SUPPORTING VICTIMS OF TORTURE

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The views expressed in this article are those of the author and do not necessarily reflect the policy of the Medical Foundation for the Care of Victims of Torture.
A UK registered charity that grew out of an Amnesty International medical interest group, the Medical Foundation for the Care of Victims of Torture is a human rights organisation, established in 1985 by Helen Bamber. Survivors of torture and organised violence face a massive struggle if they are to be able to get on with the rest of their lives.

In 2002, some 4,200 people from almost 90 countries were referred to the Foundation and it accepted 3,027 as clients. At any one time, it assists between 2,000 and 2,500 people with a range of services including medico-legal reports, counselling, social care, psychotherapy and physical and complementary therapies. It also has an important role in raising awareness about torture and in documenting evidence and carrying out research, as well as providing training in a number of specialist areas to other agencies. This has become increasingly important with the introduction of dispersal of asylum seekers throughout the UK.

The Foundation is made up of approximately 130 voluntary and 110 salaried staff working in a variety of disciplines, aiming to provide a holistic approach within an integrated service. Interpreting is an essential service at the Medical Foundation and underpins almost all its clinical work, with the majority of clients who come here receiving treatment via an interpreter. The team numbers roughly 70 linguists with 30-40 attending on a regular basis. It is a growing team, covering 50 languages and with a changing make-up to meet the language demands of our clients. The languages that are currently most demanded are: Turkish, Kurdish, Arabic, French, Farsi and increasingly Amharic and Tigrinyan from Ethiopia and Eritrea. Fluctuations occur: for example, the demand for Tamil has decreased considerably over the last 2 years, whereas demand for many African languages is rising steadily. The interpreting team has to be flexible in order to be able to adapt and to meet approximately 60 bookings per day.

Because of the nature of the work, interpreters need to have a special set of skills and not least of all, a great deal of versatility as they see clients in a variety of settings from legal assessments, medical examinations through to psychotherapy. When it comes to recruitment, a recognised qualification is desirable (DPSI or LOCN Community Interpreting), but equally valuable is the candidate’s experience and interpersonal skills as the interpreter is in a key position for gaining the client’s trust. Body language and sensitivity are hugely important.

The model of consecutive interpretation is adopted in sessions that deal with factual and practical situations such as welfare advice and legal assessments, where the skills required are predominantly linguistic and terminological. But resilience and a certain degree of maturity are essential: the stories related by clients who have undergone unimaginable horrors and atrocities perpetrated on them and their families could have a
devastating impact on an inexperienced interpreter. Both clinicians and interpreters need to be familiar with the methods and effects of torture. Misunderstandings, embarrassments, emotional upsets are counterproductive in work that can cover the worst accounts of one person’s inhumanity to another. That said, it would be impossible not to find harrowing stories like the eloquent and graphic narrative of a quietly spoken young girl, recently arrived from Rwanda, who witnessed the annihilation of her entire family, the stabbing and setting alight of her surgeon father because he dared to operate on wounded rebel soldiers. She has come to see one of the doctors for a medico-legal report in order to document her scars and injuries. The doctor examines her, and we see the deep and fresh knife wounds on her body – she had been left for dead buried under the pile of bleeding corpses of her family, but she survived.

In this triadic setting the interpreter matches the intonation of the client’s voice, reads the body language and facial expression and renders a verbatim interpretation. This is of crucial importance in medical and psychiatric assessments as the client’s verbal idiosyncrasy could be a valuable clue for the accuracy of the medical diagnosis. Seating arrangements are also important in a triadic setting: an equidistant triangular arrangement will ensure that no one is excluded or isolated in the session.

The three-way relationship between the interpreter, the clinician and the client is the cause of much reflection at the Medical Foundation and one of many complex issues that arise, especially in the therapeutic setting. Therapists may find it difficult to establish a therapeutic alliance initially with the interpreter, who often shares the same culture as the client, and may find it difficult to control identification with them possibly making him/her feel excluded. Interpreters can have a protective attitude or become frustrated if they feel the client is disappointed or is not being given the help they think they need. The interpreter may experience the therapist as harsh and it becomes crucial that the interpreter understands the therapeutic process in order to be able to facilitate it fully. Time spent together by the therapist and the interpreter before and after the session can put right any misapprehensions.

This is particularly important in long-term psychotherapy as well as ongoing family therapy. Mutual trust and knowledge evolve in regular and long-term collaboration between clinician and interpreter. The interpreter is aware of the clinician’s methods and intentions, and the clinician has resolute faith in the interpreter’s competence with the language. The interpreter is also empowered in a session to intervene when he/she feels that explanations or clarifications are needed in either direction. Often, these may be of a cultural nature. The interpreters’ non-linguistic contribution in these discussions 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.

While there are clear benefits of working with interpreters who come from the same country or region as the client, occasionally clients who come to the Medical Foundation for help are so mistrustful of their compatriots that they prefer an interpreter of a different nationality. This is particularly true where a close-knit ethnic community exists in London. A client may request a different interpreter in this instance and likewise, interpreters may prefer not to work with a particular client although this rarely happens.
As with all interpreting work, confidentiality for our clients is vital. But this can leave the interpreter with a huge burden of secrecy, especially when they have been the recipient of such extreme material. This may be compounded if the interpreter works for the same client on separate occasions with different therapists. For example, a Kosovan interpreter worked with a woman client and a therapist before working with the same client with a family therapist where the husband was also included. The interpreter was clear that secrets divulged in the one-to-one therapy should be kept as secrets because of cultural considerations; the family therapist, on the other hand, was working towards openness between the couple. Interpreters here can finds themselves torn and left with feelings of betrayal.

Interpreters need support to help them manage the distressing emotions they will experience when they work at the Medical Foundation. Discussion after the session between the interpreter and the therapist is helpful for the interpreter in this respect. The interpreter becomes fully participant in the therapeutic engagement, her responses to the material being a valued part of the process.

On a more general level, interpreters attend a monthly support group for sharing experiences and strategies. While clinicians generally receive fortnightly supervision, interpreters do not, and this is an area for future development: there are plans to combine supervision sessions for interpreters, including case presentation, with an internal training programme. Work is already underway, and a supervision group is about to start specifically for interpreters working with the family team.

An extra set of challenges faces the interpreter working in group therapy sessions (up to 15 people in the room) and family therapy sessions. The latter may comprise mother and father, two or three children, one or two therapists and the interpreter. The seating arrangement is circular. The interpreter’s work in the family team is made very difficult when chaotic and loud scenes ensue in situations when family members speak all at once, each vying to be heard. When communication becomes incoherent and heated, it falls to the interpreter to prioritise and make sense of the situation. It is never practical in these instances to speak in the first person singular as this will only add to the confusion.

For the family team model of work, paraphrasing or accurate summaries of the narrative often replace the literal interpretation in a therapy session, as this will allow the client time to go with the flow of the story. For example: the team has been seeing a Kosovan family who had marital problems. Since the birth of their child, the father has been unable to listen to the baby’s cries. He becomes angry and agitated at home and has to leave the house in order not to get aggressive with the members of his family. Over many months of therapy the story unfolds slowly: he had been hiding in the forest from Serb militiamen along with mothers and small children. Fearful of being discovered, the mothers, in an attempt to stifle their babies’ cries, would put their hands over their babies’ mouths, sometimes with fatal consequences. Paralysed by fear, the father was powerless to do anything. His story had to be told in an unhurried and uninterrupted way; the flow of his narrative needed to be continuous and reflective and the interpreting, unobtrusive and discreet.
The different approaches and techniques that a Medical Foundation interpreter needs to adopt are identified in the induction programme and explored in training sessions held three times a year. Clinicians are also given initial training on working with interpreters and there are various forums within the foundation where models of clinical practice, including relevant interpreting issues, are debated. Interpreting is an integral part of the Medical Foundation’s work and we seek to reflect this with a joint approach where clinician and interpreter are working as a team. Carefully balanced collaboration, enabling both professionals to understand their mutual expectations, will enhance clinical practice and give the best service to our clients. And this is the message we relay to outside agencies seeking advice or training.

We often run workshops that are co-facilitated by clinicians and interpreters to demonstrate the pitfalls and good practice strategies that we have identified over the years. There is growing demand for training in this area as statutory and voluntary organisations try to address the problem of access to healthcare, including mental healthcare, as well as other key services for refugees and asylum seekers. Need is particularly acute in the regions where interpreting for torture survivors in the therapeutic milieu is underresourced. Many areas are unable to recruit interpreters in the languages they need or are able to take on only untrained interpreters resulting in second rate services for people whose need for protection and treatment is greatest.

Nonetheless, it is hoped that the expertise interpreters have built up at the Medical Foundation over the last 18 years, working in such a unique and complex environment, can be shared further and can be drawn on to develop more widespread and established specialist training programmes in the future, helping to boost national standards for this vital area of work.

This article is based on a talk to the Institute of Linguist’s London Group.