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The social organisation of remembering in interpreter-mediated encounters

During the late 20th century, millions of people have been forced to leave their homes and become refugees, due to wars and political or religious persecution. Their experiences of violence, terror and forced migration sometimes lead to urgent need for mental health care, a care which in some cases cannot take place without the assistance of interpreters.

Interpreting in mental health encounters

How is the interpreter-mediated therapeutic conversation qualitatively different from therapeutic encounters where the participants communicate directly? I take it that it is different. For better or worse. During the latest decades, articles on migration and mental health within the field of psychiatry and social medicine has brought up questions connected to the need for interpreters in medical encounters, basically as a methodological *problem*. To my knowledge, there are few efforts made to describe interpreter-mediated mental health care on its own conditions, one exception being a chapter in a handbook for interpreters by Gentile and his colleagues (1996). To my mind, there is reason to explore the potentials of interpreter-mediated therapeutic care; the *possibilities* provided by the interpreter-mediated mode of communication. What impact does the presence of a third, mediating and translating party have on the therapeutic functions of talk - on the careprovider's work and on the patient's recovery?

Analytical focus: Interpreters' placement in joint narrative activity

These questions comprise the general aim of a research project which I started recently at the Department of Communication Studies, Linköping University, Sweden - "Interpreter-mediated communication between refugees and mental health-care providers". Within this project I have video recorded encounters involving a patient, a careprovider and an interpreter. The patients are all descendants of the former Yugoslavia. The careproviders speak Swedish. I have recorded and started to analyse eight encounters, moreover, interviewed ten careproviders and eight interpreters. In one of the first interviews with an interpreter, an issue was brought up which I have found useful as a first analytical focus. The interpreter in question expressed a very strong opinion about how to sit in relation to the others in the room. She did not like to be placed too close to the patient. She meant that the therapist had promoted the opposite of what he intended, when he insisted on placing her beside the patient and out of direct sight, what he thought would be a way to minimise the risk of her getting involved in processes of transference and countertransference. The interpreter had felt caught in an undesired relation with the patient, sitting physically close to her. This comment has led me to start my investigations of the video recordings by reflecting upon the impact of the interpreter's position with regard to the core activity taking place in therapeutic encounters, namely narrative activity.

In her book *Trauma and Recovery,* Herman (1992) convincingly argues in favour of an idea which today is widely shared within the field of psychotherapy. She has found that the very activity of re-telling a traumatic experience in the safety of a protected relationship can make patients change their view of the memory of this experience (1992:183).

Remembering is also forgetting, as Milan Kundera (1981) has it. Hence, when this very activity - the re-telling - is performed in interpreter-mediated interaction, what does it mean for the patient - storyteller, for the practitioner providing care, and for the interpreter enabling communication between them to take place?

Summarising a great diversity of work on narrative and its role in human interaction, Ochs and Capps (1996), US researchers of anthropological linguistics, note that narrative is a fundamental means of making sense of experience. "Personal narrative simultaneously is born out of experience and gives shape to experience. In this sense, narrative and self are inseparable" (1996:20).

What is the role of the interpreter in the shaping of orderliness and in the reconstruction of selves? What about the interpreters' own safety? What does the re-telling of others' traumatic memories demand from them? How can interpreters avoid burnout and vicarious traumatization, consequences of working with refugees found among therapists (e.g. McCann & Pearlman, 1990, van der Veer, 1992: 241-8). A recent interview study among interpreters (Plimer & Candlin, 1996) indicate that interpreters indeed may suffer burnout, resulting from their work, and may need to offload anxieties in confidence. Elsewhere (Wadensjö, 1998/in press) I discuss the marking - in interaction - of a distinction between the speaking self and the meaning other as something belonging to what can be seen as an interpreter's normal needs while on duty in face-to-face interaction. All the more understandable this need would seem in conversations where narrators' selves "open themselves to reconstrual", (Ochs & Capps, 1996:37).

Focusing on *communication* , I have found it useful to think of the interpreter-mediated talk in terms of a communicative *pas de trois* (Wadensjö, 1997, 1998/in press). Taking and interactionistic approach, applying a dialogic view of language and mind, I foreground and describe the intimate interdependence between the participants involved and their respective communicative projects and goals. The dialogical perspective treats all participants in a communicative event as doing interpretative work. In making sense, people may bring all kinds of rationalities to interaction. Hence, the primary parties - as well as the interpreter - may occasionally mobilise various levels of understanding, i.e. understanding of the situation, of the participants as individuals and as group members, of what information and emotions are currently relevant, to whom and why.

Working with narrative activity, I am interested in how people construct versions of past events within the joint practices of the conversation. The discourse-analytic approach orient me to look at the particular communicative circumstances present in the encounter at various levels; peoples' background assumptions about the situation as a whole and about each other, peoples' communicative behaviour as they develop on a turn-by-turn basis. Scrutinising video-recorded interpreter-mediated interaction between patients and practitioners I can observe remembering as a social, joint activity, in line with psychologists like Middleton and Edwards (1990). I will use two excerpts - drawn from two encounters - to point to some factors which are potentially important in the social organisation of remembering, and discuss how they link to the issue of interpreters' placement in relation to the primary participants.

One patient - two encounters, two stories, two interpreters

A male patient who has spent two and a half year in concentration camps in the former Yugoslavia, visits a Swedish Medical Centre for Refugees, where psychiatric, psychosocial and medical care is provided. The patient is treated for various physical injuries and he is also offered therapeutic talks. In the excerpts he meets a doctor who is ultimately in charge of the whole treatment. They met at several occasions. I video-recorded in two of them. In the excerpts selected, the patient makes quite opposing statements about remembering. The doctor had planned both talks partly as opportunities for the patient to tell some of his war experiences, but while the second one came out as such, the first one did not.

The first excerpt starts where the doctor follows up on a question concerning the patient's eating problems. The patient's stomach was severely injured by torture in the camp. He had got a spoon stuck down his throat, and it remained in his body during four years. This is known to the doctor as a fact, but he had no details about the event. The parties are assisted by an interpreter, here called Irina. Five minutes after the beginning of the talk, the doctor asks the patient about the torture with the spoon:

Excerpt 1. "I don't remember that well"

		ORIGINAL CONVERSATION	*AUTHOR'S TRANSLATION*
1	doctor	hur gick de till?	*how did it happen?*
2	Irina	°kako se to desilo°?	*°how did that happen°?*
3	patient	pa ne secam se dobro bio sam u komi	*er I don't remember that well I was in coma*
4	Irina	de kommer ja inte ihåg-	*I don't remember that*

5	patient	tokom bio- ne u: da kazem u nesvescenom tucu	*during I was- no in: to say I was beaten unconscious*
6	Irina	ja var i koma har har något så när kan man säga att ja var medvetslös av allt stryk ja fått	*I was in coma I have in a sense one can say that I was unconscious because of all the beating I got*
7	doctor	°mm° (3s)	*°mm°* (3s)

Four turns excluded (pat., Irina, pat., Irina). The patient mentions a visit to the doctor - some years after he had been released from the camp - in which he learned that he had a spoon inside his body.

		(11s)	(11s)
14	doctor	hur mycke kommer du ihåg eh fram tills att du var (.) medvetslös?	*how much do you remember er before the point that you became (.) unconscious?*
15	Irina	koliko se secas dok nisi se unesvestio?	*how much do you remember before that you became unconscious?*
16	patient	pa secam se ovo kad su (mi) dali tu porciju (.) pa sam poceo nekaku corbu da jedem °i nista vise°	*er I remember that when they gave me this portion (.) er I began to eat some kind of stew °and nothing more°*
17	Irina	ja kommer ihåg tills dess dom kom fram me en sån portion me nåt slags flytande soppa me skeden i så ja skulle äta °å inget mer sen dess°	*I remember before the point when they came forward with this portion with some kind of liquid soop with the spoon in it so I was supposed to eat °and nothing more after that°*
18	patient	tek eh su- eh sutra dan pa sam tek poceo da se-	*not until er mo- er the next morning I eventually began to-*
19	Irina	inte förrän dan därpå så har ja vaknat till	*not before the next day I did come round*
20	patient	((coughs)) (7s)	*((coughs))* (7s)
21	doctor	va de i samband me de som du också fick eh ((touches his own chin)) slag mot (.) käkarna?	*was it in connection with this that you also got er ((touches his own chin)) blows on (.) your jaws?*
22	Irina	jel isto uz tu priliku ((touches her own chin)) (xx) kad si dobio udarci prema vilicama?	*was this in that connection ((touches her own chin)) (xx) when you got blows on your jaws?*

This whole sequence, including the four missing lines in the middle, takes two minutes and five seconds. To give an idea of how the setting looked like, I have made a stylised picture on the basis of the video recording.

Picture no. 1. The patient in the middle leans backwards while saying "I don't remember that well I was in coma" (1:3).

The second excerpt is from an encounter recorded a month later. The doctor and the patient had met in between, assisted by Irina and another interpreter, the one who was present for my second recording. Here I call him Izmet. In this second excerpt, the patient is apparently more prepared to tell about his experiences from the concentration camp and the war. The doctor asks about his sleep, and the patient starts mentioning his bad dreams. Asked to be more specific what he dreams about, the patient tells about a series of traumatic experiences and starts reflecting upon how this might have changed him as a person.

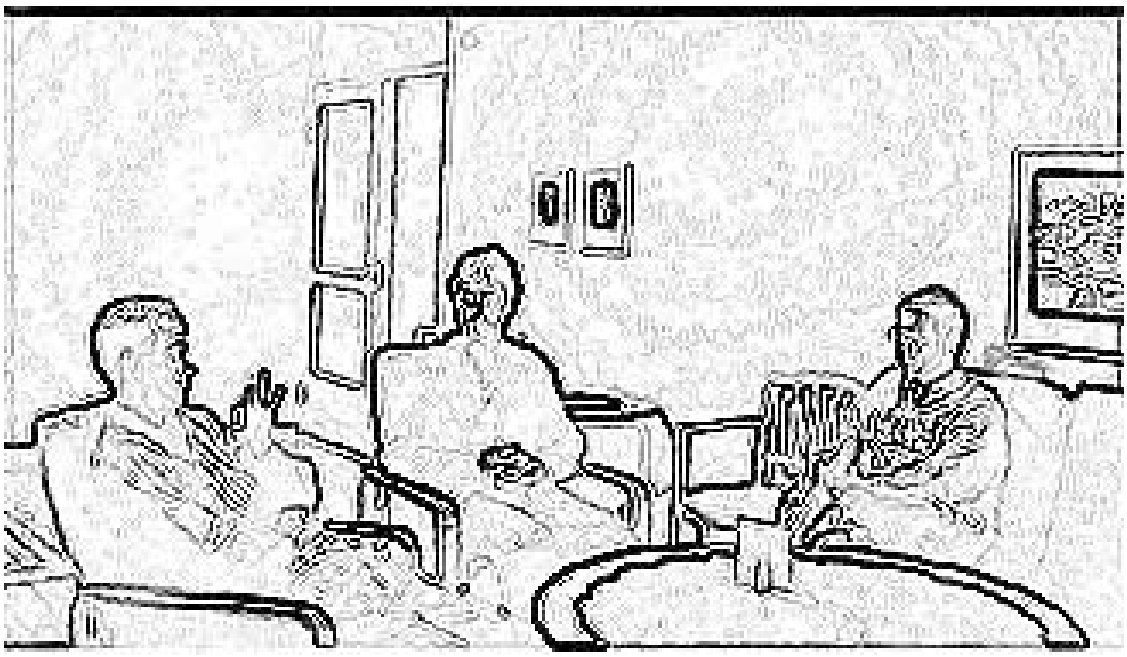
Excerpt 2 "dates and days and minutes"

		ORIGINAL CONVERSATION	*AUTHOR'S TRANSLATION*
1	doc	vad är det för bilder som kommer tillbaka?	*what kind of pictures are coming back?*
2	Izmet	a koje ti se slike to vracaju?	*and which are the pictures coming back to you?*

3	pat	pa recimo isto ta sila koja se desila na	*well let's say also these the violence that took place on*
4	Izmet	våldtäckter som ägt rum	*rapes that took place*
5	pat	ubijanje tih ljudi civila sto ja znam to su- pokupio sam tih	*the killing of these people civilians what do I know they are- I gathered these*
6	Izmet	dödandet av dessa civila människor jag har ju själv fått gräv- begrava många av dom	*the killing of these civil people I had to dig- burry many of them myself didn't I*
7	pat	izvadio isto iz vode °i tako°	*I dragged these out of water °and so°*
8	Izmet	molim?	*sorry?*
9	pat	izvadio iz vode isto	*I dragged out of water these*
10	Izmet	jag har dragit upp dom ur vatten	*I have dragged them out of water*
11	pat	i tako °da se to° vraca mi se sve film unutra (iz pocetka i tako)	*and so °it is like° the whole film is played inside of me (from the beginning and forth)*
12	Izmet	så allt detta °alltså° filmen rullas tillbaka å de börjar från början åter igen	*so all of this °that is° the film is played back and it starts all over again*
13	pat	ali recimo od sve to vreme ja sam presisovao i datum °i dana i minute°	*but let's say of all that time I have specifications of both dates °and days and minutes°*
14	Izmet	ja kan minnas allting ... eh kronologiskt både dag och timmar och minuter (2s)	*I can remember everything... er chronologically both day hours and minutes* *(2s)*
15	pat	i sta ja znam i sam sebe nekad pitam odkud bas to kad ne mora ustvari uop- uopste kako kako sam normalan °uopste°	*and what do I know I even ask myself at times from where just that when it doesn't have to in fact real- really how how I can be normal °really°*
16	Izmet	ibland frågar jag mig varifrån ja får (har) ett sånt minne va eller hur hur ja överhuvudtaget (.) har förstånd kvar	*sometimes I ask myself from where I get (have) such a memory where or how how I really (.) have [my] reason left*

The above sequence in reality took 58 seconds. During the coming 20 some minutes the patient tells a number of personal stories about horrifying war experiences. He had survived not only the torture with the

spoon, briefly touched upon in the first talk, but also hard imprisonment, being selected to act a living shield, and being selected to be executed. Moreover, he mentioned the loss of several close relatives.



Picture no. 2. The patient to the left says "I have specifications of both dates °and days and minutes° " (2:13).

Exploring the transcriptions as texts, comparing primary interlocutors' utterances with the interpreters' renditions of them, the second excerpt can be seen to containing inconsistencies of translation (cf. utterance 2:3 and 2:4, 2:5 and 2:6). Irina's renditions matched more in detail the preceding originals. Comparing the transcriptions of the whole encounters, the general impression remains of Izmet producing less of 'close' renditions and Irina more of them. Moreover, when Izmet keeps his hands together on his lap practically all the time, Irina performs using accompanying gestures, reminding of the gestures performed by the primary parties (see utterances 1:21 and 1:22). Occasionally, she varies between higher and lower pitch as the preceding speaker did in the corresponding original (see

1:16 and 1:17). Her performance gives a relaxed impression. Izmet, in turn, does not make any efforts of the described kind to 'replay' (cf. Wadensjö 1998/in press) prosodic and other features of the preceding utterance. He speaks in the same, even pitch throughout the encounter, in a rather monotonous voice. Later, when the interpreter and I looked at the video recording together, he commented spontaneously, somewhat surprised and slightly disappointed, that he found himself to sound quite strained. Apparently, there is no simple correlation between 'closeness' and scrupulousness of interpreting of spoken 'texts', and adequacy of the situation for narrative activity. In any case, equivalence between 'texts' in interpreter-mediated interaction does not in itself constitute the necessary condition. The actions and interactions performed in a social encounter, depend not only of the participating individuals' individual capacities, but also of how personal preferences and individual skills fit together in the given constellation of people and the current situation.

After the first encounter, the doctor said spontaneously that talk had developed in a direction he had not counted on. He had felt as if being tested and, in a sense, not approved of as a listener. In the beginning of the encounter he made several efforts to frame the conversation as a remembering-the-war-time-experiences situation. Fairly soon, however, he dropped these initiatives, when the patient switched over - in the midst of mentioning war experiences - to more recent experiences of practical problems and frustrations. The second encounter, in contrast, mainly consisted of the patient's telling of his experiences from the recent war. The three persons came out from it markedly touched. I was waiting in a room nearby when it took place. My impression from meeting them was confirmed by what I heard and saw on the videotape.

Differences between the situations

Comparing the two sequences, some features can be sorted out quite obviously as linked to remembering as a joint activity. To start with, one could compare the situations 'globally', i.e. concerning the conversations as wholes, including some general assumptions brought to them by the participants. Obviously, factors like the current time, place and relations between the participating individuals could increase or reduce the chance of talk developing into telling personal stories.

		I don't remember that well	Dates and days and minutes
G	TIME	The participants meet in this situation for the first time.	People have met in a similar situation before.
L O B	PLACE	relatively new place for the patient video recording - a new thing.	relatively well known environment video recording - a thing made before.
A L L Y	RELATIONS	patient - doctor: newly acquainted. male patient, female interpreter, noticeably various linguistic background (on the level of dialect) between interpreter and patient.	patient - doctor: more acquainted. male patient, male interpreter, slightly various linguistic background (on the level of socio-lect) between interpreter and patient.

In the second encounter - if we take it from the point of view of the patient - he arguably had had more time to get used to the idea of speaking with the doctor, of doing this assisted by an interpreter, and of talking while being video-recorded, compared with the first occasion. As a matter of fact, what is here the second recording, in reality was the third one I did with the same patient. In between the two from where the above excerpts are drawn, I recorded a meeting between the patient and another careprovider, a woman psychologist. The interpreter present was then Irina, the same as in the first talk. Meeting the psychologist, the patient

talked very openly on various personal matters, however, his experiences from the war were not touched upon.

The value of gender differences between participants in social interaction should not be understated, yet I would argue that there is no need to overtax neither this differences nor differences in linguistic or ethnic background. Obviously, features of social identity are mobilised as communicative resources when people come together and talk, but precisely which features, and how, can be hard to predict. However, to judge from the interview with the interpreter Irina, her being a woman appears to indeed have influenced on interaction in encounters involving her and this particular patient. She occasionally felt somewhat disturbed by his flattering comments to her appearance - delivered off-the-record as it were - while she was on duty interpreting. He might have disliked the idea of being seen by her as pitiful and week. He might also have wanted to protect her from hearing about his horrible experiences.

Elsewhere (Wadensjö, 1992, 1995, 1998/in press), I have discussed the interpreter's skill as a mastery of controlling various modes of listening and speaking. Interpreters' listening behaviours is one of their main resources for demonstrating their status of being excluded from the exchange but included in the exchanging. One of the therapists I interviewed mentioned that feelings of strong affection during a therapy session was not more strange or uncommon than feelings of strong antagonism and anger. "All patients have the right to fall in love with their therapist", as she expressed it. While therapists are trained to not take patients' emotions to their hearts, but make them work for the patients' recovery, interpreters are normally not. While therapists are trained to

listen attentively and respond, interpreters are trained to mobilise mainly another mode of listening; to listen attentively, render in a new version of what they have heard, and avoid direct responses. They might be trained in distancing themselves from others' emotions, concentrating as they are on the verbal means by which emotions are expressed. Yet, as Watzlawick and his colleagues argued in their studies of human interaction already in the sixties, when present in an interactional situation, "no matter how one may try, one cannot *not* communicate" (Watzlawick *et al.* 1967:49). A person who pays attention to someone will interpret the mere appearance of this person and his or her behaviour (whether verbal or non-verbal). Hence, each time the patient looked at Irina must have put an additional strain to her need to mark the distinction between her own speaking self and the meaning other, given she felt that he was interested in her reactions to what he said.

Differences in the organisation of interaction

To judge from the talk it was evident that the second encounter had much more of focused communicative events, where all participants present seemed to share involvement and focus, while the first one had much less of such moments. Comparing the two encounters, in search for differences manifesting 'locally' - at the turn-by-turn organisation of talk - I have found some features to notably vary. Potentially, I would venture, they make a difference in the joint activity of remembering. These features may again be connected with time, place and personal relations.

		I don't remember that well	Dates and days and minutes
L O C	TIM ING	The participants' talk seems less synchronised.	The participants' talk seems more synchronised.

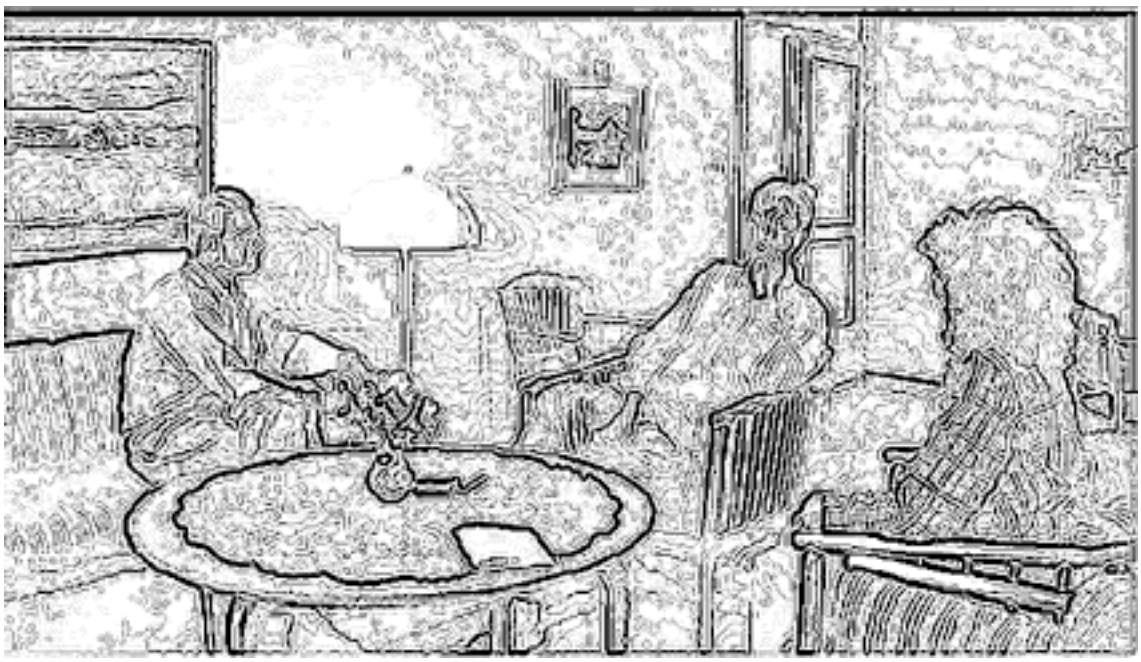
A L L Y	POSITIONING	The interpreter is outside of the communicative radius formed between the patient and the doctor.	The interpreter - right in the middle between the parties - forms part of a communicative radius shared by all the persons present.
	RELATIONS	The interpreter avoids exchanging gazes with the patient and does not engage in any direct verbal exchange with him.	The interpreter occasionally allocates turns at talk using gaze and head movements. He also engages in clarification sequences with the patient.

The method of analysing at the 'local' level includes comparing impressions from repeated, concentrated listening to the two recordings. In the first recording, I then noted that the participants talk in each their pace, quite stable at the personal level, but different from one another. The doctor's speech is notably slow. The interpreter talks faster and in quite a modulated voice, with changing pitch, while the patient talks relatively still faster, with an even, more monotonous pitch. In the first encounter, there were quite a few long silences, like those seen in the transcription (3, 11 and 7 seconds long). In the second encounter the participants talk in quite a similar pace. Moreover, the interpreter and the patient talk with similar, quite monotonous voice pitch throughout the encounter. There were few long silence. Like the one in the transcription these were relatively shorter than in the first encounter. During these silences, the primary parties exchanges gazes and nods. In the first encounter some of the pauses were too long to be filled only with exchanges if gazes, nods or smiles.

In the second excerpt, the interpreter addresses the patient with a question of clarification ("molim?" 2:8). This is one of 22 occasions he does so during the 45 minutes long encounter. In the first encounter, the primary parties might have talked more clearly, and/or the interpreter listens more attentively. Irina not once asks back to check a term or a formulation.

From the point of view of the patient, Izmet's questions in his address are concrete reminders of the current communicative conditions. The patient is hereby urged to repeat what he just said, in order to make the interpreter grasp it as an auxiliary listener and provide a second version of it for the doctor. These temporary mini-exchanges between the interpreter and the patient becomes a resource by means of which Izmet distinguishes himself as a speaker of others' words. Irina thus has to rely on other ways of marking her particular mode of listening and speaking only on others' behalf. One is her non-standard direction of gaze and talk to signal non-involvement. She avoided to answer directly when she was addressed directly by the patient. Moreover, she was probably counting on an understood contrast between her own voice and the words she voiced.

In the second encounter, the patient did not at all ask back to check something with the interpreter. In the first one, he did. When the patient every once in a while looked in Irina's direction - to check the content of talk, or its current state of progression, or to see how she reacted to given information - he had to turn his head away from the doctor. One could say that the participants did not share the same *communicative radius*.



Picture no. 3. When the patient every once in a while took a glance at Irina, he had to look away from the doctor.

In the second encounter both primary parties could see the interpreter in the corner of their eye, without changing their main orientation towards one another. In the first one, they were seated in a less immediately available way in relation to one another.

Preliminary conclusions and further questions

In their book *The Counselor as Gatekeeper*, Erickson & Schultz (1982) examined the temporal complementarity between speaking and listening behaviour in face-to-face institutional encounters. They observe that rhythmic regularity, for example, nods, body positioning and prosodic pattern of speech, more than the substance of talk, made the participants (students meeting with students' counsellors) perceive each other as "being *with*" one another. In contrast, while jointly performing in "interactional arhythmia", they were revealing themselves as not sharing an adequate interpretative framework (Erickson & Schultz 1982:143). This remains to

be further explored in the context of interpreter-mediated encounters. The present investigation suggest, however, that - in interpreter-mediated encounters - the rhythmic regularity, playing a constitutive role in the social organisation of interaction, is intimately connected to how the participants are positioned in relation to one another; to whether they share the same 'communicative radius' or not. The observation goes in line with what Apfelbaum (in press) have seen in video-recorded interpreter-mediated instruction data (French and German). Analysing in detail ten hours of interpreter-mediated interaction, she notices that the synchronisation of interaction is highly dependent of *the interpreter's* anticipation of turn taking and turn allocutions. Only when being within a shared communicative radius, interpreters can - when they feel the need for it - mark their anticipation of the current participation framework, i.e. the distribution of responsibility for turns at talk, some milliseconds ahead of time and with non-verbal means, while talking. Thereby they can potentially promote the primary participants' experience of "being *with*" one another.

The eight interpreters I have interviewed so far within my present study all mentioned that they preferred to look straight ahead in front of themselves and to avoid exchanging gazes with the primary parties in the process of therapeutic encounters. Three interpreters mentioned that they had been specifically instructed by the therapist to avoid looking at the patient, and to avoid moving their head back and forth between the parties to mark the anticipated exchange of turns. Maintaining this as a general bearing, some experienced interpreters mentioned, however, that they had found occasional eye-contact with the patient to be a way to handle temporary tension; to help 'normalise' the situation, as it were. Once in a while,

primary parties may feel a need to check up on their understanding of the substance and progression of current talk, which means that they will take a rapid glance at the interpreter. The patient, in contrast to the therapist, may lack a theory of what the encounter is generally designed for, and what kind of commission the institution has predefined for the interpreter.

No doubt, interpreters indeed have part in the framing of encounters as opportunities for remembering personal traumatic experiences. A preliminary observation, which is more a research issue than a straightforward finding of my present project is that interpreters seems to be more 'out of the way', when they are present in a communicative radius, compared to being present in the room but without access to, and not immediately available in a common, triadic, focused interaction.

To my mind, the seemingly simple issue of the interpreter's placement in relation to the primary parties in therapeutic encounters is worth considering in theory and in practice. Here are what I belive to be main reasons why.

- Given a shared communicative radius in the encounter, the interpreter's coordination of interaction - performed by his or her taking every second turn at talk - is immediately and simultaneously available to both primary parties. This potentially facilitates the participants' synchronisation of talk.

- Given a shared communicative radius, the interpreter's marking of necessary distinction between the speaking self - i.e. him- or herself - and the meaning other - i.e. the primary participants - can be conveyed immediately by both verbal and non-verbal means.

- Moreover, given a shared focus of interaction including the interpreter, he or she can support the necessary spiritual affinity between the patient and the careprovider (provided, of course, that the patient finds it relationally relevant to recall traumatic experiences in the presence of the current careprovider, and the current interpreter).

Working with traumatised refugees puts specific demands on all professionals involved. The presence of interpreters puts additional demands on the careproviders, simultaneously as they add to the potentials of the therapeutic encounter, and to the possibilities of traumatised patients' remembering - and forgetting - the past. Exactly how I hope to be able to tell you more about as I continue to work on my current research project.

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