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Bridging the gap or damming the flow? Some observations on using interpreters/bicultural workers when working with refugee clients, many of whom have been tortured

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This paper will comment upon some of the dilemmas inherent in the task of using interpreters/bicultural workers when working with refugee clients who have fled to Europe, many who have been tortured. A high proportion of refugees may not speak European languages or share explanatory health beliefs. The author would argue that these differences should not act as barriers to obtaining health and counselling services and that employing interpreters/bicultural workers may help to bridge these gaps and improve service provision and delivery.

Throughout this paper the term 'bicultural worker' will be used to describe someone whose primary task is to interpret for a client the spoken word, cultural symbols and beliefs to a health practitioner. The term 'practitioner' will be used to describe someone who is working as a health worker. The focus in this paper is on the role of the bicultural health worker and how their contribution can be maximized in this context rather than on the client and health practitioner.

The problem is that the signifier has become severed from the signified

Hoffman in *Lost in translation* (1989)

Historical background

The work on which this paper is based began with the Medical Group of the British Section of Amnesty International, some of whose practitioners established the Medical Foundation as a separate organization in 1985. It is now an independent charity based in London established to provide a comprehensive health service for individuals and their families who have survived torture and other forms of organized violence; the staff team work closely with colleagues in Europe and the rest of the world.

Through a combination of medicine, psychological services, psychotherapy, social work, complementary medicine and human rights work, a philosophy and practice have developed which attempt to encompass the needs of the whole person and family. This

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work includes: a range of medical and psychological therapies; medico-legal assessments and documentation; social work and support services; and advice and consultancy for other agencies.

The Medical Foundation has two major components: medicine/therapeutic work and advocacy. These dual aims sometimes lead to dilemmas for all concerned. For example, the organization provides reports for individuals documenting physical and psychological injury resulting from torture, which can then be used in support of a claim for asylum. This may mean a client having to disclose experiences and give information at a pace which is seriously out of alignment with the therapeutic process.

Client base

The clients come from over 60 countries and speak at least 25 languages. Eighty per cent of clients are asylum-seekers and therefore are seeking refuge in Britain under the terms of the 1951 UN Convention Relating to the Status of Refugees. This states that a refugee is anyone who has a

well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion.

Thus clients may have not only been severely tortured, but may also be suffering from the trauma of exile—the loss of family, friends, job, country, language, role and identity.

Although a number of countries are represented by full-time staff members, there is still a need for sessional bicultural workers. There is a philosophy that language skills should not be a variable in determining or limiting access to services; a large proportion of refugees are, of course, not fluent in European languages.

This paper will give an overview of the major issues in this area of work; it is an extremely complex field which requires considerable and thorough analysis if clients are to be given a service of quality.

Bicultural worker base

The bicultural workers came from 28 countries and spoke 20 languages. The bicultural workers are a heterogeneous group in terms of age, education, or motivation for doing the work. Some of the bicultural workers wished to do the work because they wished to support other members of their own community, whereas others hoped for full-time employment in the future, and others to earn a living. A proportion of the bicultural workers wished to work only with clients sharing their own political viewpoint, others only with those known to them, and others wished to work with anyone. Many of the bicultural workers were highly qualified in other areas of work, and many were studying for additional qualifications. A significant proportion were working as interpreters in a range of other agencies. Short courses in interpreting skills were held within the agency to develop skills further. Seminars were also organized by the bicultural workers and author for health professionals. The latter group reported an increased understanding of some of the dilemmas and issues raised by working in a triadic situation as opposed to the more traditional dyadic consultation.

There may be numerous anxieties on the part of the client about having to use another

person as their voice, who may not represent them correctly or accurately. This is likely to have particular resonance for a refugee who is displaced, and may be suspicious of compatriots' motivations in helping them. The open articulation of dissent or opposition may have been what led to them being forced to flee their country and become refugees in the first place.

The Medical Foundation's clients are given the right to refuse a particular bicultural worker and vice versa without having to give any reason, although this is not without its own set of dilemmas. This was one of the first components looked at when a code of practice was developed for bicultural workers. The following is a case example of this aspect.

Mr X had been referred by an NHS psychiatrist to the author. The referrer was concerned for Mr X's psychological health, as at the assessment meeting details of the atrocities inflicted upon Mr X and the traumatic events experienced in his country of origin had emerged. Mr X was from Central Africa and had arrived in Britain recently following political unrest. On approaching the waiting room with my bicultural worker colleague, she looked through the glass panel on the door, stopped in her tracks, grabbed my arm and told me it was imperative she had a word with me immediately in private. It transpired that she blamed the relatives of Mr X for 'many bad things which have been done to my people.' She felt unable to work with him and his appointment was re-scheduled.

The Medical Foundation employs bicultural workers on a sessional basis and therefore their workload may vary widely depending on the needs of the clients at any one time. They have no security in terms of finance, hours, or job advancement. This is not without its own set of difficulties.

Why are bicultural workers needed?

Bicultural workers are frequently the link between a client and a worker based in the host society and may share not only a language, but a whole set of cultural beliefs. If the latter is not understood and adequately integrated into clinical practice, the risk of misunderstanding and alienating clients is likely (Tribe & Raval, in press).

Fernando (1995), Lago & Thompson (1996), MacLachlan (1997) and Tribe (1998a) have all written about the relationship between psychological therapy and culture, noting that the relationship between a culture and its healing rituals is a complex one. The methods which people use to maintain their psychological equilibrium and to find help are, in large part, developed and defined by the cultural, societal and health rules and meanings these are ascribed in their 'world'. Other authors have also noted that different cultures will define different behaviours/feelings as problematic (Herr, 1987; Torrey, 1972; Westwood, 1990).

At the time of referral many clients may have just recently arrived in Britain and therefore have little understanding of the aims and objectives of the organization and therapy itself. Factors that will influence their image may include:

- travelling on the helping circuit;
- referral by someone else or another agency;
- fear of officialdom in general;
- belief that the organization is part of the Government structure and is involved in the decision regarding asylum.

The bicultural worker's task is central to the task of not helping to bridge the gap these beliefs may engender at the reception stage, but continuing throughout the treatment process.

Dilemmas

Words and meanings

Well known expressions include, 'the map is not the territory' and 'the translator is a traitor'. The practitioner must recognize that the bicultural worker is delivering, at best, an approximation of the client's statements and often an intervention in the client's emotions. In addition, words and meanings are often not interchangeable between languages. These aspects have been written about in a most moving way by Hoffman (1989); she writes in *Lost in translation*:

The words I learn now don't stand for things in the same unquestioned way they did in my native tongue. 'River' in my language was a vital sound, energised with the essence of riverhood, of my rivers, of being immersed in rivers. 'Rivers' in English is cold - a word without an aura. It has no accumulated associations for me, and it does not give off the radiating heat of connotation. (p. 47)

The language of psychology and mental health has been based on a western vocabulary and world-view which reflects the cultural and historical context of its authors. As the post-modernists have pointed out, language is not a transparent medium, as was assumed previously, but is itself a defining structure. In addition, words relating to trauma, counselling, stress, and mental health may not have the same valence in another language, or may not even exist.

The following examples from within European languages illustrate some of the complexities of language interpretation, which have particular resonance when working in psychological and physical health domains. In German there is no word which could be translated exactly as meaning the mind, but rather several words for example, Gewissen, Gehirn and Bewubtsein, which mean conscience, brain and awareness respectively. It is often assumed that with increasing Europeanization there will be more consistency across countries and professions—language may prove one initial hurdle. For example, there is no word for counselling in Polish, the nearest word translates into advice giver or adviser. Also in German and Spanish there is no linguistic distinction made between counselling and psychotherapy. Issues relating to the translation or possible mis-translation of Freud and the ideas of the id, ego and super ego have long been discussed. Psycholinguistic studies have noted the complexity of the task facing the interpreter (Roe & Roe, 1991; Roy, 1992).

Many authors contend that faithfulness is the fundamental object of interpretation. In reality this may not be so straightforward. This theme is discussed by Alpert & Marcos (1976) in their paper, 'The phenomenon of language independence; Strategies and risks in psychotherapy with bilingual patients'.

The assumption that meaning can be merely translated across languages is not a reality; for example, a British person would be reasonably happy if asked if they are feeling depressed. In Turkish culture this is not a question which can easily be asked. When our Turkish bicultural workers started discussing this, it transpired that they were all translating this in a slightly different manner and all felt uncomfortable doing so. Drawing on the title of this paper 'Bridging the gap or damming the flow', it is important to look at this gap.

Some health practitioners working within physical medicine may wish for a literal translation and believe this to be the only way in which translation should occur, whereas

those working in the psychological domain may be more concerned with the 'feel' of the words and emotional content. This dilemma is likely to be inherent in any research or practice endeavour which encapsulates a range of health professionals with different training and objectives. This can bring about difficulties when a bicultural worker is required to swap paradigms often without explicit indications from practitioners.

A number of authors have noted that professional interpreters tend to provide a better service than friends or someone who happens to be bi-lingual (O'Neil, Koolage & Kaufert, 1988), whereas Raval (1996) claimed that practitioners had increased respect for interpreters if they had been trained. Clients themselves reported that using interpreters led to a higher return rate following assessment in a study conducted by Hillier, Loshak, Rahman & Marks (1994) and an enhanced sense of being understood was noted by Kline, Acosta, Austin & Johnson (1980). Faust & Drickey (1986) argue that clients may have a heightened sense of professional attention when an interpreter is used to help ensure that a language gap is bridged adequately and appropriately.

Case illustration

Joyce is a 35-year-old community worker in a refugee agency in London. She comes from a minority group in Latin America. We have a history of working together, particularly with female clients. These experiences have given us confidence in each other, and respect for each other's contribution which might be described as familiarity with her society, its culture and upheavals in her case, and in my case, familiarity with psychological reactions to trauma.

Joyce referred Manuela, a woman in her early 20s, from a similar traditional rural background. Manuela had been in Britain for only 3 months when she was referred to me. Her family and community had sent her out of her country as they were concerned about her safety and their own, as the result of her traumatic experiences in her country.

Joyce now in many ways stood in proxy for Manuela's community network. The commonality of their general life experience produced a close emotional bond between them. The level of trust between the two women made my task much easier and we were able to use this constructively in our work.

Joyce had explained to Manuela why she was making the referral, how this might help her and the form the process might take. The preparatory work Joyce had already completed, her relationship with the client, her cultural and personal understanding as well as her language skills all contributed profoundly to the outcome of our work. As a result of this contribution, my role could be limited to only 15 sessions when the three of us met for an hour at the same time every week.

Before we entered the trauma story, we explored issues she felt ready to share; her personal and family history, her emotional experiences and most importantly her name which had particular significance for her identity and the sense she carried with her about being violated and despoiled. The three of us had a warm and convivial exchange, trying to find the English word for her name derived from her native language.

Once a climate of trust had been established, Manuela's story unfolded and she disclosed that she had been brutally raped by three soldiers, 5 months previously. She had been picked up on the street and taken for questioning at the army base on account of her ethnic origin. She had eventually been released and her family had sought private medical

treatment for her. They were also extremely worried that the news would get out and her marriage prospects would be ruined. They were also worried for their own sake that the soldiers might return and that all the family would then be at risk. She was subsequently smuggled to Britain.

The sessions progressed through an initial phase which was concerned with releasing traumatic emotions, including fear of death, anger, outrage, shame and helplessness. Joyce could be said to 'stand' on the bridge between Manuela's experience and these emotions and her access to starting a new life for herself in Britain.

On arrival in Britain she found she could not travel on public transport in case a man came and sat next to her. Her traditional lack of exposure to men meant that the close proximity of strangers, particularly men, was distressing and this was compounded by the abuse she had suffered at the hands of the soldiers. She was worried that her intolerance of any male presence would affect her ability to lead any normal life on a permanent basis.

Joyce found that there were various words which I used which she could not 'remember' in her language. These seemed to be words with a high emotional content and related to Manuela's experience of rape. This led to a discussion between the three of us as to why this might occur and we were able to use this profitably in our work together.

In the later sessions the three of us went on to look together at different aspects of her experience, but before we could do this the pent up emotions overwhelmed her, and the early sessions were dominated by her state of utter wretchedness, bitter weeping, wordless tears interspersed with an almost childish giggling that sometimes had about it a slight disinhibited or hysterical quality.

Relieved by this cathartic aspect of the work we were able to move on and examine the political and social context in which they occurred. On all of these aspects Joyce's contributions and insights were invaluable, as was her ability to deal with and share difficult emotions which were being discussed in our sessions.

Eventually the three of us were able to reframe her experiences in such a way as to enable Manuela to start having hope for her future. Prior to her rape she had always dreamed of getting married and having children. She had totally forgotten this idea since her traumatic experiences. In our last few sessions Manuela told me that once again she was able to think of this dream as a vague possibility. Through the later sessions we saw real changes in Manuela's presentation of self, these included her clothes, hairstyle and body language. This sense of being irretrievably violated is one of the most common features in the experience of people we work with and one of our primary objectives is to help free them from this.

Joyce and Manuela still have contact with each other through their community group and continue to support other members of their community. I believe that without Joyce I would have had a much harder task to perform and it is quite possible I would have been unable to succeed without her.

This case hopefully illustrates the potential contribution and importance of bicultural workers in undertaking therapeutic work.

Bicultural workers, practitioners and clients—dilemmas relating to triangulation, power and control issues

In the session there might be conflict, conspiracy or cooperation between the bicultural

worker, practitioner and client. Often it is not clear to whom bicultural workers are primarily responsible, whether the client, the practitioner or the amorphous organization. The triangular relationship may lead to any one member being or feeling excluded from the consultation at any one time. The so called three-handed or double-headed contract may be omnipresent.

Difficulties may arise in relation to the use of bicultural workers in that some health practitioners are initially unfamiliar with the practice of working with bicultural workers and may feel threatened by the presence of a third person in 'their' consulting room. That clinicians may have doubts about their efficacy when working with clients of a different cultural and linguistic heritage had been noted (Dezelueta 1990; Watson 1984). Mental health workers may feel that they have to slow down and become somewhat distanced from the therapeutic interactions; however, Raval (1996) noted that some mental health workers reported that using an interpreter enabled them to be more reflective and that it enhanced their work, because clients felt freer in talking about their cultural and religious beliefs. The major reported exception to this was when the mental health practitioner was looking for psychotic symptoms or for child sexual abuse. Clients have reported positive feelings about using an interpreter (Kline *et al.*, 1980).

Guidelines and ethical codes on best practice when working with interpreters have been developed by Faust & Drickey (1986), Harvey (1986) and by the London Interpreting Project (among others). If their contribution is to be maximized the following must be considered as a basic minimum when working with bicultural workers:

- the health practitioners and bicultural workers need to spend time before and after interviews, discussing how best they can work together, considering issues such as the style of working and considering afterwards any difficulties that arose and how they might be dealt with (rather than exploring the issue with the client/patient in the room, who will inevitably read all sorts of things into long discussions which appear to be about them (but from which they are excluded as they do not speak the language; this is hardly an appropriate base for a consultation/therapeutic interaction);
- ensuring that cultural, political and social beliefs are understood and integrated into practice where ever possible to ensure that understanding between patient and health practitioner is maximized;
- recognizing the role and status of the bicultural worker within the triad, as a fellow professional, and also to recognize the boundaries of this role. Interpreters may be seen as role advocates, community or link worker or cultural consultant (Freed, 1988; Tribe & Raval, in press). It is important that the role of the bicultural worker is clearly understood by all members of the triad.

Developing an initial code of practice

The remainder of this paper will introduce and explain the development of a support and supervision group for the bicultural workers, which was one of a range of working practices established in an attempt to bridge the gap rather than dam the flow between health practitioners and clients/patients. As the needs of the client are paramount in the equation (for that is the *raison d'être* of the organization) the range of working practices attempted to:

- facilitate interaction and understanding between bicultural workers, practitioners and clients;
- develop the efficacy of organizational practices; and
- acknowledge adequately the contribution of bicultural workers as part of a multi-professional team.

Significantly the endpoints of this process can never be determined, for this is not an

exact science and there is still a long way to go in developing this aspect of practice, but I would like to share some of our experiences, and hopefully help others learn from this and avoid some mistakes. The establishment of a regular support and supervision group for bicultural workers run by the author and a colleague meeting every 2 weeks for 1½ hours proved very helpful. In addition to language skills, other areas which are equally important are those of awareness and the ability to deal with the difficult material and to maintain appropriate boundaries.

When the content of the material is of such a sensitive nature as that of the work at the Medical Foundation, the client may feel comfortable only if the bicultural worker is a friend, family member or from the same political group; or they may feel the antithesis of this and want a bicultural worker who they view as entirely neutral and having no personal position.

Support and supervision group

In an attempt to support the bicultural workers and to optimize practice for clients, the author and a colleague decided to offer a support and supervision group on a fortnightly basis. The bicultural workers undertake an extremely stressful and complex job. They hear people recount their experiences leading up to flight from their countries of origin; many of them have been tortured and have suffered life-threatening events. They are then expected to translate and recount this in a different language to a health practitioner immediately with little, if any, time for their own emotional processing or consideration of the issues raised. They also may have anxieties about representing the client accurately in terms of semantic and emotional content, this anxiety may be shared by the two other members of the triad.

It is important to note that the bicultural workers felt unable to say much in the first few meetings of the group. When questions relating to difficulties with the work were raised, these were always answered passively.

Members of the group were frequently competing for the same work. This, and the fact that the facilitators had never worked or had the expertise to work as bicultural workers inevitably affected the group dynamics. At the Medical Foundation both group facilitators were from the host country and this must have affected the group process.

Initially some of the bicultural workers wanted to talk about practical difficulties and this led to frustration for others who wished to talk about the emotional aspects of the work. As a result, a compromise was reached in which a short period at the beginning of the meeting was devoted to discussion of practical issues. Eventually the group achieved some homeostasis and became a safe place for issues and feelings to be considered. Difficulties could be discussed and support and supervision offered. The group struggled hard with difficulties and acquired an identity within the organization; its continued existence and the changes it has brought about perhaps speak best for its success: at the macro level, an identity and recognition of the bicultural workers within the organization, and at the micro level the personal experiences involved in being a bicultural worker in an organization which provides a space where feelings and difficulties inherent in such work can be discussed openly.

Group content

The following is a brief summary of the issues which predominated in our meetings given to facilitate understanding of the group content.

The triangular relationship within the room was a constant theme, as was the issue of attempting to establish trust and open communication within the triad. In addition, boundary conflicts and pressure from compatriots, with whom they are working to become friends or social welfare workers, caused almost all of the bicultural workers a range of difficulties.

Issues relating to the variety of health professionals and therapeutic styles used at the Medical Foundation and the difficulties of understanding exactly what was happening in any one course of therapy was another issue which was frequently discussed in the support and supervision group. In addition, feelings amongst the bicultural workers that the health practitioner they are working with was not using an appropriate approach, for example not using cultural clues, or asking questions in a manner which the client might find offensive, was discussed frequently as were ways of dealing with this.

Perhaps the most important issue raised related to the bicultural workers' experiences of, on occasions, being overwhelmed by the material, or fearing they might be overwhelmed in a consultation and the effect that this could have upon them and the other two people in the room. As well as providing a safe place for discussion of these issues, it was also possible to share ways of considering and dealing with some of these dilemmas. Although this paper was about an organization based in London, the issues and dilemmas are likely to be similar across all of Europe and even further afield. An additional paper which details some of the challenges and dilemmas associated with the use of bicultural workers in clinical practice has recently been published (Tribe, 1998*b*). It is important to note that developments are ongoing at this organization and further developments are underway.

Conclusion

This paper has given a brief overview of the potential role and importance of bicultural workers when working with refugee clients, many of whom have been tortured. If we accept that fluency in speaking a European language should not be a variable in determining access to services this will continue to be a need in Europe and these issues will need addressing. In summary, we have started the process of developing a range of working practices which both acknowledges the contribution of the bicultural worker when working the refugees, and enhances our practice. The genesis of a support and supervision group was found to be central to this process and its existence led to a range of other practices and improvements in service delivery. It is hoped that improvements will continue to be made which will enhance practice and work towards bridging the gap and not damming the flow for clients when working with bicultural workers.

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