Cultural Narratives: Bridging the gap
Educating Speech-language Pathologists to Work in Multicultural Populations

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ABSTRACT

Preparation of the clinician to work in multicultural contexts involves the identification of a range of skills, knowledge and values. The field of narrative medicine as well as an increased understanding of the dynamics of interpreting are areas which can add considerably to clinical effectiveness. The paper outlines some cornerstones of narrative medicine and their potential application to the field of speech-language pathology and audiology. An analysis of the dynamics of a mediated interview yields a series of suggestions for the clinician. Some proposals are offered for future training and clinical practice in South Africa.

KEY WORDS: Narrative medicine, interpreting, clinical interview, clinical training.

INTRODUCTION

Speech-language pathologists throughout the world participate in clinical interactions with bilingual and multilingual clients. Such interactions, which often involve a third party, have special characteristics which ideally should be included in the training and preparation of the clinician. South Africa provides an exceptional context for the examination of such aspects, as most practitioners in our field are either English or Afrikaans speaking with little or no knowledge of the other nine official languages. This paper will present some personal ideas about what the developing clinician needs to know about cross linguistic and multicultural interactions and will identify some of the cornerstones of the burgeoning field of cultural speech-language pathology. The focus of the paper will be on two issues:

1. a consideration of the potential of the narrative as a clinical tool and
2. a consideration of issues surrounding the deployment of interpreters in clinical exchanges

I will argue that the burgeoning area of narrative medicine is particularly fruitful as a cross-cultural focal point as it has the potential to minimize the cultural barriers which may exist in more structured clinical interview settings. Further, I will propose that the multiple roles of the interpreter may extend to that of facilitator through the narrative genre, for effective clinical interactions.

The focus is on how to train the student clinicians to acquire relevant, lasting and useful knowledge, skills and values for working with the bilingual or multilingual client. Put in another way: How, within a space of four years, can we best transform a monolingual and monocultural person into someone who can not only engage the challenges if the need demands it, but can embrace them and feel confident in such interactions?

WHAT IS CULTURAL SPEECH-LANGUAGE PATHOLOGY?

The field of *cultural speech-language pathology*, in contrast to the dated notion *of cross-cultural* speech-language pathology, is a branch of the discipline not so much interested in the differences between cultures, but in an approach to diagnosis and therapy which reflects a sensitivity to cultural and linguistic influences and their interface with communication disorders. The goal of any clinical encounter in our field is to maximise the flow of information and to optimise clinical effectiveness. Cultural speech-language pathology examines within (rather than solely between) cultures, what facilitates such exchange and what inhibits it. Clearly these issues relate not just to language but also to an understanding of how a range of cultural indices such as family, gender, artefact, history, geography, religion, education, myths and attitudes interface. Perhaps because of the complexity of definition of culture, we should (like some other disciplines) move to the term *critical speech-language pathology* which implies a detailed examination of bio-psycho social influences on our discipline.

A substantial amount has been written in the field about what constitutes indices of culture and highlighting the need for sensitivity in clinical interactions. This is reflected for instance in ASHA's office of Multicultural Affairs and special interest groups set up in countries such as Australia and Britain and which address the adaptation of training courses, test materials, policy and development of services. Many of these however, boil down to somewhat prescriptive/technical lists of what and what not to do in a particular clinical setting. It seems that in training clinicians, what

is more important is to imbibe an attitude which will generalise to various intercultural situations, rather than be advised about the specifics. Thus, for example, a statement like "Eye contact rules for Zulu speakers are different" is less useful than "What can I do to find out about what this patient really needs?"

This links to the warning caveat made by many working in the area that culture is not a monolithic phenomenon:

> There is a danger of seeing the world neatly divided into two - the Western world versus irrational, spiritual and non-Western world. The categories of Western versus non-Western are our creations and reflect neither the diversity of beliefs that people hold nor the commonalities that exist across very different groups of people. Acknowledging that 70-90% of the world's population first seek help for their ailments from alternative sources, there is no such thing as First and Third World vision (Swartz, 1998).

> "As we move into the 21st century of computers and scientific hi-tech, I see people, especially white romantics, who want to move my people back into the 10th century. They say to my people "This is your culture". I say this is absolute nonsense." (Dr Nthato Motlana, a Tswana speaking bio-medical doctor)

Illness narrative

The study of narrative in medicine has increased over the last decade and has added substantially to the current understanding of various medical conditions and their sequelae. The human predisposition is to create and develop narrative, and stories have the function of expressing life identity. More specifically, the story of an illness is a vital point of intersection among many disciplines, and provides fascinating and complementary perspectives on the condition as well as on diagnostic and therapeutic regimens.

Language is the basis on which all diagnostic and therapeutic interactions take place and narrative based medicine as espoused by Trisha Greenhalgh and colleagues provides an opportunity for the client to "tell the story" of the illness rather than the disease (Riessman,1993; Greenhalgh and Hurwitz,1998). Such stories are facilitated by questions based on an explanatory framework and have certain defined properties. For example, narratives have a structured sequence, provide identity, context and perspective, are typically engaging and absorbing and potentially palliative in their execution. Importantly they provide a connection between the teller and the listener. A communication difficulty is a diagnosis but, like other chronic conditions, is also a socially constructed event or label. Illness scripts and anecdotes provide an opportunity to "receive" (rather than take) a case history and help to bridge cultures as well as inform clinical decision-making. To illustrate this, the responses to a series of questions (after Kleinman,1988; Helman, 1994) posed to persons with strokes and their spouses in a rehabilitation setting are presented below (from Penn and Jones, 2000).

What do you think caused your problem?

- "The fight between my uncle and me - he wanted to hurt me."
- "The stroke, my brain had a vein that was burst."
- "He was working with the pipes and he fell down the stairs."

Why do you think it started when it did?

- "Well I think it was just chance."
- "It was because of the stroke. She shouldn't have had the operation."
- "Maybe the talk between him and me."
- "Because my brain was damaged."
- "It was because of the OT."
- "I don't know nothing about this. I don't understand."

What does your problem do to you?

- -"Very frustrated, very sad, but I found a different way of thinking. It was almost a reward. It was terrible, but maybe it's my decision to be happy."
- -"It affected her terribly. She was outgoing, always loved people and talking. The communication difficulty was worst for her. Psychologically it was worse than not walking."

What kind of treatment have you sought?

- "I did it by myself."
- "The family just included me all the time."
- "Tablets only tablets."
- "After the rehabilitation, we saw a private therapist."
- "My brother and father get me help. They brought me things from the doctor at home. They bring me the cow and animals. They bring me much from the doctor at home."

What do you fear the most?

- "I'm not afraid to die. I'm afraid of being a vegetable."
- "She feared people would not understand her."
- "I fear that I won't be able to progress like going to work."
- "I'm worried because the brain is not OK. He can't work and we've got no money."
- "I just believe that God will see everything through."
- "I understand that something is bleeding and I may need an operation. I don't understand why this has happened to me. I am young and healthy. How will I work? Where will my family get food and money? Will I ever work again? My future is very bad. My head is very sore. Perhaps I will be lucky and die."

The emergence of such subjective narrative evidence is often overlooked in clinical interactions, in the search for objective indices of site of lesion, severity and prognosis. Yet such evidence not only seems to provide a true measure of the client's needs but also an enabling framework for culturally diverse exchanges. The implication for the clinician is a powerful one. There is a need to create both the time and space for narratives to emerge, to "receive" rather than take a case history and ultimately, through asking the right questions and addressing the client's concerns, using narrative as legitimate evidence and the basis for setting joint and meaningful goals. Where a language barrier exists, this aim can potentially be facilitated by the use of the interpreter.

INTERPRETING

Most clinical settings are characterised by rushed interactions where, sometimes overtly, but often implicitly, one's worth is characterised by the number of patients seen and the speed of discharge. Interpreting services are often

performed by family members, nurses, clerical or cleaning staff or fellow patients. Except in a few defined contexts where trained interpreters are formally employed, most therapists are forced to "make do" when an interpreter is needed (Holland and Penn, 1995). Nevertheless specific and explicit guidelines have been produced about what constitutes formal training for an interpreter and codes of practice suggested. A body of local research is emerging which highlights the complexity of issues in clinical interpreting and the profound impact an understanding of such issues can have on effective service delivery. (Herselman,1994; Muller,1994; Drennan,1998,1999; Erasmus 1998; Swartz 1998; Evans, 2000). The interpreter is often expected to assume multiple roles: that of linguist, that of cultural broker, that of patient advocate and often as an institutional therapist (mediating, for example, between management and nursing staff in industrial dispute). Obviously, when a communication difficulty is superimposed on the mediated clinical interaction, the problem becomes more complex.

Interestingly, interpreting failures are most often blamed on the interpreter rather than the guiding clinician. The literature on professional interpreting is extensive and the area of clinical interpreting has also been fairly well developed. Most published papers on interpreting in medical contexts for example, focus on the errors of interpreters. There appears to be wide disagreement as to what constitutes interpreter skills or expertise and limited evidence that job experience necessarily improves or guarantees such expertise. Various taxonomies have been suggested (e.g., Vasquez and Javier, 1991) pointing to how aspects such as the interpreter's lack of linguistic knowledge, lack of medical knowledge, attitudinal factors (resistance) or lack of training interfere with the process. However, as Swartz (1998) and others have shown, interpreting breakdown can be explained through other factors, for example:

> Muller (1994) undertook a detailed analysis of a psychiatric interview mediated by an interpreter in a Cape Hospital and had three bilingual trained translators independently transcribe the interview which was subjected to a conversation analysis.

An example of their different translations (from Xhosa) of the same text follows:

> A: "I was here in Cape Town but I was upset, only thing I wanted to go home. I was really upset, really upset."
> B: "I was here in Cape Town but I was very hurt. I was hurt, I only wanted to go home, I was really hurt."
> C: "I was here in Cape Town and was very heartsore. I was sad and I wanted to go home. I was grief-stricken."

This reinforces the fact that there can be no authoritative translation of one language into another and that what we are hearing are three different voices, mediated by the translator. On-line interpreting provides an even more fleeting perspective of this voice.

A more constructive approach may be to take a dynamic view of interpreting in terms of the different roles that an interpreter fills in each interaction. Who is used as an interpreter within which context makes a difference. For example, there are different expectations from an institutional versus a community interpreter. Options exist as to the roles and relationships between participants in the mediated interview. Is the interpreter a "shadow" or is he/she professionalised? Is the process of interpretation recorded in a consideration of the facts and if so how? Very often bilingual professionals are expected to assume the role as interpreters in clinical interactions for others, which can easily cause resentment in a context like South Africa with an entrenched history of discrimination.

Drennan's research (1998,1999) adds to our insight. He conducted a detailed analysis of interpreting practices and attitudes in two psychiatric hospitals in the Cape, using an ethnographic approach, questionnaire and interviews. He found that up to 68% per cent of the clinical encounters in these hospitals over a period of time required interpreting but that often interpreters were not available. One part of his study involved follow-up of the efficacy of a project which trained interpreters in the hospital setting. Of the problems he discovered were the fact that the interpreters did not feel part of the team, often felt marginalised and were resented by the nursing staff (who had done the job previously).

More recently Evans (2000) has explored the dynamics of translated clinical encounters in mediated assessment and feedback sessions with the parents of young hearing impaired children. She highlighted the subtle differences in role as well as type of interpreting behaviour adopted in the different contexts and has stressed the need for further analysis and understanding of the mediated interview. Her work constitutes an important new direction for the South African clinician.

SPOTLIGHT ON THE CLINICAL INTERVIEW

What are the dynamics of mediated cross-cultural and cross-linguistic interactions and what content and process variables can be identified which enhance or inhibit the goal of the interaction? I have chosen to concentrate on the diagnostic interview as it is a fairly routinised interaction and often constrained by time variables. Many permutations and combinations exist in terms of degrees of bilingualism in clinical interchanges as Figure 1 illustrates.

One of the most common interviews in South Africa is one in which the clients or informants have some knowledge of English or Afrikaans, the language of the interviewer, and the interviewer has a very restricted knowledge of the language of the client. Typically the interpreter has either

INTERVIEWER   CLIENT

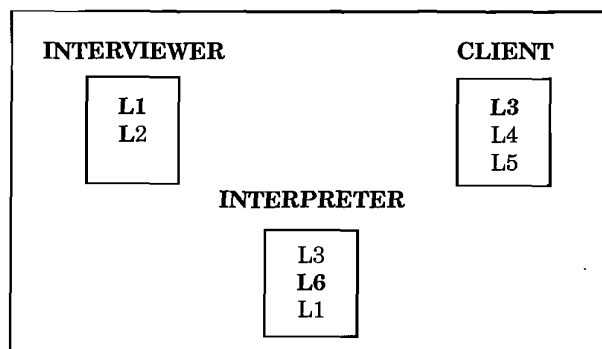| L1 | | L3 |
| L2 | | L4 |
| | | L5 |

INTERPRETER

L3
L6
L1

FIGURE 1. Language permutations and combinations of a typical mediated interview (where L = a specific language and bold indicates first language of participant).

the home language of the client or has learnt the languages of the client and the interviewer as second languages in informal or formal contexts, such as school.

I have been working for many years in cross cultural clinical interactions with aphasic and head injured clients. Recently I have had the privilege of working with a multilingual co- therapist who has greatly enhanced my capacity in the clinical interview. Over the years we have established a routine in the clinical interview which appears to be successful. This is based on client feedback as well as the information gleaned from the client (relative to the sometimes numerous other team members who typically interview the same case for medico-legal purposes).

An analysis of this process yielded some preliminary observations which may be useful to consider (see also Penn and Friedland, submitted).

In this interview, there were several participants:

- the main interviewer whose task was to establish from the parents of an eight-year-old child the case history for the purposes of a medico-legal assessment;
- a co-therapist, fluent in the client's home language, who *is a speech therapy graduate with several years expe-rience*, and more specifically two years of acting in this capacity in my practice and
- an observer therapist who notated dynamics of the interview and afterwards helped compile a list of facilitators and inhibitors.

The interview was recorded and later transcribed verbatim using Conversation Analysis notation. The Zulu interactions were translated into English and cross-checked by the co- therapist and another native speaker of Zulu.

In addition, the interpreter was asked immediately afterwards to analyse the interview and to comment on facilitators and inhibitors. *These were merged with the checklist compiled by the observer and by my own observations* (drawn from many such encounters) about the dynamics of the process. The following points have emerged:

1. Seating : In contrast to some of the suggestions made in technical translating manuals, I seat myself at some distance from the client and allow the interpreter to sit closer to the client and engage directly (often physically touching). This seating arrangement provides me with an observer advantage. It also spells out some acknowledgement that I trust the dyad. It probably underlines the cultural gap but at the same time suggests that the gap is respected.

2. The Interviewer introduces herself and the interpreter, and provides the purpose of the interview. An important part of this process is acknowledging that the client has probably had many other interviews with doctors and shows sympathy that this process has to happen yet again.

3. The interviewer provides her own language history and negotiates rules of the interview with the client and co-therapist. For example, it often happens that I speak my second language then shift to English, or suggest that the clients speak whatever they feel comfortable with depending on the question (Note: the language shifting in multilingual clients is a particularly fascinating aspect of this work. When it happens in both clinicians and clients it has a particular sociolinguistic impact. I find for instance that I can manage in the

second language when I am asking routine questions but as soon as there is more complicated affective requiring counselling skills I shift to English).

4. Not everything in the interview needs to be translated. There is often a period of flow talk between the interpreter and the client (non-translated) which establishes briefly geographic, cultural, names family connections etc. Jokes and asides usually remain untranslated. Some interesting aspects emerge in these informal moments which shed light on attitudes and power issues.

5. Non verbal interaction dynamics play an important role in mediated interviews: a constant effort was made by the interviewer to direct questions directly to the parents rather than to the Interpreter, and during long conversational turns in Zulu, to document non verbal signals (e.g. mother seems to disagree non verbally with what father is saying) The Interpreter in turn has learnt to interpret my non verbals when I need information/clarification and my tone of voice and non verbal reassurance provide feedback to the client that I am understanding without translation.

6. Interactions between the interpreter and the client enabled the interviewer to "gather herself", that is prepare for the next question and properly transcribe information and notes. This is more efficient than on-line interviewing which taxes memory and transcription skills. I have found in fact that it is easier to record more fully, contextual information (such as relationship dynamics) in such interviews than in non mediated exchanges.

7. My register (rate, speed, clarity, pauses, sentence complexity, rephrasing,) changes in these interactions and instances of code-switching abound. In later examples for instance, the use of the forced alternative emerges as a pattern, presumably to facilitate the interpreter's role or to make my English more simple for the client who has some competence in English.

8. The chain of questioning (surrounding the accident, its impact on communication, schooling, family and social relations etc) is familiar to the interpreter. She is able to initiate probes spontaneously in response to a trigger. I am less directive with her because of this shared knowledge. Because of my passive competence in some of the languages spoken, I start taking notes immediately (prior to the translation).

9. Importantly, the presence of the co-therapist is a tremendously reassuring one for the clients. In the medico-legal process specifically, they have usually been subjected to a string of alienating, often restricting medical interviews often in their second or third language without the aid of a professional interpreter. The typical medical interview has been documented as comprising close-ended questions and interruptions
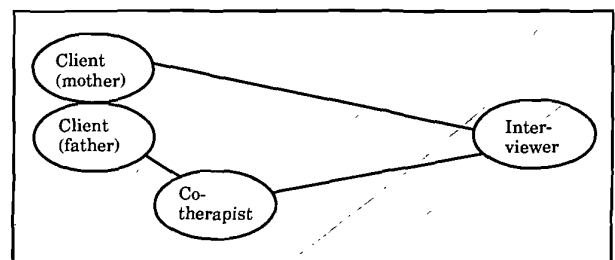

FIGURE 2: The seating arrangement.

(Ong, De Haes, Hoos and Lammes, 1995). A tangible relief is often observed when our interview unfolds. My role becomes more passive in the course of the interview and I allow for asides to happen before and after, confident that my co-therapist will share these with me afterwards. There are places where we try to allow the client's narrative to unfold without interruption. What may be lost on the swings (i.e. a sentence-for-sentence translation) is gained on the roundabouts (an opportunity, often a very healing one, for the story to unfold). While we have a standard semi-structured protocol (communication headings, hearing etc) we will often start with a much broader question following Kleinman's framework (1988). The relative importance of the speech-language behaviours emerge against a more holistic backdrop. In many cases it is the job issues and the behavioural issues that have much more impact than the communication. Patients are relieved to find someone who will listen to their concerns and they express this.

10. The process of interpreting by definition involves a repetition of the input (in another language and often in a modified form) to the client. This process, though not without its pitfalls, has a very important advantage. When working with a client who is bilingual, the repetition of an input may help to facilitate the comprehension of a message and allows opportunity for repair or modification which may not present itself in a monolingual interaction. The slowed pace of an interpreted interview may also be an important strategy for the language-impaired individual, in the same way as it facilitates processing time for the interviewing clinician.

Some examples from the transcript follow: (The bold is in Zulu. N is the interpreter, C the interviewer, M and F are the mother and father)

53 C: So we are going to be talking about speaking today, and I want to first of all find out : does B. speak nicely (.) or does she have problems with her speaking?

54 N: **(0.9) Does she have a problem speaking?**

55 M: **She does not have a problem.**

56 N: **Can she say the words nicely as well as combine them?**

57 F: **She does not have a problem.**

58 N: **What is the problem then?**

59 F: **The problems is her headaches.**

N: **Mmm**

60 F: **During the day when she comes from school or playing she tends to complain about headaches especially in the afternoon when she feels tired.**

62 N: **She suffers from headaches.**

F: **Ja headaches.**

C: Mmhm

64 N: The main concern is her headaches.

65 C: Mm I read that in the report. Have they stayed the same since they started or has there been any change?

66 N: okay .
How is it mama does it get better or?

M: **It varies.**

F: **It varies.**

We see in this extract two examples of condensation (54 and 62), and the relatively free flowing process of the interview where N expands without prompting (56). In 66 she reflects acknowledgement of understanding my question and then turns her question to the mother (presumably because of cultural conventions surrounding child care even though the father has been the main participant so far). Interestingly the father immediately responds too (69).

Another example

130. N: *okay* No problems. She makes long sentences
131 C: (1.6) Speech sounds?
132 **N: Do all the words come out normal?**
133 **Does she pronounce words properly?**
134 **M: Yes.**
135 N: Okay no problems*=
136 C: =* No problems*

The relatively telegrammatic style of the interviewer (131) reflects their familiarity with the questions to be asked, and the rapidity of turns 135 and 136 reflect the *efficiency of information flow.*

150 C: Did she have any earache or pain in her ears when she was a little baby?
151 **N: Did she have anything coming out of her ears?**
152. **M She didn't have a problem before. It was only that she started experiencing problems** after the accident.
153 N: After the accident
154 C: Let's talk about the accident now.

This example demonstrates some "cultural brokering" on the I's part aligning the question to a manifestation of chronic otitis media, presumably a more recognisable problem in the community from which the client comes. The mother responds and code switches into English, (possibly for emphasis purposes), N repeats this and C picks up the flow.

Code switching also occurs in the following example:

443 C: Okay. (0.9) Is Zulu(.) the home language and the school language?
444 M. No at home is Zulu language **and at school is Sotho.**

Another example

359 M :**The problem is with fighting and when you discipline her she becomes stubborn even when she sees that you are becoming angry with her.**
386 N: Okay. She is now stubborn and aggressive to *other children, not like before* when she didn't have the experience.
746 C: Is she difficult to discipline?
1106 **N: When you discipline her does she listen or do you need to keep on disciplining until you beat her?**

This is an example of a significant (in my opinion) elaboration which did not come to light until the transcription stage. Subsequent interaction between N and M revealed

that the child did indeed get beaten, but it was translated back to me as "discipline" and I missed the entire discussion about physical punishments which would probably have stopped me in my tracks and normally have involved some immediate feedback on more appropriate management strategies. This then is another example of cultural alignment between N and M not reaching the T.

In the above examples, we thus note several instances of what Vasques and Javier (1991) denote as "errors" of translation, including omission, deletion, condensation, addition and substitution. Examples of "role exchange" are also evident. Such behaviours have traditionally been considered as potential violations, but can equally be construed as the interpreter (in this case a well qualified therapist) assuming legitimately some of the power traditionally associated with the therapist. It seems less important to attempt to see when these problems occur than to look at the dynamics of the entire discourse, whether the interaction has achieved its goal aim, overt (in terms of information) and covert (a healing or bridging experience for all the participants). The shared responsibility for content and process can only be judged as a whole and we hope that the microscopic analysis will add to this macroscopic vision. Such an analysis will yield for example turn taking rules, when the routine turn taking of a clinical interview yields to a more natural conversational style and how much opportunity was allowed to create the story of the illness. Traditionally (and this clinical interview is alas no counter- example) the talk within an interview tends to

be formalised and structured. When a story emerges, especially when mediated by the processing demands of the interpreter, it may well be condensed (as in the example above). I suspect that cross-linguistic interactions are particularly susceptible to such "pruning" and this should probably therefore be seen as a major goal or negotiated focus in the interview for all participants.

Simply put, the words: "Tell us your story," may ultimately yield more valid information, not just about the communication disorder, but about the client, the treatment to be followed and the prognosis.

SOME RECOMMENDATIONS FOR CLINICIANS IN TRAINING

Writing this paper has helped me formalise many years of clinical intuition and ideas about the profession in the context of South Africa. It has been written at a time of change both for me personally and for the profession. What follows is a list of suggestions which may help to train critical clinicians in our multicultural context: Increased recruitment and selection of multilingual clinicians though critical, is not the only answer to our clinical challenges. Further sensitisation to relevant issues is the key; I propose that the competent clinician should develop a facility with collecting narratives and with working effectively with an interpreter.

Table 1 provides a summary of the facilitators and inhibitors identified in the mediated interview described

TABLE 1. Facilitators and inhibitors identified in an interpreter mediated clinical interview (after Penn and Friedland and Evans (2000)).

FACILITATORS	INHIBITORS
- Clearly established roles and routines - Seating - Flow talk - Metalinguistic discussion - Note taking - Non-verbals - Preparation and debriefing - Tolerance of "asides" - Code-switching - Exploration of the narrative - Cross checks - Repetition - Register	- Time - Traditional roles - Struggling language efforts - Interruptions - Complicated repairs - Lengthy utterances - Terminology - Emotionally charged sessions

TABLE 2. Student training requirements for dealing with clients.

KNOWLEDGE	SKILLS	VALUES
• Knowledge of languages used in the country and socio-political aspects, language policy. • Knowledge of bilingualism theory and research on communication disorders. • Basic understanding of cultural aspects (e.g. through course such as Cultural Anthropology/ Health beliefs etc).	• Practice in interviewing skills. • Full understanding of interpreter and translation issues. • Practice with specific interview techniques (note taking, non-verbals, flow). • How to receive rather than take a case history. • Creating time and opportunity for narrative.	• Understanding where you come from (historically, geographically, family and the biases you hold). • Respect for the role and function of co-workers.

above. It also hopefully provides a framework for future clinicians to analyse and develop some sensitivity to clinical skills.

In Table 2 some suggestions are made as to what aspects may need to be developed in training. The profession of interpreting, though a related language profession, has been largely overlooked by the speech-language pathologist in South Africa. New language legislation in South Africa provides an enabling framework for translating and interpreting services and our own profession clearly should have a major role in lobbying for and harnessing such services in its own activities. Interpreters should be viewed not as "shadows" in the clinical process, but should have the benefit of full status. Speech language pathologists should be enlisted in translation and interpreting training programmes. The components of a mediated interview should be identified and taught. There should probably be a reconsideration of the value of formal testing of communication skills. I am inclined to think that test adaptation and translation of standard tests is less useful than on-line adaptation using a skilled interpreter. It would be more beneficial to put money into the training and development of a pool of interpreters who are sensitised to specific issues of language and culture as they interface with our profession. Continuing Education; accreditation and in-service training in this area should be provided.

In addition to their discipline-based knowledge, students should ideally have a clear understanding of the nature and structure of South African languages, current language policy and of what constitutes culture. Modification of the syllabus is required but careful consideration should be given to its direction. A lesson from my own institution is instructive.

For a number of years the undergraduate syllabus for training included a year of training in one of the Black languages. This course, though useful, did not even closely address the needs of the therapists in the clinical interaction. In fact (and this is my own experience) halting and effortful use of second or third languages does very little to enhance either confidence in the clinician or free flowing interaction.

In such a crammed syllabus, time appears better spent on a course which addresses cultural issues, inter alia: input from translating and interpreting specialists and systematic opportunities to engage with other cultures (through field trips, service sites, research, interviewing methods and set assignments),and expansion of the syllabus to include aspects from Sociology, Anthropology and bilingualism. This will include a sensitivity to pitfalls of translation and interpreting. Is there a difference for instance between the terms "cure" and "rehabilitation" in the language of the client, and how may this impact on his/her perception of the therapy process?

CONCLUSION

We cannot ever really hope to know and understand the culture of another person fully. We can however develop mechanisms for finding out about the culture and recognise and identify ways in which cultural factors may interfere or clash with our own perceptions. Frank discussion and opportunities to share cultural beliefs about illness and healing need to take place so there is sensitisation not just across cultures, but across other professions. Understanding of the personal influences on the clinician (Parents, press,

public, priests and politics) is a prerequisite to understanding other's opinions. What could such guiding principles be?

Helen Sjardin's three powerful questions (1996) I think hold the key :

- Where are you coming from?
- What do you need?
- How can I best help you?

The application of such questions in mediated (or indeed unmediated) cross-cultural situations may well hold the key to effective clinical intervention. As Swartz (1998) has pointed out, no research on these issues can really be empirical or neutral. There are relationships of power, historical influences and a long history of labelling within the profession which we need to acknowledge and redress. In this country issues of language, culture and race interact in continual and dynamic ways. Ultimately one enormous advantage of working cross culturally is that it helps us to see what the real and critical issues are within our own professional culture and I urge clinicians never to cease from meeting the challenges posed by this rich land and all its people.

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