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Language, games and the role of interpreters in psychiatric diagnosis: a Wittgensteinian thought experiment

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ABSTRACT

British society is becoming increasingly culturally and linguistically diverse. This poses a major challenge to mental health services charged with the responsibility to work in ways that respect cultural and linguistic difference. In this paper we investigate the problems of interpretation in the diagnosis of depression using a thought experiment to demonstrate important features of language-games, an idea introduced by Ludwig Wittgenstein in his late work, *Philosophical investigations*. The thought experiment draws attention to the importance of culture and contexts in understanding the meaning of particular utterances. This has implications not only for how we understand the role of interpreters in clinical settings, and who might best be suited to function in such a role, but more generally it draws attention to the importance of involving members of black minority ethnic (BME) communities in working alongside mainstream mental health services. We conclude that the involvement of BME community development workers inside, alongside and outside statutory services can potentially improve the quality of care for people from BME communities who use these services.

Language is a potent marker of identity. The languages we speak disclose our nationality, our cultural group, class membership and likely religious affiliations. As the cultural diversity of British society grows, so does our linguistic diversity. This poses an enormous challenge to health workers, especially those working in mental health services. Government policy and good practice guidelines stress the importance of bilingual professional staff, and access to professional interpreters for those working with non-English speakers. In this paper we examine the role of interpreters in psychiatric diagnosis from a philosophical perspective. The later philosophy of Ludwig Wittgenstein raises some important questions about the meaning of speakers' utterances, and thus the role of the interpreter. Our conceptual analysis raises questions that can be tested empirically. To begin we outline briefly the extent of linguistic diversity in Britain, why it is important in relation to mental health and then examine critically the assumptions that underpin current opinion on what constitutes ''good practice'' in working with interpreters. We do this through a thought experiment that illustrates Wittgenstein's notion of language-games. We then consider the implications of the thought experiment for the problems of meaning and interpretation between languages in psychiatry, and conclude by briefly examining policy and future research implications.

CULTURAL DIVERSITY AND MENTAL HEALTH

Britain is becoming increasingly culturally diverse. In the 2001 census, 4.6 million (7.9% of the population) people identified themselves as belonging to ethnic minority groups. Indians are the largest, followed by Pakistanis, people from mixed cultural backgrounds, black Caribbeans, black Africans and Bangladeshis.[1] Over 300 different languages are spoken by London schoolchildren,[2] and a recent briefing paper using Labour Force Survey data collected in London[3] found that 18% of the capital's population spoke a first language other than English at home. This has important implications for health policy aimed at tackling inequalities in mental health. People from black minority ethnic (BME) communities have very different experiences in mental health services compared with the majority white British population.[4] These inequalities extend across primary and secondary care. They are complex in nature and brought about by many factors, but problems with language and communication are likely to play an important role in their genesis. The British Government has set out a comprehensive policy, *Delivering race equality*[5] to tackle these inequalities. Amongst other things, the policy stresses the importance of culturally appropriate services and help, and a culturally competent workforce.

Diagnosis and effective treatment in psychiatry is contingent on good communication between the clinician, patient and carer.[6–8] Good communication depends upon the clinician's fluency in the patient's language, the patient's fluency in English, and the availability of an appropriate vocabulary in the patient's language for signs and symptoms of mental illness described in western diagnostic classifications. There are several problems here. Many people from BME communities (especially elders) do not speak English.[9–11] Ideally, the patient should be assessed by a clinician who speaks the patient's language and belongs to the patient's culture, but this is rarely possible.

Access to interpreters is a feature of government policy aimed at rectifying mental health inequalities in BME communities,[5] and guidance to professionals for best practice.[12] These documents set out a number of principles that determine how health professionals should work with interpreters. In general they follow the hierarchy set out by Phelan and Parkman,[13] of bilingual health workers, trained interpreters, friends or relatives, and finally

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untrained volunteers. Trained interpreters are "…skilled in interpreting the sense and intent of what is said while preserving the content of the interview".[13] They facilitate the ascertainment of signs and symptoms of mental illness in a culturally appropriate context. Friends and relatives are not to be relied on because of the risk that "…someone close to the patient will not stop their own views of the situation colouring their translation".[13] Guidelines on commissioning interpreting services set out similar priorities, with a clear preference for bilingual professionals or trained interpreters. Services should not rely on family members or untrained volunteers from the community.[14]

Shah[8] has drawn attention to the practical difficulties in interpretation, whether through a bilingual professional or trained interpreter. Of particular significance here is his description of the absence of a matching vocabulary for signs and symptoms of psychiatric illness in the patient's language. The clinician may struggle to ask questions on symptoms based on Western diagnostic classifications, when, for example, there is no matching vocabulary for depression in Gujarati or Urdu. These problems are especially marked for older people from BME communities, because for many English is often not their first language,[15 16] but it is also an important aspect of communication with all non-English speakers, especially those from South Asia.

WHAT SORT OF VIEW OF LANGUAGE DOES INTERPRETATION IN PSYCHIATRY PRESUPPOSE?

Interpretation is clearly important in biomedical care, where in terms of equality it is vital that those who do not speak English are able to access modern health technology. Policy guidelines tend to see the act of interpretation between languages unproblematically. They assume that technical concepts can be translated across from English into the patient's language. The meaning of words in different languages are assumed to be transparent and equivalent in meaning, so that the meaning of the patient's utterance is readily accessible to the interpreter and rendered into English. To put it very simply, the interpreter is seen as having access to two lists of words, or lexicons, in the languages concerned. His or her task is simply that of matching a word from one lexicon to a word of equivalent meaning from the other lexicon. But Shah's clinical observation[8] that there are occasions when there is no equivalent word for depression in some South Asian languages, suggests that in reality the situation is more complex.

This somewhat simplified model of interpretation in psychiatric diagnosis reflects a particular set of assumptions about the nature of language. In particular it assumes that the meaning of a speaker's utterance is external to any particular instances of language use by the speaker, and the contexts in which the utterance occurs and that might influence the meaning of the utterance. This is because languages are assumed to possess underlying "deep" structures around which equivalence of meaning hinges. This view of language, which we will characterise as a cognitivist view[17] resonates strongly with the work of Noam Chomsky, who argued that certain features of language were universal in the sense that they could be identified independently of their occurrence in any specific language.[18] For example, although languages such as Japanese, Urdu or Welsh may differ in terms of their sentence structure and lexicons, these are superficial differences. Beneath these surface differences, all languages share a common, underlying deep structure, or universal grammar, which specifies a set of general rules that account for the relationship between deep and surface structure. For example, universal grammar specifies a set of operations whereby the surface structure of active and passive sentences can be derived from a common underlying deep structure. It is because active and passive versions of the same sentence (for example, John kicked the ball—The ball was kicked by John) share this same deep structure, that they convey the same meaning. We call this model a cognitivist model because Chomsky, whose ideas about language were immensely influential in cognitivism, argued that this deep structure of language mapped directly onto inner, mental or psychological processes.[19]

The problem here is Shah's observation that in some languages there is no equivalent to the English word depression. This is very difficult to reconcile with the view that meaning is tied to universal grammars. But as we have already seen, the use of interpreters in clinical practice hinges on the assumption that there is a direct relationship between the meanings of words across languages. Shah's clinically based observation[8] suggests that in reality the situation is more complex than the cognitivist model of language would suggest. We want to draw on philosophical arguments about the nature of language using a thought experiment to demonstrate why this is so. Philosophers have used thought experiments for thousands of years to employ imaginary situations to explore reality. Thought experiments may assume a great variety of forms. Here, we present two case histories about two imaginary women who attend their general practitioners' (GP) surgeries. The purpose of these idealised case histories is to draw attention to the importance of language games in understanding the relationship between words and meaning in clinical situations. The women are identical apart from the fact that one is a native English speaker, and the other, from Pakistan, is a native Urdu speaker who speaks no English. The purpose of the experiment is to contrast aspects of their experiences to reveal important features of the different language games they, and their GPs, are involved in. A small caveat is necessary before we proceed. It is not our intention to reify culture, and thus reduce complex, unique human subjects to crude categories. The purpose of the thought experiment is simply to establish a series of arguments about the relationship between culture, subjectivity (or personal identity) language use and meaning. It is not intended to justify a set of assumptions about the beliefs and values of particular individuals.

LANGUAGE, GAMES AND CULTURE: A THOUGHT EXPERIMENT

Our hypothesis is that language games play an important and often poorly appreciated role in the clinical process of psychiatric diagnosis. To test how this might work in practice, there follows a thought experiment in which we deliberately highlight features designed to display the nature of the language games taking place between two (fictional) women and their doctors. We then consider whether altering these language games features in small and, apparently, clinically unimportant ways might result in a change in the psychiatric diagnosis assigned in each case.

Mary, a 55-year-old white British woman was brought to see her GP, Dr Wilson, by Sheila, her best friend. Mary's three children have grown up and left home. The eldest son works in a bank, another son works at a call centre, the youngest (daughter) is at university. After marrying at the age of 20, she worked for a while before looking after her children when they were babies. Over the last 15 years she worked as a secretary, but was made redundant two weeks earlier. Three months ago her husband died suddenly of a cerebro-vascular accident. Since

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then she had experienced financial hardship. Mary tearfully told the doctor that she had been feeling depressed (her word) and that she had been crying a lot. On direct questioning she told her doctor that her concentration was poor and she had been forgetful. She had lost appetite and her weight had fallen by 5 kg over three months. She was finding it difficult to get to sleep, and had been waking earlier in the morning than usual, feeling tired and unrefreshed. At times she had felt that life wasn't worth living, but had no plans to end her life. Her physical health was otherwise good, and a physical examination was normal. On being asked, Mary told Dr Wilson that she felt she was "useless" as a person and that she thought she was "depressed". On further prompting, she said she thought tablets might help, and she also asked for counselling. Dr Wilson gave her a course of antidepressants, and arranged for her to see a cognitive therapist in the surgery. Three months later she was working in a new job and feeling much better.

Fatima, a 55-year-old woman born in Pakistan and who speaks no English, was brought to see her GP, Dr Khan, by her daughter, Saima. Fatima's three children are all still at home. The eldest son works in a bank, another son works in a call centre, the youngest, Saima, is at university. Fatima came to England straight from Lahore when she married her husband 35 years earlier, and since then had stayed at home, looking after her children and family. Three months before she presented to her GP her husband died suddenly of a cerebro-vascular accident. Since then the family had experienced financial hardship. Fatima had to handle all the family's financial affairs, something she had never had to do before. Saima told the doctor that the family were very concerned about her. They had noticed that she was forgetful and cried a lot. She had lost appetite and her weight had fallen by 5 kg in three months. She was finding it difficult to get to sleep, and had been waking earlier in the morning than usual, feeling tired and unrefreshed. When asked, she told Dr Khan that she believed that she was physically ill. She told him she wanted tests to find out what the problem was. Dr Khan wanted to ask her if she felt depressed, but he paused at the threshold of a familiar problem; there is no word for depression in Urdu, so he did not know how to ask her that precise question. Instead he asked how she had been feeling. She said that she felt her heart was sinking, and that she was letting her family down because her daughter had to have time off from university to help her sort out the finances. She had also been praying a lot, and reading the Qur'an. Dr Khan explored with Fatima and her daughter what they thought might help. Fatima said she wanted to talk about her experiences. Dr Khan referred her to a group of Muslim women with similar problems, and who gained strength by praying together. Three months later she was attending the group, and with her daughter's help she was taking control of the family's finances. She was feeling much better.

LANGUAGE AS A FORM OF COMMUNAL LIFE: LANGUAGE-GAMES

The philosophical work of Ludwig Wittgenstein can be thought of as consisting of two parts. His early work, the *Tractatus logico-philosophicus*, is concerned with the relationship between the world, language and our thoughts about the world. He proposed that language represents states of affairs in the world in much the same way that a picture depicts a real-life scene. For this reason it is sometimes referred to as the "picture" theory of meaning. In *Philosophical investigations* (PI), Wittgenstein[20] moves away from a preoccupation with the rules of logic towards a concern with the everyday use of language. This is marked by a change in emphasis, away from definition and analysis in the *Tractatus*, to language-games and family resemblances. PI deals with many aspects of language, but the particular area we are concerned with here is the importance it attaches to the role of language as a social or communal activity. The metaphor we intend to draw on here is that of language as a tool, in which the meaning of a word or utterance is understood in terms of the use to which it is put by speakers. Our purpose here is not to embark on a detailed discussion of Wittgenstein's later work. We simply want to use it to draw attention to aspects of language that are frequently taken for granted in clinical practice. We are also very much aware that there are many different ways of reading PI. Here, we draw on a reading of PI that is informed by the work of Button *et al*[21] and Williams,[22] who draw attention to the relationship between language, culture and meaning.

Wittgenstein introduces the idea of the language-game in order to draw attention to the communal aspects of language:

> But how many kinds of sentence are there? Say assertion, question, and command?—There are *countless* kinds: countless different kinds of use of what we call "symbols", "words", "sentences". And this multiplicity is not something fixed, given once for all; but new types of language, new language-games, as we may say, come into existence, and others become obsolete and get forgotten…
> Here the term "language-*game*" is meant to bring into prominence the fact that the *speaking* of language is part of an activity, or a form of life.
> (Wittgenstein 1967, para 23, emphases in the original.)[20]

Like other games, language-games are rule-governed, but the rules are not fixed or prescriptive. The rules are conventions that are tacitly followed in the communal activity of using language as a communicative tool. The analogy between language and games is important here. It is very difficult to specify precisely what a game is. All we can say is that they share general features in common, but their essential qualities remain elusive. For example, in broad terms, most games involve two or more people. This is not invariably the case; some games like solitaire are played by individuals. Here the issue of family resemblances is important in setting out in general terms some of the common features of games. Thus, language-games have:

> … no one thing in common which makes us use the same word for all,—but that they are *related* to one another in many different ways. And it is because of this relationship, or these relationships, that we call them all "language".
> (Wittgenstein 1967, para 65, emphasis in the original.)[20]

Wittgenstein draws attention to what he calls "family resemblances" as a more appropriate way of understanding instances of particular use of the same word, rather than specifying a general definition. This moves us away from thinking particular words must have equivalents in meaning across all languages. It implies that word meanings are fluid, depending upon the particular context in which they are being used.

Wittgenstein uses the word grammar to refer to the elusive network of rules that govern language games. Grammar here refers not to the Chomskyan sense of rules that govern the structural organisation of sentences (syntax) but to those tacit rules that we rely on to decide which communicative act makes sense in a particular situation or language game. In other words, they play a normative role; they help speakers to judge the meaningfulness of each other's utterances. They are not part of

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an external system of generalised, or universal, rules for speaking to which we must conform. Rather they are a set of locally agreed conventions or customs accepted by native language speakers, and which are important in enabling them to make sense of each other's utterances. Finally, Wittgenstein uses the expression "form of life" (*vide supra*) on five occasions in PI. What he means by this has been the subject of some debate. Here, we interpret the expression anthropologically, as referring to the background contexts or conventions that make a particular word or utterance meaningful. These contexts are fluid, constantly changing and tied to culture and history.

LANGUAGE AND MEANING: TOWARD AN ANTHROPOLOGICAL READING OF WITTGENSTEIN

What does the thought experiment tell us about how we use language to convey meaning? In some respects the two women are very similar. They are the same age, have both lost their husbands, and have children of the same age and gender. Both present with identical physical manifestations of distress, and both appear to be doing much better three months later (table 1). The similarities end there. An important part of Mary's life has been her work outside the family as a secretary. This, together with the fact that she presents with her best friend, suggests that a significant part of her identity is invested in areas outside the family. Her children have grown up and left home so she has a dispersed nuclear family structure. On the other hand, the most important aspect of Fatima's life appears to be her role as wife and mother within the family. Within that context her identity has largely been defined by her relationships within the extended family. She has had few if any responsibilities outside home and family, consequently the death of her husband has had major repercussions in this area of her life. The importance of her role in the family can be seen in the fact that her daughter accompanies her to the appointment.

Button *et al's* reading of PI[21] points out that the rules and languages associated with different games originate in the historical and cultural activities that are unique to each game. For example, the human activities that over time gave us the rules and language of tennis, did not give us the rules and language of football. The two games have different languages and rules because they originated in different traditions with different histories. Or, to use Wittgenstein's words, they arose out of "different forms of life". Tradition and culture are really important here; they matter to us. They carry our values, and help us to make sense of our worlds. Playing tennis, like any game, has meaning for those who play it in terms of a shared history in which the game, its rules, actions, and terminology, bind us together. Anthropologists have a very clear view of the importance of culture in meaning. Arthur Kleinman[23] writes:

> A word, after all, is a sign that signifies a meaningful phenomenon. That phenomenon … exists in the world mediated by a cultural apparatus of language, values, taxonomy, notions of relevance, and rules for interpretation. (Kleinman 1991, p11)[23]

He urges caution in how we interpret idioms of distress. In this view it is incorrect to assert that expressions such as "…my body feels heavy…" are equivalent to and can thus be interpreted as "depression". This is not an act of interpretation, but one of transformation, that is to say changing one thing into something else. Kleinman refers to this as a category fallacy. He points out that the cultural contexts in which bodily and emotional experience take place provide the means to enable us to interpret and make sense of these experiences with others who share the same cultural context, or form of life.

What can be said about the language games that take place between the two women and their doctors? First, it should be clear that these are very different games, based in different customs, conventions and rules. In broad terms the rules of Mary's game revolve around her use of the word "depression". How this is to be understood depends in turn on a number of conventions about how she understands herself as a person. For example, although the word depression may have many different meanings for English speakers, we might conclude that for Mary, depression is a deeply personal experience, one that is rooted in her physical being as a person, but that also affects her inner view of herself. Her belief is that she needs tablets is in part tied to a widely held belief that depression is a biochemical disturbance in the brain that can be rectified by antidepressant tablets. Lewis[24] points out that this is an extraordinarily influential belief in Western culture, one that has grown in strength recently, not just in the specialist world of psychiatry. Over the last 15 years, the publication of books like *Listening to Prozac*, *Prozac nation*, *Prozac diary* and *Prozac highway* together with countless magazine, newspaper and television articles suggest that Prozac and the language of neurotransmitters has become a powerful cultural trope through which in Western societies we understand ourselves as human beings. A key feature of this language game is that it enables us to talk about sadness in terms of depression arising from a chemical disturbance in an individual's brain. Another significant feature of Mary's belief is that she is "useless" as a person. This may be understood in terms of negative cognitions in her mind. In this language game CBT is understood as "rectifying" these cognitive faults so she can think more positively about herself as an individual. As language games, both Prozac and CBT locate the problem in the inner depths of the individual's body and mind respectively. In *Sources of the self*, Charles Taylor[25] sets out his view of the moral ontogeny of Western identity. One of the central concerns of his work is the rise of what he calls "inwardness" as a feature of contemporary Western subjectivity, which he traces from Plato's injunction to self-mastery, "Know thyself", through St Augustine's attempt to reconcile Platonic and Christian doctrine about truth and the good, to the European Enlightenment. But it was with Descartes' philosophy that "inwardness" became critical for the emergence of three key features of contemporary Western subjectivity. First is the view of the subject as disengaged, that is free and rational in the sense that the subject is seen as separate from the natural and social worlds. Second, is a punctual view of the self, which is free to treat these worlds and self

Table 1 Mary and Fatima Contrasted

	Mary	Fatima
Mode of presentation	Best friend	Daughter
Words used to describe distress	"Depression", "useless as a person"	"Heart is sinking", "letting my family down"
Physical features	Reduced appetite and weight, insomnia and tiredness	Reduced appetite and weight, insomnia and tiredness
Expectation of help	"Tablets", "counselling"	"Talking and praying with similar women"
Help offered	Antidepressants, cognitive behavioural therapy	Community support group for Muslim women
Family structure	Dispersed nuclear	Extended
Gender role	Relationships external to family, paid employment outside the home	Relationships within family, duties within the family home
Outcome	Good	Good

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instrumentally and rationally, to manipulate and change the self. Third is the social consequence of the first two, an atomistic view of society, which is ultimately to be explained in terms of individual purposes. In this view the use of the word depression in the sense that Mary intends could only be meaningful in a culture that assumes that identity and subjectivity are thus constituted.[26]

In cultural and historical terms the European Enlightenment does not feature in Fatima's heritage. Thus her understanding of herself as a person is different. As a result she engages in a very different language game to understand what is happening to her. She speaks about her experiences in terms of her sinking heart and her belief that she is letting her family down. This is a language game in which her relationships, obligations and duties to her family are of paramount importance to her identity. She does not use the word depression to describe what is happening to her for much the same reason that footballers do not use the words 15 love to describe what happens when they score a goal. There is no place for depression in the language game she engages in to say how she feels, because it has little or no meaning for her in terms of who she is as a person. On the other hand in Islamic culture, there are other ways of understanding her language game. Currer's study of Pathan women living in England[27] shows that the experience of hopelessness has different meanings compared with Western understandings. Sadness and unhappiness are aspects of human life over which they felt they had control, but which instead signified the importance of their moral relationship with God, who ultimately had the power to shape their destinies. Krause's study of Punjabi women in Bedford[28] found that they expressed their experiences of sadness not in terms of depression, but literally as a "sinking heart". They found that the meaning of this expression was tied to close family relationships, especially the *absence* of close family members. Fenton and Sadiq-Sangster made similar observations in Punjabi-speaking women in Bristol.[29]

Thus Fatima appears to be engaged in a language game in which family responsibilities, and one's obligations as a good Muslim are of paramount importance in shaping her identity and thus how she talks about distress. It also means that her faith plays a central part in helping her through her distress. Fatima's moral agency lies right at the heart of this language game. Her identity and value as a human being are set out by the extent to which she is able to do what is considered to be right in the eyes of her family. This is a moral game that anchors her understanding of herself, and others' understandings of her, as a human being to her faith and community.

It is important to note that both women seek help that is consonant with the language they use to talk about their experiences. Mary wants, and gets antidepressants; Fatima wants to be able to meet and pray with Muslim women who face similar moral dilemmas. Both GPs are doing their jobs properly. They tacitly understand and engage with their patients' language games. Both women make a good recovery. Of course our thought experiment presents a highly idealised view of a common clinical situation in which the GPs understand their respective patients' cultures, and the responses that are required. There is empirical evidence that good outcomes in mental health are more likely when doctor and patient share common understandings of the problem. Callan and Littlewood[30] interviewed 21 white British and 63 BME patients, asking them about their views about the care they had received, treatment preferences and explanatory models. Patients were much more likely to express satisfaction with their care where there was concordance between the patient's and psychiatrist's explanatory model. This was independent of the patient's ethnicity.

CONCLUSIONS

This paper began by asking a relatively simple conceptual question about the processes of interpretation in psychiatric diagnosis, but the issues raised in our attempt to answer this have wider implications for mental health policy and practice in relation to people from BME communities. As far as the role of interpreters is concerned, our analysis suggests that a more sophisticated approach is necessary. In the field of mental health it is probably incorrect to assume that either a professional interpreter or bilingual professional can act transparently in relation to language and access a deeper level of universal meaning common to whichever languages are involved. Such a view overlooks the extent to which culture is central to the way that speakers negotiate meaning. This may work satisfactorily across languages that originate in broadly similar cultural traditions, such as French or English, but we would argue that major problems arise if we attempt to interpret in psychiatric diagnosis between languages that originate in very different cultural traditions and histories, as is the case with Urdu and English. Williams[22] points out that the use of technical expressions by experts has a privileged epistemological position because of their specialised knowledge and social position. Under such circumstances, the non-English speaker may find it disrespectful to have his or her words twisted into an alien meaning.

Our argument provides some support for the role of the "culture broker" (although this is a problematic expression), someone who not only has linguistic skills, but is also thoroughly grounded in the cultural traditions and values of the patient. Such a person is more likely to be aware of the complexities of meaning in the patient's language, particularly of the responses that the patient's expression might require. The thought experiment suggests that people who share the same cultural referents as the patient, like community development workers, friends and family members (where appropriate) are best-placed to act as interpreters in diagnostic assessments involving people from non-Western cultures. In another paper we have examined interpretation as testimony[31] and reached similar conclusions. If the transmission of information from patient to doctor is to be as transparent as possible, then it is better that the interpreter's theoretical knowledge of medicine does not exceed that of the patient. Greenhalgh *et al*[32] carried out an empirical study based in the philosophy of Jurgen Habermas, and came to similar conclusions. They argued that because family members share the patient's lifeworld (the term used by Habermas to refer to the background of culture, practices and values that confer meaning, and which resonates strongly with our reading of Wittgenstein's expression "forms of life") this could shift the power balance towards the patient. Temple[33] also draws attention to the importance of power in understanding what happens in interpretation in clinical settings, although she is primarily concerned with qualitative research. She points out that there is little point in providing interpreters who can engage with the patient's culture and values if the services the interpreter works for are incapable of responding in terms of the patients' culture and values. This is a major challenge to the health service's commitment to deliver genuine choice for people from BME communities. It lies at the heart of our struggles to engage with difference and diversity.

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More generally, our thought analysis provides evidence in support of the role of community development workers in working alongside mainstream mental health services. Community development workers from BME communities have a detailed understanding of their own culture's values and belief systems, and how these values and beliefs may benefit those members of the community who experience crisis or distress. Community development projects can deliver culturally appropriate, non-Western systems of support based in, for example, spiritual self-help and support, and act as a bridge between communities and statutory services. Their cultural knowledge, skills and resources means they can play an important role working inside, alongside and outside statutory mental health services in improving the quality of care for people from BME communities.[34 35] Finally, we agree with Greenhalgh *et al*[23] who conclude that interpretation by family or community workers is both under-valued and under-researched. Our analysis predicts that interviews in which community development workers or family members function as interpreters should yield better quality information about the patient's problems, and be associated with higher levels of patient satisfaction (an important outcome for *Delivering race equality*). We strongly encourage future research to investigate these predictions.

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