same language as the professionals who serve them, which may result in poor health outcomes.

The research was conducted from an interpretive approach, which includes a respect for intra-personal values, beliefs and interests in the topic. The design included multiple data collection methods and analysis. The data was collected from consultation experience of thirteen caregivers of children with communication disabilities, five SLTs and one interpreter in two urban hospitals in Gauteng.

The participants were recruited using purposive sampling procedures from two urban tertiary hospitals in Gauteng. And group Research instruments used were video recordings, individual interviews.

The objectives were investigated through a qualitative study using ethnographic observations; video recordings of the interactions between speech therapists and an interpreter during interviews with caregivers of children with disabilities; audio recordings; and individual interviews with speech-language therapists and interpreters post-consultation. The data collected were analysed using thematic content analysis and conversational analysis.

The findings highlighted the diversity challenges faced by SLTs working in multilingual and multicultural hospital settings. Language and translation issues had a marked impact on information received by caregivers. Despite the challenges that clinicians experienced in multilingual settings, they seemed to find that their working experience was an important leveller when they had an interpreter present during their consultations. The findings inform academic curricula and the clinical practice of speech-language and audiology students and professionals and will help improve application to transform the way in which they apply

theoretical knowledge when treating speech and hearing disorders in a multilingual and multicultural context; thus enhancing the efficacy of management of communication disorders within this context.

Keywords: interaction, communication, speech-language therapist, interpreting, mediator, conversational analysis, caregivers, multi-cultural and multi-linguistic settings.

Declaration

I hereby certify that this thesis is my own, unaided, independent work. It has not been submitted before for any degree or examination at this or any other academic institution, nor has it been published in any form.

_____

Munyane Mophosho

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Dedication

I dedicate this thesis to my late parents, Ishmael and Roseline Motsieloa. Your love and faith in me propelled me to complete this thesis and to do well.

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List of abbreviations

HPCSA	Health Professions Council of South Africa
SASLHA	South African Speech-Language & Hearing Association
SLT	Speech-Language Therapist
CHBAH	Chris Hani Baragwanath Academic Hospital
CMJAH	Charlotte Maxeke Johannesburg Academic Hospital
PanSALB	Pan South African Language Board
HCP	Health Care Professional

CHAPTER 1: Introduction

> *"Language carries culture, and culture, carries particularly through orature and literature; the entire body of values by which we come to perceive ourselves and our place in the world. How people perceive themselves affects how they look at their culture, at their politics and at the – social production of wealth, at their entire relationship to nature and to other beings. Language is thus inseparable from ourselves as a community of human beings with a specific form and character, a specific history, a specific relationship to the world."*
>
> *Ngungi wa Thiong 'o (Decolonize the Mind)*

The above quotation by Ngugi wa Thiong'o captures the value of speech-language therapy and its greatest challenge in contemporary South Africa. In a world where language is important for self-understanding and relating, the work of a multi-lingual speech language therapist can bring one from the margin into community, from silence into communication. In South Africa, where language was a means for structural exclusion under apartheid, the work of a speech language therapist becomes empowering for clients. However,in a context where many of the speech language therapists do not speak the language of their clients, the work of the speech language therapist might be limited. The paradox remains a structural mechanism in contemporary South African public health system that does not seem to be responsive to the needs of the citizens. Communication across cultures and languages in hospital settings remains a challenge (Penn, 2007).

The South African Public Service Act of 1994 is responsible for establishing norms and standards relating- to ethics, conduct and integrity; transformation and any other matter to improve the effectiveness and efficiency of the Public Service and service delivery to the public. One of its lofty ideals is the principle of Batho Pele (People First) however, the implementation of the Act has been a challenge. Since the move towards democracy in 1994 in South Africa there have been robust debates and political speech-making on human rights, and thus the making of the health sector patients' rights charter. In spite of this, in practice we still have failed policy initiatives that have not helped transform the public health system. These failures illustrate the disjuncture between the universal aspiration of human rights norms and the complexities in their implementation.

Speech-language therapists (SLTs) working in South African state-owned hospitals find themselves in a challenging cultural and language context, where the language of the therapist is in most cases not that of the client. Again the context is also limited by existing interpreter resource challenges. This dissertation looks at the practice of speech-language therapist in post-apartheid South Africa. As communication disorder professionals, their scope of practice requires that they be clinically, as well as culturally sensitive and competent. However, it appears that training institutions may not be preparing them fully for the type of situations and scenarios that they encounter as part of their lived experiences within their profession (Penn, Mupawose, & Stein, 2009). According to Penn et al. (2009) this lack of preparedness of SLTs for a South African health context includes challenges with professional and technical issues, systemic and managerial issues, interpersonal issues and ethical issues. These can be attributed to a variety of complex factors; one key factor being gaps in resources including research, culturally appropriate intervention tools and relevant human resources.

State-owned hospitals present as multilingual and multicultural platforms within which the speech-language therapists implement their practical professional training. Trainee SLTs are required by the Health Professions Council of South Africa (HPCSA) to take the Hippocratic Oath. This oath is a mandate guiding the physician–patient relationship and is taken at the beginning and at the end of their training. The Oath is based on the premise that they will treat and serve their patients to the best of their ability, upholding principles such as confidentiality and the ethics of social justice (Ogubanjo & Knapp van Bogaert, 2009). Despite this professional training context and individual responsibility, evidence suggests that SLTs are qualifying without the requisite cultural competence and critical diversity literacy.

In this study the researcher examines language as a symbol of culture, and argues that language considerations are primary during multilingual and multicultural health consultation. Given the diverse linguistic and socio-economic context in South Africa, this study focuses on issues pertaining to SLT consultation practices during the application of the intervention process. By examining interactions between speech-language therapists and interpreters in cross-linguistic mediated consultations with caregivers of children with severe communication disabilities in public health care settings; the study establishes the need for focused policy and practical interventions to improve the cultural competence of SLTs.

Below is the study rationale, background and problem statement and an outline of the structure of the thesis.

1.2 Study rationale

This study was motivated by the researcher's exposure and experience as a clinical educator within the Speech-Language Pathology and Audiology Department at the University of the Witwatersrand in South Africa. This experience encompasses observing the challenges faced by SLTs during consultations with caregivers seeking help for their children with communication disabilities. Communication difficulties encountered by both SLTs and caregivers in these multicultural and multilingual contexts resulted in limited understanding on both sides and rendered the intervention process ineffective. Furthermore, the researcher could empathize with the caregivers' discomfort when treated by medical professionals from a different cultural background, particularly when due consideration is given to the power dynamics created by South Africa's socio-political history. As an educator, the researcher was interested in how SLT training can be improved to address cultural competence.

Failed communication and ineffective interventions in multicultural and multilingual contexts raises a number of pertinent questions for researchers, particularly in the field of speech language therapy. How does a mother cope when she has a child with a disability and does not understand that this is a severe intellectual and/or physical disability? How does a health care provider function effectively when overwhelmed by the inability to speak in an informed way with patients or caregivers? How do health care providers operate in the context of laws related to language and human rights? These many research questions must be built on the foundational understanding of the actual interactional dynamics occurring in mediated settings between the clients and health care providers. This study unpacks these dynamics in theory and practice and makes clear recommendations for the South African public health system of speech language therapy.

This research is particularly important in the context of post-Apartheid expectations for human rights and service delivery. South Africa is reputed to have the most progressive constitution including socio-economic rights; yet inequities in access to and the utilisation of

health services continues (Kale, 1995; Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana, & Chersich, 2011). Further, a study by Gilson and McIntyere (2007) found that community perceptions of the quality of public health care services in all areas in South Africa are generally declining. These perceptions are due in part to communication challenges that patients/clients face in public health care services and speak directly to the need for research on communication/language access in health care. As part of the problem and possible champions of the solution, SLTs must first examine their own practices in order to find solutions across the public health system.

English is the only language in South Africa that enjoys high status and is becoming the lingua franca in public service (Henrard, 2003). Yet the constitution, law and policy recognize eleven official languages and a myriad of cultural practices. Furthermore, South Africa is experiencing a huge influx of immigrants and refugees from across the world, and it has become common for health care professionals (HCPs) and SLTs to treat people who speak languages such as French, Portuguese, Aramaic, Arabic and a variety of Asian and Indian languages. This context extends the range of cultural practices that clients/patients have, practices that then impact not only communication in consultations but also the implementation of treatment options. In this shifting context, HCPs need to learn new ways of communicating that emphasise multilingual and multicultural underpinnings in order to fulfill their professional obligations and to bridge the gap between legal rights and service delivery.

The medical profession began to acknowledge the negative impacts of communication problems between doctors and patients as far back as the 1960's (Williams, Weinman & Dale, 1998). Studies on doctor–patient communication have found that problematic communication leads to reduced health outcomes, poor compliance by patients and poor patients' commitment to the intervention and treatment regimens (Levin, 2005; Macdonald, Carnevale & Razack, 2007). Thomas (2006) posits that the communication challenge that cuts across all health care practitioners is that of unequal encounters in doctor–patient communication.

Research has shown that the use of interpretation may not necessarily address the challenges of multilingualism and multiculturalism in contexts such as international conferences, court

interpretation, Sign Language interpretation and to some extent in medical interpretation (Langdon & Cheng, 2002). Yet, knowledge production in the field of interpretation is in its infancy (Langdon & Cheng, 2002). Research on interpretation is challenging because it cuts across diverse areas of practice encompassing the culture of spoken and unspoken language. As a result, documentation of challenges related to interpretation and how practitioners could work effectively with interpreters in the clinical fields of speech pathology and audiology has been limited (Langdon & Cheng, 2002).

The profession of speech-language therapy faces similar challenges to those of other health care practitioners in their attempts to communicate with their clients (Ferguson & Armstrong, 2004). Yet the use of language and speech lies at the core of SLT service delivery; the tools of diagnosis and intervention for SLTs are mainly centered on communication methods and approaches. Executing SLT service delivery can be hindered by cultural and linguistic differences between clinicians and clients that impact on communication. In post-Apartheid South Africa such differences replicate historical power dynamics, which render clients even more silent. This is especially because the language of the clinicians remains English which brings with it a history of oppression and colonialism. Therefore, without clear demand-driven engagement, SLT practitioners cannot provide effective interventions. This in effect creates a cycle of exclusion, with patients/clients entering the health care system but exiting without receiving effective treatment or care, because language remains a barrier.

Speech-language therapy thus creates a unique and communication-focused context within which to examine the challenges of health care communication in a multilingual and multicultural setting. This study focuses on speech-language therapy consultation practices in particular with the aim of detailing these challenges and recommending ways to address them.

1.3 Background

South Africa has a strong constitutional, legal and policy dispensation that protects patient rights. The Constitution provides for these rights in section 27(1)(a) and 27(3), which stipulate that “Everyone has the right to have access to health care services, including reproductive health care” and “No one may be refused emergency medical treatment.”

respectively. Section 27(2) of the Bill of Rights provides further that "The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights." Section 30 outlines everyone's right to use the language and to participate in the cultural life of their choice in a manner consistent with the provisions of the Bill of Rights. While section 32 provides a right to access information, in particular at sub-section (b) information that is held by another person and that is required for the exercise or protection of any rights. Further, in Chapter 1, section 6 of the constitution it sets out extensive provisions on the eleven official languages of South Africa and outlines the state's responsibility to advance the use of indigenous languages, monitor and regulate its use of official languages and ensure parity of esteem amongst all official languages. Finally, the constitution establishes a number of institutions to protect language rights including the Pan South African Language Board in chapter 1(6)(5) and the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities in chapter 9(185 - 186). (Constitution of SA, 1995).

The above constitutional provisions are supported by a strong constitutional jurisprudence that is built on the founding value of human dignity outlined in chapter 1, section 1 of the constitution. This is as a consequence of the previous apartheid dispensation; which was characterised by an even greater shortage of diverse health professionals working within multicultural public or state-owned hospitals.

According to the Patients' Rights Charter of South Africa (2001, p.10) patients have a right to participate in decisions "every patient has a right to participate in any decision affecting his or her personal health and treatment … and also a right to full knowledge, every health care provider must inform a user in an appropriate manner of health status, the range of diagnostic procedures and treatment options generally available to user and furthermore about benefits, risks, costs and consequences generally associated with each option". In addition, South African citizens have Language rights and the Batho Pele policy is aimed at people-centred public services. In 2003, the government approved the National Language Policy Framework (NLPF). This framework has the following objectives: to promote the equitable use of the 11 official languages; to facilitate equitable access to government services, knowledge and

information; to ensure redress for the previously marginalised official indigenous languages; to encourage the learning of other indigenous languages, to promote national unity, and linguistic and cultural diversity; and to promote good language management for efficient public service administration to meet patient expectations and needs (DAC, 2003, p. 13).

From the above objectives, it is appropriate to assume that citizens have the right to access basic health care from the Department of Health in the language they prefer. However, interpreting facilities are limited and the majority of intercultural interactions either take place in the second or third language of the patient or make use of an untrained interpreter (Penn, 2007a). Given that cultural and linguistic diversity has a profound effect on the ways in which families and professionals interrelate cross-culturally and participate together in treatment programmes (Centeno, 2009), the Department of Health should be investing in finding trained interpreters to assist health care providers and patients in government services. In public settings where there are no mediated/interpreter services the objectives of the National Language Policy Framework are certainly contravened. Not much evidence has been published on interpreting in health care establishments in South Africa. Studies that have been published in this area have looked at mediation in different languages and at what factors contribute to facilitating or inhibiting interpretations (Levin, 2006; Penn, 2007a).

Miscommunication in intercultural communication in South Africa is still rampant, despite the non-racial policies that came into being in 1994 (Chick, 2002). Negative cultural stereotypes among both blacks and whites still exist even though apartheid was abolished (Chick, 2002). A study by Chick (2002) among Kwa-Zulu Natal university students and rural Xhosa farmers and their workers revealed the plight of most disadvantaged people in South Africa in intercultural communications. The medical and speech-language professionals are not immune to these socio-cultural issues. Thus we need to address these issues head-on by conducting research on health interactions to investigate how we can challenge these intercultural miscommunications.

1.4 Problem statement

Kirmayer (2012) posits that culture is the way people think and act, thus highlighting that culture is significant in understanding how people think and understand their life experiences, like healing and disease. Therefore HCPs and SLTs need to see beyond just the physical, and

learn to engage with clients from diverse cultural and linguistic backgrounds in a holistic manner during consultations, as understanding their clients cultural and linguistic backgrounds will be to their advantage. South Africa has many health care workers like therapists in public hospitals that have received and implement western bio-medical approaches and generally speak mainly Afrikaans and/or English, treating patients that speak mainly African languages.

Interpretation for SLTs and HCPs with patients can render communication problems that could have an impact on compliance and patient satisfaction. The number of patients that speak different languages from that of the HCPs is increasing in South Africa. Although much research has been conducted on HCPs working with interpreters during consultations, little is known about the issues in the profession of speech-language and hearing (Penn, 2007b). Therefore, this study has important implications for policy and practice as the speech-language and hearing professionals transform and engage in debates about being contextually and culturally relevant in South Africa.

This study was conducted in two provincial urban tertiary hospitals in the Gauteng province. Most of the speech-language therapists working in hospitals in South Africa are not prepared in critical diversity literacy and power dynamics, and therefore are limited in their understanding of their patients' multicultural and linguistic needs. Limited knowledge of clients' culture is not conducive for collaboration with diverse families. For early intervention to be successful, it has to be family focused. Culture and language can be a barrier in working collaboratively when the parties do not understand each other in a multicultural and multi-lingual setting. There is no doubt that the solution to this problem lies not in having a monolingual and monocultured society, but rather in understanding how we could work effectively with interpreters. But for this to happen, we need to understand the current practice of working with ad hoc interpreters; whether this practice produces any good examples or needs to be overhauled.

1.5 Research questions that guided the study:

In order to address the problem identified in the previous section the following research question guided the study; what is the nature of the interaction processes between SLTs and

interpreters during an interview with the caregivers of children with speech and language disabilities in a hospital setting?

The primary aim of the study was to; explore experiences and workplace interactions between speech-language therapists and interpreters in a cross-linguistic mediated consultation with care givers of children with severe disabilities within a healthcare setting.

The study question and main aim were unpacked through fulfilling the following objectives;

- The analyses the interactional characteristics and features of speech-language therapists' and interpreters',
- The identification of speech therapists' and interpreters' perceptions of their competence and experiences in multicultural setting.

1.6 Brief overview of research methodology

To achieve the above goals a qualitative study was conducted using ethno-graphic observations, video recording of interactions between speech therapists and an interpreter during an interview with a caregiver of a child with communication disability; and individual interviews of speech-language therapists and interpreter post-consultation. The data collected was analysed using thematic content analysis, and a hybrid of conversational and sociolinguistic analysis.

1.7 Defining key concepts

- **Interpretation**

  Methods of interpreting can be consecutive or simultaneous. This research is concerned with consecutive interpreting whereby a message is translated into the second language after it is delivered in the first language.

- **Interpreter**

  An interpreter is not like a tool that is used to convey word-by-word translations. The emotions and tone of the original message must be conveyed as accurately as possible, irrespective of the mediators' feelings and judgment's. Communication partners will have a breakdown if there are wrong interpretations about meaning and intentions. A mediator must have true communicative competence in the second language which requires an ability to integrate language, culture, history, social knowledge and cognition.

- **Speech-Language Therapist**

  A Speech-language therapist is a professional that treats children and adults with speech and/or language disorders. A speech disorder refers to a problem with the actual production of sounds, whereas a language disorder refers to a difficulty understanding or putting words together to communicate ideas.

- **Health care provider**

  A medical, nursing or allied health professional.

- **Multi-cultural**

  The term refers to diversity cultures that clients and SLTs may have as their cultural background. For example, the researcher refers to diversity in traditions, beliefs, religion and lifestyles.

- **Multi-linguistic**

  The term refers to the use of two or more languages, either by individual SLT, client or community of speakers.

1.8 Structure of report

This dissertation is presented in seven chapters including the current chapter. Through a detailed review of relevant literature, Chapter 2 provides a broad discussion which engages with literature focused on interaction styles between HCPs and patients in a multicultural and multilingual context and the challenges that these present for SLTs. Furthermore, in Chapter

2, a brief history of the delivery of health care services in South Africa is outlined, which is further linked with the theoretical underpinnings showcasing the breadth of research within the health professions sector.

Chapter 3 demonstrates the links between the research questions and the methodology used to examine them. The chapter also provides a sense of how multiple methods of data collection and analysis were used. The chapter describes in detail the participants, instruments and procedure for data collection, the methods of data analysis as well as the ethical considerations followed in undertaking the study.

Chapters four to six presents the results of the study in thematic form, from the analysis of video consultations of SLTs and caregivers. The first chapter of results (Chapter 4) is titled: challenges of working in diverse health care settings; the themes discussed in this chapter focus on asymmetrical power relations and gender dynamics that come up in consultations as a result of the limited multicultural training of SLTs. The second findings chapter (Chapter 5) is titled: quasi or non-speech lexical objects and the interpreter role in the consultation process. The discussion of this chapter is on how laughter and other non-verbal behaviours contribute to power differentials and cultural understanding between SLTs and their clients.

The final findings chapter (Chapter 6) presents the findings and discussions of individual interviews conducted with five SLTs and one assistant/interpreter. This chapter "*Working in Diversity: some challenges*"-answers the research question: How do SLTs perceive their effectiveness during consultations with clients from diverse cultures and languages? The findings in this section are illustrated through a critical analysis of the interviews with the six participants from the two hospitals. The main theme that emerged is the challenge that SLTs face in dealing with the diversity of cultures and languages of their clients.

Chapter 7 presents the conclusion of the study by giving a reflection of the findings and discussing the clinical and practical implications for policy and practice within the profession of speech-language therapy. Finally the chapter provides recommendations for further research.

CHAPTER 2: Literature Review

2.1 Introduction

2.1.1 Scope of this chapter

This literature review in its attempt to provide an understanding of the interactional dynamics between speech-language therapists (SLTs) and interpreters in multi-lingual and multicultural contexts. The focus in this chapter is firstly on the issue of communication in health care settings. This is taken further in a review of service provision in cross-cultural settings by emphasizing the roles of the SLT and the interpreter, with their associated challenges in providing culturally relevant services. To further understand the position of the SLT in relation to the interpreter and the clients, it is necessary to also explore the concept 'cultural', both locally and internationally.

In the following section attention is paid to the health care sector in South Africa as background to the problem. This is followed by a discussion of health care provision challenges and a brief historical background of health care in South Africa is discussed. In this section of the chapter I briefly review the literature on the historical origins of PHC in SA and the role of the World Health Organisation (WHO) in primary health care is outlined. A detailed overview is provided of how medical science has been transitioned from being doctor – centered to being patient – centered. A discussion of this shift begins to illustrate how the speech-language therapy profession was shaped as one of the rehabilitation services offered within the South African healthcare system.

The following section moves the focus to the socio-political transitions specific to the provision of healthcare services in South Africa (S.A.). The review of the literature provides the background to a theoretical framework, consisting of three broad areas: firstly, brief critical review of the Foucault's perspective on power. The focus is on understanding his approach of power relations within a hospital setting. Thereafter, the argument included Critical Diversity Literacy (CDL) and how the two concepts relate specifically in the SLT practice; secondly, Conversational analysis in mediated settings and pragmatic aspects of language. Pragmatic aspects of language focussed on discourse markers, laughter and non-verbal communication. The final section provides a conclusion to the chapter.

2.1.2 Socio-political Issues in Health Care

Cross-cultural encounters have become a reality in healthcare contexts, and consequently we have ethical issues and tensions between individuals (Jecker, Carrese & Pearlman, 1995). These tensions and ethical challenges are motivated by differing traditions, power and security. Health-care professionals come from diverse ethnic groups, class, language, social life and culture. Research shows that a number of issues arise when such a diverse group are assigned to work with patients and caregivers from diverse languages and cultures (Diab, Naidu, Gaede, & Prose, 2013), as health-care consultation is not a culturally neutral context. Healthcare professionals, thus need to have 'genuineness, respect and unconditional positive regard' in order to be classified as culturally competent professionals (Diab et al., 2013, p. 45).

Due to globalisation and increased migration, the world has become a global village. As a result, policy makers and health-care providers are uneasy about the gap that exists between the types of services that patients from various sociocultural backgrounds receive (Carrillo, Green & Betancourt , 1999). Conversely, professional and patient relationship has become an important aspect of training and practice of health care providers and the approach in health care consultation has transformed from patriarchal to patient centered (Diab et al., 2013). Accordingly, this transformed approach has improved the conditions of clients for the better; communities have the right to health care and can access the medical or health related help. This approach has been well received for providing health care that is respectful of, and responsive to, the preferences, needs and values of patients and communities. (World Health Organization, 2007)

When an HCP interacts with a client, she cannot assume that there will be shared values and beliefs about help-seeking, death, causes of disease and treatments. This is mainly because in most cases in South Africa there may be intra and inter-cultural differences due to class, caste gender, age, religion or politics. Inter-cultural differences are deep-rooted and should not be treated as mild differences of opinion and backgrounds but as different meaning making and systems (Jecker, Carrese, & Pearlman, 1995). Jecker, Carrese, and Pearlman (1995) in their study of interactions with patients from multicultural backgrounds on using alternative or complementary therapy; advise that all significant others be present when such discussions are held with the patient. This, they argue would help the health-care provider to understand,

identify goals and come to mutually agreeable strategies in a collaborative manner. The differences or preferences in terms of treatment options, often pose ethical challenges for HCPs. For example, according to de Andrade and Ross (2005) some African families that have a child with a communication disability may interpret this disability as being a result of bewitchment, neglecting ancestral rituals or being cursed by evil forces, which therefore require a different type of cure. An ethical dilemma can come about when a health care provider is confronted with a cultural view that appears to violate her professional integrity; and consequently influence aspects of the health care interaction and decisions. In such a situation, the health care provider should show respect and unconditional positive regard for the client's cultural beliefs that may differ from theirs (Diab et al 2013).

2.1.3 The Introduction of SLT in South Africa and the Significance of the SLT profession

The profession of speech-language pathology in the US has its roots in Europe during the late 1800s. Though, the organisations for professionals in speech disorders such as ASHA were established around 1925 (Duchan, 2011). In European countries speech therapy practitioners were mostly trained in medicine, whereas in the UK they had training background mainly in elocution. The profession started off in working mainly with the deaf then it progressed to Audiology , with a reductionist approach focusing on the diseases of the ear rather than in a holistic or humanistic aspects of working with the hearing impaired (O'Neill, 1987). Nonetheless, the history of the science and ideas of the profession dates back to the early 1900s. The four periods are; formative years , this was followed by the processing period from 1945 to 1965 which was characterised by the intervention approaches which focussed on improving internal psychological processing underlying communication disorders. The third phase began around 1965 till around 1975; this was called the linguistic era. The focus was on treating language disorders as being linguistic and separate from speech disorders such as articulation or pronunciation difficulties. The fourth phase which started in 1975 to 2000. This period the practice of SLTs transitioned to include communication, linguistic, cultural and everyday-life contexts (Duchan, 2011).

SLT as a profession was first introduced to South Africa in 1936 during the colonial and apartheid era; using principles developed in Eurocentric countries like the UK and the US (Aron (1991) in (Bortz, Jardine, & Tshule, 1996). The impact of colonialism, imperialism and apartheid on SLT and Audiology profession was detrimental for the majority of the

indigenous people as it contributed towards serving white South Africans and neglecting the majority of Black South African (Pillay & Kathard, 2015). Similar to the European and American counterparts, the principles and practices were based on a medical model which treated a child with a communication disability in isolation to their socio-economic conditions, cultural background and family history (Balton, 2009). In addition, these intervention principles were applicable for the white middle-class population, and did not cater for people who may not have spoken English as a first language. These principles had an assumption that families are nuclear and culture is unimportant, consequently not accessible and affordable for most people especially those living in remote and rural areas of SA (Bortz, Jardine & Tshule, 1996). These principles therefore had limited scope for patients that did not have the same linguistic, social and cultural background as the clinicians. Initially five English and Afrikaans universities provided training in speech and audiology in South Africa. The sixth university which trained predominantly black students opened in the early 1990s. Although the introduction of this sixth university which is semi-rural was important; the challenge is that its teaching methods were based on the same medical principles informing the other 5 Universities. Another challenge was that all with the exception of one these universities are in urban areas. Consequently, the rehabilitation needs of the rural majority of most South Africans were not met (McKenzie, 1992), and remains so to this current day.

SLTs are an integral part of the multi-disciplinary team that is responsible for implementation and service provision for infants and toddlers at risk of developing communication disabilities (Stresheim, Kritzinger & Louw, 2011). Communication disabilities can be grouped into two main categories; hearing disability and speech and language disabilities. People with hearing disabilities have limited hearing; this may range from mild to profound hearing loss. Speech and language disorders affect the production and comprehension of language. These disabilities may range from mild articulation or ability to use voice and speech to the inability to use speech and language at all. The ability to communicate can pose serious social problems because human communication is essential to learning, working and social interaction.

When families have a young child with a delayed communication development or a disorder an SLT can do assessments and provide remediation that could eliminate or prevent the disorder. In addition, SLTs work with caregivers to provide a culturally responsive family-

centered intervention (ASHA, 2008). Yonder and Warren (1999) in their study of 58 toddlers with intellectual disabilities and their primary caregivers which was undertaken in Tennessee, USA shown that when SLTs assist caregivers in being responsive to their infants, that impacts later language development positively (Yoder & Warren, 1999). These types of family-centered and culturally responsive intervention strategies are pivotal in prevention of communication disabilities and in some cases improved maternal well-being and child health (Halpern, 2000). Since the 1990's service delivery in early childhood delivery has shifted their focus from providing intervention for the child in isolation towards working with the child in the context of family and community (Halpern, 2000). Consequently, early childhood intervention services have become embedded in the community development services, such as adult literacy and employment.

The onset of disability in families produces anxiety and disrupts its life plans (Larson, 1998). The disability forces the family members to make sense of this unintended incident and to reflect and re-characterize their family goals. Again this affects the life situation, and significance of life and identity of the affected members of the family. For example a study by Baird, McConachie, and Scrutton (2000) with 107 caregivers of children diagnosed with cerebral palsy revealed that they were dissatisfied with the way they were given diagnosis of their children. Furthermore, in two separate studies that included 16 caregivers of children with physical and mental disabilities it was shown that the certainty of the diagnosis of their children was the core of their emotional experiences, which comprised the perception of the future, realization of the condition and a change in parental expectations and hopes related to the child (Fernandez-Alcantara et al. 2013; Graungaard & Skov, 2006). Families might need assistance and counselling in facing and interpreting these challenging situation (Cottrell & Summers, 1990).

One of the reasons families might need professional assistance is because most childhood communication disabilities are by definition permanent and incurable (Cottrell & Summers, 1990). Another challenge for families is because conventional intervention is limited to long-term rehabilitation in collaboration with families and caregivers (Jones, Morgan, Shelton & Thorogood, 2007). It is well recognised that encounters between caregivers of children with a communication disability and SLTs may be on-going and may involve other primary HCPs and various specialists (Knox, 2008). The encounter starts with a diagnosis, which involves a series of well-planned activities (Hedge, 2008). In this phase of assessment the SLT attempts

to understand the child's case history; which includes the child's past and current problems. Once the family history is collected and all communication evaluations are completed, the SLT shares the findings with the family and the child. This sharing process includes the provision of recommendations and an opportunity for parents/caregivers to ask questions and received responses (Hedge, 2008). Due to the nature of this relationship, interactions between caregivers and SLTs offer critical intersection for information exchange, decision making and motivation. The ability of the SLT to engage in effective communication may therefore make a significant difference to whether the interaction supports or discourages decisions and subsequent visits that will optimize the child and family's ability to manage the communication disability. For example research by Kerse, Buetow Mainous, Young, Coster, and Arroll (2004) undertaken with 370 patients in New Zealand indicates that trust and high levels of doctor-patient agreement affects subsequent visits and medication compliance. This lack of compliance with medical treatment may cause a minor ailment to progress into a chronic condition that might eventually lead to disability.

According to the World Report on Disability (WHO, 2011) approximately 15% of the world population lives with some form of disability. According to the 2011 census South Africa has a disability prevalence of 7.5% that is 2.9 million people out of 38 million (StatsSA 2014). Further analysis of types of disabilities indicates that 11% had visual problems, 4. 2% had cognitive difficulties, 3.6% had hearing difficulties and about 2% had communication, self-care and walking difficulties (StatsSA, 2014). Cognitive disabilities seem to be higher than other disabilities, possibly due to the complexity and multi-causality of the condition. The definition of cognitive includes both mental or neurological and psychiatric conditions. Accordingly, we need appropriate policies and services that would cater for these vulnerable groups.

Individuals with disabilities and their caregivers and families are faced with opportunity barriers linked to physical, attitudinal, knowledge, and skill and policy spheres. These systemic and structural barriers limit social participation and inclusion for all. In studies by WHO (2011) and Morris (2011) it is shown that people with disabilities are limited by policy because of less access to health care services and therefore experience unmet health care needs. The social model of disability views these barriers as discriminatory and further exposing people with disabilities to poverty and oppression (Chappell & Johannsmeier, 2009;

WHO, 2011). This is because people with disability struggle to access work skills and when they do have skills they struggle to find jobs (Morris, 2011). According to StatsSA (2014) due low market absorption of persons with disabilities, the unemployment rate of disabled people stands at 12.5 % (StatsSA, 2014).

Once again, research illustrates that limited rehabilitation services have been allocated to people with communication disabilities (McKenzie, 1992). Although, you could find speech and hearing services at primary, secondary and tertiary level health facilities, due to shortages of HCPs, most communities do not have the services of SLTs and audiologists in the public sector. Posts for qualified SLTs and audiologists are also still lacking. Most SLTs and audiologists services are in private urban or tertiary hospitals (McKenzie & Muller, 2006). The table below indicates the public vs private divide for therapists as of 1999.

Table 1: The public/private divides in South African healthcare, mid-1999.

Description	**Total**	**Public sector 1999**	**Private sector 1999**	**Public-private Ratio**
Physiotherapists	3406	463 (13.6%)	2943 (86.4%)	1:6.36
Occupational Therapists	1986	388 (19.5%)	1598 (80%)	1:4.12
Speech therapists & audiologists	1388	119 (8.6%)	1269 (91.4%)	1:10.66

Source: McKenzie & Müller, (2006)

The above table shows that the majority of people in South Africa do not have access to adequate rehabilitation services. Again, of all the rehabilitation services Speech-language

therapy and audiology is the least available when compared to physiotherapy and occupational therapy. This lack is an illustration of the misaligned positioning of the services and its worth.

Since democracy, services for people with speech and hearing disabilities in South Africa can be divided into those that were provided through the education sector, and those who are serviced through the health care sector. What has improved however is that the Department of Health (DoH) does not provide services along racial lines anymore (van Rensburg, 2004) . However, despite these new developments press reports and academic articles report that access to health is still not equitable, especially for the rural and poverty stricken black communities (McKenzie & Müller, 2006; Gilson, & McIntyre, 2007). Again the use of English as the main language of consultation in health settings continues access barriers for non-English speakers.

The WHO (World Health Organisation) report on disabilities recommended an expansion of rehabilitation services to people with disabilities in developing countries through community-based rehabilitation (CBR) services (WHO, 2011). Since the 1970's, CBR has been promoted by WHO as a strategy for the promotion of the inclusion of people with disabilities in mainstream health, education, and in social and employment sectors. This strategy would not only alleviate problems for people with communication disabilities but for all disabilities. Seeing that we have a shortage of rehabilitation professionals in South Africa, it is pivotal to develop CBR. Despite the fact that research results on effectiveness of CBR are contradictory, it is recommended for all countries that have resource and service limitations to implement (WHO, 2011). One of the core notions in CBR and Primary Health Care (PHC) is that it empowers people with disabilities and their families to maximise their health by providing information, training and peer support. In addition, an important principle and practice of community-based healthcare is that it should be appropriate and relevant, which implies that the community should not feel that the services are not meeting their needs or that they are imposed on them (Fourie, van Rensburg, & de Klerk, 1995). If this principle of appropriateness and relevance are adhered to there would be an effective and acceptable health and rehabilitation service in South Africa. For this to happen proper planning in the health department and political leadership is required (van Rensburg & Pelser, 2004).

Despite efforts by the SA government to reduce health disparities and to have community participation and involvement in health and health care matters this has not been realized due to multiple factors including derailment due to long consultation in legislation and decision-making procedures (van Rensburg & Pelser, 2004). In addition other CBR principles take into account acceptability, accessibility, affordability and adaptability, which if all applied would lead to high standards and quality health, at the lowest possible cost for the broad and diverse South African population (Fourie et al., 1995).

Communication is pivotal for the existence of human interaction (Watzlawick, Bavelas, & Jackson, 2011). People use language daily within various spaces in order to be active citizens of the community at home, work and school (Littlejohn & Foss, 2010). Again, communication becomes more pivotal in diverse context like South Africa (Human, 1996). According to The Health Professions Council of South Africa (HPCSA, 1974:1), "an SLT assists in the promotion of normal communication; as well as the identification; prevention; treatment and management of a variety of developmental or acquired speech, language and oral disorders". Similar to other healthcare professions, the SLT as a service is guided by ethical and regulatory structures that have been founded to ensure that human rights are not violated during the provision of any healthcare service. Section 33(1) of the medical, dental and supplementary health service professions Act, 1974 (Act 56 of 1974) details the scope of practice of The Professions of Speech Therapy and Audiology as; firstly the assessment of any speech, voice, hearing and language pathology, and of the processes which may contribute to the development of any such pathology. Secondly the practice includes the planning, conducting, directing of or participating in the habilitation and /or rehabilitation of persons with speech, voice and language pathologies, including therapeutic procedures that enable such persons to acquire adequate speech, voice, and language proficiency and that may include counselling and guidance related to such communication disorders.

On the other hand the principal ethical guidelines of the profession are outlined by the South African Speech Language Hearing Association (SASLHA). Below are the principles that govern the functions of the SLT profession;

- Principle 1: Members of the profession shall at all times act in the best interests of and avoid harm to people receiving their services or participating in research, involve

people fully in the planning and decision making that are part of their therapeutic process, and, respect their beliefs and values.

- Principle 2: Members of the profession shall promote their professions by accurate information to the public regarding the scope of the professions, new developments, the services we provide and where to access them.

- Principle 3: ensure that services are made available and accessible, and that these services are appropriate to particular individual and community needs.

- Principle 4***:*** Members of the profession shall uphold the dignity of the professions, maintain harmonious relationships with colleagues, students and other professionals and practice in close adherence to the Ethical Rules of the HPCSA.

- Principle 5: Members of the profession shall act responsibly, regarding their ongoing professional development and maintain competence in their fields of practice whilst simultaneously safeguarding their personal welfare.

These principles are based on the ethical considerations of beneficence, autonomy and on community based healthcare and rehabilitation as advocated by World Health Organisation (WHO). Even though these principles are significant for both the well-being of the SLT professional and their clients, lack of multilingualism on the side of the SLT and other unequal power relations that affect consultation processes might create challenges for the proper use of these principles. This means that the notion of cultural competency of SLTs and other health care practitioners in diverse settings needs to occur in order for equity, social justice and transformation to be a reality in SA. Multi-lingualism and multi-cultural characteristics of the country are its heritage. Consequently, all workforce including health practitioners need to be trained to work effectively and also have human and material resources to support their work e.g. interpretation services, culture fair assessment tools.

2.1.4 Cross-linguistic Healthcare Setting and the Role of the Interpreter

SLTs working in SA have to recognise that it is important to have an understanding of the complexities of working in a diverse setting. Multilingualism is a reality in SA, the highest percentage of home languages is isiZulu which is spoken by 23,8 %, followed by isiXhosa with 18, 6%, and the English language that is spoken by a majority of SLTs as a first

language, is a home language of 8,2% of the population (StatsSA, 2010). Given South Africa's diverse communities and their many languages – interpretation services in the health care services is integral. This is mainly because of the congruence in training of diverse groups of people from multiple cultural and language backgrounds. Unfortunately, there is no official data that indicates the distribution of SA SLTs in private and public sectors. However, according to the HPCSA (March, 2012) there were 2011 registered SLTs and population estimate for the country was estimated at 51, 7 million people (Statistics South Africa, 2012). Thus, it can be estimated that the SLT population ratio is at 1:25,000. This estimate is not that accurate in reality as many SLTs registered with the HPCSA are working abroad, and some are not working (Kathard & Pillay, 2013). According to a data base of the SASLHA in 2011, most SLTS ; are in private practice(67%), in urban area, and have a mother tongue English and/or Afrikaans and only 5% are Black African language speakers. This shows that the majority of African language speakers their communication needs are under served.

Again because of the dual existence of both a traditional and western or bio medicine – such communication assistance becomes a central tool for effective health care service provision. In addition, it is well reported that language discordance between health care provider and patient is related to poor quality care (Ngo-Metzger, et al., 2007). For example, in a study by Ngo-Metzger et.al (2007) among Asian-American patients with discordant health care providers reported receiving less health education, lower patient satisfaction and worse interpersonal care; when compared to those with language-concordant providers.

Despite these language barriers in health, there is a global trend of limited provision of interpreters and training for health care providers on how to work with interpreters in many hospitals (Flores, 2006). Thus, due to the negative effect of language barriers in health care; there is a need for studies that document patients' home language and English proficiency so as to give to relevant stakeholders as indication of the severity of the problem. This problem is tantamount to denying patients with limited English proficiency a right to equal access to health and a violation of their linguistic rights. Allowing Health departments not to provide interpretation services due to concerns about costs has serious legal and ethical implications and thus, should not be allowed as it violates the Constitutional rights of citizens.

As early as 1992, researchers believed that generally an interpreter is 'no longer someone who simply attempts to reconstruct a text in the target language as closely as possible to the source language text' (Cluver, 1992, p. 10). Instead, interpreters are believed to work with knowledge and information, and their duty is to make information accessible and available from a source language to the target language. This exchange of information and ideas aims to empower people to make better informed decisions, to be able to participate fully in society and make their own meaningful contributions about issues and debates (Angelelli, 2004b). This may have significant implications for how interpreting is viewed within the healthcare setting.

When a patient or caregiver visits an HCP that does not speak the same language as them, an interpreter is required. There are various ways that can be used to interpret; interpreting can be consecutive or simultaneous (Gerver, 1971). Consecutive interpretation occurs when the interpreter waits for the first speaker to complete their message or idea, and then delivers the speaker's words into the target language of the listener. On the other hand, during simultaneous interpretation, the participants put on headphones, and the interpreter delivers the speaker's message into the target language as she/he is speaking (Poyatos, 1997). Simultaneous interpretation is generally used at conferences (Jones, 2002). This research was concerned with consecutive interpreting whereby a message is translated into the second language after it is delivered in the first language; a common method of interpreting with speech therapy consultations. With this method of interpreting there is often a short time delay when the message is spoken and when it is heard (Gerver, 1971). In simultaneous interpreting which is often used in multi lingual conferences, there is minimal time delay after the message is delivered in the first language (Langdon & Cheng, 2002).

Within each method of interpreting, there are numerous variables that an interpreter needs to be aware of. According to Langdon and Cheng (2002) these variables include verbal, non-verbal, cultural and contextual aspects. The verbal aspects relate to comprehending, visualising, and being able to recreate the message in the target language (Gile, 1995; in Langdon & Cheng, 2002). It is within these verbal aspects that interpreters often face challenges. These challenges relate to embedded sentences that may be taxing to short-term memory skills, cross-linguistic references, idioms, accents, speech impairments of the

speakers, and issues with non-literal or connotative meanings. For example, in an SLT environment these challenges have a lot do with getting accurate and relevant case history information from the client. The words that a client uses to explain the statement of the problem are significant and need to be accurately interpreted.

Another significant variable for interpreting effectively is non-verbal aspects. These are particularly important in especially intercultural communication which most South African public hospital settings are faced with, they include facial expressions, tone of voice, eye-contact, movement of the body (kinesis) and proxemics (Langdon & Cheng, 2002). Again for effective interpretation of non-verbal aspects, cultural aspects of communication are important to consider. These involve the understanding of the two cultures, social and pragmatic knowledge (Langdon & Cheng, 2002; Wadensjö, 1998). In SLT contexts in South Africa multiculturalism has been found to present most of the challenges in health communication. Most clients seen in state hospitals in SA are often linguistically mismatched, with only 5% of medical doctors speaking an African language (Schwartz, 2004). Consequently, there is a need for trained interpreters during consultations in order to bridge the communication gap and also be able to produce cultural brokerage for clients. In a SA study by Penn et al. (2010) in an audiology context, she finds that participants involved in interpretation were aware of their role not only as language interpreters but also as cultural brokers in the interactions with audiologists and their clients.

Langdon and Cheng (2002) also speak to the importance of sensitivity to contextual aspects of interpretation; these include understanding the complexity or lack of dynamism in any situation. For example medical consultation interpreting will vary from interpreting in an informal situation. For example during a medical consultation such as in the SLT environment particular attention needs to be made to the specific linguistic terms used medical diagnosis. All these aspects alert one to the complexity that arises with interpreter-mediated therapeutic interventions. A detailed focus on these three aspects as set out by Langdon and Cheng (2002) is important as lack of attention to any of them may have a negative impact on the outcomes of interventions provided. According to research by Betancourt, Green, Carrillo, and Park (2005) language and cultural competence related communication barriers lead to disparities in the provision of health care and thus to poor health outcomes.

There are three different schools of thought that discuss the role of an interpreter (Angelelli, 2004). There is the social theory, sociological theory and linguistic anthropology approaches (Angelelli, 2004a). The sociological approach draws from Bourdieu's theory of practice, which states that the interactional context is shaped by participants' past, present and future characters or personalities. In this theory habitus is important, thus the interaction cannot be analysed in isolation. Wadensjö (1998) criticizes this, and calls it "the channel metaphor" as it is based on a monologic view of language. This outlook of speech as unidirectional supports the conduit model which views an interpreter as similar to a "telephone" or "echo-machine"; simply an instrument for conveying information. By way of contrast the dialogical model implies that the meaning conveyed in and by talk is partly a joint product. Communication is a reciprocal, multi directional and a multi-layered process of interaction (Wadensjö, 1998). In a country like South Africa with its diverse cultures and 11 official languages; the monologic view is not appropriate, since it views an interpreted message as "abnormal" and proceeds to ask research questions like "what's lost?", "what's added?" or "what's not included?" (Wadensjö, 1998). The research agenda would be enhanced by research using conversational analysis, which views interpreter mediated interactions in their context and structure (Wadensjö, 1998). From the interpreter mediated interactions view relevant research questions would include, "What is specific about this mode of communication?" This is because multi-lingual societies need to be investigated in their own rights, not against one language or one nation (Wadensjö, 1998). .

An interpreter in a healthcare setting can be viewed as the third party that gets invited to translate in a conversation between an HCP and a patient. The success of this interaction is dependent on the skill and experience of the interpreter (Langdon & Cheng, 2002). According to Dimitrova, 1997, in Langdon and Cheng (2002), an interpreter is at the center of the conversational turn-taking process. She is the only person in the triad who understands the messages as they are conveyed the first time around by each party. The interpreter is the one who ultimately negotiates the speaking time, indicating to each party that the message might

be too long, complex, or unclear to convey in the other language. However, in dialogues that are asymmetrical, this might not be the case, e.g. medical consulting where the medical practitioner is the expert. The medical practitioner may be the one that controls who takes a speaking turn and when the conversation should end. Furthermore, an interpreter has an added requirement to process not only the verbal message but also the non-verbal communication signals. Langdon and Cheng (2002) emphasize that a successful interpreter must understand the context of the interaction. This means that the settings dictate how interpretation will occur. For example, court or hospital context is noteworthy, as they both have different protocols and procedures in which an interpreter has to conduct himself or herself. In addition, the context requires an interpreter to have knowledge of the vocabulary used in the particular context. For example, different communication styles take place when the HCP takes a case history and when she is counselling or giving a home program. The case history session is more of an interview process, on the other hand when counselling the HCP has to bring her skills of listening and being able to respond authentically to feelings of the client. In contrast, when giving a home programme, the HCP uses a teaching style to educate or guide the clients. As a result, the interpreter needs to be able to switch as required by the context. Thus, the role of the interpreter is not only to focus on the linguistic aspects of the interaction but also on the broad communication itself.

There is a difference between “interpreters” and “interpreting", Nicholson and Martinsen, (1997) in Langdon and Cheng (2002) affirm that an interpreter is not like a tool that is used to convey word-by-word translations. The emotions and tone of the original message must be conveyed as accurately as possible, irrespective of the interpreters’ feelings and judgments. Communication partners will have a breakdown if there are wrong interpretations about meanings and intentions. An interpreter must have true communicative competence in the second language which requires an ability to integrate language, culture, history, social knowledge and cognition (Wadensjö, 1998).

Again, Wadensjö (2008) and Bot (2005) define interpreter mediated interaction as having a specific turn-taking system, different from the one found in ordinary conversation between acquaintances. People communicating through interpreters are to be alert and make sense of the content of talk. Furthermore, Bot (2005) describes these differences in turn taking in

interpreter mediated conversations as having five characteristics. The first one speaks to interpreter mediated dialogue where this process is seen neither as a two-party conversation nor as a monolingual three-party talk as the interpreter's role is unique in this setting. Which means context, there is consecutive interpreting, where the interpreter is sitting with the participants, listens to the message and then translates the meaning of the speaker in to the target language.

Secondly, there is an unequal to access talk. During the interaction there is always one person who does not understand what is being said because they speak a foreign language. Thirdly, the organisation of interpreter mediated interaction is structured - the interpreter always has the second turn. Fourthly, the interpreters' contributions are not original and/or independent but are dependent on the primary speakers' contributions. Finally, the interpreters' needs and preferences are not the same as the primary speakers. The interpreter benefits from short speaking turns, these are not the same for the primary speakers. These differences indicate that turn transfer from the primary speaker to the mediator and from the mediator to primary speaker are essentially very different (Bot, 2005). Therefore, SLTS need to be aware that the consultation is taking place possibly not in the clients preferred language, and thus this may have an effect on the quality and accuracy of the information being received From other perspectives interpreter turn-transfers are seen as a function of co-coordinating interactions (Wadensjö, 1998), in Bot 2005. This includes deciding when turns are to transfer and to whom. Roberts (1997) in Bot (2005) described the interpreter role as similar to the role of 'chair', which involves deciding who gets a turn. This is a difficult task for HCP as they lack the understanding of the content of the utterances of the client who speaks another language. It appears that turn transfer has a lot to do with power. This power has a lot to do with how mediation is understood. Is the interpreter seen as a "translation or echo machine" or as a participant in an interaction?

In the "translation machine" paradigm, the HCP is in charge of the interaction throughout the session. The interpreter works as a conference translator in a booth or a photographer of a

phenomenon. On the other hand, in the interactive model, the HCP is aware that she cannot function independently; she needs the mediation in order to understand the patients' language in the consultation. The HCP that works according to the "translation-machine" model will take charge of the turn allocation to all participants. On the other hand, in the case of the HCP who works according to the interactive model, she will allow the interpreter to allocate turns and turn transfers and can also allocate the patient a turn.

The debates on the significance of turn transfers are expanded by Bot (2005), who describes four types of turn transfers. The first one is the usual type, where the interpreter has his/her turn after the primary speaker, which is followed by the second primary speaker followed by the interpreter again an example would be - HCP-Interpreter-Patient-Interpreter. With the second type of turn transfer Bot (2005) the primary speaker takes a turn more than once before the second primary speaker is allocated a turn, an example would be - HCP-interpreter-HCP- interpreter. This turn taking can be repeated several times before the second primary speaker gets a turn. This is said to be "multiple turns" or discourse unit. Such a turn transfer usually takes place at the introductory stage of a consultation where the HCP provides introductions and frames of reference for the consultation.

Bots (2005), third type of turn transfer speaks to the process where the interpreter takes a turn in the same language as the previous primary speaker. At this time he/she is not translating – this is called non-rendition. The interpreter does this in cases where she/he would want the primary speaker to clarify/elaborate; an example would be - HCP-Interpreter-HCP-Interpreter or Patient-Interpreter-Patient-Interpreter. The final and fourth turn transfer processes as illustrated by Bot (2005) suggests that the primary speaker has a turn immediately after the other primary speaker. The interpretations does not occur, Bot (2005) calls this "zero-rendition" an example of this in the SLT environment would look like this - HCP-Patient or Patient-HCP. This is not seen often, it however usually occur at the greeting phase, or when short yes/no answers are provided. These types of turn transfer patterns occur in differing frequencies in an interaction, with the first one being the most frequent (Bot, 2005). Thus, the key research question of this study is: What is the nature of the interaction process between

the SLTs and interpreters during an interview with the caregivers of children with severe disabilities in a hospital setting? The thesis answers the question by initially reviewing the literature that explores the issues in health care. SLT services are located in education and in the health care sector. This review highlights health care communication and language related issues because the department of Health is the major employer of SLT in South Africa and the majority of clients with communication disabilities are found in the health sector.

2.2 Health care in South Africa

2.2.1 Medicine and Healthcare in South Africa

Historically socio-economic, political and cultural transitions have influenced the South African healthcare system. Historically the South African health system was solely influenced by western medicine. The paternalistic view, or technological trend of 20th Century western medicine, was focused on invasive methodologies, disease eradication and finding miracle cures for diseases (Thomasma, 1983). The practice was mainly centered on developing technology, devices and curable strategies that would only focus on eradication of transmission of disease (Hester, 2001 and Siegler, 1985). However South Africa has had another dynamic that was brought about by the existence of indigenous healers. The relationship between the western and indigenous healers has been fraught with challenges (Flint, 2001). These challenges have been around since the colonial and missionary periods, where indigenous or traditional healer's practices were deemed as 'uncivilised' and officially banned from practicing, this was so even though the majority of Africans in South Africa continue to use them (Khunou, 2015). Later in colonial times a tolerant approach was taken, because it was challenging to enforce the ban on the rights of African people. However, with the advent of the new SA and its constitution, traditional healers have been integrated into the health care system (Pretorius, 2004). The rights of citizens to consult any health care worker are now considered as basic human rights and are enshrined in the Bill of Rights s15(1) and s31(1). In addition, traditional healers have also been given to not only chose their trade but also a choice to "…practice their trade, occupation or profession freely, provided that they be subjected to legal regulation'(Pretorius, 2004, p. 550). However, the resource balance between tradition healers and medicine is still skewed towards hospitals and clinics (Khunou, 2015).

The biggest challenge experienced by health care professionals from both western and traditional or indigenous spheres is that patients often do a dual consultation without informing the other healer (Mbatha, Street, Ngcobo, & Gqaleni, 2012). Another problem in SA is that the government has taken an inclusionary approach instead of an integrative approach; this means that traditional healers are recognised but not fully integrated into the health care system (Mbatha et al., 2012; Pretorius, 2004). The main difference between western and traditional medicine is their philosophical notions (Digby, 2006). In traditional medicine, flesh and spirit are seen as interlinked but western medicine considers this in an organic way, where the doctor seeks to heal the physical body (Pretorius, 2004). The other difference is that traditional health views causality in a social context. In traditional healing diseases can 'result from breaking social taboos and/or angering the ancestors' (Digby, 2006, p. 282). According to African culture, health is an outcome of a balance in the relationship of man and his/her environment. Environment is not only the geographical or ecological background, but also includes the moods of a person and family life which is affected by spiritual forces and dangers (Ngubane, 1977). Furthermore, within this environment that is the social including the family an individual is safe; however, they can be affected negatively by outside forces. Thus disease according to African beliefs represents a disturbance of the balance, therefore, treatment is directed at restoring this balance (Digby, 2008; Ngubane (1977)). The family system is at the core of the whole intricate system of ideas, beliefs and practices relating to health and disease. As a result, diagnosis by a traditional healer or diviner would involve family members, friends and sometimes even community members as well as the patient (Digby, 2006).

In contrast according to the western system of biomedicine treatment is individualistic and private (Mbatha et al., 2012; Pretorius, 2004). The biomedical approach focuses on seeking the specific physical lesion or virus that is contributing to the patients' illness. However, recently biomedicine has incorporated a psychosocial view however it is still dominated by the biomedical approach (van Rensburg, 2004). This change has evolved to a bio-psychosocial approach which can be described as comprising the personal and social aspects of the individual's illness, which were neglected in the biomedical approach (Greaves, 2004).

The psychosocial approach lets illness or disease to be regarded as a product of interaction at the cellular, tissue organismic, interpersonal and environmental levels. The illness can thus be

made worse or better by the surrounding environment. The bio-psychosocial model is accepted as a more complete conceptual framework to guide professionals in making clinical decisions (Fava & Sonino, 2008). The integration of the biomedical and psychosocial models thus yields a holistic approach to public and individual health (Pretorius, 2004).

There has been an outcry for collaboration between the two systems of healthcare in South Africa. Arguments suggest that, working side by side in support of each other will benefit the clients who do dual consultation (Mbatha et al., 2012). As the majority of South Africans are African, most of them engage in the dual healthcare consultation system (de Andrade & Ross, 2005; Mbatha et al., 2012). Health seeking behaviours of some of the African patients' needs to be understood by HCPs as it will shed light on traditional understanding of illness or delay in consultation, which some western HCPs may not know (Pretorius, 2004). According to some African people, a traditional or faith healer may be consulted first to explain the spiritual aspect of the illness. Thus collaboration between the two health systems should be supported at policy and regulatory levels (de Andrade & Ross, 2005; Tjale, 2004). In addition, professional training of HCPs such as SLTs in South Africa needs to incorporate cultural sensitivity and competence. As part of transformational processes, the strategic planning of educational programmes, research projects and community service should be Africanized (Hugo, 1998). Regrettably, there has not been a clear consensus on what Africanisation means for a long time and how it could be achieved in training SLTs in South Africa. However, with the new decolonization theorizing on the South African higher education sector currently possibilities for radical transformation of the curriculum seem possible. Contrarily, a concept of primary healthcare has been thoroughly defined and there is a globally accepted definition.

2.2.2 Health Care Delivery in South Africa.

In looking at the history of health care delivery globally, some aspects seem to stand out; firstly, there was recognition among world leaders in health that diseases in developing countries were socially and economically sustained and required a political response (WHO, 2002) Secondly, there was an assumption that the main diseases in poor developing countries were a natural reality that required relevant technological solutions. The two positions posed a dilemma and required an urgent decision to be taken. Numerous debates and publications

among medical professionals globally, e.g. Bryant (1971) and Newell's book "Health by the People (1967)" inspired the concept of primary healthcare globally. Primary healthcare was also popular in the new political context characterized by the emergence of decolonized African countries. The 1978 joint WHO-UNICEF report, speaks to alternative approaches to meeting basic healthcare needs in developing countries (WHO & UNESCO, 1978). The shortcomings of traditional medical approaches concentrating on specific diseases were highly criticised. According to this document the major causes of illness in developing countries were poverty and ignorance (WHO & UNESCO, 1978). The report also presents successful primary healthcare experiences from numerous developing countries like Bangladesh, China, Cuba, India and Tanzania. This report shaped the WHO ideas on primary healthcare and became the basis for worldwide debate. Mahler, the Director General of WHO proposed the goal of "Health for All by the Year 2000" in 1976. The ideas from Mahler after his speech in the general assembly and a series of regional meetings led to the landmark conference for primary healthcare at Alma-Ata from September 6 to 12, 1978.

The conference's main document, "Declaration of Alma-Ata" was approved. The three principles of the declaration were: appropriate technology, opposition to medical elitism, and the concept of health as a tool for socio-economic development. The new democratic government in South Africa supported the declaration of Alma-Ata. The new democratic government had a challenge in 1994 to transform healthcare provision and to design a comprehensive healthcare programme. The new ANC-led government addressed these issues with two main policy guidelines before officially taking the reins in government, namely, the Reconstruction and Development Programme (RDP) and the National Health Plan. The health policies of post 1994 have been planned around the RDP, which had these five principles:

- Establish a people-driven process emphasizing active involvement and empowerment of people,
- Promote peace and security for all,
- Build the nation by eliminating divisions and inequalities,
- Link growth, development, reconstruction and redistribution into a unified programme, and

- Deepen democracy through people's participation in decision making (ANC, 1994a, pp. 4-7).

The intention to transform the South African Health system was also seen in the ANC National Health Plan (1994) which states that, "the challenge facing South Africans is to design a comprehensive programme to redress social and economic injustices, to eradicate poverty, reduce waste, and increase efficiency and to promote greater control by communities and individuals over all aspects of their lives". Although influenced by the declaration of Alma-Ata most of the challenges faced by the ANC government post 1994, were mainly a result of the effects of apartheid separatist's policies on the countries health system and its operation (Coovadia, Jewkes, Barron, Sanders, & McIntyer, 2009; Human, 2010).

Therefore the ANC government developed their National Health Plan based on the RDP and primary healthcare approach. The Alma-Ata declaration permeates this plan and formed an integral part of the country's National Health System (Fourie et al., 1995; Schaay, Sanders, & Kruger, 2011). Regardless of South Africa new progressive health policies being aligned with the global trends as advocated by the WHO, the health system is still dysfunctional (Benatar, 2004). Health service has been affected by previous racial inequalities and gender discrimination. Khunou, (2014) argues that, access to healthcare is still one of the major challenges for the majority of Africans who live in poverty and are unemployed. Khunou (2014) also suggests that these inequalities in access to health reflect poorly on the political will of the current government to ensure that all citizens have a good quality life (Khunou, 2014). Furthermore, an increased burden of disease, related mainly to HIV and AIDs has added in the challenges of health service provision in SA (van Rensburg, 2004).

According to the WHO Systems framework the following building blocks are necessary for equitable access to health; service delivery, health workforce, information, medical products and technologies, financing and leadership or governance. The overall goals for such a system are to produce improved health, responsiveness, social and financial risk protection and improved efficiency. The segment on health in the Constitution of the Republic of SA states that all citizens have a right to health care services and that everyone has a right to basic nutrition, shelter, basic health care services and social services (Republic of South Africa, 1996).

The new democratic government has been trying since 1994 to transform healthcare. New PHC facilities were built and free maternal and child healthcare were introduced. These new measures were later extended to include free PHC for all using the public health sector, comprehensive extension of social welfare grants to previously disadvantaged communities; and a national school nutrition programme (Kautzky & Tollman, 2008). There are many members in the National Department of Health (NDoH) that support the PHC movement. However, the legacy of past apartheid discrimination on the present care is still evident (Digby, 2008). Currently equal access to health services is a priority; however, the healthcare system still has signs of inequality even after the end of the Apartheid regime (Harris et al., 2011). Universal care is the foundation of this country's public health system. About 80% of the population relies on the public health system (Digby, 2008; Harris et al., 2011)). Public healthcare is available at clinics in most urban townships and at provincial hospitals. However, this health provision is unequal, good service is often available at urban academic/tertiary hospitals, which are inundated with requests for health services by a large of people. There is an increasing reliance on the State for all basic services and necessities Digby (2008); (Kautzky & Tollman, 2008). There are still many challenges that relate to geographic boundaries and governance responsibilities due to high number of urban residents. Urban communities like those in the city of Johannesburg are estimated to have a population of 3.9 million and is increasing at a rate of 4.16% per annum. It is estimated that by 2015 there will be about 5.2 million residents with about a quarter living in informal settlements (Vearey, Palmary, Thomas, Nunez, & Drimie, 2010). Furthermore, rural hospitals are still under resourced, and under staffed. People in rural areas have limited access to health information, and thus tend to rely mainly on traditional healers.

In July 2010, the minister of health Dr Motsoaledi stated that, "*As a country we just have to go back to the basics of primary healthcare. We have to prevent diseases even before they occur. We have to act now.*" (7 July, 2010, Issued by the Ministry of Health- http://www.doh.gov.za/show.php?id=1947). According to Cueto (2004), during the past few decades, the concept of PHC has had a significant influence on healthcare workers in many developing countries. In South Africa we now have a new terms called the Re-engineered PHC. Re-engineered PHC strengthens and works within the district –based health system,

and accentuates the delivery of community-based services and puts efforts on the social determinants of health (Schaay et al., 2011). The rationale for the government to introduce this approach to PHC came out of an increasing concern about the health outcomes since 2008. Then after numerous consultations and reports; a Ten Point Plan proposal was produced by the National Department of Health (NDoH). This plan with ten priority goals for the health sector was designed to assist the government to improve their health provision and also achieve the Millennium Development Goals (MDGs). The fourth priority states that the NDoH will strengthen health care system management (Schaay et al., 2011). Thereafter, the initiative of Re-engineering PHC in SA came about in 2010 when the ministry of health got a new interest in PHC which was progressing well in other developing countries such as Thailand and Brazil. At the core of the Re-engineered PHC proposal are the following objectives:

- Strengthen the district health system, through the implementation of the National Health Act of SA
- Focus on the delivery of community based services by "more pro-actively reaching out to families"; in addition the emphasis will be placed on disease prevention, health promotion and community participation.
- Factors outside the health sector that have an impact on health will be taken into consideration, namely, social determinants of health. (Schaay et al., 2011).

Currently, the above objectives are strategically implemented in Kwa-Zulu Natal province only through the use of community health workers working in collaboration with PHC clinic nurses in their districts. Other provinces have not as yet started rolling put the plan for Re-engineered PHC in SA.

2.3. SOCIO-POLITICAL ISSUES IN HEALTH CARE

2.3.1Interactional Challenges, Cultural Competence and Interpreter Services in Health Settings

South Africa has 11 official languages, which according to section 6 of the Constitution have to be treated equitably. In Section 9 (3), (4) and (5), the Constitution declares that;

3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3)

5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.

Unfortunately South Africa still has the majority of its HCPs (excluding nurses) as individuals who cannot speak vernacular languages (Jager, 1994; Penn, 2007a). The SA nursing Council reported a growth in the number of registered nurses from 2004- 2013; the increase was from 184495 to 260698; which is equivalent to 41%. (www.sac.co.za/stats.htm). The percentage of African medical graduates was recorded as 3% between 1968 and 1977 (Tobias, 1983). Fortunately, the number of medical students has been steadily increasing since 1994. But this cannot be said about the speech-language professions (Singh, 2007). The Health Professions Council of South Africa (HPCSA, 2008, in Khoza et al. 2008) reports that out of 147 registered Audiologists in 2008 only 23 are Black, furthermore out of 1347 SLTs registered, 56 are Black (Black includes Indians and Coloureds who may not speak South African indigenous languages). South African apartheid policies contributed to these inequities by excluding black students in the training of medical and allied health professionals like speech-language therapy and audiology from the majority of training institutions (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009).

A study by Penn (2007) compiled and reviewed about 11 studies in South Africa of interpreters in various healthcare settings from the year 2000 to 2007. The results indicated a variety of language practices and "…differences in preparedness of clinicians and the mediators" (Penn, 2007a). Furthermore, most healthcare workers did not conduct their sessions with qualified interpreters as required by the legislation, but they used ad hoc individuals such as nurses, family members or fellow patients (Penn, 2007a). The National Language Policy Framework (2003) promotes the use of trained interpreters yet none of the

sites in these South African studies had formally trained interpreters (Penn, 2007a). In some settings there was no assistance available and health care providers were challenged.

Other factors that contributed to communication challenges during patient interviews had to do with the type of questions the HCPs used, for example, history taking uses more closed ended questions than counselling. Closed ended questions require simple "yes" or "no" response, on the other hand during counselling session the patient is required to give more detailed responses in order for the HCP to work with them. In most consultations the SLTs are required to be skilled in both these types of interactions, consequently, resorting to conduct counselling using pidgin English or an interpreter can be problematic and result in patient dissatisfaction and lack of trust in the health system.. Similar findings were confirmed in a study by Saohatse (2000) in a study carried out at Chris Hani Baragwanath hospital; which highlighted communication problems when interpreters are involved. About 40% of the nurses in Saohatse (2000) reported that they were not willing to interpret for the doctors; and patients complained that nurses refused to speak in their first languages. Additional in-depth support was provided in a study in the Western Cape hospital by Schlemmer and Mash (2006) who found that language barriers caused serious ethical dilemmas, increased negative attitudes between patients and staff and increased cross-cultural misunderstandings. This is a further confirms the fact that these cross-cultural misunderstanding compromises patients' access to care and quality of that care (Angelelli, 2004)

Furthermore, in a study by Levin (2005) in a paediatric hospital, in the Western Cape, 45% of caregivers were concerned about the negative impact of poor communication on them and their children. The caregivers were also pessimistic of the fact that HCPs were not speaking their home language, which was IsiXhosa. These scenarios are an indication of ineffective service delivery in public healthcare. These poor service delivery situations are prevalent in most South Africa public health settings, yet not much is being done to improve them. An important recommendation from Levin (2005) is that there is a need for the provision of trained interpreters in the healthcare sector in South Africa. This issue is further exacerbated by globalisation and migration.

Therefore acceleration of global migration, contributes to an increasing tendency to have patients and HCPs that speak different languages that hold different illness-related beliefs and practices and have differing healthcare expectations (Hudelson, 2005). South Africa has the

issue of migration but it is also compounded by forced migrations due to wars or political and economic instabilities in neighbouring countries (Dalton-Greyling, 2008). The number of refugees and immigrants from a number of countries in Africa is increasing. South Africa was estimated to have 1.2 million illegal immigrants in 1990, million in 1990, 2,5 in 1992, 3 million in 1993 and 5 million in 2011. The Majority of illegal immigrants are unskilled (Minnaar, Pretorius, & Wentzel, 1995), as a result, the health sector is experiencing difficulties due to the large number of foreign language speakers and the lack of formal interpretation services.

The issue of global migration and the need for interpreter services was also found to be a factor in a study conducted in Geneva Hospital, Switzerland by Hudelson (2005) that involved Albanian patients; the interpreters raised concerns linked to working with medical doctors. Most of the interpreters complained that doctors don't spend time with them after patient consultation to clarify issues that might have occurred during a consultation. Of interest in this study, is that interpreters were reluctant to give suggestions or recommendations for improving cross-cultural communication. However, their descriptions emphasized the importance of the following factors:

- Awareness of potential sources of misunderstandings,
- Basic knowledge of the country of origin of patients,
- Recognition of the difficulties of translation, and
- Adaptation to patients' communication style (Hudelson, 2005).

In addition, these bilingual Swiss interpreters suggested that doctors should avoid closed-ended questions, and use more conversational types of questions during consultations (Hudelson, 2005). Closed ended questions were found to elicit yes/no answers from patients, thus leading to superficial discussion and not allowing the patient to elaborate about their health concerns (Langdon & Cheng, 2002). These interaction challenges are not only about the interview skills but also on the way the medical practitioners may perceive the foreign language patients' speech.

In a study conducted in London, UK, focusing on interactions during consultations of doctors and English foreign language speakers, it was found that the misunderstandings that occurred between patients and doctors were due to difficulties linked to pronunciation and word stress; intonation and speech delivery; grammar, vocabulary and lack of contextual information, and style of presentation (Roberts, Moss, Wass, & Sarangi, 2005).In this study, cultural differences were not found to be contributing, because most people in their sample also had a western biomedical view. Cultural differences were however found to cause misunderstandings in 20% of consultations. It was concluded in this study that communication style is a significant factor as compared to culturally specific beliefs in contributing to misunderstandings in an interpreted medical consultation (Roberts et al., 2005).

In contrast a study by Macdonald, Carnevale, and Razack (2007b, p. 444) conducted among Canadian paediatricians, illustrates that: “culture has long been acknowledged in medicine as an important element of health and illness”. Furthermore, Macdonald et al. (2007) indicate that culturally sensitive care promotes positive health outcomes in children and adults. However, in Macdonald et.al (2007) there was no interpreting involved; it was a study that focused on doctors in focus groups about how they managed cultural diversity in their consultations with the aim of developing a training programme on cultural competence.

The studies by Macdonald et.al (2007) and Roberts et.al (2005) show a balance in the way researchers have raised the problems in the field of interpreted healthcare. However, given their individual focus on either doctors or interpreters views they do not present a holistic view of the communication context. Ferguson and Armstrong (2004) assert that the communication context in a healthcare setting is asymmetrical in relation to power. Most patients have limited power. The HCP is the one that initiates and follows up in the interaction. On occasion when an interpreter is involved they are not used optimally, they function as “on-line” (Bot, 2005) translator . The HCP is the one who is the “primary-knower” and in control of the interaction. When there is limited power and control for the patient, this is also an implication of limited cultural competence on the part of the HCP.

Research on interactional theory in the speech-language therapy intervention especially in South Africa; indicates that a need exists in training of culturally competent HCPs and

institutions that are able to use their expertise of health related beliefs and practices of patients to improve the quality of care that they provide. Being culturally competent goes beyond being culturally aware and/or sensitive (Ross & Deverell, 2004). A culturally competent HCP is one with a sound understanding of their own culture and that of their clients and is able to accept the similarities and differences without being judgemental or patronising.

SLTs should understand the discourse of difference and equality by avoiding concepts of "otherness" when referring to indigenous language speakers; where "other" is perceived to be markedly different, marginal, and problematic in relation to mainstream modernist culture. Thomas and Sillen (1972) give examples from psychology and medical anthropology that demonstrate that pseudo-scientific racism can exist in some of the healthcare or counselling services. As has been cited earlier in this paper, studies by Chick (2002) reported that South Africa has extensive problems with miscommunication and intercultural communication. Negative cultural stereotypes among both black and white people still exist. The ideational and aspirational policies of the new democratic government, especially in the area of human and linguistic rights, seem not to have turned into service delivery and attitudinal changes as yet.

Flexible SLTs can achieve good outcomes and strong therapeutic alliance with culturally and linguistically diverse patients (Threats, 2010). Training on cultural competence should include being flexible and accommodating to people that are from different cultures. Cultural competence is described as a process in which the HCP aims to work efficiently within the cultural context of client, family or community from a diverse culture (J. Campinha-Bacote, 1995). Leininger's theory on culture-care diversity and universality shows that a culturally competent HCP is a person that is aware that culture has a significant impact in their interactions with clients. They check with respect and care what their cultural practices and preferences are, they integrate the personal, social, environmental and cultural beliefs in to the client's treatment plan and respect cultural diversity and are culturally sensitive and aware (Tjallinks, 2004). This theory is also called transcultural nursing theory is very comprehensive, and includes cultural shock. Cultural shock is a state of being unable to respond to a different cultural environment or beliefs because of its unfamiliarity (Leininger, 1991).

Multi-cultural counselling/interactions in America are seen as the "fourth force" after person centered approach. It is an approach that has reciprocal relationship between internal, emotional forces, environmental and cultural influences (Fassinger & Richie, 1997). An important aspect in interacting with diverse patients is acknowledgement and working through of their race, culture and ethnicity material in therapy. SLTs and audiologists should be aware of alternative approaches like traditional/spiritual healers that their patients may be consulting (Swartz, 1998).

Penn (2007a) outlines profiles of good and bad mediated interviews. A good mediated interview occurs when the HCP and patient have a common goal, good trust in addressing issues of stigma and disclosure (especially on HIV/Aids) and use the "cultural models of explanation and negotiation around management" p. 70. Training of HCPs in communication skills, especially in mediated setting can resolve the problems that are so perennial in mediated interviews in South Africa. HCPs should work with their interpreters as team members; before, during and after the interview. Penn (2007a) advocates for the inclusion of language specialists in research and training on communication in healthcare.

In summary, Singh (2007, p. 19) suggests that, "…research in our profession should ensure that we hear our patients and that we create opportunities for them to develop their own voices in order to be heard." It seems that currently the profession is unable to fully articulate the concerns and issues of the marginalized and those that fall in the minority. There is a need for broader systemic and socio-political interventions to address the imbalances.

2.3.2 Cross-cultural and Cross-linguistic Barriers in the Healthcare Context

It has been reported that more than a billion people in low- and middle-income countries encounter barriers to access affordable health services (WHO, 2010). However, little is known about access barriers to healthcare for a majority of citizens in South Africa. Limited studies have reported that in South Africa there is also a vast access barrier to health due high travel costs, high out-of-pocket payment care, long queues and disempowered patients (Harris et al., 2011). In an American study by Betancourt, Green, Carrillo, and Aneneh-Firempong (2003), socio-cultural barriers to healthcare are explored through a multilevel analysis. Their findings looked at organisational barriers, as significant obstacles with regards

to the availability and acceptability of healthcare for members of minority racial/ethnic groups. They also indicate that organisational barriers illustrate the degree to which the nation's healthcare leadership and workforce reflect the racial/ethnic composition of the general population. Their conclusions also suggest that lack of diversity in the leadership and HCPs contributes to 'structural policies, procedures and delivery systems inappropriately designed or poorly suited to serve diverse patient populations' (p. 118).

Similarly, in South Africa the majority of HCPs excluding nursing profession; do not have African local languages as a mother-tongue as most of them are white or Indian. On the contrary, South Africa due to the democratic changes has a leadership at a political level which is representative of the majority of the population, A study by Myburgh, Solanki, Smith, and Lalloo (2005) revealed that race and socio-economic factors were indicators of how patients were satisfied with health services; patients that were White and were from high socioeconomic backgrounds were more satisfied with the services.

Furthermore, institutional leadership; which is also an organisational barrier, shows that in America, despite representing 28% of the population, Blacks and Hispanics make up only 3% of medical school faculty and only 17% of all urban medical officers. Similarly, South Africa has a history of racial discrimination that had an impact on the training of African doctors. Even after the collapse of the apartheid system we still have a shortage of not only African doctors, but also other health professionals like the allied health professionals (Bateman, 2013; Kathard & Pillay, 2013). The ratio of doctors to patients is 77:100 000 in SA; due to limited numbers of graduate doctors especially blacks and females. .

The advantage of reversing this scarcity and transformation is that African HCPs will have a social and cultural understanding of the community they serve, especially if these are mostly African; on the contrary the majority of professionals from other cultures do not have this advantage when it comes to serving communities from different cultural and language background than themselves. Therefore, African HCPs would be more likely than their white counterparts to organize healthcare delivery systems to meet the needs of their communities.

Racial diversity in the healthcare workforce correlates with the delivery of quality care to diverse patient populations. Research in America has shown that for minority patients, racial concordance between patient and doctor is associated with greater patient satisfaction and

higher self-rated quality of care. Other studies have shown that patients prefer doctors from their racial/ethnic group (Saha, Komaromy, Koepsell & Bindman, (1999) in Betancourt, et al 2003).

The second socio-cultural barrier to healthcare relates to structural barriers. Structural barriers arise when patients are faced with the challenge of obtaining healthcare from systems that are complex, underfunded, bureaucratic, or archaic in design. Some examples of these are lack of interpreter services or culturally/linguistically appropriate health education materials and other non-economic burdens that make it difficult for caregivers to get their young children access to speech therapy services. Furthermore, there are three kinds of structural barriers; poverty-related, institution-related and political and cultural (Kagee, Nothling, & Coetzee, 2012). Poverty-related barriers also involve time away from work and travel expenses. Institution-related barriers include long waiting times and negative experiences with staff and HCP-patient communication without an interpreter when there is even a minimal language barrier is identified as a political and cultural challenge to effective healthcare delivery. In another study by Baker, Hayes, & Fortier (1998), it was revealed that doctors who have access to trained interpreters report a significantly higher quality of patient-physician communication than physicians that use other methods, such as untrained staff or family members.

The third socio-cultural barrier to healthcare is referred to as a clinical barrier. This barrier relates to interaction between the HCP and the patient or family. Parents and caregivers are generally under stress and concerned about the well-being of their un-well child. This barrier occurs generally when sociocultural differences between patient and provider are not fully accepted, appreciated, explored or understood. For patients to actively participate in their interaction with a HCP they need to have good communication skills. Research has shown that provider-patient communication is directly linked to patient satisfaction, adherence, and health outcomes (Cegala, Chisolm, & Nwomeh, 2013). In a study by Cegala et al. (2013) caregivers were trained on active participation which had four components. The first component was patient participation that dealt with information seeking; i.e. questioning and information verification. Question asking has been included in several communication training programmes of patients because it is a good indicator of their assertiveness and means of getting the required information (Street, 2003). Their results showed a significant improvement in parents' communication skills. Unfortunately, there is a dearth of research on

patient communication training; most of the research is on training medical professionals in consultation.

It has been proposed by Betancourt et al. (2003), that cultural competence in healthcare will involve understanding the importance of social and cultural influences on patients' healthcare beliefs and behaviour, and devising interventions that take these issues into account to assure quality care delivery in multi-lingual and multicultural settings. Thus, as is clearly shown above barriers to healthcare occur at different levels of healthcare delivery. This discussion also makes it clear that cultural competence could be achieved when barriers are addressed the multiple levels of the clinical encounter. A framework for bringing cultural competence would entail organizational, structural, and clinical interventions. This is in line with an ecological approach to medical encounters by Street (2003). In addition, Hoop, DiPasquale, Hernandez and Roberts (2008), emphasise that cultural competence is a demonstration of the ethical principles of respect for persons, beneficence (doing good), non-maleficence (not doing harm), and justice (treating people fairly).

Again for a successful medical encounter to occur between a patient and HCP the following elements are important;

- respect, including treating others as one would like to be treated;
- paying attention to the patient with open verbal, nonverbal, and intuitive communication channels;
- being personally present in the moment with the patient, mindful of the importance of the relationship; and
- having a caring intent, not only to relive suffering but also to be curious and interested in the patient's ideas, values and concerns (Duffy et al 2004; 499).

These elements have been attributed to patient and professional partnership and an indication of an educated patient that fully understands the health condition and the different options for treatment Street (2003) and Cegala et al. (2013). For this partnership to be enhanced the HCP also needs to be aware and knowledgeable about the culture of the patient. The levels referred to include organisational, structural and clinical (Street, 2003).

Given, that all healthcare or medical consultations in South Africa are cross- cultural, it would be paramount for HCPs to understand and address sociocultural barriers to healthcare. An ecological approach could also shed light on interactional styles of the majority of people that use the public health system. Street (2003) posits that medical encounters between clients and HCPs do not occur in a silo; environmental, socio-political, and cultural factors impact interaction. The ecological model by Street (2003), analyses interaction between HCP and client and is sensitive to multilevel systems that play a pivotal part in a multi-lingual and multicultural healthcare setting. Both the socio-cultural and the ecological approach show that the culture of the person is central to a positive medical health encounter. What makes up an individual's belief system is also taken into account. An individual's belief system is made up of a number of aspects, for example, culture, religion, education, family, ethnic /race group, life events, gender, personal and media.

In addition, there are the less obvious manifestations such as personal factors, such as age, gender, race, level of education and personality that also play a pivotal part in interactions in health settings. Street's (2003) framework of medical encounters, presents an understanding of the interaction between SLT and caregivers of children with a communication disability in a hospital context. In addition, researchers in health communication have been urged to include contextual factors surrounding medical encounters that they are studying in order to be able to explain the relationship between the patient and HCP (Avtgis & Polack, 2007).

South African history is characterised by a fluid transformation. The current context has been open to African indigenous medicine as noted after 1994, where a dialogue between traditional healers and the new government led to legal recognition of traditional healing practices (Digby, 2006). The WHO policy guidelines such as primary healthcare, the International Classification of Functioning, Disability and Health (ICF of the WHO 2001), bio-psychosocial disease model have an effect on how the health providers dispense their services. Thus consideration of organisational context is pivotal in an evaluation of barriers and facilitators in health provision. The Street (2003) model assists researchers and clinicians in paying attention to health in a holistic manner.

The interpersonal context has predisposing influences for the SLT and patient (caregiver). On one level, the model looks at the SLT / HCP's communication style used in the consultation. The question that is asked is the communication style "patient centered" or "doctor centered"? Patient centered interaction occurs when the SLT uses responses designed to elicit and accommodate the patients' perspective in consultation (e.g. Open-ended questions, requesting opinions and concerns, offering support). Doctor-centered communication style is focused primarily on maintaining clinician control e.g. close-ended questions giving directions, attention to patients' physical functions, interruptions and efficiently completing the tasks of the consultation.

On the other side the model looks at the patients predisposing influences which include; educational level, age, personality factors, linguistic ability and informational resources for communicating with HCPs. In addition cognitive-affective influences of both participants are analysed. The interplay of process affecting the HCP and patient communication is divided into personal and partner characteristics.

Generally studies that involve training of both HCPs and patients are still a new field of health communication (Atkinson, 1999). For example, Cegala and Broz (2003) reported on communication issues they encountered when conducting communications training for HCPs and patients in primary healthcare settings. The training approach was psycho-social; using dialogue, open-ended questions and promotion of patient participation. Strategies used were modeling and role playing with feedback. Patient training was mostly in three areas; information seeking, information provision and information verifying. Results from this research showed positive outcomes for both patients and HCPs, as some of the barriers related to health communication were addressed.

2.3.3Communication Problems in Healthcare

Information exchange during a health consultation is considered a vital aspect of the functioning of the HCP (Cegala, 1997). A review by Thomas (2006) shows that in studies on how patients evaluate communication competence of HCPs it is shown that some patients are not satisfied with the communication competence of health care providers. However, there

has been little effort in the training of HCPs that focuses on communication training, more specifically in inter-cultural communication. In a study by Penn, Mupawose, and Stein (2009), a challenge that was reported by SLT graduates from Wits University, was having to deal with linguistic diversity of patients and the lack of formal interpreters in community service settings. New graduates expressed the need to be culturally competent when consulting clients in hospitals. Peltzer (2009) conducted a study in South Africa that sought to explore patients' views and perceptions of quality of care. The study identified that 95% of participants felt discriminated against, in both public and private healthcare. Discrimination was identified by the participants as resulting from their lack of money, their social class position and their race (Peltzer, 2009). Peltzer (2009) concluded that healthcare access, communication, autonomy, and discriminatory experiences were key areas for actions to ameliorate responsiveness and patient satisfaction in South Africa (Pelzer, 2009). It therefore, appears that there are problems from both the patients and HCPs, especially in the area of communication.

Effective communication is the foundation for effective diagnosis and treatment of a patient by a physician (Penn, 2007a). Cegala (1997) described this process of information exchange which is the function of healthcare interview between the patient or caregiver and HCP. He stated that it consists of seeking information, giving information and verifying information or socio-emotional support (providing comfort or caring for the other person). However, many patients are dissatisfied with the quality of their communications with HCPs (R.K. Thomas, 2006). This disparity is more pronounced in marginalized groups such as those with disabilities, low literacy levels, limited English proficiency and low socio-economic status (Thomas, 2006). Hidden differences between HCP and patient; such as socio-economic status, physical address and education contribute towards this differential interaction in healthcare institutions (Purtilo & Haddad, 1996). Furthermore, in a study by Purtilo and Haddad (1996), poor, old Black women felt triply discriminated due to their race, economic status and age. In South Africa the most significant social and political problem affecting the majority is poverty. The national prevalence data suggests that 40% of the nation live in poverty (Statistics SA, 2002). The Census (2001) revealed that 18% of South Africans have had no schooling, 16% had some primary education and only 8, 4 % have tertiary education qualifications. The majority of South Africans live in extreme poverty; many experience

hunger and overcrowding. This means that the majority of patients in public health institutions will be poor, illiterate and possibly unable to access the health services due to cultural, linguistic, financial and transport barriers (Levin, 2005).

Many complaints about HCPs, especially medical doctors, have to do with attitudinal and behavioural problems, e.g.; poor communication skills and arrogance (Phillipp & Dodwell, 2005). In 2003 the British Medical Association published a discussion paper: Communication Skills Education for Doctors. This paper drew attention to "barriers to effective communication" ranging from personal attitudes to the limitations placed on doctors by organisational structures under which they work. Communication barriers exist in all healthcare contexts but are exacerbated when there are differences between the languages and cultures of the HCP and the patient. Considerable disparities exist in healthcare for marginalized groups, as cited by researchers (Centeno, 2009; Purtilo & Haddad, 1996) in America and locally, (Benatar, 1986; Penn, 2007a)

Individual bias can be cultural and/or personal (Purtilo & Haddad, 1996). Cultural and personal biases are not synonymous. A personal bias is individuals' emotions about other people that affect their interpretation, while cultural bias is about interpreting other's actions or words using culturally derived meanings. Being a cultural sensitive HCP involves effective self-examination and exploration of what these biases/notions about your own culture mean to you. HCPs need to avoid ethnocentrism, which means the belief that one's culture is superior. A notion made difficult by multiple factors including, curriculum, socio-economic and political structures. These in decolonial theorising is referred to as the colonial logic (Ndlovu-Gatsheni, 2016). HCPs need to be cognisant of the fact that their interactions with patients are in line with a helping therapeutic relationship as opposed to a social helping relationship. In a helping therapeutic relationship, HCPs use specific professional skills and interactional tools which are void of cultural or personal prejudices (Purtilo & Haddad, 1996).

According to the American Patients' Bill of Rights (1975), the patient has the right to considerate and respectful care. In addition, the patient has a right to obtain relevant, current and understandable information regarding diagnosis, treatment and prognosis. Having an

informed patient is related to treatment compliance. Unfortunately, HCPs have a tendency to use professional jargon. This is often used to present themselves as experts (Ferguson & Armstrong, 2004). This may be true in other contexts too, not just in developed countries such as America. The use of professional jargon, over and above the use of the patients' second, third or fourth language; makes for challenging interactions between the HCP and the patient.

According to Emanuel and Emanuel (1992), interactional styles used by HCPs can be grouped into four categories: paternalistic, informative, interpretive and deliberative. The deliberative model of interaction is the one reported to be most preferred in healthcare (Emanuel & Emanuel, 1992). All the interactional styles are careful and cognisant of patients' autonomy however, in the deliberative model the HCP is like a friend or teacher. The HCP is assumed to be capable of bringing a caring attitude to the interaction with patients. The patient is in turn assumed to be empowered and provided the space to critically assess their own values and preferences about the medical intervention. The HCP integrates the medical information and relevant values to make a recommendation and attempts to persuade the patient to accept the recommended intervention (Emanuel & Emanuel, 1992)

Even though the above types of interactional styles provide a description on the "talk "between the professional and the patient, they don't give the researcher good tools in analysing the other underlying aspects of the interaction. The description seems to accept the status quo, which can be deceptive, considering the history of opposition to the effects of power linked to knowledge, competence and qualification (Foucault, 1982) The underlying issues that occur during consultations, speak to complex, cultural and historical issues that underlie language not the unseen issues that are behind the interaction which involve power, and culture thus the researcher found it useful to draw the Foucauldian framework as it allows for a deeper and critical reading of SLT consultation interaction. The Foucauldian framework is sensitive to issues of disciplinary power and asymmetrical power relations. While it is important to study the language or interaction pattern, the researcher needed a way to address the main objectives of the study, which are: to analyse the interactional characteristics and features of speech-language therapists and interpreters; and to identify

speech therapists' and interpreters' perceptions of their competence and experiences in multicultural settings. The patients in this study were young children with communication disabilities. However, the participants also included care givers of these children, who were mainly poor and African whereas the SLTs were educated middle class white and Indian. The researcher's analysis occurred at the backdrop of unequal powers, which is an all-encompassing factor in social relations, economics, politics and religion (Cheong & Miller, 2000).

2.4. THEORETICAL FRAMEWORK

2.4.1 Intersection of Foucault and Critical Diversity Literacy: relevance for SLTS

This section of the literature review does not intend to conduct an extensive critical review of the Foucault's perspective on power. However, the focus is on understanding his approach of power relations within an organisation such as a hospital. Thereafter, the argument will include Critical Diversity Literacy (CDL) and link the two concepts in relation to the hospital context and specifically in the SLT practice.

The problem of excessive power in society and government was studied extensively by Michel Foucault, who is a French philosopher (Stein & Harper, 2003). Customary understanding of "power" is that it is about political structure, a government, a dominant social class. However, the researcher's perspective to "relations of power" in this thesis is specific to the context of HCPs and patients. The understanding of various human relations – whether it is those that relate by communicating verbally… or a question of love relations, institutional or economic relations-power is always at the core. This was anticipated to be evident during the interactions of HCP such as an SLT and their clients. The study was driven by concerns that there is lack of sensitivity in working with culturally and linguistically diverse clients in SA. The professionals don't seem to have serious concerns about the ethical implications of assessing non-English speaking clients using assessment materials developed in Europe and US (Mdlalo, 2016). This lack of urgency to change in the profession could be

due to the historical impact of living under apartheid. As Stein (2015: 381) posits that peoples thinking about difference is "socially constructed within unequal power relations". The everyday discrimination has become normalised and is prevalent in various contexts even when there is no good reason to accept the situation of poor service delivery of health and rehabilitation.

This lack of sensitivity by HCPs in terms of diversity issues is related to power; as the disempowered poor are the ones who are at the mercy of healthcare providers. There is a need for SLTs to develop conscientisation as in order to be able to critically understand the political, cultural issues of their work setting and the people they serve. Conscientisation is used in this section according to Freire's (1970:19) definition which states that ii is a "...learning to perceive social, political and economic contradictions, and to take action against the oppressive elements of reality". The SLTs in this country and globally have to accept that sensitivity to their patients cultural and linguistic context is pivotal. The ultimate point of achieving Critical Diversity Literacy is being conscientised, at a cognitive and affective level. The SLTs in SA need to be conscientised to the fact that the burden of disease and structural inequalities affect the poor which are mostly the Black people, in addition they are majority patients in the public hospitals (Kathard & Pillay, 2013). Being sensitive and acknowledging the power they bring as health care providers is paramount.

Foucault defines power as omnipresent in all human relations and everywhere.

> "*…not because it has the privilege of consolidating everything under its invincible unity, but because it is produced from one moment to the next, at the very point, or rather in every relation from one point to another (*Foucault, 1978:93).

Similarly, Stein (2010) reiterates that symbolic and material value of "hegemonic identities do become established in social relations. The professionals in health need to be able to identify the manner in which issues such as whiteness, masculinity, heterosexuality, ablebodiedness and middleclassness are accepted as the norm and are reproduced in contexts such as health care. Furthermore, it becomes very challenging to change the mind sets in society and the status quo stay as they are for far too long. Ethnic disparities in obtaining medical care are a good example in SA. Kon and Lackan (2008) reported that even fourteen years post-apartheid, Africans and Coloreds are still underserved and disadvantaged

compared to Whites and Indians regarding access to health care. Furthermore, using Afro barometer: survey of SA it was found that these disparities are not only in health care but extend to education, income, and basic public health infrastructures. The political and economic situation is controlled by government power, which is everywhere. This is a pointer in understanding power relations between HCPs and patients especially in SA where due to historical loading; culture and race often get muddled. Health care settings have many complex challenges including service delivery for diverse cultures and languages. Professionals locally and globally have for many years highlighted the language barrier in multicultural settings (Penn, 2007). This lack of cultural sensitivity among HCPs can be likened to what Foucault (1961) calls a "… a ship of fools…"where the experiences of exclusion and othering are flourishing. In a study exploring the effects of language barriers on HCPs, by Schlemmer and Mash (2006) in a SA hospital, it was who found that language barriers caused serious ethical dilemmas, increased negative attitudes between patients and staff and cross –cultural misunderstandings.

Power according to Foucault's framework has distinct but related arguments, which claim the following; firstly the vocabulary of power is pivotal and elevated to a privileged status. Vocabulary or language of power; is privileged because of its importance in conveying culture. As put in chapter one of this thesis, Ngungi wa Thiong'o (1981:4) highlights the significance of vocabulary and language, by saying that "*The choice of language and the use to which language is put is central to a people's definition of themselves in relation to their natural and social environment, indeed in relation to the entire universe. Hence language has always been at the heart of the two contending social forces in the Africa of the twentieth century."* Similarly, in CDL; it is important to have the correct vocabulary which includes words like whiteness, privilege, and internalised racism/dominance. In contexts where there is "othering" or "difference"; e.g. disability, race, gender, for emancipation and conflict resolution -it is critical for people to be able to have the right vocabulary when engaging with each other.

Secondly, Foucault argues that the meaning of power is extended to cover all human social behaviour and relations. Consequently, power and the resistance to power are integral to all

types of social relationships including linguistic, institutional, economic, and religious to mention but a few. The role of power in Foucault's words is:

"*When one speaks of "power" people immediately think of a political structure, a government , a dominant social class…This is not at all what I think when I speak of "relations of power". I mean that in human relations, whatever they are- whether it be a question of communicating verbally…or a question of love relations, institutional or economic relations- power is always present*.(Foucault, 1985; 11-12).

In the relations between a SLT and caregiver, broader actions and beliefs are defined and provided with meaning. The caregiver expects to be given help for their child with communication disorder and the SLT is there to diagnose and treat the communication disability. According to Foucault's view, what controls or restricts behaviour is an exercise of power. So, SLTs have power because of the social, cultural and educational advantage they bring to the table.

The same as Steyn (2015) recognises that the divisions along the lines of gender, race and nationalities are deeply entrenched and are historically powerful. However, a word of caution is that social spaces are also not homogeneous. For example, not all white people in SA have the same access to privilege because some may have low socioeconomic statuses. However, what is important is that the socio- economic context and its continuing logics provide them with privileges even when their socioeconomic positioning might suggest otherwise. What is significant to note is that powerful forms of these dominant positions are able to exclude others who are living in poor or lower statuses so that they may have the advantage of "psychological and material comfort"(Steyn, 2015: 382). The HCPs are generally in a position of comfort and power, even though they may blame their training or the government for lack of infrastructure in health care provision in SA. It is important to avoid "scape-goating" external forces and start questioning the reasons why these exclusionary practices still occur in the work that we do within communities. .

Finally, the importance of the external theory of power and internal understanding will be explored. For one who is external with an inspecting gaze, usually has the power to exert

knowledge, and normalising discourse on what is acceptable not acceptable (Cheong & Miller (2000). The study seeks to understand how the SLTs in the hospitals are able to work when they don't speak the same language as the patients they are treating. Will the research find that they have normalised the discourse and find it acceptable to ask a cleaner or clerk to be an ad hoc interpreter when in consultation with a patient that has limited English proficiency? As it has happened in the period of colonization, the inspecting gaze of colonial masters normalised the discourse and regarded the colonized as ignorant and objects of subjugation. Thus an individual can be watched by somebody, e.g. "Parental gaze" or "clinical gaze". This finally leads the person internalising the gaze to the point that he is his own overseer (Foucault, 1975). This could be the reason that what is referred to as collusion and co-option, to the extent that the public accept the prevailing narratives of the society (Steyn, 2015). Understanding these power dynamics from a standpoint of an internal perspective as an African SLT and also as an external researcher was a challenge which I anticipated.

Being in a position of being subordinated makes it difficult to express personhood in ways that challenge the dominant groups. As articulated DuBois (2008) in Steyn (2015:382) in her critical diversity paper: "Those who are socialised into spaces of relative disadvantage are more likely to understand and recognize that these systemic odds are at play in their lifeworlds and are stacked against them. They contend with unearned barriers in the way of their advancement, being predominantly situated in positions of service and support for those advantaged…"

In conclusion, the above discussion on Critical diversity literacy and Foucault's power relations has led the researcher appreciate that power is a two way process and to the importance of how SLTs are positioned within the relations of power that structure the consultation practices. Power relations are complex and dynamic; and the roles can be interchanged depending on the context. The contexts could be involving gender, economics, education or race as the backdrop; the resulting power relations cannot be predicted with certainty. But clearly, the practices and strategies used by SLT in consultations and treatments of clients are fraught with the effects of power and difference.. Social interaction are not purely unpolitical and clinical, as a result the research also included the micro-

analysis of natural occurring interaction of SLT and clients using Conversational Analysis (CA). Foucault's perspective allowed the researched to interpret the backdrop of deep and subtle but at times glaring issues, whereas CA provided the microscopic and linguistic lens.

2.4.2 Conversational Analysis in Interpreter Mediated Settings.

Most of the medical knowledge (scientific & clinical) is manifest at the interactional level in terms of history taking, diagnostic reasoning and offers of recommendation (Sarangi, 2005). The conversational analysis method of research design is a good analytical tool to guide clinicians in their interactions and also to study patient interactions (Perakyla, Ruusuvuori, & Vehvilainen, 2005). According to ten Have (2007) conversational analysis , "… may be conceived as a specific analytic trajectory which may be used to reach a specific kind of systematic insight in the ways in which members of society 'do interactions'"(p. 2). Conversational analysis is also concerned with contextual sensitivity of language use with the focus on talk as a vehicle in a social context. 'Conversational analysis represents a consistent effort to develop an empirical analysis of the nature of context' (Drew & Heritage, 1992, p. 17). What determines context is not the physical setting as such; however, it is what we are doing at that time. Hence this study was immersed in analysis of what and how the SLTs in hospitals were conducting consultations with caregivers in a diverse setting. Furthermore, ten Have (2007) emphasizes that Conversation Analysis is a sociological rather than a linguistic enterprise, concerned with the explanation of action in organizational terms rather than 'language use'. It is also about explaining the "why that now? According to Drew and Heritage (1992), there are four major features that make up the Conversational analysis perspective. Firstly it the activity focus of conversational analysis, includes discourse analysis which ranges between two extremes with one end looking at culture or social identity and the other extreme analysing phonological variation, syntax and vocabulary use (Drew & Heritage, 1992, p. 18). Yet Conversational analysis considers interactional accomplishment of social activities. The second principle is sequential analysis, which is an

interactional approach to the units of discourse where an utterance is seen as a by-product of the previous turn or turns at talk. This is a major difference from the speech acts analysis as practiced in applied linguistics. It requires a focus on units that 'larger than the individual sentence or utterance' (Drew & Heritage, 1992, p.18.). These units of talk interaction and their by-product unit turns-within-sequences are the focus of analysis in CA. The conception of context is the third principle and it speaks to a situation where utterances are treated contextually. Firstly, utterances and actions are shaped by context, that is the prior utterance determines what the following utterance or action will be. For example, a question will produce an answer; a greeting will produce an answer relevant to a greeting. Context is significant because the speaker relies on it to produce an utterance and the hearer also relies on it to be able to respond appropriately. Secondly, utterances and actions are context renewing. This means that the current utterance will form the following context (Drew & Heritage, 1992). The final principle is Comparative analysis. With Comparative analysis Conversational analysis realizes that ordinary conversations are the important and predominant social order and is the method that children acquire language. Thus it is against this social order that other forms of talk-in-interaction are compared. The study of ordinary conversations among peers offers a bench-mark against which other interactions are measured. For example, specialists in education or medical settings, asymmetries, gender, ethnicity (Drew & Heritage, 1992).

From the above descriptions, it is clear that with the help of Conversational analysis one can take what people are saying during an interaction at a particular moment and try to say what the utterance is doing or how it could be a solution to a problem. Conversations involving multi or third parties are complicated (Wadensjö, 1998). There are issues of asymmetry, social and cultural factors, which can have a negative or positive impact on the interaction. Negative impact on the interaction appears when one of the participants in the interaction feels disempowered, on the other hand a positive impact is felt when both participants feel that it was successful and there was equity in the conversation. South Africa being a multi-lingual country, with a majority of HCPs that are unable to speak local vernacular languages; conversations using interpreters are common especially in healthcare settings (Friedland & Penn, 2003) .Conversational Analysis is a good analytical tool for addressing these contexts. Research has shown that interpreters should not be viewed as conduits in a conversation.

Interpreters are not a "necessary evil" working in an abnormal context (Bot, 2005). Turn taking and allocation entails inviting a communication partner to take the conversational floor (Sacks, Schegloff, & Jefferson, 1974). How this happens in interpreter mediated contexts needs further research especially in medical settings.

2.4.3 Pragmatic aspects of language

Discourse markers are a sub-topic that falls under a broad umbrella of Discourse analysis, and there has been a steady interest from researchers since Schiffrin (1987) highlighted their significance and role in the five genres of talk, namely: (i) exchange structure, which includes turns and adjacency pairs; (ii) action structure including speech acts; (iii) ideational structure which is explained as semantic units; (iv) participation framework, which is described as social relations between speaker and hearer (e.g. SLT-client); and (v) information state which is about the cognitive capacities of the speaker or hearer and the management of knowledge and meta-knowledge (Verdonik, Zgank, & Peterlin, 2008). Discourse markers are pivotal in written and spoken context due to the role they play in understanding discourse and information progression.

Discourse analysis is labelled as a substantial and indistinguishable area of study (Schiffrin, 1987). The reason it is called substantial and indistinguishable is because it encompasses multiple areas of research, including many authors in fields such as pragmatics, conversation analysis and sociolinguistics (Leech, 1983). All these different views from different subject areas discuss discourse analysis with ease:

"…the analysis of discourse is necessarily the analysis of language in use. As such, it cannot be restricted to the description of linguistic forms independent of the purposes or functions which these forms are designed to serve in human affairs."(Brown & Yule 1983, p. 1)

Furthermore, Stubbs (Stubbs, 1983, p. 2) states that discourse analysis consists of:

"… attempts to study the organization of language above the sentence or above the clause, and therefore to study larger linguistic units, such as conversational exchanges or written texts. It follows that discourse analysis is also concerned with language in use in social contexts, and in particular with interaction or dialogue between speakers."

Previous studies in health communication have not focused on the use of everyday colloquial spoken language in health settings of SLTs. This study looked at the use and function of four discourse markers (*eish, ok, ja & neh)* as they were used in the interactions between SLTs and clients. The results helped to describe the aspect or register of SLT talk in consultations.

According to Müller (2004), discourse markers are essential to the organization of natural and workplace discourse, however, there is limited research in the literature on interaction in health settings. Discourse markers are described as words or phrases that function within a linguistic system to create relationships between topics in discourse (Hellermann & Vergun, 2007). In addition, they function as pragmatic markers, as they are used to comment on the condition of comprehension about what is expressed by the speaker, for example: "*Like, you know".*

Discourse markers have multifunction across discourse contexts, but the main distinguishing criteria from other grammatical items can be divided into diagnostic and descriptive features (Yang, 2012, p. 38). Diagnostic features which help to distinguish discourse markers include: Firstly, there is lexis which includes multi-resources and micro-markers which are words or phrases (*like, you know*) which are short and fixed. Secondly, prosody, which entails pause, intonation, stress and rhythm of speech accompanied with non-word verbalization. These type of structures form their own system or structure of tone, for example, they can occur at the end of sentence with a falling intonation (e.g. "*neh",* at end of sentence). Thirdly, the syntax, which can be flexible in position, independent between clauses, detachable, turn-initial or in a stand-alone position in referential relation, for example, "*ja".* This is followed by semantics which are independent, optional, and have no effect on truth conditions. Finally, indexicality, which can be either anaphoric, which includes repetition of the word or phrase

for effect (e.g., *ok, you see mama, ok*) or cataphoric which is using a word referring to something following (e.g., *it's easy to make mistakes)* between discourse units.

Descriptive features include grammatical structures and multifunctionality at referential, structural, interpersonal and cognitive level. In addition, stylistics such as high frequency and repetition, and sociolinguistics show importance of context-dependent orality.

Laughter is described as a sequence –systematic and interaction –constructional phenomenon (Jefferson, Sacks & Schegloff, 1977). In addition, laughter is regarded as a non-speech sound and is described as it's not a text but can be regarded as an object. When laughter occurs, it can be an invitational type of action, which can be accepted or rejected by the partner.

Understanding CA framework and the pragmatic aspects of language in added value to the research process which was unique. Each turn at talk was seen and understood in relation to what the previous speaker's turn and created for how the next turn was understood. Using transcriptions based on video recording of naturally occurring interaction of SLTs and caregivers regardless of the presence of the researcher was an added benefit. This methodology allowed the researcher to collect data without any specific interest or hypothesis.

*2.***5.** *Conclusion*

This chapter has examined existing literature on the provision of healthcare, rehabilitation, and psychosocial interventions generally. Such information highlights the context and challenges of health professionals working in a diverse culture and language context, in South Africa context. It is necessary to understand the healthcare setting for changes to be made to improve service provision. The chapter argued that the various medical theoretical models, philosophies, concepts and ideologies that are applicable to healthcare have a significant impact on interactional encounters during consultation process of SLT service provision.

In order to understand the interactional dynamics between SLT and interpreters a multi-lingual and multi-cultural context, issues such as language, politics and linguistic human

rights in South Africa is discussed. Cross-cultural and cross-linguistic issues in the world and South Africa healthcare contexts included an account of access barriers to affordable health and a need for cultural competence for HCPs. The role of politics and government's interventions pre and post democracy were deliberated. The approach to health provision using PHC in SA was also included. The discussion showed that health issues cannot not be resolved easily; without other factors such as policies, social and cultural being incorporated in strategic planning of the NDoH. It is imperative for the SA government to show political will in ensuring that the millennium goals are achieved.

Communication in intercultural communication in South Africa has not yet reached desirable levels, despite the non-racial of 1994. In addition, a discussion on the role of an interpreter in a cross-linguistic healthcare setting was included. The chapter also looked at what are the concerns in the South African context and problems in interpreted healthcare services in health and speech-language pathology and audiology.

Finally, theoretical framework included an Intersection of Foucauldian perspective and Critical diversity literacy, which was followed by Conversational Analysis in mediated settings. Understanding and using both approaches in the interpretation of data; armed the researcher with building blocks which were necessary for unravelling the theoretical underpinnings of power relations and the identification of particular interactional phenomenon in SLT consultation practices in a diverse hospital context.

CHAPTER 3: Research Methodology

3.1 Introduction

The purpose of this study was to explore the nature of interactions between SLTs and caregivers during their first consultation in a multicultural and multilingual health care context. This chapter provides a detailed discussion of the study approach and research methods followed in undertaking the examination.

The research design informing this study included a variety of data collection methods and analysis. Following this introduction is a detailed discussion of the research design. Thereafter, a discussion of the selection process followed is provided. The chapter subsequently presents an in-depth description of the study sites and an interpretation and analysis of the collected data.

3.2 Research approach and design

A qualitative, contextual interpretive research approach was followed in conducting the study. According to Gay and Airasian (2003, p. 163), "qualitative interpretive research is useful for describing and answering questions about participants and contexts". Furthermore, this type of design allows the researcher to study the perspectives of participants about events, beliefs or practices. Qualitative research leads to an awareness of multiple realities as opposed to assuming that there is a single reality (Erlandson, Harris, Skipper, & Allen, 1993). The qualitative method was the most appropriate approach to address the key research question for this study, namely, what is the nature of the interaction processes between SLTs and interpreters during an interview with the caregivers of children with speech and language disabilities in a hospital setting? To answer this question, various data collection procedures were used. Given that this question intended to explore a complex social phenomenon, the ability of the qualitative approach to signify context, setting and participants' frame of

reference or perceptions was appreciated (Marshall & Rossman, 2011). In this study the researcher did not only focus on recording the interactions between SLTs and caregivers, but also interviewed all participants in order to understand their frame of reference about their role and interaction with the child with a communication disability.

Given this complex intent the study therefore analysed and described the interactions between SLTs and interpreters in cross-linguistic mediated consultation settings. The therapeutic consultations under analysis were located in two urban hospitals in Johannesburg. The participants were caregivers of children with communication disabilities, speech-language therapists (SLTs) and an interpreter in a paediatric outpatient clinic.

The main objectives of the study were to:

- Analyse the interactions between SLTs and interpreters during interviews with caregivers;
- Describe strategies used by SLTs to invite interpreters to translate accurately; and
- Explore the perceptions of interpreters and SLTs of their effectiveness in these particular cross-linguistic settings.

To achieve these aims, three categories of participants were selected: SLTs, interpreters/assistants and caregivers as clients.

3.3. Selection of Study Participants

Purposive sampling was used as the study selection approach to gain access to participants for this study. It is a type of non-probability sampling and it is most effective to study a "certain cultural domain with knowledgeable experts within" (Tongco, 2007, p. 147). According to Oliver (2006), purposive sampling is a method or system of non-probability sampling that informs the researcher about which participants should be included or not included in the study. Furthermore, purposive sampling differs from probalistic sampling in that it allows for the selection of participants who will offer relevant rich information and therefore help with providing answers to the research question and aims (McMillan & Schumacher, 2001; Erlandson et al., 1993). This sampling strategy was found to be the most

appropriate for this study as the researcher aimed at getting a comprehensive understanding of the research sites and participants without generalising to similar case studies. Purposive sampling was used as the researcher was interested in participants' perspectives of both their setting and the research topic. In addition, this approach ensured that the researcher obtained more in-depth data as the participants were judged to be very similar in experience and perspective, that is, those with particular experiences in the SLT environment either as clients or service providers. Although the similarity in experience is argued to make data collection simple and analysis rich (Gay & Airasian, 2003), the simple part was not necessarily true for this study as the diverse hospital settings called for more time in the field.

Initially the prolonging of time in the field was seen as negative and somewhat of a delay, but was later viewed as an important opportunity that allowed for the analysis to evolve and for a more nuanced understanding of the settings and of how relationships unfolded in the interactions. This also afforded the researcher the opportunity to understand the multiple experiences of the participants and further allowed for deep pondering of how all these related to the research questions and the assumptions that informed these questions. One of the characteristics of a good qualitative research is that it requires the researcher to spend extended time in the research setting with participants (Gay & Airasian, 2003). The intention had been to stay for six months; however, this was extended to almost 12 months, which was worth it in the end. Below is a table that illustrates the participant's demographics and their languages.

Table2.1. Participants' descriptions

	SLTs - video recorded with caregivers	SLTs - individual interviews	Interpreter	Caregivers
Number of participants	8	5	1	13
Ethnicity	Indian, White and Colored	4 Indian and 1 African	African	African
Language of interview with researcher	English	English	English & Sesotho	Sesotho & isiZulu
Age	Between 24-50	Between 24-50	Between 45 -55	Between 23-60

Source: Fieldwork

3.3.1. Research sites

As alluded to earlier, two academic hospitals in Johannesburg, Gauteng province; were used as research sites for this study, namely the Chris Hani Baragwanath Academic Hospital (CHBAH) and the Charlotte Maxeke Johannesburg Academic hospital (CMJAH). The hospitals are part of the 40 provincial hospitals in Gauteng. Both hospitals are financed and run by the Gauteng Provincial Health Authorities and are both tertiary teaching hospitals for the University of the Witwatersrand (Pillay & Ramokgopa, 2013).

The city of Johannesburg is cosmopolitan, and has a number of well-known townships such as Soweto and Alexander. The CHBAH is situated in the south of Johannesburg and the CMJAH is in the northern parts of Johannesburg. Both hospitals serve mostly residence from Soweto and Alexander including those from the surrounding suburbs. The term "township

“has no formal definition but is commonly understood to refer to the underdeveloped, usually urban, residential areas that during Apartheid were reserved for Blacks (Africans, Coloureds and Indians) who lived near or worked in areas that were designated to whites only” under the Black Communities Development Act (Section 33).

Despite the fact that the segregation policies were abolished in 1994, many townships and other informal settlement have been growing rapidly. This growth has brought about the multi ethnic and multicultural nature of communities. According to FinMark Trust (2004) more than 40% of the urban population lives in townships. In addition, more than 20% of the population lives in informal settlement and low-income housing contexts, for example, 43 % of people of Johannesburg live in these areas.

Soweto and Alexander townships are vibrant and full of many diversities and contrasts in terms of languages, socio-economics, education, cultures and religion. Multilingual and multicultural Black urban townships are common in South Africa, especially in the Gauteng province. Due to widespread language contact, this leads unavoidably to language change and development of new language varieties and dialects. Besides the 11 official languages, there are also informal/colloquial languages, such as Tsotsi language. The number of people using tsotsi language (also known as *isicamtho*) is growing, because this facilitates communication across ethnic boundaries. According to StatsSA (Census, 2011: 25)

Predominant languages in the Gauteng province are;

- isiZulu 19.8%
- English 13,3%
- Afrikaans 12.4%
- Sesotho 11.6%
- Sepedi 10,7%
- Setswana 8,9%
- isiTsonga 6.5%

- isiXhosa 6,5%
- Ndebele 3.2%
- TsiVenda 2.2%
- Other 3%
- Sign language 0.4%.

The above statistics indicate that the first four languages are spoken by 57 % of the population in Gauteng. However, besides the dominance of isiZulu speakers, the other three languages (English, Afrikaans and Sesotho) are fairly evenly represented. English has been a highly influential language in South Africa, and also influenced and adapted in the different communities. For example, we have isiXhosa English and South African English as recognised dialects. The lingua franca in South Africa like in most countries is English; it is also used as the primary language of government, business and commerce. This scenario has uplifted English language as the language of those with power or social elite. For most Black people who were against the use Afrikaans as an official language during Apartheid era, English was seen as the language of aspiration and empowerment for Black South Africans (Silva, 1997).

There is also urban slang that is slowly growing which is used by young people. A bit of American Black English that young people who like hip hop artists use. With the increase of urbanisation, there is an increase in cultures and languages. Added to urbanisation, there is an influx of new immigrants and refugees in SA particularly African countries have led to a more diverse population. The benefits of urbanisation and immigration for the city of Johannesburg have been both, good and bad. Good in the sense that we have a mixture of diverse cultures and languages. Subsequently, the city was deemed an appropriate site for this study. On the other hand, the negatives; are poverty, crime, unemployment and xenophobia.

Between 1994 and 2000, the number of immigrants in South Africa has grown (Tati, 2008). However, it needs to be noted that this is not a new phenomenon, South Africa has historically, and even during apartheid it attracted immigrants from the neighbouring counties such as Lesotho, Botswana, Swaziland and Malawi. However, during these colonial and apartheid period most of the labour immigrants were based in the mining industry, and were

thus not part of the local day to day living. The conditions for staying in South Africa were stringent and restraining. The new democratic government has moved away from these past policies, even though migration has brought about challenges politically, socially and economically. The issues are related to the implementation of acceptable immigration policies for the developmental needs of the country, service delivery, overloaded health care provision, socialisation and xenophobia. (Tati,2008)

The fact that all African languages (local and nonlocal) are used in Gauteng was one of the motivations for choosing these two hospitals as the site for this research. The Chris Hani Baragwanath Hospital is situated in the south of Johannesburg in Soweto and is considered the largest hospital in the southern hemisphere. The hospital was initially named Baragwanath and the name Chris Hani was added later. Chris Hani was assassinated in 1993 in Boksburg, Johannesburg. He was the political leader of the South African Communist Party and chief of staff of Umkhonto we Sizwe, the armed wing of the African National Congress (ANC) (www.sahistory.org.za). He was a strong opponent of the apartheid government. The hospital occupies 173 acres of land, has 3200 beds and 6760 staff members. The hospital is situated in Soweto, which falls under the municipal jurisdiction of the City of Johannesburg. Given the migrant history of how Soweto came to be, it resulted in a multilingual and multicultural township; however the majority of people are IsiZulu and or Sesotho first language speakers (Statistics South Africa, 2011). Because of the socio-linguistic context of the Chris Hani Baragwanath Hospital, it was a suitable site to understand the nature of interactions between SLTs and caregivers during their first initial consultations in a multicultural and multilingual health care context.

The Charlotte Maxeke Johannesburg Academic Hospital is situated in Parktown, a northern suburb in Johannesburg. Like the Chris Hani Baragwanath Hospital, it was renamed in September 2008 to honour Charlotte Maxeke for her contribution to the freedom struggle. She was a social worker, teacher and political activist; she died in October 1939 in Johannesburg (“Two hospitals in Gauteng renamed”, 2008). The Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) serves Johannesburg and its surrounding suburbs. Johannesburg is a multilingual and multicultural city; however the majority of the African residents use IsiZulu and/or Sesotho as their first language (Statistics South Africa, 2011). The hospital has 1088 beds, with professional and support staff exceeding 400

(https://www.chrishanibaragwanathhospital.co.za) This hospital is also funded and run by Gauteng Provincial Health Authorities and National Treasury. Like the Chris Hani Baragwanath Hospital, the socio-linguistic context of the Charlotte Maxeke Johannesburg Academic Hospital made it a suitable research site for this study.

These two hospitals offer a full range of tertiary, secondary and highly specialised services. The hospitals serve as referral hospital for a number of other hospitals. One of the reasons for choosing these two hospitals as appropriate research sites for understanding the research problem was the possibilities for diversity in experiences – the SLTs were mainly English speakers whereas the clients were speakers of a variety of African languages.

3.3.2. Study participants

Given that this study aimed to understand the interactional dynamics in a cross-linguistic and cross-cultural health care context, the participants for the study included SLTs, caregivers and interpreter/assistants, as these are significant actors in the consultation interaction. At the end of the study, ten SLTs from the two hospitals had been interviewed, all of them with English and/or Afrikaans as their first language.

The clients or caregivers interviewed spoke a variety of African languages including isiZulu, isiXhosa, Sesotho, Setswana, Sepedi, isiTsonga and TsiVenda as their first language. A total of thirteen caregivers had been interviewed at the end of the fieldwork process. Only one interpreter/assistant was interviewed at the end of the fieldwork process – this was mainly because of a lack of formal employment of interpreters in both of these hospitals, as in most public hospitals. The unavailability of interpreters can have serious consequences as it is not only a "matter of language" but a matter of life and death (Lesch, 2007). For the patient and doctor to come to a correct diagnosis and treatment, there needs to be appropriate communication. Most provinces in SA have a language policy, but the reality is that the Department of Health still does not have official medical interpreters in most provinces (Cole, Lawrence, Nyubuse & Goddenet, 2003). The lack of appointment of interpreters in South African state hospitals is attributed to a lack of funds (Schlemmer & Mash, 2006).

Despite being a “rainbow” nation with various cultures and languages and having the Pan South African Language Board (PanSALB) to monitor implementation of linguistic rights, there are still limited linguistic solutions for the majority of the citizens that use state or public hospitals.

Speech therapists and interpreters were identified with the help of the head of department who was asked to identify the speech therapist allocated the duty of seeing outpatients in the paediatric section. A letter requesting permission was sent to the hospital managers and heads of speech and hearing therapy in each hospital. The permission from the hospital manager was granted on condition that the researcher would not disrupt or take time away from staff performing their duties. This consideration led to different adjustments and to more time at the research site. Once permission was granted, relevant and potential speech therapists were approached and invited to participate in the research. During the introductory meeting with the speech therapists, they were asked if they worked with an interpreter and it was found that in most cases the speech therapists used ad hoc interpreters. Ad hoc interpreters are individuals who are not formally trained in the theory and practice of being an interpreter, yet are called on to play the role of an interpreter (Fisch, 2001; Lesch, 2007). Although research shows that this is a regular occurrence in many health settings throughout the world, an ad hoc interpreter did not feature during data collection for this study. Some SLTs reported using ad hoc interpreters, but it was, however, not observed by the researcher.

The assistant in the department supplied the names of clients booked for each day. When the clients, that is, the caregivers arrived, the researcher personally approached them to invite them to participate in the study and gave them the participant information sheet (see Appendix F) which explained in detail what the research was about. Once they agreed to participate it was further explained that the consultation session will be videotaped to allow for analysis. Once they consented to participate, they were requested to sign the relevant consent forms (see Appendix G). None of the people invited to participate in the study refused or showed signs of discomfort with the videotaping of the consultation interviews.

Justification of inclusion and exclusion in this study was based on the principle of fairness and equity in research participation. This is an important principle that assures that there is neither an unfair share of the direct burdens of participating in research nor the unfair

exclusion of participants from the potential benefits of research participation (Teddlie & Yu, 2007). As a prerequisite of the principle of fairness the different participants were required to have the following defining characteristics: SLTs were to be qualified for two or more years; speak a different first language from the patient's first; and have been working at the research site for at least a year. Interpreters had to be individuals that primarily served a language function as part of their work context or that were ad hoc interpreters and assistants in the department of speech therapy and audiology at the study sites.

Caregivers selected for participation in the study had to be the primary caregiver or parent of a child under seven with a disability seeking speech therapy services in a hospital, thus ensuring that they would be able to provide adequate and appropriate details about the family and child during the case history interview. There were no processes for excluding participants who were considered to be proficient in English and/or Afrikaans, thus not requiring interpretation as reported by the caregiver. The caregiver also had to use the same home or additional language as the SLT who conducted the interview. The criteria for exclusion referred to participants that were proficient in English and Afrikaans, as they would not require any interpretation reported by the caregiver.

TABLE 2.2Characteristics of SLTs

SPEECH LANGUAGE THERAPIST CHARACTERISTICS								
NAME OF SLT	GENDER	AGE	RACE	LANGUAGE PROFICIENCY		EMPLOYMENT HOSPITAL	NO. OF INTERACTIONS RECORDED /CONSULTATIONS	FIELD EXPERIENCE IN YEARS
				1ST LANGUAGE	WORK LANGUAGE			
SURIYA	FEMALE	50'S	INDIAN	ENGLISH	ENGLISH	CHRIS HANI BARAGWANETH	4 INTERACTIONS	OVER 20 YRS
DEVI	FEMALE	MID-20'S	INDIAN	ENGLISH	ENGLISH	CHRIS HANI BARAGWANETH	5 INTERACTIONS	2YRS - POST COM.SERV
ELMA	FEMALE	30'S	WHITE	AFRIKAANS	ENGLISH	CHRIS HANI BARAGWANETH	3 INTERACTIONS	4-5YRS
ANIE	FEMALE	LATE 20'S	WHITE	AFRIKAANS	ENGLISH	CHRIS HANI BARAGWANETH	1 INTERACTION	5-6YRS
SIMZ	FEMALE	LATE 20'S	COLOURED	AFRIKAANS	ENGLISH	CHRIS HANI BARAGWANETH	3 INTERACTIONS	4-5 YEARS
SALMA	FEMALE	MID - 30'S	INDIAN	ENGLISH	ENGLISH	CHARLOTTE MAXEKE	2 INTERACTIONS	7-8 YEARS
SARAH	FEMALE	LATE 20'S	WHITE	ENGLISH	ENGLISH	CHARLOTTE MAXEKE	1 INTERACTION	4-5YRS
NOZIPHO	FEMALE	30'S	AFRICAN	ZULU	ENGLISH	CHARLOTTE MAXEKE	1 INTERACTION	6-7YRS
KLATS	FEMALE	LATE 20'S	ASIAN	ENGLISH	ENGLISH	CHRIS HANI BARAGWANETH	1 INTERACTION	6YRS
NICY	FEMALE	LATE 20'S	WHITE	AFRIKAANS	ENGLISH	CHRIS HANI BARAGWANETH	1 INTERACTION	4-5YRS

TABLE 2.3. Details of clients' characteristics

INDIVIDUAL SPEECH THERAPISTS CASES							
1. SPEECH LANGUAGE THERAPIST: SURIYA (hospital A)							
CLIENT & CASE DESCRIPTIONS AND CHARACTERISTICS							
CHILD NAME	**AGE**	**GENDER**	**DISABILITY**	**REFERRAL DIAGNOSIS**	**SCHOOLING EXPOSURE**	**CAREGIVER /S**	**LANGUAGE PROFICIENCY**
1. SK_BOY	3+ Yrs	MALE	NONE	Ashtmatic child who suddenly lost his physiological functioning ability, cause of which is unknown. He is also attending physiotherapy sessions. Has speech defects.	ATTENDING CRECHE	FATHER MOTHER	ZULU, MINIMAL SOTHO AND GOOD ENGLISH
2. VIC_BOY CONSULTATION	6yrs	MALE	NONE	Slurred speech, and developmental strides are slower compared to other children his age	ATTENDING PRE-SCHOOL (3YRS)	MOTHER SISTER	SOTHO & ENGLISH
3. LEB_BOY CONSULTATION	1yr 11 months	MALE	NONE	Undergoing physiotherapy, has slow developmental problems	NONE	MOTHER FATHER	SESOTHO
2. SPEECH LANGUAGE THERAPIST: ELMA & SIMZ (hospital A)							
CLIENT & CASE DESCRIPTIONS AND CHARACTERISTICS							
CHILD NAME	**AGE**	**GENDER**	**DISABILITY**	**REFERRAL DIAGNOSIS**	**SCHOOLING EXPOSURE**	**CAREGIVER /S**	**LANGUAGE PROFICIENCY**
1. M_JNR_BOY CONSULTATION & FEEDBACK	3yrs, 8 MONTHS	MALE	NONE	Speech defects and developmental strides are slower compared to other children his age. Was referred to an OT specialist, neuro-developmental clinic, caregivers referred to Lanaguage Program	ATTENDING PRE-SCHOOL	MOTHER DAD	ZULU, SOTHO & ENGLISH
2. JNR_BOY CONSULTATION	3YRS	MALE	NONE	Speech disorder, agression from frustration, still wears pampers. Possibility of Autism. Referred to Autism Spectrum disorder clinic, OT, ENT.	NOT ATTENDING PRE-SCHOOL DUE TO MOTHER'S FEAR OF HIM GETTING PICKED ON DUE TO SPEECH DEFEACTS.	MOM & GRANDMOTHER	VERNACULAR & ENGLISH
3. LETA_BOY CONSULTATION	3yrs, 4 months	MALE	BLINDNESS, EPILEPSY, PARALYSIS	Born with Hydrocephalus, Lack of proper speech, slow neuro and cognitive development, recieved neuro-surgery. Currently on medication for epileptic condition.	NOT ATTENDING, DUE TO DISABILITY	MOM DAD	SETSWANA- required translation

3. SPEECH LANGUAGE THERAPIST: SIMZ & ELMA, SURIYA (hospital A)							
CLIENT & CASE DESCRIPTIONS AND CHARACTERISTICS							
CHILD NAME	AGE	GENDER	DISABILITY	REFERRAL DIAGNOSIS	SCHOOLING EXPOSURE	CAREGIVER /S	LANGUAGE PROFICIENCY
1. ANDI_GIRL CONSULTATION & FEEDBACK	2yrs +	FEMALE	NOT CLEAR	Hyperactive disorder, not talking, very slow speech development due to brain defects from birth. ASSESSMENTS: Hearing test, CT Scan. Recommendation to attend Language Program	NOT ATTENDING	MOTHER	ISIXHOSA ENGLISH
2. NDO CONSULTATION & FEEDBACK	6yrs	FEMALE	NONE	CAREGIVERS had thought she was a slow learner, lazy, with speech problems because she hardly spoke. From speech therapy, it was discovered that the child has depression, anxiety attacks and mainly psychological and emotional problems which were affecting her speech. she had developed a "NO TALKING" defence mechanism. all of this due to the LOSS of her mother through death. the chils was struggling to deal with the loss.	PRE	GRANDMOTHER GRANDFATHER AUNT	ZULU ENGLISH
3. TT_BOY CONSULTATION	2 YRS	MALE	POSSIBILITY OF DEAFNESS IN ONE EAR	EAR Infection	ATTENDING CRECHE	MOTHER	ZULU ENGLISH

4. SPEECH LANGUAGE THERAPIST: SALMA(hospital B)							
CLIENT & CASE DESCRIPTIONS AND CHARACTERISTICS							
CHILD NAME	AGE	GENDER	DISABILITY	REFERRAL DIAGNOSIS	SCHOOLING EXPOSURE	CAREGIVER /S	LANGUAGE PROFICIENCY
1. BABY-GIRL CONSULTATION & FEEDBACK	6 mths	FEMALE	NOT CLEAR	referred by Neurology department- had epilepsy (Grand-mal seizures) at 2 months. ASSESSMENTS: Hearing test, Feeding assessment, CT Scan. Recommendation to attend Language stimulation intervention	N/A	MOTHER &DAD	SEPEDI ENGLISH

5. SPEECH LANGUAGE THERAPIST: JESSICA (hospital B)							
CLIENT & CASE DESCRIPTIONS AND CHARACTERISTICS							
CHILD NAME	AGE	GENDER	DISABILITY	REFERRAL DIAGNOSIS	SCHOOLING EXPOSURE	CAREGIVER /S	LANGUAGE PROFICIENCY
1. NEO_BOY CONSULTATION & FEEDBACK	3yrs	MALE	NOT CLEAR	Not talking, very slow speech development, obsessive behaviours, not sociable. ASSESSMENTS: Paeditric assessment . Recommendation to attend Language Program	NOT ATTENDING	Dad & Grandmoth	SETSWANA ENGLISH

3.4. Pilot study

A pilot study is a limited study organised before the main study is performed. This process includes the management of the whole study where every procedure is monitored, and thereafter the data is analysed and evaluated according to the study plan (Gay & Airasian, 2003). The researcher conducted a pilot study in order to identify errors and refine data collection procedures and research tools (Heritage, 2004). The aims of the pilot study were: to familiarise the researcher with research procedures; to determine the appropriateness of the materials; to assess the duration of the data collection process; and to familiarise the researcher with selected data analysis methods. The pilot was conducted at the speech therapy department of the CHBAH in Johannesburg, Gauteng. The site was deemed feasible

as the purpose of the pilot was to familiarise the researcher with the research tools and context. The researcher spent five days at the research site; the first four days were used for observing potential participants in all areas of the department that could be approached for research participation. Then, on the fifth and last day, the researcher observed and video recorded one consultation, which was followed by semi-structured interviews with SLTs, caregivers and an interpreter. The participants of the pilot study were not included in the main study.

3.4.1. Methodological recommendations from the pilot study.

From observation and analysis of the pilot processes it became apparent that video recordings of SLTs in mediated consultation interviews with caregivers is a suitable method for observations and conversational analysis of the study.

Secondly, it became clear from the pilot study that post-consultation individual interviews with SLTs and the interpreter should not be conducted immediately after the consultation due to time challenges for the SLTs. As a result, the interviews were conducted at a different time and this proved to be more effective. Furthermore, as the interpreter was assisting more than one SLT, her time was also limited as she was expected to move to the next session with other SLTs with no break in between her sessions. The CHBAH has two assistants that work as interpreters, one in audiology and one in speech therapy. As a result, when the fieldwork was completed only one interpreter had been interviewed and another one during pilot study l
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Thirdly, in the study proposal it was suggested that individual interviews with caregivers will be conducted at the end of the consultation. However, from the pilot study it became clear that post-consultation interviews would be inconvenient for the caregivers because, at that point, their children would most probably be tired and restless. It became clear that the best possible action would be to conduct a focus group interview with the caregivers, as that would facilitate responses without them feeling pressured to respond to every question. Furthermore, focus groups can be used as a method to jog caregivers' memory pertaining to experiences (Morgan, 2013). The focus group with caregivers was useful for closing some of the gaps regarding the data captured in the video recordings. However, given the challenges

in terms of the caregivers' time, the tiring experience of the consultation and waiting periods, plus travel times for most caregivers, only one focus group discussion was conducted. Although this data were useful for the researcher's general understanding and of the great influence on how the interview and video recordings were interpreted, the focus group data are not presented in this report.

Finally, in the study proposal it was suggested that a hospital in Mpumalanga would also be added as a study site. However, during the pilot study at the site it was found that the site was not appropriate for data collection due to a limited number of patients and the different way in which the speech therapy department was conducting their language assessment clinic. Furthermore, after a long telephonic conversation with the head of the speech therapy department in the Witbank Hospital, the researcher felt that this hospital site would not yield relevant data to answer the research question. This hospital's speech therapy department used a multidisciplinary professional interaction that would have added a dynamic in which this study was not interested. It also became clear from the telephonic conversation that three allied health professionals, that is the SLT, physiotherapist and occupational therapists, sat in on the initial consultation with caregivers. Such a consultation process can be seen as a self-contained SLT method of consultation. Although this approach allows for in-depth psychosocial-economic narratives of the child and family, it makes the consultation interaction short and brief, and fast paced. It presented more of a quantitative interrogation as opposed to a narrative interaction, and thus was not relevant for this study. Again, the focus of this research was not on multidisciplinary professional interaction, but more on the SLTs role in an interaction process; hence the clinic turned out to be irrelevant for the purposes of this study.

3.5 Data collection

As already alluded to earlier, data for this study was collected from a diverse source of participants; so as to, gain deep insight into the realities constructed about initial speech-language consultations in a cross-linguistic health care setting. The study was operationalised through multiple strategies of data collection. These methods of data collection enabled the researcher to interpret and analyse the relationships and interactional dynamics in a

multicultural and multilingual setting, with the understanding that this is a complex social and health setting of which it cannot be concluded to be a simplistic phenomenon.

This multi-pronged manner of data collection facilitated methodological triangulation, which refers to the use of more than one method of gathering data to increase the trustworthiness of the study (Denzin, 1970). The nature of consultations led to the use of the triangulated method of data gathering. Following is a detailed discussion of the individual methods used to collect the data.

3.5.1.1 Participant observations

McMillan and Schumacher (2001) describe participant observations as an interactive manner of collecting data by experiencing the daily activities of participants over a prolonged period and writing descriptive field notes. In an observational approach the researcher tries not to interpret or draw conclusions early in the study. The researcher enters the setting slowly, learning to become accepted by participants and gaining rapport with them. Over time the researcher collects data in waves; making initial observations and interpretations about the context and participants; then collecting, examining and refining more data in a second wave; then fine-tuning observations and interpretations in another wave, and so on until the researcher has obtained a deep understanding of both the context and the participants (McMillan & Schumacher, 2001). After the pilot study, the researcher followed this pattern and collected data in waves in 2010 and 2012.

The researcher observed participants as part of gaining an understanding of the research setting. These observations were beneficial as they allowed the researcher to establish rapport and trust with the participants and to familiarise herself with workplace procedures, practices and culture. The researcher spent five days in the speech therapy department during the pilot study in 2010 at the CHBAH and was able to take field notes, keep notes in a reflective diary and conduct informal interviews with participants. Participant observations continued throughout the main study in 2011 and 2012 at both hospital sites. This gave insight into the approach to be used during actual data collection. It was furthermore a platform that enabled observing of the subtle, yet very significant non-verbal, mundane characteristics of lived experiences of caregivers and children attending hospital consultations. For example, I observed the administrative procedures that are followed by caregivers before they are seen

by the SLT. In addition, I observed how caregivers had to carry their children on the back and sometimes feed them in the waiting room before consultations with the SLT. These observations further presented as a quasi-ethnographic approach that enabled better understanding of the research population and environment context.

3.5.1. 2 Video-recordings of interactions between SLTs, interpreters and caregivers

Video recordings (using Sony Handycam CX150 with Tripod CX 480) of the interactions between the SLTs, interpreters and their clients were made to allow the researcher to observe the participants' "natural" behaviours during consultation. The consultation rooms used and the settings at the hospital were not changed or influenced in any way. This study used natural observations so that the researcher could not control or manipulate the setting. This method was selected as the researcher did not have any intentions of influencing the dynamics of the interaction between the SLTs and caregivers. Additionally, it would have presented as an ethical challenge for the researcher to have been present and passive at the same time, based on one's experience as an SLT; hence the intention was to observe and later analyse the interactions as they occurred. Admittedly, the intention of having the phenomena purely natural could not be achieved as the participants would have been aware of the presence of the camera (Garcez, Duarte, & Eiseberg, 2011).

Video recordings were used rather than audio recordings so as to capture the full range of verbal and non-verbal communication during SLT–caregiver interactions. The non-verbal communication was significant for answering the research question in a more dynamic way. To allow for clarity and efficient recording, a high-quality digital camera that recorded directly onto a hard drive of a portable camera was used. This allowed for little interference in the consultation process as it would have been impractical to expect the participants to adjust camera angles. The camera lens used had a wide-angle capacity sufficient for the setting.

The video recording of the interactions in the Speech therapy departments including non-verbal behaviours during a mediated initial consultation of SLTs and caregivers was found to be a powerful tool. This instrument allowed the researcher to have verbatim transcriptions that could be translated into English when required and later analysed into themes and linguistic aspects. This research tool was pivotal to the research process as it allowed the researcher to have ample time to understand and question or explore what she was observing. Since this study had an interpretive approach as a methodology; it relied on a subjective relationship between the researcher and the participants. In qualitative research approach, having a subjective relationship with participants helps the researcher to explain from the subjective reasons and meanings that lie behind the social interaction or action (Terre Blanche et al., 2006). However, the challenge with this tool could be that the Hawthorne effect, where the participants exhibit a socially desirable behaviour when they are aware that they are being recorded.

3.5. 1.3 Semi-structured Individual interviews with SLTs and interpreters

Interviews are the most common method used in health care research to collect data (Gill, Stewart, Treasure, & Chadwick, 2008). The interviews were conducted only with SLTs and the interpreter. Semi-structured verbally administered questions were used to facilitate discussion during the interviews. Unstructured interviews are beneficial as they do not assume or reflect any preconceived theories or ideas (Gill et al, 2008). The researcher utilised a self-developed interview guide (see Appendix 1). The interview schedule had several key questions relating to how SLTs view their work position with interpreters and being in a multicultural health setting. There were several key questions that assisted in exploring the participant's views in detail. The researcher found that this approach was flexible as it allowed for follow-up questions and probing while still allowing for some structure. It also allowed for elaboration on new and unanticipated information which was raised by the participants.

Individual interviews with the SLTs and an interpreter were conducted to understand their experiences working in a cross-linguistic and multicultural context. According to Gay and Airasian (2003, p. 203) "interviews permit researchers to obtain important data they cannot

acquire from observation". In view of the fact that permission to conduct the study came with the condition that the researcher would not disturb the SLTs in their duties, the interviews were done during the SLTs lunch break and took approximately 30 minutes. This meant that even the follow-up sessions where the participants were allowed to do member checking of the accuracy of transcripts occurred during their lunch break.

The purpose of the semi structured interviews was to understand how the speech-language therapist, caregivers and interpreters make sense of their role in the mediated setting with specific focus on language dynamics. Furthermore, the researcher aimed to determine the perceptions that speech-language therapist, caregivers and interpreters have about consultations in a multi-lingual and multi-cultural setting. In the researcher's experience, the interview process was both interesting and challenging. It was interesting for the researcher to have a face to face contact with colleagues in a relaxed manner about the issues that they both feel need to be addressed in diverse settings. The fact that the researcher can speak more than one African language was useful. I was able to speak with caregivers in their mother tongue. The care givers were at ease with the researcher and almost relieved when addressed by professional in their mother tongue. The care givers were open about their challenges regarding spending long hours in the hospital, which sensitized the researcher in not expecting them to participate in another interview after consulting the SLT about their children's communication difficulties.

As the research interview used semi-structured questions, the interviewer was mindful of not making it to be a mere conversation and also avoid being a counselling session. There was a "balance between cognitive knowledge seeking and the ethical aspects of human interaction" (Kvale, 1996; p.125). The researcher's premise was that there may be many truths, beliefs and facts, thus each participants was listened to carefully in order to get their perspective. To capture these perceptions and understandings an audio recorder was used.

The questions to all participants started with a descriptive question 'what happened/ did you experience?' According to Kvale, (1996), the reason for asking a description from participants is to facilitate spontaneous descriptions before asking for interpretations or

speculative explanations. The questions were also open-ended in order to allow the participants to interpret and elaborate on them. Furthermore, uses of open-ended questions are useful in the discovery phase of the research (Fetterman, 1998).

3.5. 1.4 Focus group interviews with the caregivers

Focus group interviews are beneficial for generating information on collective views and the meanings that lie behind those views. The researcher gained understanding of how caregivers view the services that they receive from SLTs at a hospital. However, focus groups should be avoided if participants are feeling uneasy with each other, or if the topic that the researcher brings up is not of interest to all the participants (Gill et al., 2008). The participants in this study were mainly women of more or less the same age and were actually happy to share their experiences as the group provided something similar to a support group.

However, the initial focus group conducted at CHBAH was not useful as most of the participants gave socially desirable responses about the services of SLTs even though confidentiality was assured. The reason for this was mainly because they seemed to want to give a positive and enhanced impression of the SLTs and the services that they provide for their children. Thus, this clouded the analysis and interpretation of data. As a result, the researcher decided not to continue with the focus group discussion planned for CMJAH. Furthermore, the timing of the focus group discussion was problematic. The discussion was held after the support group meeting at the hospital. Due to the fact that the participants are all mothers or caregivers of young children; being away from home for a prolonged period of time was problematic.

A successful focus group is one that inspires interaction on the topic. The researcher found an existing support group at the hospital, consisting of mothers of children with language disorders. This group met about every six weeks, with some members having recently joined the group. Members have a shared experience of having a child with a communication disorder. However, this was found not to be good in facilitating the discussion and members seemed afraid to challenge each other or voice their opinions. When focus group members are not familiar with each other, it often becomes a challenge to disclose and to interact comfortably (Morgan, 2013). Participants were recruited after their support group meeting; however some of the caregivers were not willing to stay for the focus group, because of

dynamics related to context, for example, they had attended a caregivers' workshop for the day. Hence, when the researcher requested their participation in the focus group, post-workshop attendance, it became an inconvenience for some of the participants. Understandably so, when considering the context within which caregivers of young children/infants with disabilities live. More often than not they live their lives accommodating their children, and therefore time may become a luxury that they do not have. The support group meetings are held with mothers only, they are not allowed to bring their children for these meetings. The caregivers were generally compliant; to expect them to forego their time with their children and to expect babysitters to stay longer with their children would be tantamount to power abuse from the researcher's point of view.

The focus group was conducted with five caregivers (all female, all black and all mothers of children under the age of six with communication disabilities, from the Soweto Township) that had been seen at the language assessment clinic. The researcher was not present in all the initial consultations between the caregivers, the SLTs and the interpreter, and wanted to offer them time to reflect on this experience as a group, as the pilot study found that conducting individual interviews after initial consultations was not useful. The researcher's ethical obligation to the principle of beneficence had to be upheld.

Conducting a focus group at the specified time was found not to be beneficial for identifying and interrogating participants' responses about their lived experiences of being consulted by an SLT in a cross-linguistic setting. Excluding this process from the data collection affected the results, in a somewhat negative manner. The voice of the care givers was not heard, consequently, the results are skewed towards listening to the professionals' side of the story. In order to balance the perceptions and views of participants it would be beneficial in future to use a site away from the hospital, and different methods to elicit narratives such as using video or picture vignette with the caregivers.

3.6 Data analysis

The analysis of data constituted the use of a triangulation method that involved thematic content analysis and some aspects of conversational analysis. Thematic content analysis provided rich descriptions of themes across the data (Riessman, 2008) derived from individual interviews and the focus groups conducted with the SLTs, the interpreter and caregivers during the consultation process from which perceptions were derived.

The researcher was guided by Shields and Twycross (2003) recommendation of what the process of data analysis entailed. The first stage of thematic content analysis was the verbatim transcription of the interviews, which also involved checking for any omissions or errors. Secondly, the process included the review of the transcripts several times, while listing emerging and re-emerging themes based on the perceptions of the participants. The interviews and video recordings were collected over a prolonged period; consequently analysis began whilst other interviews were going on. Creswell (2014) states that data analysis in qualitative research should be conducted simultaneously with other parts of the study, like data collection. Henceforward, the themes emerged from the transcripts through words, phrases, sentences and paragraphs that represent or symbolise issues relating to cross-linguistic health care service experiences.

The analysis was of moment-to-moment interaction that occurred in a hospital outpatient child language clinic between the SLTs and caregivers, and at times an assistant interpreter was also included to highlight the conversational aspects and themes of the interaction. Not all the text and visual data was used in the analysis of the study, the researcher sifted out other parts of the data and focussed on relevant information. This is a significant part of qualitative study, where the researcher selects what to focus on in the interpretation and developing themes (Creswell, 2014).

The method employed to analyse the video recordings of consultations of SLTs and caregivers was guided by some aspects of conversational analysis, as set out by Schegloff, (2007) This included but was not limited to processes involving turn-taking, invitations to

interpret, turn transfer, instances of repair, overlaps, choice of vocabulary, code-switching and non-verbal behaviour.

Turn-taking during the interaction process consists of an interchange between the speaker and the listener, which in this case meant that both the SLT and caregiver gave each other chances at speaking. Therefore the power dynamics which could have been a result of one participant dominating the other were examined. Another aspect that was analysed involved observing the awareness of the SLT's identification of communication needing interpretation, which would essentially mean that they extend an invitation to the interpreter, visible through pausing in speaking as well as non-verbal messages.

The degree of correctness, appropriate and effective interpretation, which according to (Schegloff, 2007) would also include turn transfer during the interaction process, was also analysed with the intention of identifying the extent to which language could have been a barrier to facilitating the interaction process between the SLT and the caregiver. Furthermore, it was important to check for communication barriers or facilitation having an interpreter from a multicultural context different from the SLT but similar to the caregiver.

Through analysing overlaps, choice of vocabulary, code-switching, and non-verbal behaviours, the researcher further had insight into the contextual dynamics involved in the event of the need for instances of repair.

3.6.1 Trustworthiness

Trustworthiness in qualitative research is used as a strategy to enhance rigor, so that the research is worthy or does not become a fictional story that would lose its utility. Therefore, it is important for qualitative researchers to pay careful attention to strategies that show rigor in improving trustworthiness, which in quantitative approaches are referred to as reliability and validity. Guba and Lincoln in the 1980s substituted the terms reliability and validity with "…the parallel concept of "trustworthiness," containing four aspects: credibility, transferability, dependability and confirmability (Morse, Barrett, Ayan, Olson & Spiers, 2002: 13). These four aspects of trustworthiness are at the core of verification and rigor of the research process. In addition, by having these aspects interwoven in every part of the research, they contribute towards correcting and identifying errors before they weaken analysis.

3.6.1.1 Credibility

Credibility concerns the truthfulness of the reported data; and it also about interrogation of the relationship between research data and the phenomena those data represent (Erlandson et al., 1993). The researcher needs to show how she/he has come to the interpretations given by providing evidence that leaves no doubt to others, for example, prolonged engagement and triangulation . A good and reliable knowledge should be established during the initial stages of the research process between the researcher and the participants. In this research, prior to data collection, the participants received information on the purpose of the study and their consent was sought. Hence, initial credibility in this study was at an interpersonal level rather than methodological (Reason & Rowan, 1981)

Furthermore, strategies that help to enhance credibility were used in this study as suggested by (Guba & Lincoln, 2005). These strategies included prolonged engagement and persistent observation. Considerable time was spent at the research site with SLTs and their support staff in order to gain understanding of the needs and challenges of both the SLTs and the caregivers. The participants were recognised as individuals in their own right, and their issues and concerns were respected. Through genuine concern and frankness, I became aware of lack of focus and benefit of having a focus group with care givers. I had endeavoured to establish rapport and was also sensitive to their discomfort in spending prolonged time at the hospital after intervention or workshop with the SLTs.

Triangulation according to Denzin (1989) involves the use of multiple methods in order to remove personal biases of the researcher that could be brought about by using a single methodology. The use of multiple methods in the same study, one can prevail over the limitations that arise from one researcher or method (Denzin 1989). The researcher collected data using observations, individual interviews and video recordings. Each of these, methods provided a different angle about the same phenomena; which is the interaction of SLTs interactions with care givers in a multicultural and multilingual urban hospital setting. The video recording enabled the researcher to explore the linguistic and social aspects of the interactions and the interviews and observations gave her insight into the perspectives and mundane issues of the participants.

Furthermore, the researcher triangulated the data collection method by using extensive field notes. Extensive field notes are another significant strategy of enhancing the validity and

reliability of the study (Babbie & Mouton, 2001). The researcher kept field notes during fieldwork and referred to them regularly. These notes guided the researcher when an adjustment was necessary, such as when the focus group interview was withdrawn as a data collection method.

The data gathering approach used was guided by the view that in order to understand the context one has to be immersed in it. Thus the perspective should not be that of an outsider (etic), but emic. The process of revelation or understanding requires the researcher as primary research tool to practically be involved in the problem or context. The information that the researcher was searching for was qualitative and therefore cannot be acquired by quantitative methods that use positivist approaches. "Qualitative methods are stressed within the naturalist paradigm not because the paradigm is anti-quantitative but because qualitative methods come more easily to the human-as-instrument." (Guba & Lincoln, 2005. p. 198-199). To enhance the truth value of the study, strategies recommended for qualitative research such as credibility, transferability, dependability and confirmability were adopted (Shenton, 2004). The critical question is: How compatible are the diverse realities that exist in participants' minds with those that are assigned to them?

Triangulation was further enhanced in the study by using multiple research instruments and participants. Reaching triangulation, "…means asking different questions, seeking different sources, and using different method." (Babbie & Mouton, 2001; 277). The researcher collected data using video recordings of the SLTs and caregivers, conducted individual interviews of SLTs and an interpreter as well. Interpretation of data also used different methods of analysis, for example, interpretation of participants' linguistic and non-linguistic aspects of the interactions and thematic analysis of the individual interviews.

Furthermore, to establish credibility, peer debriefing was conducted. Peer debriefing is done with a peer or similar status colleague who was not involved in the data collection but has a good understanding of the nature of the study to analyse and test perceptions, insights and interpretations (Babbie & Mouton, 2001). In this study, the researcher supervisor served as a peer who challenged the researcher's thoughts and experiences when it was called for. The

researcher provided details in relation to the process, participants and context so that the debriefer or reader could have clarity and certainty about interpretations of results and conclusions by the researcher.

Member checking or responded validation was conducted with two SLT, as other therapists were not available. Member checking is a strategy used in qualitative research where the researcher hands the transcribed data and initial interpretations back to the participant for checking (Bloor, 1997). This was done with some SLTs from the CHBAH and CMJAH sites where the individual interview that was conducted with the SLT was read and emerging themes discussed. The SLTs further confirmed that the transcription was true and corroborated the emerging themes. There were no disagreements about the accuracy of the transcribed interview or the emerging themes.

3.6.1.2 Dependability

There are close ties between credibility and dependability – credibility ensures dependability (Lincoln & Guba, 1985). The researcher took time to ensure that this study could be replicated. The researcher should ensure that any differences that may occur could be attributed to "tractable variance". However, Marshall and Rossman (2011) argue that this is problematic seeing that no situation could be "static and frozen" as in reality life is ever-changing. To ensure the dependability of the study, the researcher reported data collection and analysis processes in detail so that this type of study could be repeated.

3.6.1.3 Transferability and confirmability

According to (Lincoln & Guba, 1985), transferability of a study is evaluated in terms of the level to which its results can be applied in other contexts or with other participants. The research has to assess the applicability of the results across contexts and in addition provide adequate detail of the research context, so that readers can decide if the context described is similar to another context which is familiar to the reader. Thus it is imperative to find ways to focus on aspects of the research that do not vary across or within contexts. In addition, the results of the study should be interpreted in such a way that it allows for the shift of context

(Erlandson et al., 1993). In the interpretation of the results the researcher provided thick description by using verbatim quotes from participants to explain the interpretations. To further enhance transferability of the study, the researcher provided details about sampling, the number of research sites, data collection methods, and the time period of data collection.

"Confirmability is a criterion for neutrality"; it relates to "the freedom from bias in the research procedures and results" (Krefting, 1991, p. 216). Confirmability in qualitative research is comparable to the concept of objectivity in quantitative research (Shenton, 2004). To ensure confirmability, the researcher documented an audit trail by recording field notes, used video and audio recordings, stated how interpretations were reached and included instrument development information.

3.7 Study ethics

This study was guided by the following ethical principles: fairness, beneficence and no harm (Davies & Dodd, 2002). According to Davies and Dodd (2002, p. 281), "[e]thics are an essential part of rigorous research. Ethics are more than a set of principles or abstract rules that sit as an overarching entity guiding our research … Ethics exist in our actions and in our ways of doing and practising our research; we perceive ethics to be in progress, never to be taken for granted, flexible, and responsive to change". To follow these principles, this study was also facilitated by the attention provided by the Wits Ethics Committee. After their rigorous interrogation of the study proposal, a clearance certificate, *no. M091163,* (appendix A) was issued in November 2009.

Below is an outline of the ethical considerations followed in the study:

3.7.1 Permission to do the study

A letter requesting permission from the hospital's manager and Head of Speech and hearing therapy was sent. Once permission was given, relevant and potential participants were approached. Speech therapist and interpreters were identified with the help of the head of

department who was asked to suggest the speech therapist that is allocated the duty of seeing outpatients in the paediatric section. Then the speech therapist was approached and invited to participate in the research. The speech therapist was asked if she works with an interpreter or if she uses an ad hoc interpreter. If she worked with an assigned interpreter then, the interpreter was also approached and invited to participate in the study. If an ad hoc interpreter was used, then the researcher waited for when the speech therapist managed to find someone, then that person was also be asked to participate in the study just before they commenced with the interview.

3.7.2 Informed consent

Letters of consent outlined the whole process and purpose of the study so that participants were fully informed of what their participation entailed. Letters requesting permission to conduct the study in the hospitals were sent to the Chief Executive Officer at the Chris Hani Baragwanath Academic Hospital, Charlotte Maxeke Johannesburg Academic Hospital and to the Mpumalanga DoH Research and Ethics Committee (see Appendices B to E). Permission was granted for the researcher to undertake the study at all three venues. The staff in the speech therapy departments in the three hospitals was then invited to participate in the study. The Mpumalanga hospital was eventually not included in the study due to difficulty in finding relevant participants. The researcher visited the hospital on two occasions for a couple of days but was unable to find suitable clinics or clients for the study.

3.7.3 Voluntary participation

Voluntary participation relates to informed consent and is a decision to participate in a research study taken by a competent individual who has received the necessary information; who has adequately understood the information; and who, after consideration of the given information, has arrived at a decision without having been subjected to cohesion, undue influence, inducement or intimidation. Voluntary participation was upheld by following the principle of autonomy (Council for International Organizations of Medical Sciences, 2008). To ensure that the participants were given an opportunity to agree or refuse participation in the study, the researcher explained the details in the information sheet in the participants' mother tongue. Thereafter the participants confirmed their willingness to participate by signing the consent forms for both participation and audio recording, as well as video recording where relevant.

The researcher ensured that the principle of autonomy was upheld at all times, as was indicated in the participant information sheet (see Appendix F-I) as well as consent forms.

3.7.4 Confidentiality

An assurance of confidentiality and anonymity was given to the participants. Only the researcher knew the names of the participants. Their contribution to the study was kept anonymous through the use of pseudonyms in the recording transcriptions of the interviews as well as in the presentation of the results. Also, the video tapes will be stored safely and be accessible only to the researcher and supervisors of the study (Council for International Organizations of Medical Sciences, 2008).

3.7.5 Non-maleficence and beneficence

Participants were notified that they were free to discontinue their participation if at any point they felt uneasy with the collection of data. It was not expected that any trauma would be experienced by participants, but the subject of caring for a child with a disability can be sensitive and participants were provided with relevant contact details should there be a need for counselling. The researcher had highlighted during the ethics clearance phase that there was unlikely to be any foreseeable harm to participants or risk associated with participation in the research (CIOMS, 2008).

3.8 Reflexivity of the researcher

On entering the research process, the researcher had to consider the shifting roles of being an academic, mother, African woman and a SLT. The researcher I had to remain reflective of my position, role and provide a balanced perspective in data collection and interpreting results. Subjectivity guides everything – from choosing the topic that one studies to selecting methodologies and interpreting data (Ratner, 2002). As a child born and bred in the township of Soweto, I have experienced the political unrest in the 70s and 80s. I was educated through Bantu Education. I am in awe of how SA – my beloved country – has transformed politically. We now have a democratic government and yet we still have challenges in other spheres of life like health, education, labour and the economy. Health administration and service

provision cannot be depoliticised, due to complex power and other related issues that underlie this government department.

I have chosen this topic because I know what it feels like to be an African patient treated by an Indian or white health care provider. The feeling of anxiety and being disempowered due to class, language and cultural barriers is frustrating. Consequently, when I became a qualified SLT and clinical educator at the hospital, I knew that I need to advocate against this lack of adequate health provision for people who come from diverse languages, cultures and low socio-economic backgrounds. Research has shown that there are many layers of historical complexity and power that underlie service provision. The Health department claims that budget constraints are a hurdle in proving equitable service; this statement proves that access to health care SA is more of a political-strategic challenge than a depoliticized performance management challenge. The researcher had to also contend with historical factors that contributed towards the asymmetrical power relations between races in SA. Thus, using Foucauldian approach was found to be beneficial during the data analysis phase. Foucault's approach was found to be sensitive and crucial in interpreting the politically charged power relations that were apparent in the interactions between the SLTs and their clients.

The researcher is an experienced Setswana-speaking SLT and lecturer. In these two capacities she has conducted clinical supervision of students in hospitals and observed numerous consultations where an interpreter was involved. Therefore this characteristic would contribute towards the clear definition of the level of bias and objectivity of the researcher. There are notable strengths and challenges of being caught in the space of insider and outsider status, as highlighted by (Dwyer & Buckle, 2009). These authors posit that the researcher's membership in the group being studied is significant at all levels of the methodology approach; for instance, the researcher found herself having a direct and intimate role in both data collection and analysis. "The qualitative researcher's perspective is perhaps a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others

– to indwell – and at the same time to be aware of how one's own biases and preconceptions may be influencing what one is trying to understand"(Maykut & Morehouse, 1994, p. 123).

The researcher is one of the fortunate South African people to have lived under and after apartheid. This makes my role in this research significant in collecting data at a hospital that I had known to have treated some of my close family and community members. Being in such a position brings to one the notion that I am not there as a professional but as a patient. I have to consciously remind myself that in this setting I am a researcher even though most patients may assume that I am one of them and some of the professionals or fellow SLTs who don't know me may also assume that I am one of their patients. Finding oneself in such a situation is like a parody of my role. It seems as though I may be misrepresenting myself, especially in my community. African people are not a common feature in the corridors of power. We are the ones who are disempowered and the health care professionals are the empowered ones who give their expert knowledge and power.

Yet on the other hand, this was a positive experience for the participants and for me. It became easy for me to collect data to speak to caregivers in their mother tongue. The participants responded positively towards me, for example, they willingly agreed to be part of the study even when I initially felt that they did not fit the participant's criteria. For fellow SLTs, when approached they expressed the sentiment that this is such a relevant study, and to be conducted by a person who comes from the patients background was an added benefit. I always felt accepted and appreciated by my colleagues. Some even expressed that, they feel at loss with lack of interpreters and multicultural challenges that they face daily in the hospital.

As both an SLT and a researcher, one found oneself constantly having to shift from one position to the other; hence moving within the spaces of insider (SLT) and outsider (researcher). Thus, the manner in which the questions were framed was influenced by this paradoxical relationship. As a researcher, one was at times conscious of one's own biases and preconceptions regarding the limitations of interacting as a professional within a multicultural context as well as in instances when the limitations were through the use of an interpreter. It was therefore important for the researcher to bracket these preconceptions and biases (Dwyer

& Buckle, 2009), particularly with reference to the interpretation phase of the study. During the interpretation stage it was beneficial to have my supervisor and I to have a peer debriefing session, this helped with the understanding of the data.

The benefits of being a member of the SLT profession included being privy to gaining a level of trust from the SLT participants; something which might have been somewhat challenging to attain had the participants been from an entirely different profession. Hence in this case the position of insider proved very beneficial and convenient for the researcher. However, having said this, the position of outsider, that is being a researcher, was prioritised. This therefore meant that as researcher one was also aware of the disadvantaged position of having to separate the two states, namely insider/outsider status.

From a South African context, the positions of insider/outsider became even more complex and dynamic when considering the diversity of ethnic and racial backgrounds. This meant one was insider only as a professional SLT; yet also a quasi-insider in view of being an African SLT with the advantage of being proficient in more than one local language including Setswana, Sesotho and IsiZulu. Although one's knowledge as a researcher was always based on the positionality, as a qualitative researcher one appreciated the fluidity and multi-layered complexity of human experience (Dwyer & Buckle, 2009). By this one refers to the fact that even though the researcher shared group membership with the participants, it did not constitute as complete sameness. Sameness would mean equal in power and access to knowledge which was not the situation for most the participants. The reason for this is that public hospitals in South Africa are affordable for the poorer sector of the economy. Majority of people from middle and upper socio economic sector, have access to the private hospitals.

3.9 Limitations of the study

Limitations take place in all research studies; and due to the characteristic of doctoral study, the data were coded and themes interpreted by the researcher and analysis later discussed with a supervisor. This practice allowed for consistency and trustworthiness but had a disadvantage of not providing adequate multiple perspectives from other people with a differing perspective and expertise. Further research, could include other researchers in the data analysis with themes being developed using discussion and collaborations with other researchers, a panel of experts and the participants themselves.

3.10 Summary and conclusion

This chapter presented the research process, procedures and conditions that shaped this study. Furthermore, this chapter demonstrated the uniqueness of different data collection methods in obtaining understandings into the health care communication research. The ethical issues of the protection of the participants' interest and well-being, maintaining the confidentiality of the source of data and the anonymity, and concealing the participants' personal details and identifying information were addressed. Ways of ensuring the consistency and integrity of the data were discussed, including credibility and dependability as well as transferability and confirmability.

The role played by the researcher in conducting a pilot study was also highlighted in detail, as was the significance of conducting this pilot, which provided guidance and insight into the main study. The chapter has discussed the positionality of the researcher, highlighting the significance of holding two statuses, that of insider (SLT, Lecturer) as well as outsider (researcher).

The chapter that follows presents the research findings and discusses how power dynamics work in clinical service encounters and how these affect or are affected by the multicultural nature of the context.

CHAPTER 4: Interaction dynamics in clinical consultations

Introduction

The previous chapter provided a critical examination of the methodological approach used for this study. It also provided details of and a reflection of the data collection process. This chapter discusses the experiences and nature of interactions between SLTs and interpreters during interviews with caregivers of children with disabilities in a hospital setting. It also details how SLTs experienced interpreter-mediated and non-mediated consultation interactions in a multilingual setting. In an attempt to provide a detailed picture of the context in which such consultations happen, an interrogation of the nature of the specifics of the process of hospital settings is also illustrated. The discussions in this chapter are based on video analyses of eighteen sets of care givers' initial speech therapy consultations, using a hybrid of conversational analysis and thematic analysis. From the analysis of these consultations it can be argued that unequal power dynamics resulting from socio-economic and cultural differences affect the ease of communication and thus the therapeutic relationship in detrimental ways.

Consequently, the chapter illustrates that understanding therapeutic relationships, hegemony and responsibility between an SLT and a client may be difficult if one does not comprehend the dynamics of power in this therapeutic relationship (Benjamin, 2004). The manner in which the health care professional uses his or her power in the therapeutic relationship while engaging with the client is likely to affect the healing and education of the client. Hence, the chapter argues that health care professionals need to be consciously aware of the ethical principle of beneficence that guides them.

Power differential exists naturally in most relationships, such as between a child and parent, teacher and pupil, employer and employee and health care provider and patient/client. Parents, teachers, employers and health care providers have the greater power in these relationships. They are regarded as authority figures who, by virtue of their roles, directly affect the well-being of the other. The child, pupil, employee and client/patient are thus vulnerably positioned in such interactions (Benjamin, 2004).

As a result, ethical practice requires that this power differential should not be to the detriment of the vulnerable party. The position of power should instead benefit the vulnerable party through the enhancement of the client's or patient's well-being. Power differentials in the context of this study reside in the differences in roles of the expert and client that result in vulnerability on the part of the client. Furthermore, according to Barstow (2008), power differentials are the enhanced amount of power that accompanies any position of authority".

The person who is in power has many roles, for example, he or she is the one who sets and maintains the boundaries of time and clinical setting; is paid a fee; encourages the other to be vulnerable and self-revealing; is recognised as having particular knowledge, training, and skill; and is responsible for making assessments (Barstow, 2008). An understanding of these power differentials calls for the setting of boundaries and responsibilities (Barstow, 2008). Thus, in the context of this study, the key function of the SLT as the one who holds power was to set and maintain boundaries with the client/patient in mind, so as to make sure that the clinical service encounter is effectively kept safe for both the client and the professional.

Power dynamics that surfaced in this study are linked to the socio-economic and cultural differences between the SLT and the clients and became apparent during the clinical consultations. Power differentials in service provider–user relationships are documented more in healthcare-related fields such as medicine and social work than in speech-language pathology (Levin, 2005; Swartz & Kilian, 2014; Sakamoto & Pitner, 2005). Analysis of how power differentials affect the service provider–client relationship in social work is viewed as significant because it challenges health care providers to critically question their relationships with clients at an individual level (Sakamoto & Pitner, 2005; Strier & Binyamin, 2013). Foucault (1985) also reiterates that all human social behaviour and relations are embedded with power issues. Social inequality with regard to access to the SLT profession by black Africans in South Africa, the apartheid history and language differentials experienced in SLT practice are important markers of complex power dynamics.

The intersection between racial, economic and cultural power dynamics further complicates the nature of inequalities experienced in these contexts and how they are experienced. To understand these complexities when analysing the data, the researcher paid particular attention to how these inequalities were further complicated by the different education levels

and socio-economic statuses of the SLTs and the caregivers/clients. The argument of this chapter is presented in three sections. The first section looks at how gender differentials play an important role in shaping the clinical encounter. The following section covers cultural competence in clinical consultations of SLTs working in a multicultural and multilingual context. The third section looks at SLTs' competence in diverse health contexts. Diversity also includes socio-economic status, race and ethnicity.

4.1 Differential gender roles and the consultation process

Gender dynamics in SA context still need to be attended to. The new democratic government is working on complying with international commitments, such as the 1995 "Beijing Platform of Action" and the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) which the country ratified in 1995 (Walker, 2003). A report by the SA Commission on Gender Equality (CGE, 2000) concluded that gender relations still favour men: society informs women that they should "… be subordinate to men, they should have lesser power, less opportunities, and less access to resources than men" (CGE, 2000). In the past, Black South African women were not only oppressed as blacks, they were oppressed as women. The gender differences in SA families and households have a long history since colonial and apartheid periods. These gender dynamics were brought about by a severe impact on men through their participation in the migrant labour system (Morrell, 2001).

This history of racial division was complemented by patriarchy with women of all races subordinate to men (Littrell & Nkomo, 2005). Women of all races were not expected to be career driven or playing an important part in the economy and were legally classified as "minors". On occasion, when they did work, African coloured and Asian women worked mainly as domestic or unskilled factory workers, on the other hand white women were in the administrative and female dominated occupations such as nursing and teaching. This kind of exclusive cultural history is bound to produce unprecedented attitudes, communications and behaviours on all spheres of life in the country (Hart & Padayachee, 2000).

The everyday gender differences in communication play a significant part in the way women and men participants interact with each other during the SLT consultation where gender-differentiated caregivers are present. The gender-linked communication styles of the caregiver and the SLT seemed to also influence the consultation process. Most significantly for this part of the chapter is how the SLT's behaviour towards his or her clients is influenced by his or her gender schema. Henning-Stout and Conoley (1992) write that we cannot divorce ourselves from the social situations in which we provide our services. Henning-Stout and Conoley (1992) further maintain that, as we work with others, we often consider the social groups with which we identify from the perspective and/or influence of our own membership in a variety of groups. This explanation, like the theory of intersectionality, is significant for understanding how different positioning affects everyday life and in these context clinical consultations between the SLT and her clients. How a female SLT "does" gender is seen in how she assumes the position of women caregivers as compared to those of the men caregivers during consultations. However, what is important in this part of the chapter is how complex and shifting these assumptions are (Crenshaw, 1989).

For example, for Bapedi ba Moletji (a subgroup of the Sepedi-speaking people from the Limpopo province) communication across gender is complex. This is especially so for the older generation where talking involves going back and forth as if to confirm understanding. Again, in other contexts where men hold the authority in decision making they also hold the power to speak and define the nature of problems in their families (Padavic & Reskin, 2002). A similar scenario seemed to play itself out in one of the observed SLT consultations. In this consultation, every time a question was directed to the female caregiver she would consult with the male caregiver before responding. This happened even though the question was clearly directed at her, for example, the SLT had asked, *What is your concern, Mommy?* The communication dynamics illustrated here are important as they allow for both genders' perspectives on the question to be shared with the SLT. Although at face value it might seem like the woman is disempowered, such a consultation might allow her to deal with the unfamiliar clinic setting, the power dynamics with a health professional and the communication gender dynamics of her culture. The fact that the SLT asks the woman the question might also speak to her own personal identification with a particular way of doing gender, where the woman will be more knowledgeable about childcare-related questions.

People are more susceptible to group and situational influences than is usually recorded. For example, when couples were interviewed, the SLTs generally directed their questions to female caregivers. Furthermore, the female caregivers would generally consult with their partner before answering a question. In another example at the beginning of the interview of a couple, after the SLT had taken contact details of both parents of a young boy with severe communication disabilities, she started questioning the couple. The consultation went as follows:

SLT:	And you are dad?
CG2 (male):	Yes! (emphatic)
SLT:	Ok Mom, what is your main concern? Why are you here today?
CG1 (female):	(Inaudible too much background noise)
SLT:	Why are you worried? What are you worried about?

The above example shows the inclination of the SLT to refer questions to the female caregiver. After having confirmed that the male is the child's caregiver (*and are you dad?),* she does not ask both caregivers the question, but directs the question to the female caregiver (*ok, mom, what is your main concern?).* This excerpt illustrates that the SLT in this example attributed caregiving responsibility of the child to the female caregiver. This type of interaction may cause the father to feel excluded from this consultation. The SLT could have directed the question about concern to both parties. On the other hand, this tendency to refer care-related questions to female caregivers could be attributed to a cultural belief that associates caring for young children with women (Cancian & Oliker, 2007).

This cultural difference was also found to be true in a South African study in the Western Cape by Levin (2005) who found that HCPs preferred to deal with female caregivers. Similar findings emerged from this study, although here this is also seen as an opportunity for a more gender-integrated communication style preference. For example, in one of the SLT consultations both the SLT and the interpreter communicated their preference for the mother's presence in the consultation processes to a male caregiver by indicating that, *we*

would like mom to come. The second SLT agrees with the interpreter by adding, *'cause she also sees a different side of him that you don't see.* At face value one could argue that these particular SLTs and interpreter prefer the female caregiver as they assume that she plays the central caregiving role. If this was true, it would be a concern since fathers do play caregiving roles, and in the case of this particular father, the fact that he brought the child to the clinic should be seen as an indication of this role. In such a case it would be expected that the SLTs and interpreter would rather encourage the father to continue the good work of caregiving. However, a deeper reading of the extract below suggests that something else is at play in this interaction and in the seemingly gendered preference:

SLT2: … at speech therapy. It teaches mothers and caregivers, whoever takes care of the child how to stimulate communication and get them to start interacting and stuff …

INT: We would like mom to come...

SLT2: … To come with ...

SLT1: Ya, ya, ya. I'll ... We'll have to arrange something.

SLT2: 'Cause she also sees a different side of him that you don't see.

SLT1: Mhmm mhmm (affirmative)

SLT2: And maybe even his sister to see how he plays with his sister. OK! Mashudu?

The above excerpt displays the preference of the team for the mother of the child to attend future speech therapy sessions, not because the father is incompetent per se, but because they understand that the different gender roles played by both parents and others around the child are significant for the development of the child, and thus for their further understanding of the child's concerns. For example, SLT 2 adds that maybe the child's sibling could also come to the consultation sessions since she will have something to add to the consultation.

With the couples that participated in this study, the males were more proficient in English and thus assertive as compared to their female partners in how they communicated with the SLTs. This could be clearly linked to the fact that more men have access to education than women. Education research shows that in 2011, 11.9% of women had no schooling as compared to only 8.7% of men (Statistics SA, 2011). The same is true with regard to literacy – more women (860) as compared to men (661) were recorded as illiterate in 2011 (General Household Survey, 2011). Education is a powerful tool for women and men for many reasons including socioeconomic development. Although men are not naturally superior to women, Baumeister (2007) argues that their benefit from patriarchy allows them better access to social and economic opportunities as compared to women. In these consultations it was quite evident that female caregivers were insecure and disempowered. The female caregivers have a social and political problem of being from poverty-stricken households (Statistics SA, 2011). For example, from the excerpt below it is evident that the SLT asks questions to indicate that she is in power and the caregiver (who is also a sister to the child with communication disability) politely answers them without visible signs of being uncomfortable.

SLT Are you living in a house? A room?

CG Ya, we're living in a two-bedroom house.

SLT A house. (writing) And you said mom's working?

CG Yes, she's working.

SLT What does she do?

CG She's a security.

SLT Any contact with dad?

CG My dad is coming like after a month or two months.

SLT Is it the same father or different fathers?

CG Different fathers.

SLT So his father visits monthly?

CG Mhm (affirmative) monthly.

SLT Does he help support him?

CG (Shakes head no)

SLT Is he getting a grant?

CG Yes.

The above transcript shows the SLT asking a young woman, who is a sister to the client, about having the *same or different fathers*. The caregiver in this case was about 16 years older than the client and was from a home headed by a single mother. The SLT is experienced and has worked in this hospital for many years. What could have been the SLT's cultural schema or thinking that was motivating her to channel her question in this direction during this consultation? The answer lies in understanding how those in positions of power

stereotype and use profiling to deal with those they serve. This is especially true when those served are not seen as equal in terms of class, cultural differences, race and gender. Again, the fact that there are high numbers of absent fathers in black African communities (Khunou, 2013) does not necessarily mean that all black women with children are single or have children from multiple fathers. Stereotyping is described as the process by which people use social categories such as race in acquiring, processing and recalling information about others (Smedley, Stith & Nelson, 2003). This phenomenon of stereotyping or "group categorisation" has also been found in the US by Van Ryn and Burke (2000), where white medical doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice, and more likely to lack social support than white patients, even after the patient's income, education and personality characteristics were taken into account. These results indicate that cultural competence is complex and affects gender, the SLTs' perceptions and attitudes towards clients and communities, and can generate health disparities (Balsa & McGuire, 2003). In order to avoid this perennial issue of disparities in health care, there is a need for SLTs and other designers of health care curricula in training institutions to engage in cultural competency comprehensively in the earlier years of training undergraduate students (Lo & Stacey, 2008).

The gender position of the caregivers was also signified in how the consultations unfolded. The influence of culture and tradition on masculinity/feminity dimension became evident in some instances. Masculinity represents a society where men are believed to be assertive, tough and focused on what they can show materially as success; and women are thought to be modest, tender and concerned with quality of life (Littrell & Nkomo, 2005). Below is a quote from a transcript of grandparents of a child who had a communication disability. When the SLT asked them how they were handling their granddaughter *when she's crying a lot*. The grandmother said that she comforts her and the grandfather added that he is firm with her. This showed the gender role differences in caring; in this instance the grandmother is more "feminine" in her caring; which is characteristic of SA culture generally. The extract below illustrates how these differences influence the consultation process:

SLT 1: Ok, and when she's crying a lot? What do you do to calm her down?

Grandmother: Ah we just say sorry, thula and (comforting gestures).

SLT: Ok.

Grandfather: And we ask her, why must you cry? Why can't you accept what is true you know … so you should give her (clenches arms to show strength).

SLT1: Make her strong?

Grandfather: Ya stronger.

It is evident from the above extract that the caring roles played by the grandparents in this case are gendered. While the grandfather is clearly illustrating the idea of strength as important for how the child should deal with her challenges, the grandmother is "softer" in her caring. These gender differences are also clear in how the actual consultation processes are dealt with. The grandfather responded assertively and was direct in his responses to the SLT. For example, when the grandparents were asked by the SLT, *is she coping at school?* the two caregivers explained this very differently. The grandfather responded that *she's too dull and down*. On the other hand, the grandmother responded in a more indirect way, *they say she's a slow learner … she has to repeat, to repeat again.* The grandmother's response was more sympathetic and less final than that of the grandfather, which was more conclusive in its tone. Studies by MacCoby and Jacklin (1974) and Prakash and Flores (1985) on gender differences in normative data concluded that women scored lower than men on assertiveness and higher on gregariousness, anxiety, trust and nurturing. These differences have an impact on the consultation in that the grandfather's parenting style is noted as assertive, whereas the grandmother's is caring. The significance of having both primary caregivers in the above case

is that it gave the SLT a broader and more varied sense of the child's condition and an understanding of the family context and social life of the child. Consequently, this affects what the SLT hears and will influence her diagnosis and treatment.

In another consultation there was evidence of male assertiveness on the part of the father who brought his son for an assessment behaving in a caring way. This father had brought the child for consultation without his wife. He was in his mid-thirties at the time of the consultation. What was observed in how this father spoke was the specificity with which he described the challenges experienced by his son. Such a clear way of explaining was rare in this study. The extract that follows provides an example of how clearly he described his reasons for bringing his son to the clinic.

SLT1: Ok. So what is your main problem with Junior?

CG: Ya the main problem is he can't pronounce a word.

SLT1: He can't pronounce?

CG: Ya and it's been now … it's almost four years now. Ya and he's turning… he's about three and eight months years old. So it's just lelelelele. You see now eish, it's been worrying us now.

SLT2: Ok.

The response style of this father was informative and direct, and thus influenced the consultation process in a positive and useful manner. After the SLT asked for a statement of the problem, he accurately stated that the son experienced articulation challenges. In addition, when the SLT probed for more information, he was able to give details about the duration of the problem, description of the speech problem, and his concern about it. His replies were direct and organised, which indicates his "masculine" parenting style. On the other hand, the researcher also sees the femininity in the behaviour of the caregiver. He brought his child for

an assessment, which was unusual in the setting. Femininity, in a community sets both men and women as modest, tender and concerned with the quality of life.(Littrell & Nkomo, 2005).

In addition, it was noted that is beneficial for intervention purposes if parents showed a clear understanding of their child's problem, in that the SLT can work with them when they know their child's problems well. This type of interaction style could prove to be a good prognostic factor for future family communication interventions, as parents are vital participants in early interventions. Early intervention services support children with disabilities or developmental delay by building on opportunities for learning and development that are provided at home. The reason why parental involvement is important in early childhood intervention is that young children spend most of their early childhood with parents. So, it is helpful when a parent understands t he problem and seems keen to participate, as shown in the above extract (Learning links, 2014).

4.2 Cultural competency and asymmetrical knowledge–power relations during SLT consultations

This part of chapter four focuses on SLTs' cultural competency and their interactions with clients from different cultural and socio-economic backgrounds as those they occupy. In such encounters interactions tend to be complex. The complexity is due to differences in culture and the inherent asymmetrical knowledge–power relationship between the SLT and clients (Bowe, Martin, & Manns, 2014). Therefore the focus of the analysis is on how the SLT portrayed the cultural competency, sensitivity, in how they delivered their service. Cultural competency is "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, 1988, p. 1).

Furthermore, cultural competence operates at system, organisation, and service provider level (Betancourt et al., 2003). Cultural competency manifests in the way an organisation and the people who work within it provide services to clients with a diversity of values, beliefs and behaviours. An organisation can plan services to meet the social, cultural and language needs of a community. The SLTs can be trained in cultural competence by enabling them to explore their own values, beliefs and ideas, including an evaluation of their therapeutic relationships with clients from diverse backgrounds (O'Shaughnessy & Tilki, 2007). Given that this study is concerned with encounters in a health setting, Campinha-Bacote's (1999) cited in (Pacquiao, 2007, p. 499) conception of cultural competence in health care is important here when he defines it as a situation "when the practitioner understands and appreciates differences in health beliefs and behaviours, recognises and respects variations that occur within cultural groups, and is able to adjust his or her practice to provide effective interventions for people from various cultures." How SLTs attempt to gain insight into clients' cultural beliefs concerning their child's disability and their attitudes in terms of respect play an important role here. The significance of having culturally competent clinical encounters is that they prevent health disparities for different races. Health advocates and scholars have established that certain race groups obtain poorer health care when compared to whites (Lo & Stacey, 2008). Consequently, health care providers such as SLTs need to implement culturally competent care that includes a patient-centred approach.

Conformity has been a topic of researchers for a long time. It is described as a product of cultural condition (Bond & Smith, 1996) and is usually high in collective cultures, such as Asians and Africans. This was seen when SLTs interviewed couples. The female caregivers invariably consulted their male partners before they would answer a question. In addition, collective cultures stress "we" consciousness, group solidarity and decisions, sharing, and obligations (Bond & Smith, 1996). Unfortunately, the term, conformity, has been used to stereotype some cultures as submissive and others as independent. Reasons for conformity are twofold (Heine, 2007). Firstly, there is a normative influence which occurs because people want to be accepted, do not want to "stick out" and want to be respected by their peers.

Secondly, there is the notion of informational influence. Individuals depend on others for the impression or view of reality and for the perception they hold of the world. This occurs particularly in situations of ambiguity.

Other important distinguishing factors separating the clients and the SLTs are the uniform, language, hospital context, and authority vs. help-seeking. The uniform most SLTs wear, that is, the white coats and navy blue surgical scrubs, could be intimidating for patients as it signifies power and authority. It appears that many medical professionals recently have moved away from wearing a white coat to wearing a navy blue surgical "scrub suit", which is similar and represents the same meaning of power as the traditional white laboratory coat. The benefit of a uniform is that it could make patients trust that the person who is consulting with them is genuinely qualified and registered for the profession they are practising. Alternatively, white coats can create a professional barrier between the physician and the patient. The scrubs and uniform worn by SLTs also give them a sense of authority and hierarchy, which contributes to uneasiness during interactions.

There were a few caregivers that showed signs of anxiety and discomfort during consultation as observed from their coiled posture and sitting on the edge of the chair. Although this uneasiness could be a result of multiple factors, Lawrence (2003) highlights the fact that the critics of the white coat claim that it creates a negative barrier between the medical professionals and their patients, which leads to ineffective communication. For example, in one consultation the caregiver was very uncomfortable and sat on the edge of the chair throughout the consultation. The SLT tried to make her comfortable at the beginning of the consultation by saying, *relax, mama.* The feeling of uneasiness could also be related to the fact that the SLT holds the knowledge that his or her patients need but do not have. This dynamic of having cultural capital affects the power relations between HCPs and their clients in that the one who has knowledge leads and controls the interaction. The caregivers of children with illness or disability also would feel vulnerable and powerless when bringing their children for medical assessments. Thus, having a child with a disability leads to the anxiety when thinking about consulting a medical professional (Bearden, Feinstein & Cohen, 2012). In addition, a study by Siu (2015) found female patients reported being too intimidated or afraid to speak up when they disagreed with the doctor.

Another practice that seemed to create a barrier in the consultation process was the case history question-and-answer session. Although this practice is a historical norm and serves an important purpose, the manner in which the questions were phrased and cultural incompetence on the side of the SLT created some communication barriers during consultation. Below is an indication of how these barriers were experienced:

SLT: Who said you must come here? To speech therapy.

CG: (No response. Looks confused.)

SLT: Did you go for a hearing test?

CG: Yes.

SLT: And what did they find; was she ok?

CG: Yes. She's ok.

When an authority figure's first words to you are, *who said you must come here*?, it seems as if you are being dismissed, that you might have made a mistake. Given the widespread negative treatment of patients in South African public hospitals, such a question seems inappropriate at this point of the interaction. This is illustrated by the confusion and lack of response by the caregiver. Although the SLT could have adhered to this through probing and clarity-seeking questions, such interview skills seemed to be undermined by cultural incompetence. For example, most SLTs started the interviews using the same sentence: *So, what is your main concern?* Most of the caregivers in this study appeared to be surprised by this question because most of them were referred by their primary health care provider who wrote a referral letter. The caregivers expected the SLTs to have read this letter stating the details of their problem prior to starting the consultation, while all their demographic information is on the cover of the hospital file. The problem with these questions is that they are repetitive and somewhat irritating for the clients/caregivers. In one consultation the following took place:

SLT: What is dad's number and name?

Mother: (Points to the form on therapists lap.) It's that one. I've given it to you.

It is clear from the response of the caregiver that the line of question is seen as repetitive. This might also be seen as incompetence on the side of the SLT, as if the caregiver queries why she is asked a question to which she has already provided the answer. It would appear that the SLT was following a protocol of filling in the information for her records, as the questions appeared to follow the sequence. Below, we see how the caregiver initially responded to the SLT's question. The SLT managed to get the required response when she rephrased her question to this young mother. The first question asked should make the caregiver aware that it is not a general question but more about communication concerns of the caregiver. The excerpt below illustrates:

SLT 1: Ok. Ok. So the first question, what I want is what is your main concern?

CG: About?

SLT 1: About Lethabo's development and communication, or what are you mostly worried about him?

CG: Mostly, I'm worried about the eyes 'cause he is blind and even about the legs 'cause he can't stand right now. But he can sit and *hape, ke batla a gole akgone huyi keletsa, aska dependela honna, wabona.*

[*And again I want him to grow and be able to fend for himself, not become dependent on me, you see*].

INT: Mhmm. Mom says she would like the child to grow and be independent; shouldn't depend on her.

SLT 1: Ok, and what about his communication? What are you most worried about his communication? Or are you not worried about it?

The example starts with a sequence in which the SLT starts the interview according to her hospital form, which requires her to fill in what the "main concern" about the communication

disability of the child is. However, her question as seen in the above excerpt was broad, not specific. She could have asked an open-ended question such as "describe to me your child's communication/speech-language difficulties". The SLT failed to interpret the questions on the form and asked them in ways that are understandable for a lay person in the consultation and thus failed to allow the mother to clearly express the main concerns with regard to communication. Another limitation shown in the above extract pertains to how the concerns raised by the mother were not acknowledged by the SLT as they were not in line with her expertise. Lappen (2011) argues that the biological or scientific style of interviewing patients does not provide an opportunity for them to lead the service encounter because the approach is clinician centered. When the mother expressed concerns relating to her child's blindness and inability to walk, the SLT responded with "*okay, what about his communication, or are you not worried?"*

In a study by Beckman and Frankel (1984) it was also revealed that doctors failed to allow their clients to complete the opening statement of their problem and concerns in 69% of the visits, and that they interrupted clients after about 18 seconds. Two approaches, namely, the biopsychosocial approach and the patient-centered care approach, emerged in order to overcome problems in the biomedical approach, which is doctor-directed. In the patient-centered approach, patients are allowed to convey their concerns in a manner that does not make them feel inferior or interrogated (Lappen, 2011). The biopsychosocial approach considers the biological, psychological and social aspects of the client; hence it is known as a "patient-centered approach". The SLT in the above example failed to empathize with this caregiver who had explained her concerns relating to her child's severe sensory loss (... *he is blind*) and motor disability (… *he can't stand*) and need for her child to be functional and have social participation (… *a gole , akgone hu yi keletsa/that he may grow and be able to fend for himself*). While the researcher agrees that it is important for SLTs to ask questions about communication, being their scope of practice, the caregivers' concerns should be acknowledged and where possible referral to a relevant section in the hospital should be given.

The mother's concerns raised issues related to social participation, which are included in the International Classification of Functioning, Disability and Health (ICF) and endorsed by the WHO in 2001. The ICF is a comprehensive tool for countries and health care providers to use and has the potential to help understand health and functioning of individuals and groups. In addition, the ICF framework shifts the focus of patient consultation from disease identification and classification to functioning within daily living (Zraick, Harten & Hagstrom, 2014). This biopsychosocial approach has been recommended as early as the 1970s by Engel who reiterated the need to focus not only on the disease but on the client, including the emotional and social factors on the clients' health, and to incorporate a patient-centred approach into a biopsychosocial approach to health (Engel, 1977). In addition, the biopsychosocial approach allows for the clinician to understand the cultural dynamics of the client because the focus of interaction with the patient extends beyond illness issues.

In most African cultures it is traditionally considered rude to refuse help when someone is being hospitable. During one interview, an SLT made recommendations to caregivers, who responded by saying *we can't deny help;* which can be viewed as a polite refusal or "no" in this situation. Below is an example of a case where the SLT shows lack of understanding of where her clients are coming from:

SLT 1: Ok, granny, it's ok. So do you want us to help her with her communications, speaking, and language? Is that what you'd like us to help you with?

Grandmother: Well you can't deny help. Provided how often, well how often does it come hence we've got time to attend and all that.

Starting a conversation with a closed-ended question; as shown in the above extract; this style forces the caregivers, to respond in a positive and polite manner. In this example, the SLT seems to have failed to recognise the cultural context. In African culture it is considered

impolite to refuse help, especially if it is a cure for a disease from a health care provider (a respected figure of high status). On the other hand, in most Western cultures it is acceptable for the host's offer to be politely refused with just a "no, thank you" (Sue & Sue, 2013). On another hand, the above extract can be understood to show simultaneous effects of power and context, which can occur in any situation; African or western culture. Power and context are intertwined in particular ways with specific and identifiable effects (Ahonen, Tiernari, Meriläinen & Pullen, 2013). This context positioned the client as powerless and the SLT as powerful service provider; this can be a possible situation in any culture. The issue is, who is positioned as powerful and who is positioned powerless, thus making the powerless unable to refuse help.

Refusal of help by the caregivers tends to translate into being passive in conversations with the respected figure. The analysis indicated that most caregivers were not asking questions but largely responding to questions during consultation. The caregivers did not raise any of their concerns willingly, even after the SLT had asked or invited them to ask questions at the end of the consultation. This could be attributed to power differentials that occur in this type of interaction. The unequal powers between the SLT and her clients appeared to interfere with their interactions. Furthermore, this issue could also be linked with the concept of *sick role,* which according to Nettleton (2006) means to be socially and biologically in an altered state. In this instance sickness is associated with the family of a child with a communication disability. Consequently, the sick role assumes that the sick child or his/her caregivers should want to get well and, therefore "*must seek and co-operate with technically competent medical help"(*p. 73).

This perennial problem of unequal power in medical consultations has been discussed by authors such as Cooper & Roter (2003) who suggests two possible solutions, the first being that medical service providers and clients should engage in a systematic patient review and being patient centered. This process would involve seven dimensions of care, which include: respect for patient values, preferences and expressed needs; communication and education; coordination and integration of care; physical comfort; emotional support and lessening of anxieties and fears; involvement of family and friends; and continuity and transition. Systematic reviewing of the patient can assist in encouraging both the patient and health care

provider to deal with individual preferences and values. Furthermore, it provides an explicit framework for patients to participate actively in their care. This strategy has been found to be useful in preventing passivity and embracing empowerment strategies in patients during medical consultations.

Sleath, Roter, Chewning, and Svarsstad (1999) conducted a study to investigate doctors' and patients' question-asking about medications. The results showed that almost half of the 467 patients who participated did not ask any questions, although medical doctors tend to perceive questions in a positive light. These findings highlight the significance of improving patients' and doctors' question-asking about treatment, especially in primary health care settings, so as to prevent problems with medicine compliance.

Below is an example of a caregiver who failed to report to the doctor her concerns about the child's deteriorating health problem. The SLT encourages the mother to express her concerns to the doctor on her next visit in the following ways:

When the SLTs encounter a caregiver who seems to be disempowered, as shown in the extract above, there is an opportunity to explore why she does not raise her concerns about the child's deteriorating condition with the doctors. The researcher suggests that, in addition to giving advice, the SLT could write a supporting referral letter indicating what has been reported to her to the relevant section in the hospital. However, instead of making an effort to get the caregiver appropriate intervention at the hospital, the SLT opted for giving the caregiver advice on what to do if the child's condition deteriorates (*if you find his vomiting is increasing …).* Again, in this interaction, the SLT's opportunity to explore the caregiver's possible fears or feelings of intimidation by the doctors was lost. The caregiver's lack of expression caused a dilemma for the SLTs. From the above discussion, it is evident that the instances of cultural competence on the part of SLTs are limited. These, however, should not be seen as blanket statements of what happens in a hospital setting. There are also evidences of good practices, where SLTs show care and respect for their clients.

4.3 The use of professional jargon in consultation settings as incompetence

This section discusses incompetence on the part of SLTs in relation to their interaction style and language during consultation with caregivers. There are structural issues where one is positioned as insider and the other as outsider. In the analysis of the consultation transcripts it was found that professional jargon was used, albeit not always. The use of professional jargon is a way of maintaining power through a form of exclusion. Crawford (2012) claims that professional jargon can be used to portray expertise, special knowledge, power control; thus putting a distance between those "*in the know*" and those "*who do not know*". It is therefore important for SLTs to maintain a reflective practice and self-critique so as to be aware of the language they use with caregivers.

However, before delving further to the use of professional jargon by SLTs one needs to understand contextual institutional issues. Working in a public institution like a hospital, there are strict protocols that are followed in terms of how the SLT conducts the intervention. The assessment questionnaires are in the format that is approved by the department and all clinicians use it when conducting interviews. These protocols are written in English, thus leaving the SLT who is not fluent in any African language with no available avenues or translated vocabulary to use during the consultations. Thus they all follow a scripted format to use with all their clients. Understanding context and the way in which SLT function operate is what the researcher interprets with caution and produces as findings is beneficial in this study on how power relations are experienced in diverse setting. According to Ahonen, Tiernari, Meriläinen and Pullen (2013) context is also understood as a flexible entity occurring in taken for-granted practices and interactions; it also serves as a way in which individuals organize their social reality, which is subject to change over time.

By using medical terms when they communicate with clients/caregivers, SLTs appear more knowledgeable and thus more powerful than their clients. In consultations where the SLT was more aware and thus competent in inclusive consultation, terms like "Caesarean section"

was avoided and replaced by *did they cut you*? Such inclusive ways of communicating are in line with the SLTs' use of language to communicate and also language as part of their work. This is unlike other health care professionals, such as medical doctors and physiotherapists, where language is what is used to talk and not an intricate part of their work. In cases where professional jargon is used, it becomes difficult for the client/caregiver to follow the conversation or to feel equal to the SLT.

The excerpt that follows shows how the use of terms like "Caesar" and "full term" in a context where the client/caregiver has awareness does not affect the flow of communication during consultation. Again, the conversation style of the SLT in asking for clarity is also important here. In the excerpt the SLT asked a question which she followed up with a clarifying question to make sure that they both understood the meaning in the same way. However, when asking about the type of delivery, she did not follow up with a clarifying question to make sure that the caregiver has the same understanding as her of the term "Caesar".

SLT1: Ok. Mommy I wanna ask you, was she born at full term?

CG: Yes.

SLT1: Nine months?

CG: Nine months.

SLT1: Ok. And was it a normal birth or a Caesarean?

CG: A Caesar.

SLT1: A Caesar. Ok. (Writing)

SLT1: Small … (Looks at card) Any problems after she was born?

Generally, before beginning an interview, SLTs are supposed to review the client's file for basic demographic information. Having this kind of information assists them with how to carry out the interview. In addition, having face-to-face interviews provides good clues on

whether the client comprehends or not what the SLT is saying. However, the following extract shows how exclusion can occur as a result of the use of unfamiliar terms coupled with a lack of a clarity-seeking conversation style. In this example the SLT used the word "operation" instead of "Caesar".

SLT: Ok and was it a normal delivery or operation?

CG: Operation.

SLT: Were there any problems with her after she was born?

Another challenge with this consultation was that the SLT was not able to follow up to clarify if what she meant was understood in the same way. Hedge and Pomaville (2012) indicate that it is the role of the therapist to obtain additional information, to have the information printed in the file clarified or expanded, to become familiarised with the client and family, and to make initial observations of the client, the family and significant others. The two examples offered in the extracts above occurred after the SLTs had made their opening remarks and established rapport with the clients and caregivers. Thus, it could be expected that they have made judgments and good observations about which terms they could use with a specific client. Consequently, one cannot comment on their cultural competency skills without looking at the whole context in the interview. Nevertheless, one could suggest that when the SLT asks questions about the actual birth, he or she could say, "Was the birth on time, too early or overdue?"

This was also evidenced in the case history discussion with grandparents of a child whose mother died. The SLT asked them about hereditary illnesses that relate to communication disorders. Initially, they did not understand that the question was not about general illnesses, and the grandfather reports about his "asthma". When asked specifically about the child's paternal family, they became uncomfortable and laughed a bit, stating that they did not know about him.

SLT1: Ok, ok.

SLT1 And is she on a … are you receiving a child grant for her? A child grant.

CG2: Yes, yes.

SLT1: Is there anybody in the family that you can think of that has the same problem that she has? Or similar problems? Any?

CG1: Uhm. Actually I for one, when I was three, I was asmamic … nxa, asthmatic.

CG2: (Laughter)

SLT1: Is she also asthmatic?

CG2: No.

CG1: No. But now as soon as I grow up I started to treat myself and then …

SLT1: Ok. And anybody else – who has? Anybody that you've noticed who has a hearing problem in your family? Speech problem or any problem with language? Can you think of …

CG1: Nah … Well we don't know on his father's side. 'Cause we don't know his father, how do they live like, who are they … we don't know these things. (Laughs)

SLT1: You don't know … you don't know anything. It's fine. No problem.

Ok so she's at crèche. When did she start crèche?

The SLT in the above transcript revealed impatience. She cuts the caregivers short while they are speaking – when the caregiver explains that he had asthma and later when he says *we don't know these things*. When the SLT responded by saying, *you don't know anything. It's fine*, her tone suggested limited empathy or disinterest Furthermore, SLTs should show sensitivity to social issues in relation to absent fathers and single-headed homes that is prevalent in South Africa. These results show that a variety of issues needs to be considered for SLTs to be inclusive in how they consult with their clients/caregivers. These include language, how one follows up and cultural sensitivity to social circumstances (Angelelli, 2004).

4.4 Conclusion

The chapter highlighted some challenges the SLTs face working in a multilingual and multicultural hospital setting. Although this situation is neither unique nor uncommon it still presents challenges that need attention. The first section discussed the way gender differentials play an important role in shaping the clinical encounters. It was argued that SLTs seemed to prefer to speak to female caregivers and furthermore that there was a distinct way in which male and female caregivers communicated.

The second section looks at SLTs' competence in diverse health contexts. The section looked at cultural competence in a context where multiple ways of exclusion such as race, class and gender are still important markers of who is in and who is out. The section argued that inclusive ways of consulting and language use are important for improving the inclusion of clients/caregivers as compared to the exclusionary use of professional jargon.

In conclusion, there was a variety of ways that different SLTs used in interacting with caregivers. The relevance of understanding of understanding power dynamics, contextual issues and cultural competence in various consultations, offered the researcher a framework for identifying how the analytic approach suited the epistemology of the SLTs' intervention

approach. Starting with this broad deductive approach created a ground for moving into microscopic analysis of aspects of language which included pragmatic aspects.

CHAPTER 5: Pragmatic aspects of language: Delving into fine details

Introduction

This chapter provides an analysis of three non- or quasi-lexical speech objects, namely, discourse markers, laughter and non-verbal behaviours used during consultation with SLTs in a multilingual hospital context. Communication behaviours such as laughter and gestures may substitute linguistic aspects of language in a way that may be understood by intuition and context. For example, a head nod may be substituted for a verbal affirmation, and will be accepted as such in many cultures. However, the understanding of such signs has to be understood by intuition, which means a grasping of the special interaction between the linguistic and non-verbal gesture, which complete each other (Fischer-Lichte, 1984). Thus, non-verbal communication, laughter and discourse markers function as having quasi-lexical meaning. The analysis provides an understanding of fine speech details and speaks to one of the research aim which was set out in the methodology regarding analysis of the interactions between SLTs, interpreters and caregivers. This was primarily an exploratory study where the researcher wanted to identify the strategies or techniques used to render a good as opposed to a bad consultation. By looking at the discourse markers, laughter and non-verbal communication, the researcher was given microscopic views of what occurs during a consultation that might not be evident if only the content of the interviews was analysed. Language and translation issues can also have a marked impact on information received and therefore it was significant to analyse the role of the interpreter.

Thus the chapter may appear to be focusing on microscopic aspects of the interactions between SLTs and caregivers during consultations; however, the researcher found these aspects of language salient because they occurred frequently and almost unconsciously. Labov and Fanshel (1977) remarked that the outcome of looking closely at mundane interaction activities that participants experience unconsciously and do not remember easily can be significant. This analysis is useful for providing an in-depth understanding of the interaction styles of SLTs and their clients in clinical settings. The analysis and interpretation approach are balanced, looking at both the SLTs and caregivers as recipients and producers of laughter and pragmatic aspects of language. The researcher felt that this study could contribute to research on SLT consultations by looking at specific and concrete aspects of the

activity rather than looking at the global or general approach. The researcher wanted to introduce the life experience of these consultations moment by moment. The previous chapter focused on the power and gender dynamics of SLTs' interactions in a diverse setting; this chapter selected specific pragmatic aspects of talk and action that were observed as frequently occurring. The brief interpretation was aimed at understanding the impact on the consultation outcomes.

Pragmatics in this study was conceptualised as the study of language in use, that is, it refers to the branch of linguistics that studies language use rather than language structure (Watzlawick, Bavelas, Jackson, & Hanlon, 2011). Hence it would entail the functional use of language in communication to convey meanings, as well as the appropriate interpretation and production of spoken messages in relation to the communicative context. For example, good pragmatic skills involve the sequential organisation and coherence of conversation (Shames, Wiig, & Secord, 2011), which could include the ability to allow for turn-taking during a conversation, topic initiation and maintenance thereof, evident in verbal and non-verbal features of conversation. In addition, for this study, a relevant description of pragmatics includes interpretation and communication of subtle meanings for social effect by means of non-literal language forms (de Villiers & de Villiers, 2008).

Heritage (1989), cited in Roger and Bull, (1989) posits that quasi-lexical speech objects in conversations, such as laughter, are considered "back channel" response tokens. Back channels are feedback given in conversation while another person is talking to indicate attention and interest. "Back channels" or "signals of continued attention" have been underestimated in previous research.. These response tokens, such as *mm hmm*, *yes*, and *oh*, are extremely common in ordinary conversations. For Schegloff (2007), the position or placement of items such as *ja* or *yes* in conversation allows them to be understood as "continuers", "acknowledgements" or "agreements." In comparing *mm hmm* and *yes* production, Jefferson (1984), cited in Roger and Bull, (1989) showed that *mm hmm* is a response usually used for "passive recipiency", while on the other hand, *yes* frequently gives a sketchy outline of a topic-shifting or topic-curtailing activity by the speaker. Quasi-lexical speech objects can inform an analysis of interactions where individuals are operating from different perspectives, such as health care providers and parents of patients, as in this study.

The focus of the first section of this chapter is on the types of language structure that are used in terms of stylistic or pragmatic functions known as discourse markers. By focusing on this, the researcher was able to obtain insight into particular speech aspects of multilingual health care communication, and identify some of the characteristics of the types of discourse marker used. The claim this study makes is that the data consist of particular discourse structures or markers operating in the interaction between SLTs and clients, which assist in navigating multilingual and multicultural service encounters. The chapter's interpretation of discourse markers is based mainly on the work of Schiffrin (1987). Schiffrin shows that discourse markers have a meaning, which is procedural, not conceptual; furthermore, their meaning is interpreted by the context. For example, a discourse marker can be a response to, or a continuation of, some portion of the discourse.

The second part of the chapter discusses laughter and contrasting perspectives. Although laughter may have been considered an insignificant aspect of human communication, conversation analysis research has found it to be a highly significant part of human communication as it highlights how people show, respond to and relate to one another (Glenn, 1991). In addition, it was highlighted that co-participants laugh serially, with a finely coordinated sequence (Jefferson, 1985; Jefferson, Sacks, & Schegloff, 1973).

The researcher analysed incidences of laughter and its occurrences in certain contexts during communication between SLTs and clients, bearing in mind that communication in health care settings is usually formal and does not often exhibit laughter. Again, given that in this study laughter occurred at unexpected points, accompanied by discomfort for the clients/caregivers, it was thus significant for the researcher to explore the reasons behind these occurrences. Glenn (1991) argues that the production and placement of human laughter in conversation and other activities uncover much about emerging meaning and activities or actions. As part of the analysis the study looked at the context within which it occurred, that is, whether the laughter emanated from a single individual or was ignited in both participants, as well as the person that initiated the laughter, to understand how each situated context has implications for/on the communication session and how participants potentially view the occurrence of laughter (as hostile or intimate).

The third section looked into the non-verbal behaviours as well as speech aspects such as tone of voice that could occur during the interaction process. Non-verbal aspects, especially

in intercultural communication, could present as facial expressions, eye-contact, movement of the body (kinesis) and proxemics (Langdon & Cheng, 2002). Cultural aspects in communicative behaviour could involve the appreciation of different socio-cultural pragmatic knowledge (Langdon & Cheng, 2002; Wadensjö, 1998). Contextual sensitivity includes the understanding of the complexity of a situation or lack thereof. For example, in a courtroom or medical consultations that are markedly formal, the interpretation will vary from that of an informal situation. All these aspects alert one to the complexity that arises with interpreter-mediated therapeutic interventions, complexities which, if not addressed, may have a negative impact on the outcomes of the intervention provided. Non-verbal behaviours that are mostly physical in nature, such as hand signals, shrugs, gazes, seating, facial movements, facial expressions, head movements and gestures, were also examined. These were seen as significant even though the study was mainly focused on verbal interactions.

5.1 Use of discourse markers: "ok", "ja", "neh", "alright"

The use of discourse markers was found to be of interest in this study as they were used frequently in the participants' verbal utterances. Researchers generally define discourse markers, for example, *okay*, *neh*, *ja*, as having a pragmatic function in a conversation, that is, they are markers that convey little or no propositional content. Even though there is some understanding of their pragmatic function, there is no agreed upon description of discourse markers, which has led to a lack of uniformity and thus ambiguity in the classification of them (Jucker & Ziv, 1998). The definitions vary from discourse marker, pragmatic marker, discourse particle, pragmatic particle, pragmatic expression, or connective expression. They also has numerous functions in varying definitions, such as discourse connectors, turn takers, confirmation seekers, intimacy signals, topic switchers, hesitation markers, boundary markers, fillers, prompters, repair markers, attitude markers, and hedging devices. This diverse use of the term is indicative of the various functions and linguistic analytical approaches that have been used in the field.

Characteristics of discourse or pragmatic markers are described as follows (Jucker & Ziv, 1998):

- They do not affect the truth conditions of an utterance (semantic);

- They do not add anything to the propositional content of an utterance (semantic);
- They are related to the speech situation and not to the situation talked about (pragmatic); and
- They have an emotive, expressive function rather than a referential, denotative, or cognitive function (functional).

Furthermore, (Brinton, 1996) has provided other characteristics, which are not included above, such as the sociolinguistic and stylistic features. These features explain that discourse markers in conversation appear in high frequency, are stylistically stigmatised, are gender specific, and are more typical in women's conversation.

"Discourse particle" is used to describe words such as *ja* and *okay* that occur in most languages in South Africa, while "pragmatic expression" is generally used for markers with more than one word such as *you know*, *you see* or *I mean* (Jucker & Ziv, 1998). The common South African discourse markers include words like *you see now*, *ok* and *ja*. These discourse markers were used at the start of a sentence and as conversation filler and at other times to shift between topics and alternate between spoken and read text, for example *ok*. These discourse markers were frequently used throughout all consultations. The extract below illustrates the use of discourse markers to indicate agreement and to indicate stance or turn-taking by an SLT. The consultation was with a single mother of a child that had severe disabilities;

CG: When I got home after three weeks, I came back because he was not breathing properly. I went to clinic, like the one in …

And they sent me here because they said he had bronchitis.

SLT: Ok.

CG: Ja.

SLT: And then was he admitted to hospital?

CG: Ja (nods).

SLT: And then how long was he here for?

CG: For … I think it was to a month. Ja.

SLT: Oh, ok. And when he was in hospital, any other problems?

CG: No, he only had bronchitis. ’Cause when I asked them they said he doesn’t have jaundice ’cause he was yellow.

SLT: Yellow. And when he was in hospital, was he eating ok? Feeding fine?

CG: Ja, but I was feeding him with the injection, you know the …

SLT: Syringe?

CG: Ja. Because he was in the head-box.

SLT: Oh ok.

CG: Ja (nods).

SLT: Was he at Bara? At Bara in hospital?

CG: No, I think he was at the …

SLT: Oh, so he was here.

CG: Ja, he was here.

SLT: When did he first start uhm sitting by himself? Can you remember?

CG: Uhm, five to six months.

SLT: Ok, and did he crawl?

CG: Ja.

SLT: And when did he start crawling?

CG: Eight, eight or nine.

The extract above shows a high use of *oh* and *ok* that indicated agreement, topic shift and active listening, and also appeared to be the SLT's style of communication. The use of these markers did not alter or add any truth or facts to what was discussed. It acted as confirmation of conveyed fact – the individual indicates that she or he has heard and understood, and can thus continue the interview/conversation. The following extract is another interview between an SLT and a father of a young child. While the father and the SLT both used the discourse markers *oh* and *ok*, we note that the male client used the discourse marker *ok* purely to indicate agreement while the SLT used it to take a turn or stance. The father accompanied his utterance with head nodding. According to the Cambridge dictionary online, we use discourse markers such as *so, right* and *okay* to connect, organise and manage what we say or to express attitude (Cambridge University, 2010). The following extract shows how discourse markers can indicate assent in a brief fashion:

SLT: Ok. I am just going to explain to you what's going to happen.

I will be doing an interview with you.

So I am going to ask a lot of questions and

it's quite lengthy (using hand signs to show long).

CG: Ok … (nodding).

SLT: Another therapist is gonna come in and

she is going to be spending time with your son …

umm … to see what she can get out of him as well.

CG: Oh, ok … (nodding).

SLT: So the whole idea of the interview is for us to get a good enough understanding of him, his development and his functioning within the home as well.

CG: Oh … ok … (nodding).

SLT: Ok … if there's anything you don't understand and you need us to explain,

please stop me and maybe we will … we can discuss it. Ok?

CG: Yes ….

SLT: I see, I read from the file umm …

that he was initially diagnosed as an asthmatic?

CG: Yes ….

SLT: Then last year April there was an incident where

he couldn't walk in the morning, neh?

CG: Yes ….

The SLT starts the conversation using *ok*, then proceeds to explain the process and procedure of the consultation to the caregiver. The caregiver responds verbally and nods his head to indicate that he understood and agreed to the process. The caregiver using the marker *Oh … Ok* indicates that the situation may have been unclear before, and what the SLT is explaining to him makes the situation clearer. The introduction of the process also reduces uncertainties on the client's side and is a way of "breaking the ice". The SLT used the discourse marker *ok* to check if the client is on the same page as her and to mark the beginning of her turns. Both individuals used the discourse marker *ok* to different effects – the SLT used it to mark the beginnings of her turns; a sign that what she was about to say needed to be taken seriously or that she was conveying instructions. The caregiver used it to convey confirmation of understanding and agreement, encouraging concord in the interview process. The difference is that he did not use it to take a turn or as a stance marker.

The discourse marker *neh* can be regarded as roughly equivalent to the English *right*, as it was used when posing questions to encourage answers in the affirmative. In the following extract, the interpreter SLT engaged with the child while the SLT conducted the interview with the caregiver. The child, Mashudu, did not readily interact, and the interpreter along with the child's caregiver, was attempting to get him to play.

CG: Hello.

INT: *Yazi ngifuna siye estoro siyo thenga ichocolate. Ye Mashudu? U zo hamba nami neh?* Bye bye (laughs).

[*You know I want us to go to the shop to buy chocolate. Hey Mashudu? You'll go with me neh? Bye bye.*]

The interpreter attempts to get a reaction from the child by offering chocolate, or the prospect of getting chocolate, but this does not get any attention from the child. She proceeds to call him by his name – both the question intonation and the use of his name are intended to get his attention and to make it clear to the child that he is the one being addressed. When this does not seem to work, the interpreter does not propose a course of events (going to the shops) or pose a question, but rather makes a statement that the child can either accept or refuse. The *neh* does not position the statement as a command, and as the child is not willing to interact, it begins to focus the interaction as reliant on his interaction without pressuring him. The interpreter highlights the lightness of this line of encouragement with her laughter.

The discourse marker *neh* was also used as a means of naturalising conversation, particularly in the space of an interview. Though its positioning in conversation allows the person being spoken to, to agree with or refute a statement, it mostly works to elicit agreement to move the conversation along. In the following extract, the SLT and the assistant SLT explain to the caregiver that her visually impaired child may benefit from other forms of sensory stimulation:

SLT: You get uhm, books that also has different uhm textures in the book, and …

ASS: But you can also make one. And it comes out nice.

SLT: Ja. You must see Miriam's one, Miriam can make such a nice neh.

CG: Ok.

The SLTs explain to the caregiver that one gets book with differently textured pages and fabrics that the child can use, and the assistant SLT adds that she can make one herself. The

SLT concurs that a home-made book will do just as well as a shop-bought one. Her use of *neh* serves two purposes: it complements the interpreter's work, but it mainly informs the mother that she can make a book herself for her child, and that it does not have to be very impressive. If the interpreter can make one, she can too. The book itself is not present in the interview, but the fact that a person who has made such a book is present in the room is reassuring, and the *neh* encourages a positive response from the caregiver.

Other discourse markers that were consistently displayed were *alright* and *uhm*. These seemed to indicate that the SLT was trying to gather her thoughts in the conversation, or finding her place in the interview schedule that she was reading and writing notes on. The following discourse markers appear to be used by the SLT while reading the questions from the interview schedule:

SLT: Is there water and electricity? Do you have water and electricity at home?

CG: Yes.

SLT: Alright. And who's working at home? Anybody working?

CG: My mom is doing piece jobs. She didn't work full-time.

SLT: Are you getting a grant for her?

CG: Yes.

SLT: Alright. Is there anybody else in your family who has speaking problems, problems with learning a language?

CG: No.

SLT: Anybody else who has a weak side of the body?

CG: No.

SLT: No one else. It's just her that came out?

CG: Mhmm (affirmative).

SLT: Alright. Is she at crèche?

In this instance, the SLT appears to be ensuring that the responses she receives from the caregiver fit the questions that she has asked. She probes further, obtaining more relevant information, before "closing" the question and moving to the next, marking the beginning of the new question with *alright*. This is clear from the extract above: first she asks about utilities, then the different sources of household income, then a family medical history, and then the child's education. The use of *alright* could also indicate to the caregiver that the information received thus far has been deemed sufficient.

Alright can also be used to get people's attention, as in the following extract:

CG: (Gets distracted by son, who is busy, up and down, touching anything he comes across; she's frowning at him as if to tell him to stop what he is doing.)

SLT: Alright, uhm, I just need a contact number, there wasn't one available.

SLT: (Pointing to Kathlego) So you don't worry … about him ….

The caregiver is distracted by the child moving around in the consultation room, and the SLT needs the caregivers' attention to complete the interview. The use of *alright* calls the caregiver's attention away from the child without indicating that they had become distracted. Rather, it is plausible that the caregiver might have become distracted while the SLT was

taking notes, and the SLT indicates the completion of her previous actions and the continuation of the interview. Discourse markers were also used in interviews to allow interviewers time to ensure that the interview questions were being posed clearly and simply, such as in the following excerpt:

CG: I breastfed him for about seven months and then I bottle-fed him.

SLT: Bottle-fed until?

CG: I bottle-fed him until two years six months.

SLT: Ok and tell me … errr … are there, were no problems with sucking or anything like that?

CG: He is still sucking, he doesn't chew even now and he is grinding his teeth.

In this instance, the SLT uses *ok* to gain time to read the questions from the interview schedule and, possibly, to paraphrase the questions to add a natural and conversational cadence to speech. Natural cadence increases positive rapport in the interview as it communicates genuine interest and encourages participation in the interview.

The above analysis of discourse markers showed that communication is context sensitive. The forms, functions and patterns of communication such as the use of discourse markers are also sensitive to context and need intuition to be understood. Furthermore, discourse markers highlight the "shared meaning and world views" that are used by people during interaction (Schiffrin, 1987, p. 4) – "… it is not only intuitions about grammaticality of sentences which are inherently contextualized: so too, are intuitions about semantic meaning".

5.2 Laughter and contrasting perspectives

Laughter is a normal occurrence between people, which can be used to convey multiple meanings, for example, hostility, warmth or enjoyment (Glenn, 1991). However, this important aspect of human communication is often overlooked in research (Glenn & Holt,

2012). Jefferson (1985, p. 25) refers to unpublished lectures by Sacks (1966) which caution social scientists of being too concerned about what is known as "big issues" and ignoring aspects which are considered as "terribly mundane, occasional, local, and the like". Jefferson (1985) postulates that any kind of phenomenon undertaken by humans can be examined to discover meaning and detailed order from it. Furthermore, detailed analysis of a small phenomenon may result in immense comprehension of the way in which individuals communicate or do things and what kind of objects they find useful in constructing their affairs. Therefore, documenting and transcribing actual occurrences moment by moment are a way of delving into the social order in fine details. This section gives some details of what was observed in the consultation practice of SLTs.

Observation of the extracts showed that at times laughter appeared when there were contrasting perspectives. Due to the nature of diaspora and migration worldwide, multiculturalism and multilingualism increasingly affect the dynamics of everyday communication (Wei & Zhu, 2013). When SLTs asked questions relating to pregnancy, the caregivers' account appeared to be divergent and implausible to the SLTs on many occasions.

These contrasting perspectives could be rooted in the differing life worlds and cultures and thus lead to communication partners looking for strategies to cope with their differences (Wei & Zhu, 2013). The following extract captures a talk between an experienced SLT (SD) and an unemployed woman in her late thirties from an informal settlement. Here the SLT is interviewing her about her pregnancy with the child she has brought in for language assessment.

SLT: Ok, (looks down, writes notes, then looks back at CG with her head tilted) were you pregnant for full nine months?

CG: Mhmm (shakes head).

INT: One ole?

[*You were?*]

CG: About eleven months.

SLT: (Looks back at interpreter, smiles) Eleven months? (looks down, takes notes) What's today our …

CG: (Laughs softly, holds out one hand) Ten to eleven months.

INT: (Laughing) Ten to eleven.

SLT: (Looks up without lifting her head up) Eleven months?

CG: Ja, I did (pauses) *ne ke setse beke eyi-one hoba* eleven months.

[*Yes, I was left with a week before it was eleven months*]

SLT: [Ayayayayay (tucks hair behind her ear, looks up at CG).

In this instance the SLT seemed to accept the caregiver's narrative of her pregnancy even though it is not considered normal. Though the SLT was the first to express some humour through a smile, the caregiver was the first to laugh. It is important that the individual divulging this information was the first to laugh – she makes it all right for the others to laugh, and when they do, the laughter is not overly derisive or mocking (Glenn, 1991). In addition, the caregiver's laughter seems to minimalise the situation that seems to be unnatural, that is, being pregnant for eleven months. The caregiver's laughter is an invitation to the SLT to laugh as well. This type of sequence was also reported by (Jefferson, 1979) stating that laughter can be managed as a sequence in which the person who sends a message invites the recipient to laugh and the receiver accepts the invitation. The technique of inviting laughter is by its placement – the speaker places it at the end of an utterance – and the technique of accepting it is by laughing just after the onset of the speaker's laughter. However, in this case the caregiver's invitation was placed at the beginning of her utterance,

which seemed to be referring forward to what she sees or knows to be a funny outcome in her talk. This phenomenon of forward referral of laughter is often observed when people tell jokes and know where the punchline is before it is verbalised (Jefferson et al., 1973).

The SLT expresses her incredulity of the statement through *Ayayayayay*, but as this is done in the space of laughter initiated by the caregiver, she does not discredit her experience and accepts it, even though she might not believe it. The caregiver herself does not attempt to convince the SLT further, but accepts that, even though it is a dubious situation, it is what she believes she has experienced.

The above extract also illuminated two features that are similar to those identified by Jefferson et al. (1973), which showed that when people laugh together they are not essentially laughing in unison. The SLT smiled first and the caregiver laughed in response before making her statement. Consequently, it can be noted that communication partners at times laugh sequentially with a bit of overlapping and with no pause in between. The second feature corresponding with the study by Jefferson et al. (1973) was that when laughter and speech are adjacent, the laughter usually stops soon after speech starts. Thus, it can be concluded that the production of laughter is orderly, which means that laughter can be stopped, and periodically is stopped, when a communication partner indicates for the laughter to stop by using speech (Jefferson et al., 1973). It appears that the production of laughter in communication serves many functions, not only in casual situations but also in clinical settings. Clinical settings can be overly formal, where natural interactions can be difficult to elicit, and laughter could lessen rigidity in rapport. Glenn & Holt (2012), reiterate that laughing has a multifaceted nature; at times it allows participants in formal or delicate settings to have social agreement and may also indicate intimacy or alliance. In the following extract, which occurs early in the interview, the SLT attempts to ease the situation for the caregiver.

SLT: Ok. Miriam please bring that chair. Ok, umm, please put your chair a little bit back, dad. What is your name dad?

CG: My name is Frank.

SLT: That's very English, Frank! (Laughing)

CG: (Laughs)

INT: (Laughs)

At the beginning of the interaction, before the actual interview commences, the SLT refers to the caregiver as dad, and only once he is seated, does she ask for his name. It is not clear why the SLT is surprised by the caregiver's name, but the laughter engages the caregiver, the SLT and the assistant SLT. The laughter is initiated by the SLT and it is reciprocated by the others. It does not appear to be a joke, because most Africans who are Christian tend to use English or Biblical names in Africa as a result of European colonization and the white missionaries. Most Africans have more than one name and the English name is mostly used in formal setting such as at school or work and when in company of non-African people. The African name is usually used in the context of family or people from African background. Accordingly, the above extract could indicate power dynamic, where the caregiver distances himself and sees the SLT as culturally "outside" from being given his African name.

Laughter can also display some measure of embarrassment, as in the following extract.

CG: Oh, anytime?

SLT: Is one thing or two things?

CG: At the moment I was sending him maybe one thing. I didn't try, maybe.

ASS: (To the child) *Kune źinto ezizo kubonisa zona. Sizodlala ngazo ne?* [There *are things that we will show you and we are going to play with them ok?*]

SLT: Oh, you never tried?

CG: (Laughing and nodding) I didn't try it.

The caregiver was asked if his child can identify objects and whether he had sent the child to fetch objects that would indicate that the child can identify these objects in context. He explains that he only tried to send his child for one object at a time. When the SLT asks if he has ever attempted to send the child for more than one object, he realises that it has never occurred to him to do so. The caregiver appears embarrassed, but not very deeply, and the laughter indicates that, though it might have been something he could have done easily, he did not. This incident shows the caregiver using laughter as an interactional device to laugh at his ignorance, which is similar to the Finnish study that reported that laughter is often used as a patient's resource (Haakana, 2008) to deal with delicate medical interaction.

The caregiver feels comfortable enough to admit this in the interview. The caregiver continues to use laughter to divulge some other instances of embarrassment or discomfort, such as in the following extract:

SLT: Ok. Can you give me an example?

CG: Mmm …

SLT: You can give the example in Zulu, it's fine.

CG: Oh … ok … (laughs) mmm … eish … err … like sometimes, there is times, he goes with his mother; his mother used to go with him at e Pick 'n Pay, so when he … is speaking she couldn't hear … ja ….

SLT: Ok.

CG: But I keep on correcting him … mmm.

At this point in the interview, the SLT had asked for examples of the child's behaviour where the caregiver had felt that there was a lag in development. The caregiver takes some time to think of an example, to which the SLT suggests that an example in Zulu would also be appropriate. The hesitation that the caregiver displays, using multiple discourse markers and laughter, may be an attempt to delay his response or indicate his discomfort, particularly as he is describing a situation where the child's developmental lags are evident in a public setting. Though this is only a second-hand account from the caregiver, it is experienced by him as though it were a first-hand experience. Laughter here indicates discomfort and a potential unwillingness to discuss or admit to this situation. Haakana (2008), reports that patients often laugh alone, doctors not reciprocating their laughter. This laughter is due to various reasons, including discomfort.

Laughter can also serve to redirect a conversation, to lighten the atmosphere of the interaction. This example is from an interview where an SLT explained the information on the child's clinic card.

SLT: Apgar is what they uhm, it's this over here (points to card) and it's uhm abbreviations for basically they look at the child and they test him out of ten. And there's certain things like was he breathing, was he crying, all those things.

CG: Oh, ok.

SLT: And if it's good, like if it's like nine or eight out of ten, then it's good. That means that everything was fine, he was a normal child when he was born. Ok. And then what I want to check is the birth weight. So he was not too big, hey.

CG: Ja. (Laughs)

The caregiver did not know what the information on the clinic card meant and the SLT explained it very briefly. The caregiver does not interject, but confirms that she has understood the information given to her. The SLT finds the information that she is looking

for, the child's birth weight, and says, *so he was not too big, hey*. After explaining that Apgar charts a child's development against what is considered normal, the SLT's statement can be interpreted as an indication that the child was not developing optimally. The laughter does not indicate flippancy on the caregiver's part, but can be an attempt to lighten the turn of atmosphere as she may have had concerns about the child's weight herself (Wanzer, Booth-Butterfield & Booth-Butterfield, 2005). She manages her emotions about this through laughing, which is a common occurrence in medical interactions (Francis, Monahan, & Berger, 1999).

According to Holland (2001), all therapeutic relations are complex and interactive. Holland (2001) adds that therapeutic relations occur in a cultural context with cultural factors that require awareness and sensitivity. Consequently, the above extracts the SLTs seemed to recognise that the explanations were from lay perspectives or non-professional views which are from the community that is not familiar with health related professions taking time to explain the Apgar score and to ask the care giver to explain in isiZulu was found to be beneficial and indicated a socio-environmental or holistic view. An understanding of lay beliefs and cultural factors is of value to SLT practice. This awareness can be documented as a successful clinical skill that can contribute to an understanding of professional-patient interactions, in that it can give an insight into local lay understandings which if not acknowledged may be treated as ill-informed knowledge by SLTs (Nettleton,2006). Above extract showed laughter from the participants when discussing the aspects that they were not familiar with or had a lay knowledge. Understanding of lay health beliefs may add to the body of knowledge and to enriching the status of the patient in the context of healthcare and power relations.

Essentially, it appears that laughter is not only something that occurs when there is something funny happening. The SLTs and caregivers in this study used it for various functions, such as to ease the atmosphere and to minimalize their concerns. In addition, laughter was found to be used collaboratively among the SLTs, interpreter and caregivers. Declination to laugh was not observed in this study, which may be an indication of warm rapport in the consultations. As noted by Jefferson (1985, p. 34) "… laughter can be managed as an interactional resource,

as a systematic activity that warrants and rewards more than naming of its occurrence, but close attention to just how and where it occurs".

5.3 Sensitive issues and non-verbal responses: Some questions

According to Goodwin and Goodwin (1986), non-verbal communication is intended to indicate to a conversational partner an individual's interest, involvement, attention and emotion within a conversation. Head nodding and shaking are often produced to indicate a response during conversation, giving the speaker an indication that one is attending to the conversation topic being discussed, or to permit the listener a way of giving a non-verbal response to questions that require yes/no responses (Argyle & Cook, 1976). Furthermore, the sequence of non-verbal behaviours is a display of understanding, while the lesser display of non-verbal behaviours such as head nods could be an indication of limited understanding or little attention to the presented conversation or topic, such as in the following excerpt:

SLT: Ok. So does he vomit during the feed or afterwards?

CG: Ja … (nods head)

SLT: After the feeding he vomits?

CG: Ja. (nods head)

SLT: Ok. Was he bottle-fed and breastfed?

CG: No, only bottle-fed.

SLT: Was there any problems with him sucking on the bottle?

CG: I don't know …

SLT: Can't remember?

CG: He was sucking like properly. But he was making the noise like (makes vomiting sounds)

SLT: Oh ok. In our report you said he was hospitalised before. Was there any tubes in his nose that you can remember?

CG: Mhmm, the one day, when we came here for the first time, there was the tubes, two of them going inside his nose …

SLT: Ok. And when he started to eat like porridge and hard food, how was he eating?

CG: He was eating like normal ...

SLT: No difficulties, like with solids or anything?

CG: Ja, but you know the bread, he doesn't eat like all of it, just the insides, ja, ja (uses hands to show SLT2 the part of the bread that the child eats and then pause a bit to scratch her chin).

SLT: How is his health? Is he a healthy baby?

CG: Ja. Everything, ja (nods head).

The caregiver in the extract above appears to nod even when she does not understand the questions, such as in the initial question, where she nods *yes* to a question that proposes two different possibilities. To the questions that follow, she provides more detailed responses with examples. With the final question, she says *ja* and nods again. It is not clear whether she understands the question or not, particularly as the responses she has given for preceding questions may not exactly be interpreted as good health. Also, her response is very unclear:

Everything, ja does not elucidate what she means. In this excerpt, the caregiver tends to nod when it appears that she does not quite understand what is asked of her. Gestures such as nodding can be used to conceal a lack of understanding, without impeding the conversation. In addition, this could be a reflection of language asymmetry between the caregiver with limited English proficiency and the SLT. This finding is similar to a finding by Estrada, Reynolds, and Messias (2015) that communication trouble spots often include a lack of understanding of the English spoken by the health care provider.

Eye gazing is considered an important and powerful aspect of non-verbal face-to-face interaction (Hansen, Novick, & Ward, 1998). A gaze, mutual gaze, and averting gaze all signal presence or non-presence in a conversation. At times, an averting gaze could be an indication that a sensitive topic is being discussed and the respondent is feeling some discomfort or it could be an indicator of unwillingness to be involved in the interaction with the conversation partner. Mutual eye gazes signal listeners' interest in and understanding of the topic being discussed and also permit turn-taking between the conversational partners (Argyle & Cook, 1976). However, it has been reported that in African culture a lack of eye contact is an indication of respect. This occurs when speaking to a communication partner that is in authority, for example, a child talking to a parent or teacher. Thus, in interpreting the eye gaze in this study, one would have to be careful of the cultural differences among the individuals involved. The following excerpt is from an interview where two caregivers came with the child. The first caregiver, male, tended to speak more frequently and notably louder than the second caregiver who was female. She also tended to avoid making eye contact with the SLT. Below is an extract that tries to show these differences:

SLT: So what is your main concern? (Looks at child)

CG2: (Looks at child briefly)

ASS: (Speaks to child, unclear)

CG2: (Shifts in chair, looks at CG1) Ok? *Uzwile ukuthi i problem yakhe, ye- ye speech* (shifts uncomfortably, fidgets, then shrugs quickly).

CG1: Main concern actually is, because she is, uhm …

CG2: (Drums her fingers on her knee as she looks at CG1.)

CG1: Not active right in the house and in the house, and she's always crying. Whenever.

SLT: Ja.

CG1: Ja. She doesn't participate in all the activities. Other children and stuff.

SLT: (Taking down notes, long pause in talk.)

The SLT initially addressed both caregivers in the interview, but from the beginning, the female caregiver did not readily respond. With her attention mainly focused on the child, she spoke softly and the male caregiver confirmed and translated everything she said. Her gaze was not directed at the SLT, and she tended to look at the child when questions were asked about the child. One would have to be very cautious in claiming the reasons why her gaze was directed at the child and the male caregiver and not the SLT – she could have been nervous about communicating in English (which she does not do much) or she could have been concerned about talking about the child's medical history in the presence of the child, as in the extract on disclosure discussed below where the child had lost her mother due to HIV/Aids.

Body posture includes leaning, folding legs apart or closed and folding or resting arms. All these behaviours are an indication of involvement or lack thereof in the topic being discussed (Argyle, 1996). Leaning away from the speaker is an indication that there is a lack of interest in the topic under discussion or a display of speaker–listener relationship dynamics that could be unfamiliar or uncomfortable. Increased inattentiveness is often displayed in body posture such as a lowered head position (for example, supported by the hand) or self-grooming movements and the shifting of legs and body.

SLT: Ok, (writing notes) so describe her health to me. Is she, like, a healthy child?

CG2: (Swallows, purses lips)

SLT: Does she get sick often?

CG2: (Shaking her head, looks away from caregiver 1 to child) Healthy?

CG1: As well as her ups and downs. Actually, eh, her mother …

CG2: (Looks at CG1)

CG1: She passed away of, uh, oh well, she was possessing …

CG2: (Watches SLT take down notes)

CG1: HIV/Aids then.

SLT: Ok?

CG1: The mother.

CG2: (Looks at CG1)

CG1: Then eh, we started to notice after the death of her mother …

SLT: (Nods head)

CG1: We thought maybe she re … (throaty sound, gestures with hand moving in circles)

CG2: (Lowers her gaze, eyes almost closed)

CG1: It's still remembering her mother or, that's how we wanted to ...

SLT: (Nods) Right?

CG1: Since from that, never been the same.

CG2: (Looks up at CG1, nods and looks at SLT)

SLT: Ok. Does she get sick? That she needs to come to the doctor? Since that time? Has she been to the doctor often … because she was sick? She had the flu?

CG2: (Takes a deep breath, kicks legs out and leans back in her chair)

SLT: Or an infection? Anything like that?

CG1: Ah …

CG2: (Looks at CG1, then looks quickly back at SLT)

CG1: Actually, not, not like that. It started that …

CG2: (Nods quickly)

CG1: Since she started this medication.

SLT: Ok.

CG1: It's only eh sometimes she’s got a swollen eye?

SLT: Oh. Oh.

CG2: (Opens and closes mouth)

CG1: Uh red eyes

CG2: (Looks at child, frowning) Just like it today? Now. (Looks at SLT as she takes notes, looks at child)

Caregiver 2, the female described in the excerpt above, continues to show some level of discomfort in the interview and of the line of questioning. For the most part she does not answer questions verbally and only responds to the SLT's question on the child's health with a seemingly rhetorical question, "Healthy?", and nods on occasion. She fidgets in her chair, which could indicate discomfort or impatience with the situation. Her infrequent responses indicate that she is paying attention, but as she does not verbalise her responses, she may be uncomfortable in the space of the interview and in talking about the child's illness and their concerns. The findings indicate a need for communication training for SLTs on how to work collaboratively in an interpreter-mediated encounter. It would have been important for the female caregiver's active participation in this encounter. Her presence is as important as that of the male caregiver's since it would enhance decision taking regarding their child's intervention.

5. 5 Conclusion

This chapter highlighted some of the challenges that SLTs face working in a multilingual and multicultural hospital setting. This situation is neither unique nor uncommon. Globally, due to immigration and other factors, HCPs have to treat clients that do not have the same culture and language as theirs. For example, Rader (1988) in California, US, found that 61% of clinic staff members, for example nurses and clerks, provided more than half of the interpretation required, while employed interpreters provided 35% of interpretation.

Providing trained medical interpreters is not an easily attainable goal, especially in developing countries with a history of limited resources and multilingual and multicultural populations. Similarly, we also need to serve our clients in their own language so that they may understand what needs to be done for their communication-disabled child. There is a need to further explore alternative solutions in mediated clinical encounters.

CHAPTER 6: Working in diversity: Some challenges

"We must work for the day when we, as South Africans, see one another and interact with one another as equal human beings and as part of one nation, united, rather than torn asunder, by its diversity."(Nelson Mandela)

Introduction

Communication between health care professionals and their patients is a critical aspect of the scope of practice because it is a key component of the interactions and has a serious impact on the client or patient health outcomes (Garth & Aroni, 2003). The SLT profession faces similar challenges than other medical professions in their attempt to improve communication with their clients (Ferguson & Armstrong, 2004). The communication challenge experienced in these contexts is that of unequal encounters in doctor–patient communication (Thomas, 2006). The medical profession has acknowledged the communication problems between doctors and patients, hence the large volume of research on these problems. Studies on doctor–patient communication have found that problematic communication leads to reduced health outcomes and poor compliance by patients (Levin, 2005; Meropol et al., 2008). Problematic communication also occurs in rehabilitation services, where SLTs work with children and adults with communication disabilities. The SLTs whose views are shared in this chapter all but one spoke English as their first language and had limited or no knowledge of any of the other South African official languages.

Childhood communication disabilities are by definition those which mostly have no cure and conventional interventions are limited to long-term rehabilitation in collaboration with the caregivers. It is well recognised that encounters between SLTs and caregivers of children with communication disabilities may be on-going, occasional or intensive and may involve

another primary HCP or various specialists such as neurologists and paediatricians. Due to the nature of this relationship, encounters between caregivers and HCPs with whom they engage are a critical intersection for information exchange, decision making and motivation (Tannen, 1986). The ability of the SLT to engage in effective communication may therefore make a significant difference to whether the encounter supports or discourages decisions and subsequent visits that will optimise the child and family's ability to manage the communication disability.

Communication between SLTs and caregivers of young children with communication disabilities has been recognised as pivotal in providing support and rehabilitation services in early childhood communication intervention. Family-centered early childhood intervention is accepted as an alternative paradigm focused on strength-based values, practices and policies that align to capacity-building intervention for families and their children with and without disabilities (Dunst, 2002). The participants in this study used the family-centered approach in their consultations. The explanations of why this is significant are described from the six participants' emic perspectives.

This chapter sets out how SLTs identified and talked about their effectiveness during consultations with clients from diverse cultures and languages. These perceptions of SLTs are presented through a detailed discussion emanating from five interviews conducted with SLTs and one interpreter.

6.1 SLTs' adaptation to challenges

Clinicians work in a cultural context with cultural issues that need the clinician to be sensitive and aware (Holland, 2001). A clinicians' response to diverse cultures and languages can be positive or negative depending on their personal awareness and belief systems. A negative response can be exhibited in the form of being afraid or unable to relate to those individuals

who are seen as having an unknown culture. Furthermore, a positive response can be seen as welcoming, understanding and respectful of other cultures. Understanding and recognising other cultures provide richer relationships which are necessary in a diverse society. However, this understanding and recognition should not be seen as being simplistic or ignorant of the complexities of cultural differences, especially in a country like SA that has a history of racism, sexism and class discrimination. The past realities of an apartheid society are deeply entrenched; thus when discussing diversity and difference we should be mindful of their existence. The SLTs in SA need to be active and visible in challenging the current status quo so as to provide effective care to their clients.

A powerful approach when working in diversity is being able to delink diversity from static or frozen opinion about culture. This approach creates a deeper and clearer differentiation of individuals and their potential and leads to a situation, not contrary or refusing the significance of culture, but approaching it in a more dynamic way (London, Ismail, Alperstein & Baqwa, 2002). In order for SLTs to have a deeper understanding of the culture of the people they serve, they need to move away from viewing culture as the static knowledge of facts. We need to understand culture as dynamic and ever-changing. This understanding shows that people can have different identities related to age, gender, ethnicity/race and socio-economic status, while at the same time share and access similar or related cultures.

It was clear from all the SLTs and the interpreter that their everyday work involved interaction with clients and caregivers from diverse language, cultural, and socio-economic backgrounds. What was challenging, however, was the thinking that it was easy to deal with these diversities without adequate and appropriate support from the hospitals. Appropriate support in this context would be the provision of formal interpreter services for effective communication. For example, Fatima, a Muslim woman working as a SLT for almost six years at the Charlotte Maxeke Johannesburg Academic hospital, stated that working in a multilingual and multicultural hospital was not a significant challenge. She said:

> ***Fatima**: But to be honest, I really haven't had much of a problem because there is always someone to help and, like I said, most of the times someone speaks English; either the husband or the wife or maybe the cousin or somebody who speaks English.*

But my cases, I see mostly adults and kids as well, but mostly adults so maybe that's why I haven't encountered that many problems. (Interview, December, 2012).

It appears that Fatima do not consider having a caregiver or "even a cousin" as an interpreter in her clinical intervention an ethical issue. Ethics of health care states that when a person who is not trained as a health care interpreter is asked to interpret, basic ethical issues of health care between the professional and client are compromised (CHIA, 2002). The fact that people who are not trained in health care interpreting are requested on an ad hoc basis to mediate during Fatima's consultation is not raised as a problem. Using an untrained interpreter such as administrative or nursing staff has come to be accepted as adequate professional health care delivery by the SLTs who participated in this study. The main reason for this practice was the unavailability of formal interpreter services and consequently the SLTs found a way to do their work. Although this is better than thinking that such services are not necessary, what was concerning was that they did not think about what this meant for the consultation sessions ethically. There seemed to be ignorance about possible ethical challenges presented by this scenario such as loss of confidentiality and potential misdiagnosis.

Nozipho, an SLT who has been working at the Charlotte Maxeke Johannesburg Academic hospital for three years at the time of the interview, speaks IsiZulu and is proficient in other local African languages. Like Fatima, she also stated that working in a multilingual and multicultural setting did not pose serious problems. She said:

Researcher: *Ok, so tell me how do you find working with multiple languages?*

Nozipho: *I am not really struggling. There are a few languages that I understand, I have been exposed to, so I know like Zulu, Xhosa, Sesotho, Setswana. I can still understand it but my speaking Tswana is not perfect. I cope mostly. It hasn't been that hard.* (Interview, December, 2012)

However, as the interview progressed, she indicated that the situation was actually challenging. Her understanding of the situation relates to the aspect of local and foreign clients, for example, for Nozipho, given her proficiency in IsiZulu and other local languages, diversity was not seen to be challenging. Nevertheless, given that the hospital caters for clients from other African countries with languages unknown to Nozipho was seen as challenging. Nozipho's ability to speak three African languages does not necessarily help her to communicate with all her clients. At times she faces the same challenges that her non-African colleagues have to deal with, albeit not as regularly as other SLTs. Nonetheless, she does experience what others experience as well. She reported her difficulties when interacting with clients that only speak Portuguese or French. The following extract indicates this difference.

> ***Researcher:*** *From our last conversations you indicated that you get people from upper Africa and North Africa. How is that experience?*
>
> ***Nozipho:*** *Yah, that's hard. This year alone we have had a patient that only speaks French and Portuguese and they didn't have family who visited regularly and that becomes a challenge 'cause I know we are supposed to have interpreters in this hospital but they are not readily available and we haven't been able to use one.* (Interview, December, 2012)

Nozipho admits that when working with foreign language speaking patients it is difficult to consult and interact. She further comments that the hospital does not have an interpreter and added that *they are not readily available.* This statement seems contradictory, as she states that there are no interpreters, yet in the same vein she states that they are not easily accessible. The statement that interpreters are not *readily available* in the hospital appears to be linked to poor communication between hospital management and staff. She highlighted disappointment in the DoH and hospital management by further stating that she knows the hospital is aware of the need for interpreters. The disappointment among hospital SLTs seems to be shared in South Africa. A recent, phenomenological study conducted in the Western Cape reported that SLTs find the realities of their practice different from their

expectations (Warden, Mayers, & Kathard, 2008). In addition, the SLTs felt disappointed by the public health system because it was not organised.

It would appear that SLTs are at "the reality of practice stage", as described by Tryssenaar and Perkins (2001). At this stage the professional realises that what they have learned as students does not always happen that way. Physiotherapy graduates were also reported to experience the professional world as not meeting their expectations (Curtis & Martin, 1993). Despite the fact that the South African DoH has made great strides in making health care accessible, it is still facing challenges in providing equitable health care. The effects of apartheid are still felt, as health care is accessible but most hospitals that serve the poor majority still lack resources.

On the other hand, working in the same hospital as Nozipho who reported that she has not used an interpreter before (*we haven't been able to use one*), Salma seemed to know how to arrange for an interpreter to assist her when she needed help. Salma is a Muslim woman who has worked at the CMJAH for more than four years by the time of the interview. Salma speaks English as her first language and is not proficient in any other languages. She said the following of some of her experiences:

> ***Salma:*** *Umm no, not all the time. I don't always know, especially if it is an assessment. I only know when they get here what language it is. If it's a patient I have been seeing, you know, for longer. Umm … you know if it's someone I have made the appointment for then at least I know, then I can at least prepare. But what the hospital does is a list of interpreters, so its people who work in the hospital who speak various languages.*
>
> ***Researcher:*** *Oh I didn't know you had those; so you do get them.*
>
> ***Salma:*** *Yes and they are on standby to interpret for whoever in the hospital needs them.*
>
> ***Researcher:*** *Oh so do you have to book?*

> ***Salma:*** *You just call them and say, look I have a patient; are you willing to come and they do come.* (Interview, December, 2012)

A particularly interesting point in the extract above is that there is a list of people who speak different languages in the hospital who could be used as interpreters when they are available and willing to interpret, as they have other than interpreting responsibilities in the hospital. The dilemma of ethics is again not indicated as a significant factor for Salma. It was noted that the SLTs in both hospitals seemed to operate on a highly developed occupational culture and covered with tacit skills and knowledge of their field of expertise in communication disorders. However, with regards to diversity issues, they have resorted to *planisa*. *Planisa* means that *they get on and get by* in the hospitals through their improvisation and the teams' self-initiated action; which is similar to what was found among miners in the study by Phakathi (2006). *Planisa* is a Fanakalo (mining *lingua franca)* tip for miners guiding them to problem solve day-to-day challenges (Phakathi, 2013). However, the challenge is that "making do" could become permanent, where formal interpreters would not be trained and employed. It is important for this *planisa* culture to stop and that the higher authorities such as the DoH put in place formal health interpreters as permanent employees in the state hospitals.

Unlike Nozipho and Fatima, Salma seemed to have a middle ground approach as she reported that working in diversity was very difficult. Salma indicated that the problem is not exclusively about the South African languages but that their interaction problems are compounded by the fact that they consult with clients from all over Africa who speak languages that most hospital staff do not speak.

> ***Salma:*** *I just used to pick it up. But now that I am here it is more difficult simply because there are so many different languages I am exposed to. So it's not only the South African languages but because we see patients from all over Africa it's a lot of other languages that we deal with. There is Shangaan, then there is all those other North African languages, all those other patients come from Malawi, Eritrea …*

Researcher: *Wow, you get so many.*

Salma: *Yeah, and there is the ones from the Congo and that's French and umm, it's not okay but I have a wordlist for French going. But the Eritrean patients, you know, and the Somalians and those who speak Arabic. So it's really quite difficult. So I use the moms or I use the caregiver or whoever comes.* (Interview, December, 2012)

Salma is from the same hospital as Fatima and Nozipho and she reported that the problem of clients who speak diverse languages was very real and can be challenging, whereas the other two SLTs seemed to be tolerant of the challenges. On the other hand, similar to Fatima, she also reported using ad hoc interpreters that are not trained. Salma reported an incident when she consulted a Shangaan-speaking patient and asked for one of the people assigned to assist in interpreting in the hospital. These assigned hospital interpreters are not trained interpreters, but are hospital staffs that are African-language speakers, working in various departments in the hospital. Salma found the Shangaan-speaking administrative staff member falling short in interpreting for her client. This situation indicates that the language rights of patients in hospital contexts are not taken seriously by the management. The hospital took inadequate measures to resolve the language problem in CMJAH. Asking staff members who speak African languages to volunteer and to do ad hoc interpreting for medical staff seems to be an inadequate solution. There is no formal structure or position to employ interpreters in the DoH.

Salma: *Umm, I had a patient who spoke, I think it was Shangaan, and, umm, no-one around here, none of the assistants, none of the cleaners. So I actually had to call one of them and they had to come. She was a clerk and it was fine to come and help translate. But the problem I find with translation is that a lot of it gets lost in translation and I feel I am not getting the message across, what I want to say, especially with the counseling or with getting the information available, you know, umm, from the patients …* (Interview, December, 2012)

The quote shows that Salma recognised that the ad hoc interpreter was not useful in her session. However, there was no mention of how the interpreter was briefed or prepared for

the role she was going to play and on terminology to be used during consultation. There is a duality in Salma's response to the situation: she called for help, which shows that she cares for her clients, but on the other hand she did not prepare the ad hoc interpreter on what was expected of her during the session. The ad hoc interpreter came in cold and probably appeared not competent in translation. In addition, she was not knowledgeable about the work of an SLT. There seems to be a knowledge gap on the SLT's part on how to work with an interpreter. The importance of planning and briefing the interpreter about the purpose of the interview and the ethics thereof were not addressed.

6.2 "That was hard!" Barriers and facilitators to working in a multicultural and multilingual health setting

Socio-political factors, cultural background and working experience affect how individuals engage in their work environment (Butter & Hermanns, 2011). The more experienced the person, the more knowledgeable and aware of the rules and solutions to work-related problems. Benner's (1982) model was found to be relevant as it highlights the transition of professional nurses from novice to expert. The professional expert is able to multitask and has a high level of intuition. In the CHB hospital, Suriya had the most experience and was thus the most senior SLT. During the interview she appeared knowledgeable about the rules and regulations. She stated that her experience facilitated her ability to collaborate with other stakeholders, assistants and therapists. Her perspective was balanced and showed that she has learned a lot while working in the community. Suriya, who is an English first-language speaker, has been working for more than 20 years at the CHB hospital. For example:

> **Suriya:** *Ok, so as I said before, in terms of as a clinician I think initially when I graduated it was very challenging. Uhm, I think the biggest challenge was not having the appropriate tools to be able to work with. Uh, and at that stage not understanding enough about the language uhm, and the community that I'm working in. But obviously, with experience and being immersed in the setting for a long time,*

I think I've learnt a lot from patients themselves and from the assistants that I work with. (Interview, October, 2012)

Suriya acknowledged that her beginning was difficult due to two reasons: cultural and linguistic challenges. First, as a clinician, her challenge was not having culturally relevant tools to use when assessing and giving intervention to clients from diverse language backgrounds. Secondly, her inability to speak and understand her clients' languages and a lack of understanding of the community she was working with were challenging. Gauteng is South Africa's most densely populated province (Johannesburg, 2015) and thus SLTs are seeing multilingual and multicultural clients regularly. Suriya acknowledges that she has improved and learned about diversity, which she attributes to her experience, clients and assistants. There appears to be adequate cultural competence in the way she describes her development. Suriya appears to be an expert practitioner, as she recognises the reciprocity and respect that are expected of her. In addition, she has a good sense of what is important. An expert practitioner, according to Benner (1982), has an intuitive grasp of the situation, and Suriya seemed to possess this.

The problem of limited resources for SLTs working in public service with diverse patients is common in South Africa, as reported by Barratt, Khoza-Shangase, & Msimang (2012), who posit that: "The South African healthcare system is plagued with challenges, including but not limited to shortages of skills and equipment and staff retention difficulties … there is the challenge of providing an efficient and equitable service to patients from diverse cultural and linguistic backgrounds". Suriya said the following to indicate how she gained useful experience:

Suriya: *Uh, I think with the, working with the assistants and because they've also been in the department for so long and have a wealth of experience, uhm, the relationship isn't always one of therapist–assistant but more of working with a colleague within the session, where we chat afterwards to confirm our findings and*

> *our interpretation. So, I think that has also changed over the years. I think as we've become more comfortable with each other uhm, and I'm comfortable with for example the assistant, uh suggesting to me something within the session or me giving her suggestions and I think the working relationship rather than the defined roles. Ya*. (Interview, October, 2012)

The above extract shows that Suriya's experience has allowed her to have an accepting attitude towards the role of an interpreter. She works in a collaborative manner and listens to the input from an interpreter as a person with *a wealth of experience*. Furthermore, by referring to the interpreter *as a colleague* shows evidence of respect of interpreters, who in this hospital are referred to as *therapists' assistants*. Salma also states that she now feels *comfortable* in taking suggestions from an interpreter on matters relating to culture. Although this is an important move, the challenge might be the fixing of the ideas presented by the interpreter as final on what the culture of the client is. There needs to be openness to the idea that a person might hold a different view of culture. Again, given the diverse cultures experienced by South African's who might speak the same language and belong to the same ethnic group, the idea of cultural competence should be treated with the complexity it demands.

The fact that an individual came from a background that allowed exposure and participation in the politics of South Africa was stated as facilitative for the SLT. For example, Suriya highlighted that her political background made her feel at ease working in a multicultural setting. Racial groups living in separate areas in South Africa and not being active politically may make a person ignorant of other races and unable to live in an integrated society. Suriya saw her cultural and political background as an asset that helps her to work in a hospital catering for a race and culture different from her own. On the other hand, this assumption could also contribute to underplaying the significance of cultural and language diversity. The researcher posits that culture is dynamic; it is not about knowing a static list of facts or having knowledge about a group. When entering another culture one must do so with caution, and be open to new discoveries as there are always changes and new developments.

***Suriya**: So I think xxx hospital and I fitted each other well. So for me I don't think it was a huge transition. The difficulty was more, not in terms of my personality but I think not in having the right tools for my training.* (Interview, October, 2012)

Suriya emphasised that she had no challenges as she coped well, except for the lack of resources and adequate training, which was a significant barrier in working with diverse languages and cultures. She blamed the inadequate services being provided on poor training from her training institution and the lack of culturally appropriate intervention resources. Most clinicians in South Africa rely on American tests that were not standardised or adapted for the local context. The use of tools that are culturally and linguistically not appropriate is also an ethical dilemma for SLTs (Mdlalo, 2013). This dilemma is resolved by using the tools qualitatively and not relying on the norms as they have not been changed and adapted for the local context. The local context is diverse in terms of languages and cultures (Pascoe & Norman, 2011).

Despite the Constitution of SA, PanSALB and the Bill of Rights advocating respect for all cultures and ensuring that everyone has the right to communicate in his or her own language, we still find hospitals not providing culturally and linguistically appropriate services. Interpreting facilities are very limited and the majority of intercultural interactions either take place in the second or third language of patients or using an untrained interpreter (Penn, 2007). Given that cultural and linguistic diversity has a profound effect on the ways in which families and professionals interrelate cross-culturally and participate in treatment programmes (Centeno, 2009), the DoH should invest in finding trained interpreters to assist HCPs and patients in government services.

The South African Health Bill (2001: p. 1) states that patients have "a right to participate in any decision affecting his or her personal health and treatment". It further states that they have a right to full knowledge: "[E]very HCP must inform a user in an appropriate manner of health status, the range of diagnostic procedures and treatment options generally available to user and furthermore about benefits, risks, costs and consequences generally associated with each option". However, the actual experiences by the SLTs in public hospitals are different.

The SLTs felt that there was a need for interpreters – this indicated that they experienced challenges with communication breakdowns in the services they provided. According to Khoza, Ramma, Mophosho, and Moroka (2008), a major challenge for practitioners in the field of speech-language pathology is the lack of appropriate assessment of communication differences and disorders in diverse languages and cultures. Below Nozipho expresses her difficulties in assessing clients from multilingual and multicultural backgrounds.

> ***Nozipho:*** *Yah that's hard. This year alone we have had a patient that only speaks French and Portuguese and they didn't have family who visited regularly and that becomes a challenge 'cause I know we are supposed to have interpreters in this hospital but they are not readily available and we haven't been able to use one".* (Interview, December, 2012)

The above quote shows that the challenges seem to be enormous for South African SLTs. Due to the influx of immigrants, they not only have to deal with the local cultures and languages of South Africa, but they also have to be equipped to work for the Southern African region. On the other hand, there appears to be 'othering' and power differential of the person who is non-South African by the SLT. The issue is about polarization of mutually exclusive binary opposites, which in this case is South African/non South African. As Steyn (2015) explains; "*one side of the binary is above the other"(381).* SA has had violence which was termed xenophobic, towards foreigners. So the above excerpt could have subtle leanings towards being interpreted as an inequitable social arrangement towards non-South Africans. The linguistic and cultural communication breakdowns can have serious consequences, leading to clients not adhering to recommendations and not actively participating in the intervention of their child Below is an incident that was reported by Salma.

> ***Salma:*** *So they come to me and they are like, "my child needs to have their tongue cut". And I had one dad who was really cross with me and was like, "you are not cutting the tongue", and I was like, "I don't need to", and he walked out and was like, "if you are not going to help me then I better go somewhere else". …* (Interview, December, 2012)

The above transcript is an indication of two distinctive cultural lenses: a non-Western and a Western paradigm. Cultural beliefs have an important influence on many aspects of a person such as concepts of time and causes of illness (Helman, 1990). The above transcript show Salma's challenge in understanding the causality viewpoint that differs from her cultural belief. Due to the lack of implementation of language rights, as articulated in the SA Constitution, we still find SLTs serving clients with little understanding of their clients' culture and language. Salma continues to explain that she later managed to explain and educate the client but due to her age and being a young person, this difference caused communication and cultural barriers:

> ***Salma:*** *Yeah, I was just, "let me just explain to you first", and he was like, "no, but you don't wanna help me", and I was like, "let's sit down and I will explain to you about the anatomy about language and speech and how they are two different things and lets just see what happens". And I showed him, I did an examination, I showed him the child can lift the tongue and move it and so it's not speech. He does not have the language to speak you know that. But when it comes from a younger person it's so difficult. …* (Interview, December, 2012)

The above communication between Salma and a caregiver illustrates an example of stressful intercultural communication and Salma's culture shock. The situation raised issues of accommodation of and adaptation to cultures for both the caregiver and Salma. In addition, culture shock is part of the route of learning and points to development in the area of tolerance of cultural differences (Dutton, 2012). Seemingly, this situation was resolved because Salma and this caregiver came to a resolution and changed what started as a negative experience to a growth experience. The departments of speech therapy in hospitals need to take active steps in diversity management and work on guidelines and policies that speak to culturally and linguistically fair services.

Suriya is the most qualified in the department; thus her knowledge of evidence-based practices is advanced. The following clarifies this:

> ***Suriya:*** *Uhm … and I think that probably has a lot to do with my post-grad studies. Uhm, especially with my ECI, and that very much focusing a lot more on the child within a context.* (Interview, October, 2012)

Academic knowledge, experience and age seem to be a facilitator for Suriya. She has a post-graduate degree in Early Childhood Intervention (ECI) and she does not have age as a challenge as, for example, Salma. For Salma age represented a cultural barrier when having to advise clients that are older than her. She reported that on many occasions she has been challenged: "*… because I am young I have been asked lots of times if I have children, I have been asked if I am still a student, how many years have I been working for."* According to Cherry et al (2010), ageism is a type of discrimination that involves prejudice against people based upon their age. In the context of this study, there appears to exist a socio cultural stereotype: first, adults are assumed to be experienced in nurturing children; and secondly, individuals with children will have more experience in nurturing than those without children; hence the SLT is judged on these two levels. Furthermore, in Chapter four, the researcher noted that Benjamin (2004) addresses the dynamics of power in therapeutic relationships, which are considered as natural in many relationships. However, in this case what is observable is the reversal of power relations. Barstow (2008) defines power differentials as

the enhanced amount of power that accompanies any person in a position of power. In this case, we observe the SLT feeling challenged by older clients. The attitude of the SLT shows that she is confident in her role and the discrimination does not distract from her role and the way in which she engages with her work.

Employees' psychological connection with their work has gained critical importance in the information/service economy of the 21st century. In the contemporary world of work, to compete effectively, companies must not only recruit the top talent, but must also inspire and enable employees to apply their full capabilities to their work. Contemporary organisations need employees, who are psychologically connected to their work; who are willing and able to invest themselves fully in their roles; who are proactive and committed to high quality performance standards. They need employees that are engaged with their work (Bakker & Leiter, 2010). Below, Suriya explains how her cultural background has made it easy for her to adapt in the diverse hospital setting.

> ***Suriya****: I think for me, I come from a background that, I think, while I've been immersed in, being brought up in an Indian community attending an Indian school; uhm … from my political involvement from the time I was a scholar, I think my awareness so far issues has been – always been there. Uhm, so for me it wasn't a huge transition fitting into this environment. Uhm, I think also for it wasn't me coming in as an Indian working with African patients, it was just me coming in and basically doing my job. And I think because of my mind frame and perhaps it was because of the way I was brought up and the organisations I was involved in from, from my youth. So to give you an example, I was in the youth league in Lens* [Lenasia] *and we did a lot of community outreach from the time I was a scholar.* (Interview, October, 2012)

The above transcript shows that Suriya was politically aware since her youth. Her political participation in the youth league seems to have been effective for personal development. Her perception of politics of race seems to have been cultivated by activism. SA politics in the

1980s prior to democracy was characterised by much protests from various communities and movements. Politics generally involves social relations and confrontation of power or authority. Thus, activism seems to have had a positive effect on how she approached her work environment and how she related with patients from other cultural backgrounds.

Devi, a junior SLT in her mid-twenties with two years' experience, stated that she came from a multicultural background (Indian and Muslim). Devi, similar to Suriya, also felt that her professional training was not adequate in how it prepared her to work in a diverse setting. Contrary to Suriya, she feels that her difficulties were mostly related to not only training, but also the lack of appropriate clinical tools for assessment and intervention in multicultural settings in SA. Devi previously worked at a hospital where the community was mostly monolingual and she was beginning to understand and speak the local language (isiZulu). Her main hurdle relates to the training she received as a speech therapist student. She explains that she was not equipped to work in multilingual and multicultural settings. She adds that working with an interpreter was also difficult as she did not know the role of an interpreter in relationship to her clients. She said:

> ***Devi****: … you know it needs to be dealt with properly and they need to explain on, you know what, these are the issues; these are the people you're gonna be seeing and the different languages involved, and how do you culturally appropriately interview them with the use of an interpreter, and how do you make them feel more at ease with the interpreter being there, and the role that they play in the assessment, I think …* (Interview, October, 2012)

In addition, Suriya concurs with Devi by describing the significant barriers related to her professional training. She felt that the emphasis in the curriculum at her institution was biased to training a clinician that would be working in a monocultural and well-resourced setting. This barrier also occurs in other professions such as teacher training, where globally, findings show that initial teacher training in the area of multicultural education is grossly inadequate or mostly non-existent (le Roux & Möller, 2002). Thus, it cannot be expected of SLTs to work effectively in multicultural and multilingual settings without being professionally prepared for this undertaking. Multicultural and multilingual issues were addressed in a

limited manner in the undergraduate curriculum. Suriya said *that was hard* more than once, indicating how extremely challenging it is to work in an environment that you feel unprepared for. Training institutions should avoid cosmetically adding a clause about respect for other cultures; which is what is seen in most programmes (le Roux & Möller, 2002). Since the early 2000s, South African institutions of higher learning have been pushed by the minister in the Department of Higher Education (DHE) to introduce service learning (SL) as a way of increasing "… social engagement, accountability, relevant knowledge and the education of ethical, competent leaders and citizens" (O'Brien, 2005). SL has been introduced in most South African universities, including the Speech-Language Pathology and Audiology department at Wits University. A study by Mophosho and Stein (2009) indicated that students learned about working in diversity and reported that SL prepared them for the realities of SA's communities. It would appear that the clinicians' competencies in multicultural settings were challenged, thus making them feel like novice professionals. The following captures what Suriya said:

> **Suriya:** … *I think a lot of what I saw at Baragwanath was covered in maybe one or two very superficial lectures. Where something like stuttering got weeks and weeks and weeks of input and I come to Bara hospital and 80% of the kids have dysphagia. So that for me was hard. Uhm, also being trained only to do standardised assessments at that stage and you were used to pulling out a bag and being able to test the kid with that, uhm, not learning or being taught how to deal with varied languages, uhm without the necessary standardised tools – that was hard …* (Interview, October, 2012)

Furthermore, Suriya pointed out another barrier related to the way in which her institution trained her as a speech therapist. She explains that disorders like stuttering made out a major part of her studies. However, in the South African context, the caseloads of many SLTs, especially in public hospitals, have very few stutterers as clients. The bulk of her paediatric cases was treated for feeding and swallowing (dysphagia) difficulties: … *and I come to Bara hospital and 80% of the kids have dysphagia. So that for me was hard.* In addition, she notes the problem of not being well qualified to work in a multilingual context. It would seem that

Suriya's training institution did not prepare her for the community she was to serve. The training institution prepared her and others to work in a first-world context and not the South African context. It is unfortunate that Suriya was trained before the new democratic South Africa came into being, where service learning has been put in place as a legal requirement for all universities.

Service learning has the key objective of meeting the needs of a community, while simultaneously enhancing academic curriculum content. It can also be referred to as a form of experiential education (Bowen, 2010). The nature of service learning includes reflective practice, which helps the current students to be aware of the needs and culture of a community, and thus prepares to train speech-language pathology students for their nature practice as qualified SLTs (Mophosho & Stein, 2009).

The Department of Health in SA has not brought the Department of Higher Education into the fold with regard to the needs of the profession. Educational and learning institutions should review their policies on admission and funding of students, especially for the previously disadvantaged groups. In addition, the inclusion of service learning and language policy in curriculum planning for the profession should be carefully considered. According to (Michelle Pascoe & Vivienne Norman, 2011), SA still has insufficient numbers of SLTs to provide services to citizens, and the qualified SLTs are not representative of the country's demographics due to the limited number of black students registering in this profession. Despite the goals of the democratic constitution that SA adopted in 1994 to provide all its citizens with "equal access to quality healthcare and education", we still find poor provider-to-client ratios and inadequate material resources in public hospitals. A call has been made that there is a need for the professions of SLT and audiologist to transform and develop their practice (Michelle Pascoe & Vivienne Norman, 2011). Below is a quote from Suriya, commenting on the limited number of African SLTs and audiologists in SA and about limited teaching on working with contextually relevant intervention resources in diverse contexts.

> ***Suriya****: … It's still unfortunate that we don't have a sufficient number of African graduates each year, uhm, but it also depends then on where people apply. So in our staff of twenty-nine, we only will have two African therapists.*
>
> ***Suriya:*** *… I think … well when I was trained two decades ago, I think a lot of what I saw at Bara was covered in maybe one or two very superficial lectures. Where something like stuttering got weeks and weeks and weeks of input and I come to Bara and 80% of the kids have dysphagia. So that for me was hard. Uhm, also being trained only to do standardised assessments at that stage and you were used to pulling out a bag and being able to test the kid with that, uhm without the necessary standardised tools – that was hard.*(Interview, October, 2012)

Suriya's statement was alluded to by other SLTs in this study as well, who also felt the frustration of being inadequately prepared for working in diverse settings. It appears that, even though some universities have introduced service learning post-1994, all the challenges with diversity and lack of preparedness of working in a multicultural and multilingual health care context have not been resolved. The training has a Western biomedical view of health care that believes in a scientific basis for disease, diagnosis and treatment. The South African speech therapy training relies on the biological view of treating or rehabilitation of communication disorders. As previously stated, diagnostic tools are also limited, thus clinicians still use assessment tools developed in countries such as America. Using culturally irrelevant tools negatively affects the relationship between the family and the SLT and contributes to a lack of participation in child intervention.

According to Borrell-Carrió, Suchman and Epstein (2004), a biopsychosocial approach in clinical settings is justified because it focuses on self-awareness; active cultivation of trust; an emotional style characterised by empathic curiosity; reducing self-bias by reflection; and fostering dialogue between the clinician and clients.

In addition to reflective practice, SLTs have to integrate the relevant medical information and values to make a recommendation and attempt to persuade the patient to accept the recommended intervention (Emanuel & Emanuel, 1992). Some of the good that came out of these barriers were that SLTs had to start teaching themselves ways of working effectively and in a relevant manner, using *planisa*. Suriya, reports that, due to a lack of preparation from her university in Gauteng, she had to teach herself how to be relevant in the hospital. Nozipho was trained at a different university and also commented about training.

> **Suriya**: … *"Ya. I can't say I got a good idea of what the profession was about. So ya, I think it was more just in terms of not being prepared to cope in an environment that's diverse and busy like this one, where a patient would truly represent what a South African patient is, the norm and not the exception. And I think twenty years ago when I was trained at XXX varsity, it was more that if an African child walked in, it was more the exception rather than the norm at XXX university.*
>
> ***Nozipho:*** *So, I think there is a bit of shortfall in our trainings, it does not cater for everyone's language. …* (Interview, December, 2012)

The barriers in Suriya's and Nozipho's clinical practice seem to be related to the lack of multicultural education in their undergraduate training. As students, they both trained at an institution that had a diverse student population; however, the curriculum did not emphasise multicultural and multilingual awareness and competency. Cultural diversity can have a significant impact on the way students think, learn and interact. Clinical educators need to consider the significance of this impact (Tjallinks, 2004). Suriya was trained pre-1994, when the South African government was still under apartheid; thus one realises how some academic institutions did not train their students in a progressive manner to prepare them for future practice as SLTs. Unfortunately, these communication challenges can lead to patients not complying with clinical recommendations. For example, Fatima noted:

Fatima … *otherwise they will just say yes … yes … yes and leave and they were too shy to tell you that they don't understand and then nothing gets done, so yeah.*

The above quote is similar to other research findings of medical communication in different cultures. In a review study in the Netherlands of intercultural communication in health, it was also claimed that medical professionals' culture and ethnicity are often barriers in establishing an effective doctor–patient relationship (Schouten & Meeuwesen, 2006). This study identified five predictors of culture-related communication problems, namely, cultural difference in explanatory models of health and illness; difference in cultural values; cultural differences in patients' preferences for doctor–patient relationships; racism/perceptual biases; and linguistic barriers. These findings of intercultural miscommunications are similar to findings in the current study, as indicated by participants' reports of a lack of compliance with recommendations.

An effort on community engagement in the curriculum for training SLTs is viewed as a possible solution to the required national transformation and reconstruction efforts in SA. Including community engagement in clinical training is not only important for social justice, but also for ethical practice.

> The contention is that by demonstrating their social responsibility through community engagement, higher education institutions will be able to meet the national requirements for transformation in terms of broader participation, greater responsiveness to the challenges of society, and the formation of partnerships with other constituencies. (Erasmus, 2009, p. 45)

Transformation in student and staff demographics in universities brings with it a possibility of cohesion and cultural sensitivity. Culture expresses itself in many forms, for example, religion, music, media, sport and everyday activities (Moua, 2011). Furthermore, culture is fluid and complex. Similar to Suriya's experiences at the CHBH, it appeared that cultural background and the experience of working in a township clinic helped Fatima (at CMJAH) to

adapt to the diverse interactions. The extract below shows Fatima's view about other cultures that she is exposed to in the hospital.

> **Fatima:** *I mean, if you see with the very traditional homes, there is always that respect thing, it's umm ... I don't know how to explain it, like with your older patients there is always that respect, like with the husbands and wives patients, if it's the husband coming the wife will always be there, but for me I understand the culture, so it's not difficult to adapt to it.*
>
> **Researcher:** *And others that are not familiar to you?*
>
> **Fatima:** *There haven't really been any unfamiliar ones, but I think it helps because I learn a lot about African cultures when I worked in Soweto.* (Interview, December 2012)

This level of confidence regarding another culture indicated that Suriya and Fatima seem to view culture as static or a collection of facts that one can learn. On the contrary, culture is dynamic, adaptive and ever-changing, and cannot be approached in an unassuming manner (Kashima, 2014). The assumption that one knows other peoples' culture or assigns certain attributes such as the *respect thing* can be problematic and can lead to overgeneralisation and stereotyping a community. The above transcripts of Fatima and her colleagues indicate the limited awareness that these SLTs have of their cultural capital. As indicated in Chapter 4, the power and linguistic cultural capital of professionals have a significant impact on their interactions with clients that are poor and have limited education. Ignoring the impact of professionals' cultural capital can lead to undesirable results, which can be perceived by clients as not being respected or acknowledged.

The interconnectedness and similarities between cultures should not be taken for granted. Due to globalisation, migration, asylum seekers, and economic migration, many cultures show similarities. Fatima states that her culture (Muslim) is similar to African culture as respect is valued very highly by both. Fatima found adjusting in a multicultural environment "not difficult" because she has learnt from families and clients. Being open to learn and to

listen to your clients is a pivotal skill when working with families, especially in early childhood communication intervention.

Early childhood intervention services are based on three foundational principles: First, that all human beings are capable of adapting to their environment; secondly, that childhood development can be understood fully in a holistic ecological context, which includes the family at the core; and finally, due to the diverse nature of developmental hurdles and opportunities, the field is interdisciplinary (Shonkoff & Meisels, 2000). All participants in the study were involved in providing early childhood intervention services in the contexts as part of their duties. All qualified SLTs have to be competent in working with families of young children with disabilities. The description of family-centred practice has changed over the years. In a comprehensive description by McWilliam, Tocci and Harbin in 1995, the four dimensions of family-centred practices and policies are: responding to family priorities, empowering family members, employing a holistic (ecological approach) to the family, and demonstrating insight and sensitivity (Shonkoff & Meisels, 2000).

In the transcript below, Salma, who can be considered a competent or expert clinician with her six years' experience, explains to the researcher how she works with caregivers in the early childhood language assessment clinic. The approach that Salma describes is in line with the family-centred practices, because it indicates sensitivity to families and respect. Salma works in the Charlotte Maxeke Johannesburg Academic Hospital, where there are no interpreters, but she manages to interact in a respectful and cordial manner with her clients. She said:

> **Researcher:** *Maybe you can outline for me what strategy you use to make sure that the mom is comfortable with you and will assist you. How do you build that relationship?*
>
> **Salma:** *Umm, I always sit on the smaller chair, face-to-face, I never sit behind the desk, ok. And I always say to the moms, "why are you here, what is it that you want?" I am worried about the moms, I am not interested in the child in the first visit and I always say to the moms, "today it is about you and me. When we are done here, I will speak to the child". Because I can't start with the child if I don't know what the goals*

*of the mom are, ok. But then I try get a relationship going by trying to find some maybe common ground that I have with the mom. (*Interview, December, 2012)

Salma's experience as an SLT is a significant facilitator that allows her clients to feel respected and at the same level with her. Building rapport and trust with caregivers at the initial interview is critical as it makes the client feel accepted and also start trusting the professional (Forry, Tout, Rothenberg, Sandstrom &Veseley, 2013). The strategies employed by Salma and Suriya may minimise defensiveness and assist in working collaboratively with the family. A collaborative consultation is reported to empower clients to participate in their care and that of their child. On the other hand, a technical as opposed to a collaborative style of consultation may reduce rapport, respect, compliance and treatment outcomes (Forry, et al., 2013). A collaborative consultation style is essential in a multilingual and multicultural context, as there are diverse class and cultural issues that may threaten respectful and collaborative teamwork. Work engagement is most often defined as "a positive, fulfilling, work-related state of mind that is characterized by vigour, dedication, and absorption" (Schaufeli & Bakker, 2010; Schaufeli, Salanova, González-Romá, & Bakker, 2002, p. 74). In essence, work engagement captures how workers experience their work: as stimulating and energetic and something to which they really want to devote time and effort (the vigour component); as a significant and meaningful pursuit (dedication); and as engrossing and something on which they are fully concentrated (absorption). In the CHB academic hospital, Devi explained her approach to patients and caregivers as helpful and fair. She said:

Devi: *… Like that's always my thing, even with my sessions, to say: "I'm here to help. But you're just as important as I am".*

The above extract illustrates that Devi, a young therapist, is sensitive to the image that she may be portraying as SLT; so she takes time and make an effort to make her clients feel important. In addition, she is cognisant of socio-cultural issues that may make clients feel disrespected.

According to Campinha-Bacote,(2003), becoming culturally competent involves consideration of cultural desire, cultural awareness, cultural knowledge, cultural skill – conducting culturally sensitive assessments – and cultural encounters. Cultural competence starts off with cultural desire, which involves a commitment to care for patients from diverse cultural values and beliefs. In addition, cultural competence is explained as a "practical, concrete demonstration of the ethical principles of *respect for persons, beneficence* (doing good), *non-maleficence* (not doing harm), and *justice* (treating people fairly" (Hoop, DiPasquale, Hernandez, & Roberts, 2008). In summary, cultural competence involves both positive acceptance and being ethical. Devi explained an app roach that showed her cultural competence.

Another extract that shows cultural competence involves Salma dealing with a traditional family, where the husband who spoke a bit of English was asked to be an interpreter for his wife. The husband kept on disrupting the session with his views and did not cooperate with Salma. She described her initial interaction with this Somali-born family as a struggle. She went on to say the following:

> ***Salma**: One dad, it was a Somalian dad, his wife didn't speak English, so he came with her for a session. And the Somalians, I don't know if umm you know about them, but the men are very overpowering and the wives are the subservient types, they just passive and they sit. So I had this mom who was very nice and I struggled 'cause I picked her up in the clinic and I struggled and struggled. So I said to her you need to come and she came in with her husband. And at the end of it, he says, "how many children do you have?", and I said, "I don't have any", and he is like, "that's fine and I know you are a doctor but I have 10 children and I don't think you can tell me what I know".* (Interview, December, 2012)

The transcript shows Salma's prejudice or generalisation about this community when she describes them as follows: *the men are very overpowering and the wives are the subservient types, they just passive and they sit….* The situation indicates that Salma's initial consultation with the mother was difficult seeing that she was non-English proficient and unaccompanied. Her suggestion that the mother brings her husband to help interpret did not work out well, because she was challenged about her age. Salma's professional authority was also challenged by this man who said *"… I don't think you can tell me what I know."* The statement from this Somali father seems to prove Salma's "prejudice" (so called by the researcher in the previous paragraph) that Somali men are "overpowering".

On the other hand, Nozipho's cultural and language background worked as facilitators in her practice, because she is African and a first-language Zulu speaker. The transcript below shows how her cultural awareness helped her to understand the beliefs of the client. She commented that she knew from the dress code of the client (a badge and head-wrap) that she belonged to a group of people who have specific religious practices, which include "purging"**.** She said:

> ***Nozipho:*** *I have, I have a patient right now, but it's an adult patient, so maybe it is different. She is presenting voice difficulties, hoarseness for years, and ENT found she has vocal polyps. And she goes to a church where they purge and they do a lot of stuff that is harmful.*
>
> ***Researcher:*** *How did you find out about it? Would she tell you, or what?*
>
> ***Nozipho:*** *I asked her.*
>
> ***Researcher:*** *Oh ok.*
>
> ***Nozipho:*** *I asked her 'cause I could see the head wrap and the badge. So I said, "do you? I know your church does something like this. Is it something that you do regularly?" "Yes, but then ENT says you have vocal polyps." And she is not*

> *recovering on medicinal 'cause she is not willing for the doctors to do any further tests, because she wants to go to church and do the cultural treatments first? So now, the thing is I said to her, "go home and think about it first, but I would advise you to look at this option first, and maybe you can decrease what you are doing, you do half of this, and we can sort this out first because polyps can go awry if you don't do the right thing". So it's very difficult to get the right thing*. (Interview, December 2012)

This quote indicates that Nozipho did not just assume she knew the patient's cultural and religious beliefs when she saw how the client was dressed, but she had the courage to ask the patient first. This is a good demonstration of Nozipho's highly professional attitude and cultural competency. Thus, it is recommended that training institutions should accept a diverse group of students in the health care profession, as all cultures contribute to learning and teaching. Information about what is acceptable or not acceptable in different religions is pivotal as it will assist in preventing mistakes, miscommunications and misconceptions (Lubbe, 2004). Furthermore, despite being called the "Rainbow Nation"; ethnic and cultural intolerance is still alive (Scheepers, 2010).

Participants in both hospitals showed commitment to finding workable solutions. It appears that most of the work was not done by their hospitals but that they had to individually make plans to learn, as reported by Suriya: *Uhm, so ya. Then a lot of learning thereafter had to be self-learning.* Some of the strategies that were introduced seemed to be related to engaging the political consciousness of the professionals. At the CHB hospital, based in Soweto, it was found that the strategies that were introduced are not one-off, but seem to be cyclical, and also involve the SLTs and their families. Below Suriya talks about the excursions the Speech therapy department made in order to bring socio-political and historical understanding of the people of Soweto. She said:

> ***Suriya****: We also actually have planned, for example, a tour, which is not just for the department but therapists and their families to Lillie's Farm next year. Uh, and we've organised for someone who was with Mandela uh, to come and chat to people. So just changing people; and a lot of the young therapists do not have the knowledge of the history of the country, which is an integral part to understanding the history of Soweto …'*(Interview, October 2012)

The CHB hospital's cultural interchange and awareness strategies are recognised as assisting in changing the cultural world views of their staff. However, these attempts seem to be superficial; the researcher is of the view that to understand intercultural beliefs and communication requires deep-going attempts and not surface activities that seem suited for tourists. Perceptions, values, attitudes, prejudices and stereotypes need to be worked on extensively so that cultural world views can be transformed. This change is possible if the work is done in a systemic manner. Using an open system that allows for the multidirectional movement of information and ideas among HCPs, hospitals, patients, the DoH and communities can result in healthy interaction (Dutton, 2012). At an individual level, SLTs should ask themselves the following basic transformative questions suggested by Bongwe (2010): "What is my core belief and my philosophy about people and about differences? How is this core belief helping or hurting my personal growth and effectiveness in this diverse world of today and the future? And what am I going to do concretely to make necessary change?"

t the Charlotte Maxeke Johannesburg Academic hospital the researcher also found that their intervention seemed to be individually based and on an ad hoc basis. The three participants spoke about their individual solutions, most of them relating to finding appropriate resources to help address their interactions with clients. Salma spoke about finding words from Google and Nozipho uses pictures and gestures. Salma manages to find out about the cultural issues that might be relevant for her clients. Below Salma, Fatima and Nozipho explain how they overcome the language barriers when their clients are not proficient in English.

Salma: *If their English is not good themselves, it actually is a struggle, we get nowhere, then it's very hard with case history taking. And again, because I only see paediatrics, a lot of it is language therapy, so it's very very difficult. So I can't say to you its successful, we just struggle and go along.*

Umm if the patient is not English I just try and research. I try and get the words and make a wordlist but that's difficult 'cause I am googling those words and sometimes the dialect isn't the same as that on Google. (Interview, December 2012)

Nozipho: *You use gestures, you write pictures, but you never get full picture.* (Interview, December 2012)

Fatima*: I mean, I know in some cultures they shouldn't give proper eye contact because it is disrespectful, it is considered disrespectful, yes that one I have seen, I mean I understand that aspect. So to me, it's not really a problem from the caregivers.*

But other than that, there haven't been any cultural issues. Other times with the therapy you will have to adapt it to go with the culture of the child. (Interview, December 2012)

The above transcripts show how the clinicians at this hospital, similar to those at the CHB hospital, have become resourceful. However, their strategies are not systemic. A systemic approach will not only unravel the multilingual and multicultural issues, but will also benefit the intercultural communication dyads and intercultural transformation theory (Dutton, 2012). Furthermore, a transformation theory of intercultural communication addresses the adjustment of an individual to a new culture and also facilitates the transformation of the person within the new culture. The main purpose is to enable the individual to become a multicultural person. The SLTs above illustrated some strategies that they found useful in becoming multicultural.

6.3 Interpreter's role in meaning making

Despite the challenges that clinicians face in multilingual settings, the professionals seemed to find that their working experience was an important leveller when there was an interpreter present during their consultations. It seemed that Suriya, who is the most experienced clinician at the CHB hospital, had a positive view about working with an experienced interpreter. Suriya can be considered an expert professional as she is able to acknowledge the importance of the resource that the interpreter brings to the table. The following excerpt illustrates Devi's view of interpreters:

> ***Devi**: Uhm, well just from knowledge of how interpreters work and things like that, it's very important. I feel that the ladies that work here have been working here for years and years, so they know how to go about doing it and know what's expected of them and how they can help us.* (Interview, October 2012)

Devi's and Suriya's confidence in interpreters seems to be based on knowledge and experience. They acknowledged the experience of the interpreters, and further stated that they are competent in what they do because they were trained to work specifically in the Speech therapy department. It appears that the two trained interpreters at the CHB hospital have clear guidelines and have been sufficiently trained. One interpreter works in the Audiology department and one in the Speech therapy department. However, the position of the interpreters is officially that of an assistant SLT for the department. These interpreters at the CHB hospital benefit the department because they are trained. They do not serve merely as message converters or clarifiers, but their role extends to that of cultural clarifier. Suriya shared her experience with an interpreter thus:

> ***Suriya:*** *… have a wealth of experience … So, I think that has also changed over the years. I think as we've become more comfortable with each other. Uhm, and I'm comfortable with for example the assistant, uh suggesting to me something within the session or giving her suggestions and I think the working relationship rather than the defined roles. Ya.* (Interview, October, 2012)

Suriya feels that the department assistants, who also work mostly as interpreters, are competent and can be trusted. She further explains that she is *comfortable* with the assistant clarifying or making a contribution during family consultations. In addition, Suriya indicates that she has a collaborative working relationship with the assistant. It seems that the lines of professional divide have been ignored, which indicates that the type of teamwork could be described as transdisciplinary. Transdisciplinary services have been advocated as exemplary service for intervention with young children and adults with developmental disabilities (York, Rainforth, & Giangreco, 1990).

6.3.1 Communication breakdown: A service delivery dilemma

This part of the discussion is divided into two subsections to elaborate on the communication challenges in diverse contexts and how SLTs solve the problem of limited resources. Studies on doctor–patient communication have found that problematic communication leads to reduced health outcomes and poor compliance by patients (Levin, 2005: MacDonald, Carnevale & Razack, 2007a). The profession of SLT faces similar challenges to those in the medical field in their attempt to improve communication with their clients (Ferguson & Armstrong, 2004). In the context of health care provision, communication is important for the provision of excellent service. Research by Travaline, Ruchinskas and D'Alonzo (2005) indicates that patient–HCP communication matters, because it allows for patients' healing and reconnection. Therefore, in situations where communication is not signified, health care provision cannot be adequately provided. Thus it was surprising to find that in a context of diverse languages, service providers in the area of speech do not speak or understand the languages of those they serve.

The communication challenge that is common for both doctors and SLTs is that of unequal encounters in doctor–patient communication (Thomas, 2006). Salma reported some of the challenges in communicating with clients who have a different belief regarding causality and medicine:

> ***Salma:*** *… and that just is it. I had one patient who said the lady at Dischem said she must come to get the pills to make the child talk and like after the two minutes of stunned silence, I said to her like, "umm start from the beginning that your child does not talk" and then ... so I try also to make them see for themselves where the logic is. So it's pills to make them talk, and another thing is very odd is the tongue type. It's always the tongue is short and the tongue needs to be cut, that's why their children can't speak, and you find that if they come from the locations, that's the common thinking that if your child is not talking, then you need to have their tongue cut.* (Interview, December, 2012)

In the above quote, Salma does not share the caregiver's cultural beliefs, and struggles to get the caregiver to think the way she does. SLTs need to note that clients are "culturally unique individuals and as such are products of past experiences, cultural beliefs and cultural norms" (Tjale & De Villiers, 2004). Salma's statement of *like after the two minutes of stunned silence* is problematic, because it comprises an element of judgment of the logic that is used by the caregivers regarding the causality of speech disorders in children. In addition, she appears to have a limited understanding of this prevalent frame of reference that she ascribes to people she says *come from the locations*. The understanding of causality of disease and illness varies from culture to culture (Nkosi, 2012). In most Western countries, disease is explained in empirical or scientific terms, whereas most African cultures believe in supernatural beings and powers such as gods or spirits (Tjale & De Villiers, 2004). Cultural beliefs are complex and need to be treated with caution and little or no judgement at all. Speaking or understanding the language of the community is not sufficient knowledge of their culture and cultural beliefs.

Although it is commendable that SLTs find other ways of coping with the diverse languages and cultures, they should be required to learn these languages or have interpreters that speak these languages fluently. Below is a transcript of Nozipho, who was the only African therapist at CMJAH. She discusses the problems that occur due to the lack of interpreters and the misdiagnosis that occurred.

> ***Nozipho:*** *I don't think it's fair on the patients; they are not getting full service; there is something that needs to be done. There can be misdiagnosis done in the wards. You will go and find that this patient has expressive aphasia, but when you go, you find out that they speak Zulu, and you speak in their home language, they can actually respond. The problem was maybe they didn't understand English, so maybe they just looked at someone, whatever assessed them first, and just assumed they are, they had issues.* (Interview, December, 2012).

Nozipho was speaking from experience that patients receive unequal and unfair treatment if they do not speak English. This disparity in health care for people who have limited English proficiency is also documented in other countries such as the US (Balsa & McGuire, 2002). Nozipho felt that *something needs to be done* but appeared not to have a solution. The human and language rights of patients have been violated for many decades – since before and after the new democratic government – and still no action has been taken, politically or legally. The professional and regulatory bodies have policies on the provision of equitable health care and rehabilitation services; however, the challenge lies in implementing these policies.

Misdiagnosis of patients is a serious ethical and clinical malpractice, which appears to continue unreported by the professionals and researchers. In most cases this is unintentional misdiagnosis, but it is still a misdiagnosis. The difficulty regarding such disclosures is that they are scarcely reported in research, because researchers have to choose between maintaining confidentiality and protecting the public (Skweyiya & Jewkes, 2011). Similar findings are reported in other countries such as the US, where it was found that many hospitals were not providing language services for patients not proficient in English in compliance with their federal law on National Standards for Culturally and Linguistically

Appropriate Services in Health Care (CLAS standards) (Diamond, Wilson-Stronks & Jacobs, 2010). In this US study, the majority of hospitals stated that they use family members or untrained staff as interpreters. Only 13% of hospitals in this study met the criteria of the CLAS standards, while 19% met none of them.

Salma reported that they face serious challenges when they have to consult clients and record their case histories. Like Nozipho, she also recognises the challenges that they experience when they have to consult with a client. She states that clients' basic conversational English skills make it easy during brief interactions when clients come in to make an appointment only. However, when they have to take a case history, the language problems become evident.

> ***Salma :*** *Umm, because it's a referral hospital, a lot of the patients are referred either from outside doctors or hospitals or clinics here. We don't always know what the language is 'cause they come here with the referral letter, they come here to make an appointment, and you know, that basic conversation we are able to have at the front desk, when must you come back and all the documentation you need to bring. It's just that when you are sitting here, you are delving into the deeper case history, that sometimes things just get lost.* (Interview, December, 2012).

Even though Salma reports that in her consultations "things get lost" due to communication barriers, she continues her work and seems to have no solution to the problem. Despite the common communication challenges due to diverse populations in the Gauteng province, the SLTs appeared to be keen on delivering their services respectfully. The researcher observed ethical behaviour in most situations. Families and caregivers of young children were collaborated with, and seen as team members. Devi's attempts at collaboration seem to be limited to caregivers being interpreters of their child. However, Salma's approach is very different, as it involves asking open-ended questions and making the environment hospitable. The following quote indicates these different approaches:

***Devi**: Uhm, personally I use the parents as the main person and I do everything through the parents. So if there's anything that I'm doing, then I make sure that the parents know what it is that I want and what we need in this session and they do all the interpreting. So everything that I'm saying, they're interpreting to their child.* (Interview, December, 2012).

***Salma:** Umm I always sit on the smaller chair, face-to-face, I never sit behind the desk, ok, and I always say to the moms, "why are you here? What is it that you want? I am worried about the moms, I am not interested in the child in the first visit and I always say to the moms, "today it is about you and me. When we are done here I will speak to the child"….* (Interview, December, 2012).

Both Salma and Devi seem to be aware of the importance of parental involvement when working with young children. Nonetheless, they have completely different approaches – one at the level of assisting the SLT to give intervention to the child through the parents, and the other, inclusive and expecting participation in decision making. Salma's approach is aligned with the guidelines for best practice in early childhood intervention services, which state that the service should be individualised and relevant for families. In addition, the early childhood services should ensure that parents are actively involved in planning the services for their child and themselves. This strategy requires SLTs to implement services that recognise the value and support of this collaborative team approach (Bailey, Curtis & Nuna, 2001).

6.4 Conclusion

In answering the question about how SLTs perceive their effectiveness during consultations with clients from diverse cultures and languages, the five SLTs and one interpreter that participated were analysed according to themes. Four themes emerged from the analysis of

the transcriptions: adaptation to the situation; the benefit of cultural background in adapting to diversity; the role of the interpreter in adapting to a lack of professionally trained mediators; and communication challenges in diverse contexts and how SLTs solve the problem of limited resources.

The findings also confirm the culture of *planisa* that seems to be operating in the profession and it is suggested that this is a good strategy. However, on its own, *planisa* is not effective because it has negative consequences for social justice, resulting in poor health provision for people who have limited English proficiency in SA. Although there was limited evidence that the experience and cultural understanding of some SLTs had a facilitatory effect on the health care provision for families of children with communication disabilities, there is a need for further research on the barriers to effective strategies for SLTs that work in a multicultural and multilingual context.

Finally, it appears that the redress of admission policies and the radical inclusion of service learning and multicultural competency in the curriculum of speech pathology can significantly influence and assist in transforming the professional training of SLTs at South African universities. Transformation of the curriculum, profession and practice of SLTs will require immense commitment and understanding and unpacking of critical diversity literacy and decolonization concepts not at a theoretical level only but also in how to implement it. The following chapter will address the recommendations related to research, policy and practice.

CHAPTER 7: Conclusion and Recommendations

7.1. Summary of report

The aims of the study were to explore the experiences of and workplace interactions between SLTs and interpreters in a cross-linguistic mediated consultation with caregivers of children with severe disabilities within a health care setting. Specific objectives of this study included analysing the interactional characteristics and features of SLTs and interpreters as well as identifying the perceptions of their competency in multicultural settings.

The broad aim of the study was to provide an indication of the dynamics, complexities and issues involved in a multicultural and multilingual health care consultation practice session of caregivers of children with communication disabilities. The main study question was: What are the experiences and nature of interaction between SLTs and interpreters during interviews with caregivers of children with disabilities in a multicultural and multilingual urban hospital setting? The information on the main question was mainly descriptive, that is, how SLTs conduct their initial consultations in a multicultural and multilingual hospital setting. The study presented evidence that the persistent limited understandings between HCPs and their clients from diverse backgrounds and cultures had the potential to lead to poor service and violation of the language rights of the clients that SLTs serve within state-owned hospitals.

In addition, the study explored the interactional dynamics between the SLT and interpreter in one particular hospital where assistant speech therapists are also trained as interpreters. Furthermore, the researcher undertook to explore the strategies used by the SLTs to invite the interpreter to translate accurately. Finally, the researcher explored the perceptions of interpreters and SLTs of their effectiveness in a cross-linguistic setting. Detailed discussions of these issues were presented in the six preceding chapters.

The literature review gave a reading of literature that spoke to the schematic genealogy of the medical science as it transitioned from being doctor centered to being patient centered. This section of the study engaged with literature portraying that HCPs still grapple with being fully patient centered, even though policy guidelines provided the practice platform, for example, the Constitution and Patients' rights charter. This chapter highlighted that patient-centered health care drives health care that is respectful of and responsive to the preferences, needs and values of clients. Patient-centered care would therefore be a practical expression of

ethical ideals as outlined by the HPCSA. To provide excellent rehabilitation or health care, SLTs need to live out the principles that patient-centered care requires, which includes information and communication, involvement of family and caregivers and emotional support. Thus, the patient-centered approach is recognised as high quality care as it aims to improve access and care.

The methodology chapter demonstrates the links between the research questions and the methods used to examine the objectives of the study. The point of departure was that the study was explorative and interpretive. The chapter provided a sense of how multiple methods of data collection and analysis could be utilised to yield rich research results. The chapter described in detail the participants, instruments and procedure for data collection, the methods of data analysis as well as the ethical considerations followed in undertaking the study. The methods utilised in this study involved the researcher conducting ethnographic observations; video recordings of an interaction between an SLT and an interpreter during clinical consultations with caregivers of a child with a communication disability; audio recordings; and individual interviews of SLTs and interpreters post-consultation.

The findings of the study are presented in three chapters. In an attempt to answer the research question, the findings support the argument that cultural competence and recognition of asymmetrical power relations in clinical consultations of SLTs working in diverse settings is a pivotal skill. Chapter four focused on how power dynamics affect clinical consultation processes and looked at gender dynamics in clinical encounters, cultural competence in clinical encounter contexts, and multiculturalism as sources of misunderstanding in clinical settings. All of these have important implications for how we practice as communication disorder specialists. In summary, this chapter indicated that culture matters and that unequal power relations affect the way in which we understand disease, health care and healing Communication interventions are managed on people who come from a cultural context , thus the cultural assets are in communication. Therefore culture and the power positionalities they occupy should not be overlooked during the implementation of practice by SLTs or HCPs.

Chapters five and six showed that there were some cultural and language challenges that affected all SLTs. The SLTs reported that they had to treat local and foreign language speaking clients. Some SLTs minimised the problem as they felt that they were coping. In addition the, there was lack of sensitivity on how power was also evident in how the SLTs

defined the outside 'other' clients such as foreigners from other parts of Africa. It appeared that the experienced SLT was more aware of the patients' rights and the importance of audits on patient satisfaction than the less experienced SLTs. One hospital provided services for language and cultural interpretation, thus sensitising SLTs to the community's culture and language. All participants agreed that there was a need for more interpreters to be trained by SLTs, not just technical language interpreters.

Chapter six discussed four themes dealing with communication challenges: (1) *planisa* or adaptation to the situation and power dynamics were evident. The SLTs seemed to be focusing on working as teams to get the work done despite the challenges of working in diversity; (2) the advantage of cultural background in adapting to diversity; (3) the role of the interpreter in adapting to a lack of professionally trained mediators; and (4) communication challenges in diverse contexts and how SLTs solve the problem of limited resources. Most SLTs in South Africa have spent four years learning the scientific, theoretical knowledge and clinical skills to become professionals. Unfortunately, it appears that the professional training does not include in-depth aspects of being culturally competent and in addressing the importance of how SLTs are positioned within relations of power that structure hierarchies; when consulting and treating clients of diverse cultures and languages. These findings raise a number of practice-related issues that must lead to new ways and strategies if the professions of speech-language and hearing are to provide ethical and efficient service of the highest quality.

The same chapter emphasised the challenges that SLTs generally face when working in a multilingual and multicultural hospital setting. Cultural issues are one of many challenges. Globally, the trend is that HCPs have to treat clients from diverse cultures and languages. Providing trained medical interpreters is not an attainable goal, especially in developing countries with a history of limited resources and multilingual and multicultural populations. There is a need to further explore alternative solutions to mediated clinical encounters.

This study also highlighted the fact that the post-1994 South African government is paying more attention to fundamental human and language rights through policies based on social justice, human rights and equity in access to health care and rehabilitation services. However, due to the fact that people with disabilities and their families/caregivers are among the

poorest in South Africa, these rights are not fully realised. The level of poverty is reported to act as a barrier to accessing resources such as transport and health services. Consequently, global leaders in health care recognised that diseases in developing countries were socially and economically sustained and, in essence, required a political response.

The study also pointed out that SLTs work hard to find solutions for making their services culturally appropriate. Furthermore, caregivers of children with disabilities are appreciative of the health care services but they still find it challenging to interact in a diverse cultural setting. Recognition of how current power relations are maintained and supporting transformative programmes is essential for SLTs. Both primary and secondary data were used for this study: secondary data came primarily from individual interviews with SLTs and an interpreter and primary data were from video recordings that were analysed.

The study also found that understanding from the point of view of the SLTs or interpreter was compromised mainly by a lack of trained interpreters. However, at one hospital they have managed to train assistants also as interpreters. This suggests that policies that focus on the human and language rights of the patient could help to promote accessible and culturally appropriate health care provision. But the implementation of such policies in public hospitals would require a campaign to change the profession and training of SLTs at all institutions of higher learning.

The study was able to qualitatively show that there are practice challenges and that, at times, even the SLTs were not satisfied with the services that they provide. The difference between the procedures at the two hospitals – one with an interpreter and one without – proved to be significant in that the caregivers tend to leave the consultation with a good understanding of what they could also do when dealing with a child with communication disabilities.

As urban black hospital clients were able to consult easily with SLTs in English, some of the SLTs were of the opinion that they do not have major problems. The study showed, however, that this is not the case. Many misunderstandings still occur and it seems that no one is raising the issue to a higher level or seeking a solution. Even though the SLTs experience these difficulties they seem helpless. In addition, it appeared that there could be traces of stereotyping that SLTs seem to use in order to cope with the diverse clients. This racial or cultural stereotyping seemed to give them a sense of false self-confidence as they incorrectly

assumed that they were doing well, that the problems were not complex and that they understood their clients' cultural frame of references.

In spite of the limitations listed above, the research process of this study has received validation from the SLTs that reported the need to do something about being culturally competent. The SLTs felt that training institutions should train SLTs to be relevant and effective when working in multicultural and multilingual settings. Despite the Constitution, Batho Pele principles, the Patients' Bill of Rights and audits that are being carried out by the DoH, there is a dire need to change how HCPs communicate with their clients.

It is hoped that the issues identified in this study relating to the cultural competency and power relations of SLTs and clients' human rights will assist the relevant authorities in addressing the plight of the public that needs the services of SLTs. Improving the training of SLTs in the area of cultural competence will enhance their service and care, not only for African clients but for all South Africans.

7.2. Concluding remarks and recommendations

The main study answered the question about the interactional strategies used by SLTs during interviews with caregivers who come from multilingual and multicultural backgrounds. In addition, the perceptions of an interpreter and SLTs on their effectiveness were explored. The main argument put forth is that, for the profession of SLTs to develop and transform, the strategies should move away from complacency and *planisa* towards engaging with the broader politics of transformation that occur in higher education institutions and in the health and medical professions. The recommendations are multiple and are discussed below. As a result of the complexities experienced in practice by SLTs, the recommendations offered here speak to issues for further research and for policy (teaching and training of SLTs and Hospital Management), and, finally, the implications for practice.

7.3 Issues for further research

The main argument of a particular section in the study was that the academic curriculum and clinical practice of speech-language and audiology students as well as professionals will help improve practice implementation and thus transform the way they applied theoretical knowledge in treating speech and hearing disorders in a multilingual and multicultural context. This will further enhance the efficacy of the management of communication disorders within this context. By implementing and researching other teaching methodologies, such as service learning in undergraduate training, will contribute toward the development of human and culturally fair clinical practices. The study indicated that service learning provided at training might have a positive impact on issues of cultural competence. The profession of SLT does have a role to play in social justice and thus contributing to democracy.

The data collected with a video camera and observations suggested three important issues concerning SLTs' cultural competency and power dynamics. First, the ambiguity that exists around power and cultural differentials are shaped by the participants' understanding and management of tasks that form part of clinical interactions. Secondly, the opacity of the extent to which the conversational practices that participants use to clarify, question and defend cultural competency differed across diverse cultural groups. Thirdly, the question of how these practices would shape the management of hospital consultation practices of SLTs with clients was highlighted.

A future study directed at responding to these ambiguities would highlight ways in which cultural competency can be adapted and be effective in clinical consultation practices. Furthermore, a study of this nature could be conducted on a larger scale with participants from different racial/ethnic disparities. Such a study could constitute a larger pool of participants which could include caregivers from these racial groups being interviewed in

their natural settings and at different research sites to improve the generalisability of the study. This could also help to facilitate discussions concerning transformation and equity in communication used by all HCPs.

A fruitful area of research may also be to explore the strategies that SLTs use when working directly with patients and family members that have limited English proficiency. A study which would document how the SLT intervention is implemented in order to remediate the patient with communication disorders paying attention to how the language and cultural aspects are addressed would provide the field with insight. A further interesting area for research would be to conduct a comparative study of communication intervention of SLT with patients who are first language speakers versus patients with limited English proficiency. An important area of future research would be to document the role of interpreters during communication intervention in a diverse setting. Such data could potentially yield valuable knowledge in the field of Health communication in a multilingual and multicultural hospital context.

7.4. Policy recommendations

As there appears to be a deficiency in policies that focus on the language rights of clients and patients in state-owned/public hospitals, except for position statements and principles such as the Patients' Rights charter and Batho Pele principles, it would be imperative for the DoH to support language interpretation services of SLTs and other HCPs by introducing:

- formal interpreter services at hospitals;
- firmer language policies for clients in hospital settings; and
- training of interpreters for the medical sector.

Although there seems to be insufficient training on cultural competency that influences how SLTs practice in hospitals, in their everyday interactions with their clients they appear to be working towards a better understanding of cross-cultural issues and on observation they seemed to exhibit aspirations to be culturally competent. This objective can be achieved only if training institutions and professional organisations increase awareness of racial disparities in rehabilitation services by SLTs. Transformation of the profession should also deal with

decolonization of the curriculum by introducing political consciousness and critical literacy diversity.

Political consciousness in the curriculum and training is not just about learning to pass but it teaches students on how to respond to cultural context, foster connection with patients/clients and invest in relationships with the communities. There seems to a need for the profession of SLT to encourage training institutions to provide a curriculum that does not suppress critique but to foster values that stand for social justice, human rights and equity. In addition, it is necessary for a shift from a culture of technocratic efficiency in terms of SLTs just providing communication therapy towards political consciousness. The academia should be able to also assume the responsibility of producing intellectuals who can transform the communities and the profession. An agenda for political consciousness and critical diversity literacy would be incomplete without a comprehensive policy for HCP training and implementation of measures to restore social justice to the marginalized communities.

The current status quo in the way the SLTs conduct communication therapy with most of their patients indicates leads to unquestioning of power dynamics and health inequalities. Engagement with critical diversity literacy would enable the profession to locate power dynamics in the relationship with communities and to intervene in a way that would eliminate health disparities. The current pitfall is in assuming that the profession delays with technocratic issues which are void of power. It is a priority to have policies that would seek to reduce negative power imbalances when HCPs consult with their patients.

The number of African SLTs in state-owned/public hospitals is not sufficient for the South African citizens who need their services. It is important for the training institutions and other stakeholders in health care to find effective ways of recruitment, retention and promotion of previously disadvantaged Africans, not only in hospitals but also at other levels on the academic ladder, so that they can become a mainstream admission and promotion policy. The reason for this recommendation is to develop a multicultural and multilingual rehabilitation workforce that can cater for the needs of an increasingly diverse client population.

As discussed in the review, the socio-cultural differences between patients and HCPs affect communication, clinical decision making and outcomes, and therefore it is important to introduce cross-cultural education in the training of SLTs. I posit that it is pivotal for socio-

cultural differences between SLTs and clients to be appreciated, explored, understood and communicated so as to avoid client dissatisfaction.

The findings indicated that some SLTs were not aware of either the extent or the severity of racial and cultural disparities in their consultations and interventions. Awareness training could therefore be conducted during clinical practical and projects as part of on-going curricula. It has been reported in literature on social cognitive theory that human beings have a tendency to use stereotypes to which we apply beliefs and expectations about groups of people to individuals from that group. This is a normal cognitive process that is automatic and that focuses on characteristics that are visually noticeable, such as race, gender and age. This tendency is most active when we are stressed, multitasking or under time pressure, which are the trademarks of clinical consultations in a public hospital.

It needs to be acknowledged that our cultures shape the way in which we see and approach the world and that all of us are part of or belong to various cultures, be they social, professional, religious, or socio-economic. These cultural aspects of ourselves transcend our race, ethnicity and our citizenship. Although complex, the SLT profession should not exclude the concept of culture from the training and curricula of SLTs.

This study showed that SLTs felt that they were not adequately prepared to work in multilingual and multicultural settings. This raises the question of whether it is acceptable for the majority of clients that are seen in public hospitals to be treated by SLTs that have limited cultural competency.

7.5. Practice implications: Using a culturally sensitive approach in SLT communication

The study has shown that cultural competence of SLTs appeared to be limited in some aspects related to their consultation interviews of caregivers. This finding raised further concerns to how the SLTs give therapy to the clients when they have inadequate cultural competence. This aspect of their work was not part of the aims of this study. Therefore the role of the SLT in working in multilingual and multicultural context is crucial. This role needs to include the following: improving communication skills of the patient in their language and in a manner that is culturally appropriate; being an educator or facilitator for families and caregivers, providing support and education to families and caregivers. In order to facilitate

communicate and language learning the SLT should focus intervention not only of functional aspects of communication skills but to bear in mind the cultural and linguistic aspects as well.

The researcher proposes that adequate training in cultural competency is crucial for enabling SLTs to provide services to all clients from diverse cultures, languages and countries. To be successful as SLTs in providing quality rehabilitation, we not only need culturally appropriate material resources such as assessment and treatment tools, but we also need to work in such a way that our clients do not feel culturally distant from us. This is important for ethical and professional behaviour, and our clients would benefit from this. The researcher recommends the following based on my research:

- The transformation of admission criteria of trainee SLTs in undergraduate programmes, so that the profession is accessible to African language speaking students. This will bring about transformation and redress practice and balance of power of the workforce in public hospitals.

- The curriculum should include cultural competency skills in a comprehensive manner. There is a need for extensive training on this. It would be important to incorporate teaching on the impact of race, ethnicity and culture on clinical decision making in the curriculum. Stereotyping could have an impact on how certain races or cultures are treated and on the SLTs' clinical decision making. This can be prevented by training SLTs to be aware of these stereotypes.

- Training institutions should have language policies that bring redress. This will translate into trainee SLTs studying or having a basic or introductory knowledge of at least one local African language.

- The integration of service learning in the curriculum to inculcate the importance of social justice and the human rights of citizens. SLTs are bound by the ethical principles of justice, beneficence, and human rights. According to the South African professional body (SASLHA), SLTs have to "ensure that services are made available and accessible and that these services are appropriate to particular individual and community needs". This could be conducted by using formal, informal and in-service training of qualified SLTs on cultural competence.

- Training institutions should encourage students to conduct and disseminate action and emancipatory critical research that can guide the regulatory body, such as the HPCSA, in drafting position statements on language and culture, and codes of conduct for SLTs.

To add to this, it is hoped that the speech-language profession would transform and start discussing and sharing targeted strategies that could resolve the issues relating to working with different power differentials. Given the evidence of socio-cultural barriers to health care at public hospitals, culturally competent care appears to be a pivotal cornerstone in an attempt to reduce power differentials and the lack of access to culturally appropriate services in rehabilitation and health care.

In an attempt to address this, the researcher believes it is relevant to endeavour the design of a *practice model* that is *culturally sensitive*. The model should ideally focus on addressing the questions: “What is in the best interest of the family and child with a communication disability?” and “What is in the best interest of the SLTs?”

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