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Reimagining language access in mental healthcare through cultural integration in KwaZulu-Natal

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Introduction

South Africa's complex linguistic landscape reflects its historical legacy of segregation and inequality. Despite constitutional guarantees of language rights and healthcare access (Department of Public Service and Administration 1997; Republic of South Africa n.d.; Republic of South Africa 2004), the dominance of English and Afrikaans languages in mental health services perpetuates barriers to mental healthcare for the majority of South Africans (Deumert 2010; Swartz & Drennan 2000). Work carried out with Prof. Swartz in the Western Cape highlights the unfortunate, yet pervasive challenges in providing adequate mental healthcare due to language barriers (Benjamin et al. 2016; Hagan et al. 2013, 2020; Hunt & Swartz 2017; Kilian et al. 2014, 2021). His work has explored the use and reliance on informal interpreters, and the diverse roles they assume in clinical consultations (Hagan et al. 2013; Kilian, Swartz & Chiliza 2015; Swartz et al. 2014).

In KwaZulu-Natal, where isiZulu is the predominant language among patients, the ongoing and pervasive disconnect between healthcare providers and patients' languages represents more than just a communication gap; it embodies ongoing systemic inequities and healthcare delivery injustices. The historical use of language as a 'marker of difference to justify segregation and oppression' (Elkington & Talbot 2016) continues to influence contemporary mental healthcare, with less than 5% of health professionals being able to conduct clinical interviews in patients' home languages (Levin 2006). At the University of KwaZulu-Natal, medical students undergo a one-year isiZulu clinical communication teaching and learning programme to improve their communicative competence, which is necessary for effective communication with patients. Sadly, a study by Matthews in 2012 found that while their competency in isiZulu had improved, students rarely used the language in the clinical setting (Matthews 2013).

The current situation in KwaZulu-Natal mirrors broader national challenges in mental healthcare accessibility. The reliance on ad hoc health sector staff, who are untrained in the practice of translation, as interpreters – often cleaners, security guards, or other available staff – is standard practice, despite its significant limitations (Kilian et al. 2014). Research has shown that untrained interpreters are more likely to make clinically significant errors that can affect diagnosis and treatment (Al Shamsi et al. 2020; Hagan et al. 2013; Karliner et al. 2007), often resulting in patients appearing more psychiatrically ill than they actually are. This makeshift approach also raises serious confidentiality concerns, particularly in mental health settings where sensitive personal information is discussed (Elkington & Talbot 2016). Additionally, impromptu interpreters often lack awareness of their professional boundaries and ethical obligations (Blake 2003; Elkington & Talbot 2016; Smith et al. 2013). For example, lay interpreters working as security guards or cleaners may be from the same geographic area, community and social groups (i.e. churches) as the patients, and are unlikely to recognise the importance of rules of confidentiality and objectivity, raising ethical concerns.

The challenge of language and culture in mental health service delivery

The effects of inadequate language access or proficiency extend beyond simple barriers to communication. Introducing an interpreter significantly alters therapeutic dynamics, creating a complex three-way relationship that requires careful management (Elkington & Talbot 2016;

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Hunt & Swartz 2017). Language barriers often intersect with cultural differences including gender and power dynamics and may affect the expression, understanding, and treatment of mental health symptoms (Smith et al. 2013). Without proper cultural awareness, clinicians may miss crucial culturally-informed symptoms that can inform the diagnosis and treatment (Hagan et al. 2020; Krystallidou et al. 2024; Penn & Watermeyer 2012a). Additionally, staff members serving as informal interpreters face conflicting responsibilities between their primary duties and interpretation tasks, which can compromise both their regular work and the quality of their interpretation services (Penn & Watermayer 2012b; Smith et al. 2013).

Prof. Swartz's work underscores the broader challenge of language and cultural diversity in mental health service delivery in low- and middle-income countries (LMICs), and advocates not only for improved language services, but also for knowledge-sharing to enhance care in resource-constrained settings (Swartz et al. 2014). Moving beyond conventional interpretative approaches, we propose a framework that integrates traditional healing systems and community cultural expertise. Building on the concept of interpreters as cultural brokers (Miller et al. 2005; Penn & Watermayer 2012b), we suggest formal partnerships with traditional health practitioners, who can provide much better cultural context and interpretation capabilities. This approach acknowledges the importance of Indigenous knowledge systems in mental healthcare while maintaining professional standards (Zuma et al. 2016). Drawing from the successful human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) programmes in KwaZulu-Natal (Moshabela et al. 2016; Zuma et al. 2017), we propose a model in which professional interpreters work alongside traditional healers (who have extensive cultural knowledge) and community health workers to provide comprehensive language and cultural support.

Literature highlights the significant role played by traditional and faith healers in mental healthcare provision in sub-Saharan Africa (SSA), often serving as the first point of contact for individuals seeking treatment (Ae-Ngibise et al. 2010; Berhe, Gesesew & Ward 2024; Williams et al. 2025). While this preference is often influenced by various factors, including limited access to biomedical services, cultural beliefs, and social norms, they have been shown to contribute to improved health outcomes (Berhe et al. 2024). Traditional healers provide culturally embedded meanings of mental illness or explanations of distress, which are perceived as more relevant and meaningful than biomedical diagnoses that can feel foreign, far removed from people's everyday lived experiences (Crawford & Lipsedge 2004; Moonsamy & Gurayah 2024). As such, the use of traditional healers as interpreters (or alongside professional interpreters) can additionally support the integration of traditional and biomedical approaches to enhance mental healthcare delivery in culturally rich isiZulu communities in the province of KwaZulu-Natal (Berhe et al. 2024; Williams et al. 2025).

To make this a reality will require formal partnerships that recognise the authority of traditional healers within their communities while offering clear guidelines for ethical collaboration, which can include joint referral arrangements, healer-led psychoeducation sessions, and shared care protocols. Studies in Ghana (Ae-Ngibise et al. 2010) and Uganda (Abbo 2011) have highlighted the benefits of similar structured partnerships to treatment adherence and trust between communities and the health systems. We therefore suggest a collaborative role with traditional healers acting as cultural brokers which includes interpreting idioms of distress back into experience, describing culturally relative aspects of 'symptoms' to clinicians, and working to align clinicians' therapeutic recommendations with patient's belief systems. This engagement may also facilitate early identification and treatment of mental disorders by counteracting help-seeking by counteracting help-seeking delays.

Recommendations

Based on this evidence, we recommend several concrete implementation steps. To begin, there is a need for institutional changes which will be crucial for sustainable improvement. Literature has shown that dedicated interpreter services enhance patient experience, increase return rates, and improve satisfaction, medication adherence, and treatment compliance (Elkington & Talbot 2016). We recommend the creation of dedicated interpreter positions within mental health facilities to address the current problematic reliance on informal interpreters (Benjamin et al. 2016; Drennan & Swartz 2002). The additional implementation of pre- and post-session briefings between clinicians and interpreters has been shown to improve therapeutic outcomes (Benjamin et al. 2016; Gartner et al. 2024). Clear protocols for interpreter-mediated sessions are essential, particularly given the complex dynamics of therapeutic relationships in mental healthcare (Benjamin et al. 2016). Additionally, healthcare institutions should establish formal culturally sensitive training programmes for healthcare interpreters (including traditional healers) specialising in mental healthcare and support. Ideally, this could take a collaborative approach involving co-training initiatives, where interpreters and traditional healers are equipped with foundational knowledge in mental healthcare, cultural brokerage, and confidentiality. In this collaborative model, interpreters would not only facilitate linguistic translation but also bridge semantic gaps in how symptoms are described, while traditional healers support interpreters in decoding idioms and metaphors that are deeply culturally situated. In turn, interpreters can help convey healers' insights in clinical settings with appropriate nuance and clarity.

Ongoing supervision and support for interpreters should be provided to prevent vicarious trauma, and develop cultural competency training for mental health professionals (Delizée & Bennoun 2024). The risk of vicarious trauma for interpreters is particularly concerning, as research has shown significant psychological impacts on interpreters

working in mental health settings without adequate support systems (Geiling et al. 2021). While there is need for formal interpreters, South African institutions also need to empower mental healthcare practitioners with basic language skills, particularly in African languages like isiZulu which are the most spoken languages in South Africa. In KwaZulu-Natal, this could be built on the backbone of the one-year isiZulu clinical communication teaching and learning programme for undergraduates and postgraduates, focusing on improving proficiency among healthcare workers.

Quality assurance measures must be established to ensure effective service delivery. This includes developing standards for mental health interpretation, regular evaluation of interpreter services, and creating feedback mechanisms for patients and providers (Benjamin et al. 2016). Research has shown that when interpreters are properly trained and supported, the quality of care and levels of satisfaction for patients with limited English proficiency can approximate that of patients without language barriers (Karliner et al. 2007).

Cultural competence in mental healthcare delivery requires more than just linguistic translation. It necessitates understanding the often-complex cultural context of mental health experiences and expressions (Swartz & Kilian 2014). The role of interpreters as cultural brokers is particularly important in the South African context, where traditional healing systems and Western psychiatric approaches often intersect (Penn & Watermayer 2012a). However, care must be taken to avoid oversimplifying cultural differences or assuming that interpreters can speak for entire cultural groups.

Looking to the future, while maintaining the primary importance of human interpretation in mental healthcare, technology offers potential supplementary solutions. Digital platforms could support interpreter training and supervision, particularly in rural areas where access to professional development opportunities is limited. However, introducing technology in mental healthcare should be navigated with caution (Kolding et al. 2024; Seedat 2024), with a focus on ethical and meaningful inclusion of technology in ways that complement rather than replace human interpreters, especially given the nuanced nature of mental health communication (Kilian et al. 2014). Developing specialised mental health interpretation applications – many of which may be informed by artificial intelligence (AI) – and remote interpretation services could help address some access issues, particularly in underserved areas. However, as AI in particular is challenged with an underrepresentation of African languages like isiZulu for natural language processing (NLP) and machine learning (ML), we strongly advise that users critically evaluate their outputs before including them in mental healthcare setting.

Most importantly, research and clinical priorities should include evaluation of innovative interpretation models, investigation of patient outcomes with different interpretation approaches, and cost-effectiveness assessments of technology-supported and non-technology-supported formal interpreter services. These studies should consider both the direct impacts on clinical care and broader implications for mental health service accessibility (Swartz et al. 2014). The experiences of other countries in developing professional interpreter services can inform South African efforts, while acknowledging the unique local context and resource constraints (Elkington & Talbot 2016).

Conclusion

Addressing language barriers in mental healthcare requires a comprehensive approach that goes beyond basic translation. By integrating cultural expertise through formal collaborations with traditional health practitioners and community health workers, while maintaining standard professional guidelines, we can work towards more equitable and effective mental healthcare delivery in KwaZulu-Natal. Success will require sustained commitment from policymakers, healthcare administrators, and practitioners, alongside adequate resource allocation and ongoing evaluation of outcomes. The right to mental healthcare in one's own mother tongue is not merely a matter of convenience but a fundamental aspect of healthcare justice and human dignity (Swartz & Drennan 2000).

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Competing interests

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G.N.W., S.K. and B.C. contributed to the conceptualisation and writing. L.M.-T. and V.V.M. also contributed towards the writing of the article.

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Data availability

The authors confirm that the data supporting this study and its findings are available within the article.

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