WORKING AS A TEAM: THE IMPORTANCE OF TRAINING AND CLINICAL SUPERVISION OF INTERPRETERS AND PRACTITIONERS FOR BEST PRACTICE IN GENDER VIOLENCE CONTEXTS

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Abstract

Traumatic stories are at the core of interpreter-mediated communication with patients who have experienced domestic/gender violence. Practitioners who work with interpreters to facilitate communication with patients in this context may underestimate the impact on interpreters. Practitioners, usually very mindful of the dynamics of power when working with victims of domestic/gender violence, may feel wrong-footed by having an interpreter in the room. Trust, which is so important yet so fragile in this context, can be shattered easily in this way. Besides trust, power, control and fear are all components of unconscious communication which gets stimulated in the context of gender violence. The way in which an interpreter behaves in the room can have a significant impact on the patient's sense of dependency and of their sense of autonomy as an active agent in the communication. This paper outlines the ways in which preparation through training and clinical supervision can help the patient, the interpreter and the practitioner to co-create an environment of trust in the communication process.

Key words: *dynamics of power, communication, training, clinical supervision, gender-violence.*

1. Introduction

Traumatic stories are at the core of interpreter-mediated communication which interpreters need to translate for patients who have experienced domestic/gender violence. There is a real challenge for interpreters to maintain boundaries when they hear such powerful stories and when patients have expectations of them beyond their role (Sande, 1997).

Practitioners who work with interpreters to facilitate communication with patients, who have experienced domestic violence, may underestimate the impact on interpreters. They seldom have the same professional and personal preparation as practitioners who work regularly in a domestic violence context. Practitioners, usually very mindful of the dynamics of power when working with victims of domestic/gender violence, may feel wrong-footed by having an interpreter in the room. They may feel deskilled in addressing the power dynamics with another person in the

room. This may leave both the patient and the interpreter unprotected. Trust, which is so important yet so fragile in this context, can be shattered easily in this way.

Interpreters who work in settings which require them to listen to patients' traumatic stories and where safeguarding and risk issues are in the foreground of the work, are often underprepared. They are underprepared for the impact this may have on them personally, underprepared in terms of the support which they may need to access and underprepared for the intensity of the emotions experienced by the patients. Interpreters frequently refer to their codes of conduct which may prize neutrality and impartiality. In a gender violence context interpreting relationships take place in emotionally powerful contexts. Although neutrality may be aspired to, the reality is that the interpreter becomes invested with feelings, albeit at an unconscious level, driven by the intense emotionality of the context in which the interpreting takes place (Costa & Briggs, 2014). Unconscious processes do not disappear if we ignore them or if we attempt to override them. If we do not attend to them, we can «act out» on them without awareness. Supervision and training give a space and an opportunity for our unconsciousness processes to be explored safely so that we can act within awareness. This is not just an interesting and optional exercise. It is an essential component to our preparation as practitioner or interpreter working in this context if we are to provide the best possible environments for our patients to access the help they need, to heal and to thrive.

This paper outlines the ways in which preparation can help the patient, the interpreter and the practitioner to co-create an environment of trust in the communication process. In the following text the terms therapist and clinician will also be used as well as practitioner to denote the fact that many of the most sensitive situations for interpreter-mediated conversation in this context, are therapy sessions.

2. Power and control, trust and fear

Research into clinicians' experiences has found that therapists believe patients initially relate more readily with the interpreter causing the therapist to feel excluded (Miller et al., 2005). In a situation like this, therapists may start to feel that control is slipping away from them and that they are losing their therapeutic footing. A kind of struggle may ensue, with the clinician attempting to regain potency and inclusion by acting on an unconscious drive to be perceived as *good*, as a reaction to the feeling of exclusion. If that is the case, where does that leave the interpreter? And if that struggle is taken up and continued by the interpreter, where does that leave the patient?

Other studies exploring clinicians' experiences of interpreting in therapeutic settings initially noted that clinicians found the area 'fraught with difficulty'. They feared the loss of depth and accuracy of communication and experienced difficulties in establishing a constructive working alliance with interpreters, and thus also with

the patients (Raval & Smith, 2003). In training sessions, clinicians frequently report concerns about working with interpreters that include: not being able to form a rapport/relationship with patient; losing control of the session; feeling excluded from the interpreter/patient dyad; concerns about the safety of the therapeutic frame. The inability for the clinician and the interpreter to trust each other will have inevitable pejorative effects on the patient's experience of the therapy.

Patients who have experienced domestic violence will frequently have difficulty trusting in any other human relationship. Building up trust with the patient is a crucial initial task for the therapist. Attribution of blame and the formation of including and excluding alliances, left unexplored, impact on the dynamics of the triangular relationship in the room and are almost always counter-therapeutic.

Interpreters may bring their own fears about working with distressed patients; identifying with patients' stories, having problems in their own lives and containing their own emotions. Interpreters also reported that they felt challenged to maintain boundaries when they heard such powerful stories and when patients had expectations of them beyond their role (Doherty et al., 2010).

Karpman's (1968) Drama Triangle (See Fig. 1) draws on the model of Transactional Analysis in order to provide one explanation for human behaviour in relationships. In the Drama Triangle each person in a triad occupies and moves between the position of Persecutor, Victim or Rescuer.

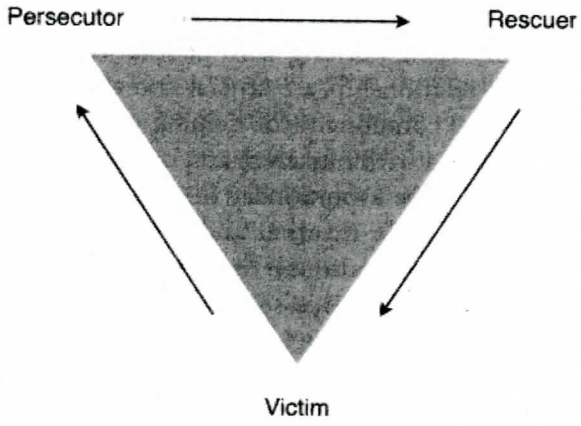

Figure 1. Karpman's Drama Triangle

Even though only one is called victim, all three originate out of and end back at the position of victim. If the clinician and the interpreter are not aware and do not pay attention to the way in which they move into and occupy these different positions, the dynamics will probably have a negative impact on the therapy.

An example may be of use here. If we think back to the situation where the clinician is determined to keep themselves as the *good doctor* (or Rescuer) this will place the interpreter in the Perpetrator role, the therapist may experience themselves as the Victim and the patient is left to work out how to deal with this unhelpful dynamic —either by taking on the role of Rescuer or by leaving and taking themselves away from the help being offered. Research has shown that victims of gender violence who were interviewed frequently did not return after a first interpreter-mediated session, even though they desperately wanted help (see article by Pérez Freire in this same volume). Although there may be many reasons for this, the unhelpful dynamic described may be one of the reasons.

3. Dependency in relationships. Independence and agency in the world where gender violence has been experienced

Infancy is the period of time in our lives when we are dependent on older human beings for our food and shelter. Even at 7 years we cannot survive on our own without it taking a brutal toll on our psyche. The relationship with our care-giver is crucial for our physical and our psychic survival. But if that relationship does not go well it can mean our destruction.

Because this dependent relationship goes on for so long, it forms a blueprint for our future patterns of relating: «the Child is Father of the man» (Wordsworth, 1840).

Relationships for human beings are the well spring of human survival and conversely, of its destruction and destructiveness. This is why the quality of all relationships in the room, when working with people who have had abusive and destructive experiences in relationship, are crucial and cannot be left to chance.

Language is an essential component for helping us to form constructive relationships with people and also with ourselves and our sense of external reality. De Zulueta (1993: 329) explains the evolutionary function of human language as the way humans «make sense of their external and internal world through increasingly complex conceptual representations». She goes on to say that: «This creative interplay between human thought processes and environmental activities is what is referred to as "culture": it is the product of a human mind in interaction with its environment».

It is also one of the ways in which we can find a sense of agency in the world. When people have been traumatised by experiences of gender violence, that sense of agency and connectedness to the outside world can be damaged. The way in which we use language to communicate gives us a model for making sense of how we feel and of how we experience the world. It is one of the essential skills that help us to move from a disempowered infancy to a productive and creative adulthood, or from a disempowered to an empowered adulthood. It helps us to make sense of our internal worlds and to help us to connect with the bigger reality outside of ourselves.

Winnicott (1971: 2) reminds us that we engage throughout our life-span with «the perpetual human task of keeping inner and outer reality separate yet interrelated».

An interpreter working with a therapist plays a significant role in helping with this delineation and bridging of realities. The interpreter helps to link the inner world in one language (the patient's) into an outer world conveyed in another language (the therapist's). The interpreter helps to build the bridge for the survivor of gender violence from passive victim to active agent. And crucially, the interpreter enables a relationship between the therapist and the patient who wish to communicate with each other.

4. Training and Supervision

Gender violence shatters trust. And trust is vital for reparative healing. It is therefore imperative that all relationships in the helping interventions be examined. A model of reflective practice enabled by training and supervision can provide a base for this examination. Training is important because of the need for practitioners and interpreters to work collaboratively together. If practitioners do not feel confident they will find ways to avoid this work and will expect communication to be problematic. Therapists' anxieties left unresolved can be reacted upon rather than understood and creative solutions found.

Where possible clinicians and interpreters should be trained together so that they can understand the extent and limits of each other's' roles and responsibilities. They will also, while together, have a chance to hear and understand each other's fears.

Both parties will need to understand what they bring to their working relationship in terms of experiences of previous triadic relationships —both personal and professional. Triadic relationships are frequently problematic. The way we have dealt with them in our lives in the past will seep, unnoticed, into the room unless self-reflection and careful preparation has occurred. Therapists will need to think about how they conceptualise the therapeutic frame in order to include the interpreter within it and to be able to keep control of the sessions. Not to do so risks the patient feeling unsafe and unable to rely on the clinician's ability to contain the material in the session.

Supervision gives an opportunity to reflect on actions, behaviour and feelings in order to learn and develop in the way that Kolb's (1984) experiential learning cycle describes. «Supervision is a way to 'recycle' our experiences into useful, transformative learning. To avoid going round in circles» (Bager-Charleson, 2012: 33).

There is a variety of definitions of supervision. They generally include the idea of a protected, reflective, shame-free space to think about our work and the ways in which unconscious processes can be acted out by the therapist, the interpreter and the patients. Supervision provides an opportunity for transformative learning

which otherwise may be lost in the repetitive cycle of acting out familiar dynamics. It is an essential component of the therapeutic frame.

Without supervision of this nature, crucial material can be left unexplored and acted upon. A variety of unwanted consequences can occur. For example practitioners, unused to working in the context of gender violence, may feel unable to support their patients and rely too heavily on the interpreter to do the supporting (Maatta, 2014). Interpreters can misinterpret practitioners' intentions and intervene inappropriately. This is an experience shared by interpreters in varied situations of conflict and sensitivity. A survey of the interpreting process conducted by the International Criminal Court revealed the commonality of experience of interpreters and practitioners working in highly charged situations. This interpreter, in the survey, describes how she takes her own initiative in managing the session because she says she feels that she: «was trying to keep a peace that the interviewer (practitioner) was not aware he was constantly disturbing» (Zanen & Gillogley-Mari, 2014).

So, supervision provides an opportunity for transformative learning which otherwise may be lost in the repetitive cycle of acting out familiar dynamics. It is important to pause a moment to consider the particular relevance of this to working with survivors of gender violence. The model of the Drama Triangle (Karpman, 1968) demonstrates a repetitive cycle where people occupy various positions at different times. Walker's (1979) explanatory model of violent relationships: The Cycle of Abuse, identifies a 4-phase cycle where abuse is perpetuated by reconciliation followed by further abuse. It is therefore crucial when working with survivors of gender violence that dysfunctional dynamics do not get repeatedly played out, echoing the Cycle of Abuse, by the people who are supposed to be helping them.

A model of supervision is proposed here, which incorporates some aspects of clinical supervision. An interpreter can be left with intense feelings or vicarious traumatisation after taking part in a therapy session. One of the functions of supervision is therefore (as a source of support) to help interpreters process and manage the resultant emotions with which they are left. Above all, supervision provides a shame-free space where supervisees can talk freely about their uncertainties and any mistakes they may have made, so that they can learn and improve.

The model described in this paper includes 5 functions of supervision (Costa, 2011) and draws on Hawkin's and Shohet's (2000) model of supervision, called the 7-eyed model of supervision. The examples, which illustrate the following model, are drawn from the experience of supervision of mental health interpreters from Mothertongue multi-ethnic counselling service. *Mothertongue* (2014) is a culturally and linguistically sensitive counselling service, which provides professional counselling to people from black and ethnic minority backgrounds in their preferred language. It has its own pool of specially trained mental health interpreters who interpret for therapeutic sessions.

The 5-stage supervision model is as follows:

1. Managerial supervision. This process will vary according to the needs of each service and is beyond the remit of this paper.
2. Professional support and mentoring to handle issues pertaining to the role and the context (as illustrated in the above examples and below). This is the 7th eye in Hawkin's and Shohet's (2000) model of supervision, called the 7-eyed model of supervision. Interpreters interviewed commented on the impact on them of sometimes being treated as a «tool» by clinicians with very little attention given to the impact of the work on them. They need to be supported with this on a personal level. Interpreters may also witness practice by clinicians, which gives them cause for concern. This can be a source of stress for the interpreters. Contextual supervision plays a vital function if there is going to be a systemic change. If there is no mechanism or process for feedback to go back to the clinicians, their managers and commissioners, then it can leave interpreters feeling disempowered and unsupported. They are left to continue to manage situations without optimism for a possibility of change. Interpreters who were interviewed (Costa, 2011a, 2011b) commented on the importance of being able to give feedback to a person who had the authority to challenge the service providers so that the work could be improved.
3. Case management to deal with ethical issues, to ensure that guidelines are followed, and to identify gaps in skills, training and development needs.
4. Personal/pastoral support to discuss how outside factors may be affecting work; helping the supervisee to stay fit for work by e.g. managing stress, taking care of himself/herself before it becomes critical.
5. Clinical supervision to explore issues of the patient's work (individually with the interpreter or in joint supervision with the clinician), including: risk issues; transference, counter-transference and alliances (Tribe & Thompson, 2009) and to help them to process distressing and traumatic material they might hear which may affect them emotionally and personally. Interpreters who had experienced this aspect of supervision regarded it as important (Costa, 2011a).

The following examples describe issues that might be raised and addressed in Supervision stages 2, 3 and 4.

2. Professional support and mentoring e.g. The interpreter describes a situation where the practitioner leaves the room and leaves the interpreter on her own with the patient.
3. Case management e.g. The practitioner invites a family member into the room and allows her to interpret informally from time to time.
4. Personal/pastoral support e.g. An interpreter finds a lot of personal resonance with the patient's story and starts to experience vicarious traumatisation.

Stage 5 Clinical Supervision

The following examples illustrate the kind of material which might be addressed in Stage 5-Clinical supervision with both the interpreter and the practitioner present.

Example 1

> An interpreter is worried because the practitioner seems to be annoyed with her. The patient keeps looking at the interpreter and not at the practitioner. In the de-brief with the interpreter, the practitioner asks the interpreter to stop looking at the patient as it is disrupting his ability to achieve a rapport with the patient. The interpreter is worried about the impact it might have on the patient if she avoids her gaze but appreciates that the practitioner is finding it difficult to form a working relationship with the patient.

If this situation is left unexplored an unhelpful dynamic will be present in the room. One possible outcome of reflecting on this together in supervision might be that: the interpreter realises that he/she is taking on the responsibility for the practitioner's relationship. If the practitioner wishes to address the issue of eye contact, then the practitioner can use his/her skills to do this with the patient in the room. All kinds of anxieties can be elicited when one member of the triangle feels excluded. This needs to be reflected on and worked with rather than acted out on. This is a delicate situation as the interpreter will need to remind the practitioner of the limits of her responsibility and to encourage the practitioner to address this issue in the room therapeutically. It may be that the interpreter needs the support of his/her managers to achieve this successfully. The practitioner should also have his/her own supervision to address this. The example illustrates how useful it can be for the interpreter and the practitioner to have supervision together.

The reader might like to consider how supervision could be used to help the interpreter and the practitioner think about the best ways of approaching patients' concerns about interpreter mediated communication. These examples come from research interviews with mental health patients/clients who have received therapy through an interpreter with the NHS in the UK. (Costa & Briggs, 2014)

Example 2

One interview mentioned an interpreter's inappropriate response to painful material; the interpreter laughed:

> Interviewee/patient (C): I do know that sometimes I said something that made her laugh. For me it was something important and she found it funny. I didn't really like it, so to say.
>
> Researcher (R): I see, so it seemed like unprofessional behaviour?
>
> C: Exactly. I mean, I'm saying that she was professional and suddenly I'm saying there were a few situations, but as I say, I tried not to think about her, what she was like.
>
> R: Do you remember such a situation?
>
> C: No, I don't remember it right now, what it was about, there were so many meetings that I don't know, I don't know; but it was a bit out of order, because something is painful for me and the same thing makes her laugh, it's not fair, but ok.

R: Did the therapist react somehow? Did he say anything to the interpreter?

C: No, he didn't say anything to her. Neither he, nor I, I only looked [at her] and that was it. I didn't tell her anything, because maybe I lacked courage (laugh). I just thought you were there just to interpret and your feelings...

R: Should be kept to yourself?

C: Exactly.

This interaction between the interviewee/patient and the research interviewer shows, firstly, how the interpreter's laughter impacted on the patient and, secondly how the therapist's lack of response left the patient isolated. In a session with a patient without an interpreter a therapist would probably behave very differently. We are all fallible and therapists might find themselves in a situation where their own reaction to the material they are hearing is to respond inappropriately, by for example, laughing. A therapist is trained to pay attention to this and to address this behaviour in the room. Everything that happens in the room is worthy and eligible for examination including the therapists' own mistakes. In fact, it is often through «mistakes» that therapeutic discovery and transformation are made possible. Having to deal with and manage a mistake made by an interpreter is not something for which therapists are regularly prepared. This is where, as referred to at the beginning of this paper, therapists may lose their therapeutic footing. The consequences of losing this stance are described by the patient in the above excerpt. This excerpt provides an excellent example of the way in which clinical supervision can provide (as stated previously): «a shame-free space where supervisees can talk freely about their uncertainties and any mistakes they may have made, so that they can learn and improve».

Example 3

A key concern of patients, raised specifically by three of the patients interviewed was how interpreters were perceived as interrupting the communication flow in therapy. Two of the patients mentioned that «they did not like speaking in small chunks» as they reported was requested by the interpreters. For example: «I wanted to say something more and then the interpreter was saying that in rather short sentences, because then she wouldn't know how to say it. And like that it is simply not possible» (I/patient).

The interruption to communication flow was seen as breaking up the patient's direct contact with the therapist. One patient gave this example as occurring when the interpreter's request to use short phrases was seen as slowing down the process and as a barrier to direct access to the 'doctor', as if the interpreter were not necessary:

C: ...the doctor... communicated with me with in a good manner and calmly and I was very happy with my doctor.

R: And can you tell me the roles of the two people who you had met? What were the differences between them?

C: Well, there wasn't much of a difference, but for me the only difference was that I believe that without the translator I could say my problems...: Because I wanted to, and I had said that it has been approximately 3-4 years that everyday my memory has got weaker and everything that I wanted to say, the translator would tell me to wait and to tell him one word each time

R: Ok

C: And while waiting, everything I wanted to say would be forgotten.

The commentary from Costa and Briggs (2014) on the above fragment is that:

> It is noticeable that a particular criticism is that the interpreter brings an unwanted disturbance to the dyadic relationship with the therapist, and is an interrupting influence. Potential triggers for a shift from the collaborative to the 'interrupting' mode of relating to the interpreter include the patient's fragility. For some patients the need for therapeutic help generated defences against anxiety which include splitting the therapist and the interpreter, blaming the interpreter, as discussed by Costa & Dewaele (2012), for example, through being protective of the therapist and blaming the interpreter (for example, for breaking the communication flow).

These examples provide rich material for exploration in clinical supervision and training.

5. PROFILE OF CLINICAL SUPERVISOR OF INTERPRETERS AND THERAPISTS IN THE CONTEXT OF GENDER VIOLENCE

Sande (1997) ran group supervision for 5 years for interpreters interpreting for psychosocial interventions with asylum seekers and refugees in Norway. His experience and feedback from interpreters (which echoes the experience at Mothertongue) led him to believe that interpreters needed a supervisor who had understanding and experience of both the clinical and interpreting aspects of the role. There are plenty of training routes available for clinical supervisors at the moment. Perhaps it is time to introduce a new specialism of supervision for health and social care interpreters.

6. CONCLUSION

Without this type of training and supervision, unconscious processes can be acted out by the therapist, the interpreter and the patient and the opportunity for transformative learning for the patient may be lost in the repetitive cycle of acting out familiar dynamics, as opposed to examining and reflecting upon them. Interpreters do not have the same preparation as other professional workers in health and social care. Many therapists spend years in personal therapy as part of their training to help them to look after themselves so they remain fit and available for the patient. They still need training and dedicated supervision to understand the

processes affecting them when working with an interpreter in a gender violence context. Interpreting in a gender violence context can be challenging yet hugely rewarding work. We need to make sure we support the people doing this work so that they stay fit and well and are able to contribute their vital skills to the process of helping people to heal.

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