Family Therapy in Translation – Clinical Work Through an Interpreter

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Abstract

This paper will describe how language is used in a systemic, psychotherapeutic context in long-term work with specific objectives when treating non-English speaking families who have suffered physical and mental torture.

The systemic family therapy is concerned with the circularity of the therapeutic process which looks at how each member of the team affects and is affected by the actions and reaction of every other member. The interpreter is the manager of the language and co-facilitator of the process. Thus, in this setting, the interpreter, as the medium through which communication takes place, becomes an active member of the team with as much influence on outcome as every other participant. The shared responsibility includes understanding each other's methods and models.

Family therapists and interpreters at the Medical Foundation for the Care of Victims of Torture have, over the years, articulated and established well-defined co-operative working practices. These include the importance of trust in the therapist/interpreter partnership in order to engender trust in the client, pre and post session discussions and debriefings, discussion of the holistic and practical approaches towards the family, cultural applications of the language, the interpreter's adaptation and use of the language when the client has poor native language competence.

Résumé

Ce document décrit la manière dont le langage est employé au cours du travail psychothérapo systémique de longue durée. Accompagné d'objectifs particuliers lorsque les familles traitées ont subi des tortures mentales et physiques et ne parlent pas anglais.

La thérapie systémique familiale, prend en considération la complexité du processus thérapeutique et tient compte du procédé par lequel chaque membre de l'équipe influence et est influencé par les actions et réactions de l'autre. L'interprète co-facilite le processus et contrôle le langage. Par ailleurs, dans ce contexte, l'interprète, en tant qu'outil à travers lequel la communication se fait, devient un membre actif de l'équipe capable d'influencer les résultats tout autant qu'un autre participant. Cette responsabilité partagée requiert la connaissance des méthodes et modèles employés par chacun.

Au cours des années, les thérapeutes familiales et interprètes de la Fondation Médicale, pour les soins des victimes de tortures, ont élaboré et institué des pratiques de travail de coopération bien définies telles que; l'importance de la confiance au niveau du partenariat interprète-clinicien, afin de mettre en confiance le patient. Les discussions en pré/post séances et critiques, discussions concernant les approches holistiques et pratiques en rapport avec la famille; sur les pertinences culturelles de la langue, l'adaptation et emploi du langage par l'interprète lorsque le patient rèvéle une compétence linguistique limitée.

Introduction

Journey from home to host country

Geopolitical upheavals including war and its violations have produced global migrations with a refugee population that has experienced and witnessed untold horrors and suffering. The Medical Foundation for the Care of Victims of Torture is a United Kingdom based Non Governmental Organisation that provides a clinical service within a human rights frame for many adults, children and families who are the survivors of such extreme experiences. Most lived in stable and healthy families and communities before their exposure to the traumatic effects of war. Then they suffered torture and deprivation of basic human rights which included multiple losses of family and friends, possessions and social roles and control of how they lived. These violations often led to flight, dislocation and relocation and to a sense of fragmentation and severe psychological disturbance for both individual and families.

Working with such extreme symptoms of complex trauma, the holistic model helps the clinician adopt an integrated approach and thus avoid the invitation to mirror the clients' experience of fragmentation and disintegration. It is for this reason that this model forms the basis for the clinical work at the Medical Foundation. It lays emphasis on all levels of client need which includes protection such as child, welfare, immigration, health, advocacy both at an individual and national/international level, integration into the life of a community and therapy. These levels may be attended to sequentially or concurrently depending on where the family is in the therapeutic process at any one time. It also places value on clinical work being team work and where possible, multi-disciplinary so that the difficulties can be considered from multiple perspectives.

Another theoretical model that provides the frame for the work of the Family Therapy Team at the Medical Foundation is that of systemic psychotherapy. Important principles underpinning this model include the notion of 'layers of context' which shape how a family lives its life from the outer socio-political layer to the inner world of each family member. In the case of a refugee family, context includes not only that of the host country but also of the home country and the journey between the two. The interactions between the layers of context are seen to be 'circular processes' as are the interactions within a family system. Thus each context/family member both influences and is influenced by every other in such a way that the whole is greater than the sum of the parts. Sometimes change happens from the outer to the inner layer and sometimes from the inner to the outer.

A third concept following on from the above is that of 'objectivity in parenthesis.' This refers to the idea that it is not possible for any person who is part of a system, whether, for example, family member or clinician, to be an objective observer standing outside that system. Thus in the Medical Foundation, the family-therapy system includes all family members, the therapist and the interpreter. Each has a different but equally important role to play in the bearing witness to and the co-creation of new narratives that will integrate the past with the present in a way that promotes healing and rehabilitation.

The holistic and systemic frames together set the theoretical backdrop for how the interpreter joins with the therapist and the family as a co-worker with a clearly defined role. In this role, according to Miller, the interpreter is "far from being invisible or dispensable but is an important witness to the client's experience and the gradual unfolding of the client's story reflects a growing sense of trust not only between client and therapist but also between client and interpreter". (Miller, Martell et al, 2005). Miller also mentions that, at least initially, the

relationship between the interpreter and the client is the strongest as it is the interpreter who is most likely to accompany the client through various parts of the service.

The trust and the confidence engendered in the clients must emerge from the collaborative work between therapist and interpreter which is based on a shared commitment that has been established through working together regularly on long-term and multiple cases. It can be challenged by the difficult and painful nature of the work but can also provide a forum for great creativity and cooperation.

Linguistic nuances and therapeutic decoding

Clients referred to the Medical Foundation bring to us severe and complex layers of psychological trauma that need to be carefully decoded and deconstructed by the therapists. Most referred clients are not English speakers and a very large proportion of the therapeutic work is undertaken with the help of an in-house interpreter. The interpreter therefore plays an important part in decoding the linguistic nuances and subtexts brought into the session by the family. The therapist pays great attention to the family's use of language by carefully listening to words, phrases and meanings.

Eva Hoffman says that "when we do not have words with which to name our inner experiences, those experiences recede from us into an inner darkness; without words with which to name the world, that world becomes less vivid (Eva Hoffman, 2002).

With this in mind, we would now like to describe a successful case with the emphasis placed on the linguistic/therapeutic aspect of the relationship between the participants. The co-author was not the interpreter in the session but part of the multi-disciplinary team behind the screen, observing the verbal and non-verbal interaction in the session

[1]*This is a vignette of an Albanian family who has lived in the UK for five years. The mother, Mira, speaks little English. The daughter, Suela, in her late teens, speaks it fluently and is studying in college. She is also fluent in her native tongue, Albanian. Mother and daughter attend therapy sessions together. By opting to speak English in the session and by refusing to speak in her mother tongue (literally that of her mother), Suela introduces a subtext which denotes that her mother tongue has become the trigger for painful and unbearable memories. The mother tongue, their shared language, has become the language of the past for the daughter. Both Mira and Suela were raped in front of each other. The language they have in common brings back the humiliation of the shared violation and torture from which each recoils in horror and pain. Suela says: 'Mum asks if I am embarrassed by her as I know what happened in the past.' Both say they dare not revisit this shared experience together for fear of being completely overwhelmed by the past.*

The fact that Suela is electing to raise a linguistic emotional barrier between herself and her mother in therapy is obvious to the interpreter. The interpreter but not the therapist (who, when the family first came, had asked Suela to speak in Albanian but she persistently ignored this request) recognises the subtext and picks up what is alluded to but not said. The interpreter here helps the therapist to understand the subtext and its nuances which later enhance the session as the therapist is able to offer Suela space to talk about what has not been said.

After several months of mother and daughter regularly attending therapy together and when a visible reconnection between them is slowly and obviously emerging, the

issue of language is brought up again. "What difference would it make to you now if you spoke Albanian?" asks the therapist. "I could try slowly but it would be like talking to her directly and looking straight at her", says Suela. One of the team members remarks that the language of directness is more impulsive and less reflective. Even though great changes have been achieved, the team believes that a deeper level of healing would occur when they will be able to reclaim and emotionally communicate in their native and shared language. As another team member behind the screen remarks: "They will then be able to move forward without the fear of falling down.

Respecting professional boundaries

As mentioned earlier, a clinically significant relationship based on trust is an important part of the therapeutic process. For revelations of family hurt, humiliation and secrets to emerge and to be shared, the family must feel safe, respected and supported by both the therapist and the interpreter. A collaborative component of our work is to build this trust. Without the co-working of a sensitive yet rigorous interpreter and without the therapeutic input of the clinician the entire process is destined not to succeed.

However closely and respectfully therapist and interpreter work together there is a very clear demarcation of professional roles. Indeed, the more each party abides by their own boundaries, the better the understanding is for achieving a common objective. This entails understanding each other's models of work and sensitivity to each other's personal/ professional stories and how they impact on the work.

The responsibility for the content and course of the session remains at all times, unconditionally, with the therapist in order to help the family move towards new ways of

functioning. In a good relationship the therapist will, pre and post-session, explain and discuss with the interpreter the therapeutic direction and how the dynamics of the family are helping or hindering these objectives. The interpreter will highlight the level of linguistic competence and understanding of the client as sometimes the therapist needs to modify or simplify the use of English to ensure a fit. The socio-cultural knowledge of the interpreter might relate to rules of politeness, understanding of idioms, figurative language and dialect as well as customs and beliefs. Whilst all this might be a helpful contribution by the interpreter, the therapist should not view this as cultural expertise. In family therapy the interpreter's role is neither that of a cultural ambassador nor of advocate. Multiple cultural perspectives and the therapist's own curiosity should be the defining framework for understanding the client's cultural background. Culture, like language, is constantly evolving and many cultural customs vary within small geographical areas from one ethnic community to another and from one family to another. The interpreter and client, even from the same home country, might not share the same sub-culture.

Both therapist and interpreter must be alert to the interpersonal dynamics that unfold in the session, whilst all throughout the therapist attends to the content and the process and the interpreter attends to the language. However, it is essential that the therapist and interpreter both keep connected at all times and also remain sensitive to the need to hold boundaries.

Therapist and interpreter co-working also includes the need for post-session reflections on the feelings that a family's experience has aroused for them and how this might have touched or mirrored their own professional narratives. This reflective practice of processing together their experience after the session is an essential part of the co-working relationship, if it is to be one that provides a safe space for the family to work in.

Lost in translation

Family therapy requires a specific set of interpreting skills from the interpreter. These involve a great deal of previously negotiated co-ordination and flexibility between therapist and interpreter. Because of the number of players often involved in the interaction, the interpreter needs to follow several threads of speech almost simultaneously. Hence, it falls to the interpreter to judge the appropriate timing of the interpreting, turn taking and prioritising and at the same time, maintaining contact with the therapist throughout. The interpreter's mode of listening must be different from that of the therapist's. Whilst the interpreter is listening in order to reproduce, the therapist is looking to understand the context and the meaning of the utterances.

The breach of boundaries or professional lapses might result in co-working difficulties that could jeopardise a positive outcome of a session. One such illustration is the following vignette which stands in stark contrast to the earlier case.

In this example the interpreter and the therapist have not had a regular co-working partnership, the interpreter is much less familiar with the ensemble work of the team and is also less experienced with family work than the Albanian interpreter in the previous example. The same criteria also apply to the therapist who is less mindful of the individual protagonists and less attentive to the whole system.

Both fail to fulfil their respective professional roles. The use of different languages by family members during therapy lends an added difficulty to the interaction which would need careful handling to avoid situations of exclusion and disempowerment.

This is an Iranian family who fled their country with two teenage boys but left behind three other children because the father was unable to negotiate their passage out of the

country. The children have disappeared and the father is held responsible by the mother and the son. Prior to the session described here, the issue of the missing children had never been openly discussed by the family members. The parents do not speak or understand English but both boys are almost accentlessly fluent. As in the previous case, they also refuse to speak in their mother tongue, preferring to express themselves in English. As in the previous example this might be attributed to the sons wanting to create a linguistic emotional barrier between the past and the present. When the session starts and the parents are addressed directly, both therapist and interpreter abide by their roles. Then the younger boy says in English: "It is better not to talk to dad as it brings back memories for him – I keep my feelings to myself". The older son adds: "I rather talk to mother and support her in anyway I can". "Dad blames himself for losing the children" says the younger son, "it was his fault". The interpreter does not interrupt the flow of the narrative and the therapist does not prompt her. At this stage his monologue veers into a different direction when the therapist asks: "How would life be if you hadn't left Iran?" The older son replies "We would be a family, I would have finished university but now I have no future ahead of me". The therapist gets drawn into the son's story and forgets to attend to the whole system and the interpreter is not sufficiently self-confident to intervene.

This was a crucial and substantial segment of a monolingual conversation which remained uninterpreted, unexplored and unchallenged. When the team behind the screen remind the therapist and the interpreter of the uninterpreted narrative, a summarised version is rendered of what went on before. The full translation of the text was thus lost

and by excluding the parents, an invaluable therapeutic opportunity was missed which might be recovered another time - but it might not.

Had the collaboration between therapist and interpreter been more regular and had they been more familiar with each other's working methods, they would have previously negotiated a creative communication system and a common understanding. This might have been a discreet hand gesture, eye contact or other previously agreed non-verbal cues.

The number of the participants and the linguistic problems in the large group raises the question of how to manage the many voices and how to create order in a many layered interaction. The available tools for the interpreter are the appropriate use of several techniques as and when the situation arises: minimising ambiguity, striving to maintain the balance of power between the protagonists, keeping the focus on the primary speaker and respecting and allowing for hesitations, pauses and silences.

According to Wadensjö "the coordinating aspect of the role of the interpreter derives from the interpreter's middle position. Interpreters are establishing, promoting and controlling connection between primary parties in conversation (Cecilia Wadensjö, 1998).

Conclusion

As we have tried to demonstrate, the prerequisite for creating a safe therapeutic environment is a collaborative process in which responsibility is shared between clinician and interpreter. Interpreting for a family is both the same and different from any other form of therapy interpreting. Principal differences include having to select, among competing voices who to attend to at any one time while having to avoid being seen as siding with any one member over

another. Dilemmas can arise around issues of respect, particularly as culturally defined, fairness and ensuring that disempowered voices are not silenced. They can also occur when a family's narrative touches that of an interpreter causing temporary distress and even 'paralysis'.

In response to many requests from interpreters experiencing these difficulties, a monthly consultation group was formed two years ago. It welcomes both those already working with the Family Team and those who would be interested to do so. This group has become a safe space in which the shared complexities of working with families who have suffered extreme experiences can be explored in depth. It includes some theoretical input on systems theory and its techniques to help make the therapeutic process more transparent for interpreters. Mostly, however, each session is responsive to what the group brings. This usually includes a clinical dilemma or challenge and how it impacts on the inner and outer worlds of the interpreter. Deconstructing the issue might involve role play and it always entails individual and group reflections including the interface between personal and professional histories.

As a consultation process, the leaders do not hold management responsibility and are therefore not accountable for the work of the participants. Confidentiality is maintained except if health or safety of a participant is threatened. This freedom to explore without managerial constraints allows a quality of working together which is a wonderfully creative and nourishing experience for all as well as being great fun!

References

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[1] Names have been changed in order to protect confidentiality