



that attention to context is important to fully gauge the attitude of a given individual. Guerin argues that discourse belongs to the community not the individual. Only by examining how racist talk is embedded in individuals' conversations and identifying its functions in given contexts, will we understand a community's attitudes towards such things as race.

The second of Guerin's papers also deals with the contextualisation of research practices. Though perhaps 'preaching to the converted' sociolinguist, his warnings against decontextualising talk collected for analysis suggests that a less careful approach to discourse misses the importance of social relationships among interlocutors. He illustrates this point by examining two devices speakers might use to get information past their listener. The first he labels the bluff game - where the speaker presents a lot of information that would all have to be challenged by the listener should they want to challenge any part of it, and the second conversational consistency, where the speaker carefully maintains information, aware of the monitoring process of the listener.

These papers from P. Guerin, B. Guerin and Sligo provide the sociolinguist with insights into language issues encountered in researching communities from the perspective of other disciplines. The shared concern with language as both an object and instrument of research and the importance placed on contexts - within particular communities and within particular discourses in various fields - should encourage further cross disciplinary engagement.

LANGUAGE AND REFUGEES:  
BEYOND MERE CULTURAL MISCOMMUNICATION

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**Introduction**

New Zealand has been a host country to over 16,000 refugees since 1980 (NZIS, 2004). The majority, if not all, of refugees coming to New Zealand have very little, if any, English-speaking ability. Effective communication is absolutely essential for the successful resettlement of refugees in New Zealand partly because of the nature of refugee migration compared with other migration into New Zealand. Refugees, on arrival in New Zealand, have many needs that need to be addressed, usually immediately, such as physical and mental health issues as well as housing, financial assistance or employment, schooling for both their children and themselves, electricity, and transportation. Successfully negotiating all these issues within a short period on arrival and without English ability is truly admirable for those who are able to achieve it, but it nearly always requires the assistance of good interpreters.

One of the major questions that needs to be addressed in the New Zealand context of interpreting is who *are* interpreters anyway and what *is* their job? Raval (2003) describes a variety of different roles that interpreters can take on. For example, interpreters can be *simple translators* who are direct, neutral and impartial. Interpreters can take on the role of *cultural broker* who gives further information and the cultural context in order to improve understanding for the service provider or professional. Interpreters can also function as an *advocate* for the client, where the interpreting is focused on

meeting the needs of the client. There is the possibility of interpreters working as a *cultural consultant* for service providers, where they can explain cultural practices that may influence service provisions. This type of interpreter can be useful in a wide range of services, for example, in electricity services to improve service provision to non-English speaking communities where standard information, such as electricity conservation, for English speakers may not be as useful due to cultural differences. A *link worker* is an interpreter who helps the service provider identify unmet needs of a client and supports the client to get their needs met. Also, interpreters can function as *bilingual workers* where they are more actively involved than just providing an interpreting service as they may also be a trained professional themselves. An example of this is a bilingual mental health worker who may themselves provide mental health services or can work in a team alongside psychologists or psychiatrists to provide effective mental health services (Tribe & Raval, 2003). Overall, there are probably more questions than answers in the New Zealand context of interpreters, but all need to be carefully thought out, in consultation with relevant communities and services.

There is some theoretical debate about what is meant exactly when we talk about 'miscommunication' (Coupland, Giles, & Wiemann, 1991). Coupland, Wiemann and Giles (1991) even state that "language use and communication are in fact pervasively and even intrinsically flawed, partial and problematic." (p. 3). In this paper, we use Banks, Ge and Baker's (1991) understanding of 'miscommunication' which they describe as:

...a label for an interpretation by one or more persons, either observing or participating in interaction. It is a decision about the meaning of another person's communication behavior and its consequences for the persons involved in the interaction. As such miscommunication in our view is a retrospective recognition that one person's intentions have not been "read" accurately by another participant and that future actions or opinions of the participant will be predicated on the inaccurate reading. (p. 104)

The important focus in this paper for refugees and their resettlement are the *consequences* of 'miscommunication'.

We have found, in our work as researchers and community advocates for refugees, a number of issues in communication and miscommunication with refugee groups in New Zealand. We have been working with particularly Somali refugees in New Zealand for over five years, but have also worked with other refugee groups, such as Afghani and Iraqi. We explore here some of the common miscommunication issues with refugees, some of which can be extended to non-English speaking migrants in New Zealand, but some of which are unique to refugees. We provide examples from our research of the complexities of communication with refugee groups and we also explore some of the possible solutions to communication issues for refugees in New Zealand.

#### **Common miscommunications**

When talking with someone with English as a second language, even if their ability to speak English seems good, there is the risk of miscommunicating. For example, a woman with limited English replied "enough food" when asked if the family had enough food to feed everyone. The service provider could have interpreted that simple phrase as indicating, yes, indeed they had enough food. However, in this case, further investigation revealed that the woman was trying to *ask* for enough food and was thanking the service provider for *bringing* "enough food". This was a case of simply miscommunicating a need, in a simple-enough situation, but when working with limited English speakers, especially those from refugee backgrounds, the miscommunication can become more complex and have significant implications. In this case, the first assumption would have resulted in a lack of action by the service provider to assist the family in getting more food.

When working with refugees, there is an often unrecognized influence of social pressure or expectation on communication. This can happen especially during sensitive conversations such as the date of last menstrual

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period or the frequency of sexual relations when a client may be feeling shy. In this sort of case of miscommunication, the consequences can be very important for a woman with sexual health problems who does not want to admit the extent of her sexual activity.

Another example in our experience is that of a new mother, concerned about her baby's coughing. While attempting to find out more about the cough, the health professional asked more and more questions about frequency, duration, and other characteristics of the cough. Both the frustration of trying to understand the English and the tiredness of the new mother contributed to the mother just agreeing to questions without really know what was being asked. Gass and Varonic (1991) describe this sort of 'problematic communication' as 'non-engagement' in which the communication is broken off because continuing the conversation, for whatever reason, is difficult, stressful, or no longer in the best interests of the communicators. Refugees, who have often not had adequate health care provision prior to resettlement in a western country, can also have an expectation that health professionals will fix everything and that, in this case, the mother can withdraw her involvement in the health care of the child once a health professional is involved. The result of this can be that the health professional wrongly perceives the mother as disinterested and unconcerned about her child.

One cultural misunderstanding that we often see, especially in our work with Somali refugees and western service providers, is the perception of rudeness or bossy-ness of Somali clients. Culturally, many Somali often do not say "please" and "thank-you" to service providers, as this is not part of their cultural tradition but is culturally preferred in a western context. For example, an elderly Somali man at a local McDonald's could only say "coffee, three dollars" to the counter attendant, who was new and in-training. His approach seemed very demanding and the girl, with no experience of elder Somali men, was terrified at his insistence for "coffee, three dollars" and rushed for some help, in tears. The man did not

understand what all the fuss was about—he just wanted a coffee—and was not aware of the impact of his manner on the young girl. Having worked with the Somali community for many years, we have observed some interesting changes concerning this particular example. For one, Somali who have been resettled for longer have now incorporated ‘please’ and ‘thank you’ into their repertoires, but the perception of Somalis as ‘rude’ has persisted. We’ve also observed new arrivals being prompted by those living in New Zealand longer to say ‘please’ and ‘thank-you’.

How events are described and understood may not be the same across cultures. This is especially true in the area of mental health for such states as depression and anxiety. As these are very abstract concepts, even within the English language, they become incredibly difficult to translate when there are huge cultural and religious differences. Another example is that of cancer (Liang, Yuan, Mandelblatt, & Pasick, 2004). For many ethnic groups, there is a belief that cancer is a ‘western’ disease and that it only affects westerners. However, with a group of elder Somali women, we explained that the life expectancy in Somalia is 47 years, whereas in New Zealand it is 78 years. We explained further that the health care in New Zealand was such that cancer was able to be detected, which was not the case in Somalia which has roughly one health professional for every 100,000 people. By reflecting on the contexts that influence both cancer detection and the ages at which it can be acquired, all of the women in the group agreed that breast and cervical screening were important and all had made and attended screening appointments soon after the session.

### **Common Problems with Interpreters**

Interpreting is rarely a simple word-for-word translation from one language to another and communication is rarely a ‘linear flow of information’ (Coupland, Wiemann, & Giles, 1991, p. 9). When interpreters are pressured, for whatever reason, to attempt word-for-word translation, there is increased risk of mistranslating. This is especially true for most medical issues where there may often not even be words available in the language to

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interpret. This is where only very skillful interpreters can aim for understanding rather than simply translating. For example, interpreting with a family newly diagnosed with HIV can be very tricky. There are no words that easily translate for 'CD4 counts' and effectively explaining the importance of taking medication regularly is more a skill in social influence than it is in interpretation.

Health professionals working with interpreters can feel 'out of the loop' when working with an interpreter when the question being asked only took, for example, ten words, but the discussion between the interpreter and client extends for five minutes and then the interpreter provides a one-sentence response from the client. This can be very confusing for the health professional and it is often reported that professionals are suspicious of such dialogue. This can then be problematic when the context is legal or relating to immigration and has contributed to the blanket or inflexible recommendation for interpreters to be "translating devices" only.

### **Subtle issues influencing communication**

There are also a number of very subtle issues that influence communication which are often not considered in the communication process. These include the influence of majority or minority status of the client, professional, and interpreters, and the influence of who has power and authority in the situation. Many refugees have problematic histories of dealing with authorities that can influence current communication (Daniel & Knusden, 1995). There are also social expectations in any communication. Much training and policy relating to interpreters treats interpreters as a translating device rather than as a person with their own influences in the communication situation and their own backgrounds in the communities being represented. Finally, the abstractness and complexity of issues are a significant contribution influencing effective communication.

Our research on the topic of female circumcision has demonstrated good examples of the influence on communication of majority and minority status

and who has power and authority in the situation (Guerin & Elmi, 2004). For example, prior to coming to New Zealand, many African refugees were in a context in which female (and male) circumcision was the practice of the majority. For those who did not agree with the practice, coming to New Zealand could be very good as they would now be part of a majority view (anti-circumcision). But for those who valued the practice of female circumcision, coming to New Zealand suddenly placed them in a minority, and even illegal, position. This has significant implications for effective communication between these refugees and the professionals with whom they come in contact. For example, because of the community knowledge that circumcision is illegal in New Zealand, families may sometimes have very young girls circumcised prior to coming to New Zealand. If there are any possible complications relating to the circumcision, such as painful periods, they may not seek out the medical assistance required due to the illegal nature of the practice and fear of being charged with criminal activity. In terms of communication, information relating to circumcision is likely to be withheld in the health and medical context because of this majority/ minority influence with health professionals.

Many refugees also have problematic histories of dealing with authorities that can influence current communication (Daniel & Knusden, 1995). For example, corruption in some of the refugee camps in the early 1990s in Africa can still have impacts on current communication. Recently, we had the opportunity to observe a discussion between some refugee women who were reminiscing about people they had known in the camps as they were there at the same time. One woman asked if the other knew of some woman who worked for immigration, "Do you remember her? She would ask as you came in the door, 'do you have any American money?' if you said no she would point to any jewelry that you were wearing and say, 'I'll take that, then.'" Because of situations like these, many refugees distrust those in authority and if they feel that the person they are communicating with has the power and authority to either provide or not provide resources, their communication can be severely influenced.

Another example here that we have heard of frequently is the 'lying' of refugees to immigration authorities. For example, a woman with many children recently arrived in New Zealand and she did not disclose to immigration authorities that she had a husband and two more young children in the refugee camp. In immigration policy, it is absolutely essential that all family are 'declared' on arrival if there is any chance of them later applying for visas to New Zealand. Some may say she lied. However, from her perspective, the immigration application had been made before she was married and before the two younger children had been born. Because the immigration application had been in process for over three years, she had married and had more children in the meantime. She feared that her immigration application would be adversely compromised if she revealed the existence of her husband and other children. She felt she would be better off not changing her story than to risk losing her visa to New Zealand. This is an incredibly complex and sensitive situation that is not accommodated well in the current bureaucratic systems even though the issues of trust with refugees are well-established. Coupland, Wieman and Giles (1991), referring to concerns about 'deception' suggest that research should look more at how deception is "interactionally constituted and the contexts in which it may be pernicious or necessary, perhaps even desirable and a matter of skilled achievement" (p. 2). This is something all interpreters need to deal with.

There are also social expectations in any communication in which one social context may elicit a completely opposing 'story' compared with another social context. Our research about female circumcision is another good example of this (Guerin & Elmi, 2004). While a woman may be completely supportive of the practice in a context of elderly Somali women, this same woman, in a context of European health professionals may report being completely opposed to the practice. This is not any reflection of the integrity of the speaker, but just an indication of the strong influence of social expectations.

Much training and policy relating to interpreters also treats interpreters as a translating device rather than as a person with their own influences in the communication situation. This became evident to us during an appointment with a family who were informed of their having a communicable disease. An extensive dialogue took place between the family and the interpreter in the middle of the appointment. When the family was asked what they were discussing, they replied that they were explaining to the interpreter how they believed they had contracted the disease. It became apparent to us that the relationship with the interpreter and reputation of the family in the community were both very important, possibly more important than the fact that they were sick and in need of treatment.

Finally, the abstractness and complexity of issues are a significant contribution influencing effective communication (Tribe, 1999). Some of these examples have already been mentioned, such as abstract mental health concepts such as depression, anxiety and schizophrenia and also complex issues such as the influence of medication on CD4 counts in HIV treatment.

Overall, there is a wealth of research relating to the cross-cultural issues for non-western groups not understanding western mental health philosophy and how that relates to practice and treatment. For example, a refugee woman had a social worker referred to her for assistance and after a few weeks she refused to see the social worker anymore. When asked why, she replied: "If I am walking all day and I come to you, I need a drink of water, you give me a drink of water, not ask me about the problem. They ask me to talk about the problem, talking, talking, talking about the problem. Always asking me about the problem. Just give me a drink of water." For this woman, she felt that the social worker was not adequately meeting her needs, and the perception of the client that the social worker only wanted to talk and talk about the problem was not satisfactory to her.

When using an interpreter in mental health, especially with refugee communities, it has not often been acknowledged that the interpreters themselves are likely to have issues that can be aggravated by their experience as an interpreter. For example, an interpreter who has never had any therapy relating to his or her experiences in war or refugee camps may become incredibly anxious and threatened while interpreting similar situations for someone in a therapeutic context. As the context is intended to treat a client and not the interpreter, the interpreter's needs not only go unmet but have been aggravated by the therapy context. These issues can also have a significant influence on the dialogue between therapist and client via the interpreter. In complex, abstract communication situations, there is also a risk of simply not getting across the subtleties of dialogue and therefore misvaluation of mental health clients (Farooq, Fear, & Oyebode, 1997; Marcos, 1979). This suggests more funding and support needs to be inherent in the development and provision of cross cultural mental health services for adequate briefing and debriefing for the interpreters.

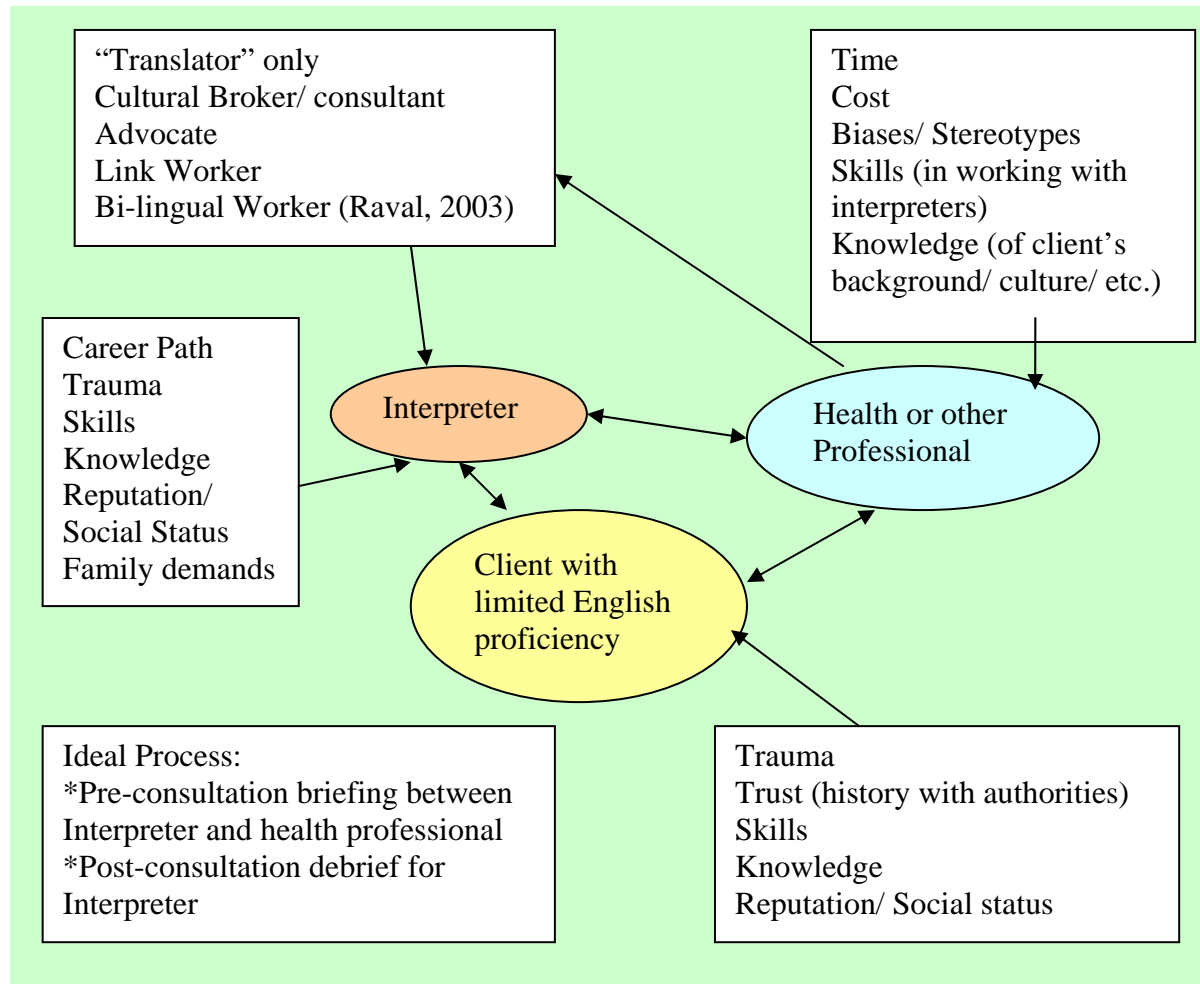
### **Solutions Relating to Practice**

Our experience has indicated that training for interpreters and adequate funding needs to be substantially re-considered in New Zealand. The context in which the interpreter is working has significant influences on the best approach at communication. For example, while word-for-word translating may be appropriate in the courts or other legal contexts, this is not generally an appropriate or effective method in health and mental health. Figure 1 shows the variety of factors influencing communication between clients, interpreters and health professionals. This figure illustrates that all parties involved in the communication have influences that require recognition. Not recognizing these can have substantial impacts on the communication and the quality of health care.

Our experience has also indicated that not only do interpreters need to be trained, but those who use interpreters need training on best-practice with interpreters (Raval & Smith, 2003). Simple communication techniques, such

as looking at the client when speaking, can go a long way in effective communication, especially in the health and mental health care settings.

Figure 1. The complexities of interpreting



**Solutions: research**

In terms of research relating to the improvement of communication practices in New Zealand, our experience, and that of some sociolinguists, is that the best way to get at the real issues involved is to take on ethnographic approaches or engage in participatory research much closer to the social networks than previous research with 'language' (Saville-Troike, 1982; Milroy & Milroy, 1992; Guerin, Guerin, Diiriye, & Abdi, 2004). To make advances in our understanding of the many influences that affect refugees in New Zealand, health and other professionals either need to consult through cultural brokers or get to know clients outside the office

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environment. Ideally, refugees and their communities will conduct their own research, but until the capacity is built in these communities, researchers and professionals will need to work alongside former refugees and their communities in order to get good understanding. Research cannot simply use questionnaire methods without spending time with the people and getting a full picture of the issues. Simple questionnaires are likely to elicit the standard, expected responses and are not likely to make the sort of advances in understanding that refugee communities deserve.

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*RIVER, CANOE: A METAPHOR TO INFORM COMMUNITY-BASED*  
**RESEARCH INTO ADULT LITERACY**

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**Introduction**

This paper describes part of an on-going journey shared by researchers from Massey University and new researchers from the community as we came together in a longitudinal, multi-faceted study of adult literacy in Wanganui and Districts. Funded by the Foundation for Research, Science and Technology (FRST), the goal of the research programme was to investigate a series of issues surrounding adult literacy and employment in Wanganui and Districts, led by the University's Department of Communication and Journalism.

At the heart of this research programme was its exceptionally strong community links. Because in the first instance it was to be grounded wholly within Wanganui and Districts, it needed to embody collaborative research protocols, combining University researchers' skills with local people's deep contextual understanding.

We explore particular challenges associated with the use of language in the study with the aim of revealing some of the reasoning and metaphor use that occurred especially in its early stages. The paper recounts how a collective attempt to name collaborate research had unforeseen effects and failed to meet participants' needs. The major beneficial outcome was the