Interpreting for Survivors of Torture

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Abstract

Interpreting at the Medical Foundation for the Care of Victims of Torture requires a great deal of versatility because clients are seen in a variety of settings such as legal assessments, medical examinations, casework, physiotherapy and counselling through to psychotherapy. Not only are interpreters specialists in all these areas, but they also need particular skills to be able to work with clients in group work, with children and adolescents as well as families. This reflects the holistic approach taken by the Medical Foundation generally, in its aim to enable survivors of torture to engage in a healing process. Added to the breadth of expertise needed for this client group is the complexity of interpreting in psychotherapy sessions. Here the relationship is paramount and trust becomes a crucial issue. Not only must the client fully trust the interpreter and the therapist, but the interpreter needs to understand and support the therapy itself, even when this might involve taking risks with the language. Many factors come into play, including cultural considerations, the burden of confidentiality and clarification of boundaries. This paper describes how the interpreter juggles these seemingly impossible demands while delivering an effective and professional service.

Résumé

Interpréter à la Medical Foundation for the Care of Victims of Torture requiert une extrême polyvalence car les clients sont perçus dans des cadres variés tels que des évaluations juridiques, examens médicaux, études de cas, kinésithérapie et assistance psychosociale. Non seulement les interprètes sont spécialistes dans tous ces domaines, mais nécessitent encore des compétences particulières pour être en mesure de travailler en groupe avec les clients, les enfants et adolescents ainsi que les familles. Ceci reflète l'approche holistique généralement prise par la Medical Foundation, dans son but de permettre aux survivants de torture de se lancer dans un processus curatif. En plus de l'éventail d'expertise nécessaire à ce groupe de clients s'ajoute la complexité d'interpréter durant les séances psychothérapeutiques. A ce moment-là, la relation est primordiale et la confiance devient un élément crucial. Non seulement le client doit faire confiance à l'interprète et thérapeute, mais en plus l'interprète à

besoin de comprendre et de soutenir la thérapie, même si cela doit engendrer des prises de risques au niveau linguistique. Plusieurs facteurs entrent en jeu, y compris les considérations culturelles, la charge de confidentialité et clarification de limites. Ce document décrit la façon dont l'interprète jongle avec ces demandes qui semblent impossibles tout en assurant la remise d'un service efficace et professionnel.

Introduction

At the London based Medical Foundation for the Care of Victims of Torture a lot of work goes into campaigning against torture and into seeking redress. The organisation is a charity that grew out of an Amnesty International medical interest group and was established in 1985. The Medical Foundation is a human rights organisation and a treatment centre, existing to enable survivors of torture and organised violence to engage in a healing process and to help re-establish a sense of dignity.

This is where the interpreters come in, as they are an integral part of this process and it is on their ears that the painful testimonies of our clients first fall. Bearing testimony is a vital part of our work. Indeed, the Medical Foundation holds testimonies of approximately 38,000 torture survivors from around the world, the number of clients who have received help from us since we first started in 1985. And it is the high number or survivors that we see each year that sets us apart from other human rights organisations and gives us the unique experience and expertise we have today. The scope of the work of the Medical Foundation means that an unusual amount of evidence can be documented enabling important research to be carried out.

When clients begin to recount their stories, this in itself is therapeutic. But they need courage to do this and need to feel they can trust both the clinician and the interpreter in order to disclose such intimate and disturbing details. So, interpreters working at the Medical Foundation need a special set of skills in order to facilitate this process.

First of all they need to be versatile given that they see clients in a variety of settings from legal assessments, medical examinations through to psychotherapy and given that the practitioners themselves work with a variety of models.

Needless to say, accuracy in both languages is of paramount importance as is familiarity with the appropriate terminology used by the different departments be it medical, legal or specific torture methods. Resilience and a certain degree of maturity are other prerequisites of the job, given the emotional impact of the work. But the best way to encourage a client to put their trust in the interpreter is for the interpreter to be totally professional. Clear understanding of where their boundaries lie and of what is and what is not their responsibility, adherence to confidentiality policy and to the code of conduct: all of this gives the interpreter confidence in their work which in turn engenders the confidence the client feels in the process.

This needs to be extended to client confidence in the interpreter and the clinician working as a partnership. We are currently developing training models at the Medical Foundation that reflect this joint approach. We deliver training sessions to interpreters as well as to National Health Service practitioners, refugee community organisations and many other bodies who want to be trained in working with torture survivors through an interpreter. A frequent model of ours is for a Medical Foundation clinician and an interpreter to deliver a workshop, highlighting complexities of the process that may arise. We are also developing a training programme for our own team of interpreters using a supervision model where interpreters attend supervision groups with specialist clinicians in order to present case studies and to develop skills needed for work in a particular department such as the child and adolescent team, group work or family and marital team.

The interpreter has been perceived traditionally to be someone sitting in the background with an allocated neutral role and a command of the two languages spoken to bridge communication by clinician and client. At the Medical Foundation the interpreter is considered as an integral part of the therapeutic experience, with contributions to make on linguistic and cultural levels. Embracing the special qualities of the interpreter into the work can have an enhancing effect, rather than becoming a problem that has to be overcome (M. Mudarikiri, 2003). This effectively makes for a partnership that could have an immensely beneficial impact on the client.

As an interpreter with many years of experience of working with victims of torture, I would like to focus in the first instance on some aspects of the interpreting process in therapy and the close partnership that exists between clinician and interpreter at the Medical Foundation, and finally highlight and touch upon some issues of interpreting in the context of family therapy.

Awareness of the consequences of torture

An important factor that facilitates good co-working between interpreter and clinician is the interpreter's familiarity with issues of displacement and persecution. Clients who have suffered torture, humiliation and untold losses use vocabularies and descriptions that evoke extreme shock and horror and therefore a cultural understanding and an awareness of the consequences of torture by the interpreter are of great help but over identification could be a hindrance (A.Fox & P.Clarke, 2003). It is counterproductive if the interpreter becomes overwhelmed and engulfed in these feelings. Torture destroys trust of the world, in fellow human beings and destroys self-esteem. When a client who has survived horrendous torture in his/her country relates the suffering to a professional, the psychological pain associated with the experience and the memory might be intensified by the client's inability to express and understand the practitioner's language.

Trusting relationship between clinician and interpreter

It is primarily the relationship of trust and confidence that a Medical Foundation practitioner will seek to build up and reinstate in the client during the therapeutic task of healing. An important prerequisite for this effort is a trusting and a well-established partnership between the clinician and the interpreter. An understanding of each other's needs, methods of work and intentions evolves from previous regular and long-term collaboration between both parties. This often projects itself onto the treatment of the client, making therapy successful.

I will illustrate this point with a case study, which has been anonymised:

Interpreter's need to understand the purpose and intention of the therapist

A psychotherapist and I worked together with an educated and deeply traumatised Middle Eastern man over a period of almost 2 years. The stability of the triadic setting ensured a familiar and continuous environment and positive collaborative work.

From the very beginning, the therapy was high level and complex. Different phraseologies, words and moods had to be used for the different stages of the therapy.

Over time, the client delivered an overpoweringly emotional description of torture, detailing with graphic clarity the cell where he had been incarcerated, the torture chamber, the sounds of the people around him, the dirt on the floor, the damp on the wall and disturbingly, the dismembered body parts brought to him by his torturers while loud music was booming in the background.

In preliminary discussions with me, the therapist highlighted his course of action, which consisted, in the first place, in allowing the client to develop a rapport of trust and safety, which would enable him to discuss his painful memories so that he could later address the emotional problems arising from his experiences.

Matching the words to the therapy

In the initial stages, the client would howl, wail, and thump the walls and the door. It was vital for both the therapist and myself to build up a trusting relationship with him. At this stage the therapist wanted to access different parts of his experience relating to his fear and rage at being imprisoned as well as his guilt and associated complex emotions. My choice was to use soft and mellow emotional language to access these feelings.

When the client spoke, I tried to match as closely as possible his metaphors and eloquence and to apply the right intonation and tone of voice when he expressed unchecked anger and rage, or slow down when he would display a palpable mood of dejection and pessimism. At the end of each session the therapist and I would discuss all the relevant clinical and linguistic issues arising from the session. In the second stage of the therapy, about how he would deal with his experiences of torture, we used more practical and demanding language. After the sessions we would discuss how to use and phrase questions and moderate and adapt the tone. One word that frequently cropped up at this stage was “cope”, the equivalent of which was very hard to find in French in a therapeutic context. Would I use *se debrouiller* or *s’en sortir*? None of which was appropriate. We agreed to give him literal examples of what the therapist meant by the word “cope” and use it as such thereafter.

Timing of the interventions

It was important to use the timing of the clinical interventions appropriately and change the tone of the dialogue as the therapy progressed. The initial soft and emotional language became over time pragmatic and concrete. Finally, the clinical language became pressing and encouraging. The therapist’s utterances, for example, of “come on, why aren’t you doing something about it?” were matched by my tone and equally urgent interpretation to the client.

The client started showing signs of recovery at the same time as a noticeable improvement in his English had set in. However, he found it hard to process his feelings in English in therapy because of being emotionally still so charged up.

Trusting the interpreter with the language

This close cooperation with the therapist had empowered me to intervene within or outside the session. My task however was to manage the therapist’s intentions to the best of my ability on a linguistic level and at all times it was clear that the overall responsibility for the session lay with the therapist. The

interpretation was the aid for the treatment, and the objective of the treatment was to be ultimately positive and effective.

When co-working over a period of time, a rhythm develops and one becomes aware of the risks one can take. The position of power has been negotiated, with well-defined boundaries and the client's perception of the interpreter is not being confused with that of the therapist. A few factors play an important role in this dynamic: firstly, both therapist and interpreter must stay within their professional role and secondly all expectations have to converge and be vocalised from the outset in order to eliminate unrealistic hopes or fantasies. For the therapy to succeed, and after all this is the ultimate objective, both parties have to come from a strong position of their respective competence. Violations are crossings of the boundaries that are harmful to he patient and his/her treatment, while transgressions are made within the context of ethical and adequate treatment (H.Bot, 2001).

Work with this highly articulate client was purely clinical and linguistically very challenging. He was very receptive to therapy, placing great faith in the therapist and totally trusting me with the language. This was a prime example where the interpreter was an essential professional member of a successful triadic relationship.

Finally, I would like to look at some aspect of interpreting for families:

Different model of interpreting for families

Through their experiences of atrocity and persecution, the familiar structure of families seen at the Medical Foundation has become fragmented and dysfunctional. On the one hand, the interpreter's non-linguistic contributions could become invaluable therapeutic tools for the clinician in understanding the client's milieu. Cultural customs, religious beliefs, sexual taboos, social conventions, family hierarchy in specific communities as well as issues of shame and pride within a community are key elements of understanding in the therapeutic treatment. On the other hand, the interpreter's understanding of the therapeutic process and family dynamics in the relationship is equally important.

The chaos within the family is often reflected in sessions when all members speak together or try to make themselves heard. At times, a particular family member will try to make an alliance with the interpreter.

A different set of interpreting skills has to be applied with families. Whilst in a triadic setting, the seating, space permitting, is equidistant and triangular, the seating arrangement with families is, as a rule, circular which allows the interpreter to forge a spacially equally balanced rapport with all family members without showing favouritism or alliances. The loyalty of the interpreter is for the session rather than for the therapist or the client.

Timing, turn taking and prioritising

In terms of timing, turn taking and prioritising, the interpreter needs to assess when to intervene to control the flow of words and diffuse the over-spilling of emotions. It is crucial to show respect for the pace of the narrative without however interpreting the meaning of the narrative i.e. explaining why a particular family member says something. An inexperienced interpreter might easily embody rather than vocalise a family's distress. Conversely, a therapist inexperienced with working with an interpreter or even a family member may consider the interpreter as a normal speaker and interrupt or overlap as in monolingual

conversation. Inadvertent or intentional pauses or hesitation by the interpreter might be construed as finished interpretation and conversation might be resumed with the loss of nuances and meanings.

Acquisition of the host country's language varies in family members, with children learning the fastest. Often children refuse to speak in their mother tongue in sessions and choose to speak in English but all utterances need to be back translated for the parents' benefit. Even maternal language competence can vary within a family: for example, an educated wife might be more likely to understand abstract thought and speech or metaphor than her less schooled husband. In these cases, the language used by the therapist needs to be simplified and rendered more literal.

Conclusions

In summary, interpreting in complex psychotherapy work that involves intense emotions requires close cooperation between those who deliver the work. For an interpreter to work efficiently in these circumstances his/her input must be acknowledged and consultation with the practitioner and an exchange of working ideas and methods must take place on an on-going basis. The continuity of using the same interpreter throughout the therapeutic course will ensure safety and stability for the client and this will work towards a positive therapeutic outcome.

There must exist support structures in the form of supervision and regular opportunities of collective discussion between interpreters. At the Medical Foundation such structures have been in place for many years: a monthly interpreters' (paid) meeting led by the head of the interpreting services is available to all interpreters. A support meeting (paid) facilitated by a clinical psychologist is open to all interpreters to discuss difficult or ethically awkward cases. In the last year a supervision group for interpreters working with families has been established and this is facilitated by two systemic family therapists. Short-term one-to-one support is also provided in some cases.

Regular and continuous training by outside bodies and professional development schemes should also be provided if professional standards are to be maintained. Through our interpreting experience and expertise acquired over many years, we are now able, in turn, to offer training programmes for practitioners in mental health and community services.

Ideally, every organisation that employs interpreters on a regular basis should draw up a code of conduct as well as formulate guidelines for best working practices, appropriate to the requirements of the respective institution.

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