Speaking the unspeakable: Female interpreters' response to working with women who have been raped in war.

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Of those women who seek asylum in Britain, a proportion will find their way into psychology services. Many of these women do not speak English and so interpreters are used. This paper investigates how interpreters make sense of and cope with interpreting rape stories.

The UK is ranked tenth among European Union countries for the number of asylum seekers per head (5.1 per 1000 in 2005; www.unhcr.org), with at least 50 languages being spoken by those seeking asylum (Tribe, 1998). Exposure to violence is widespread within the refugee and asylum-seeking population (Burnett & Fassil, 2002), with incidents of rape during war estimated to be 300%-400% higher than in civilian times (Morris, 2000). This figure is likely to be an underestimate as it only reflects those rapes reported to the authorities. Rape is recognised as a weapon of war to assault individuals, families and communities; destroying group cohesion, identity, spirit and culture (Farwell, 2004). Perpetrators have been successfully prosecuted under crimes against humanity, war crimes, and genocide, under

International Humanitarian Law since the establishment of the International Criminal Tribunal for the Former Yugoslavia in 1993.

On a micro-level, the raped woman must reconcile herself with what has happened. This can manifest in feels including shame, humiliation, confusion, self-blame, terror or rage, anxiety, depression, suicidal ideation and sexual dysfunction (Petrak, 2002). Taylor *et al*. (1983) make a distinction between those responses that are the direct result of the rape, and those which are the result of the negative reactions of others as a response to the disclosure of rape; including hostility, derogation, rejection and blame. For raped women seeking asylum, these reactions might be expressed by government officials, solicitors, doctors, psychologists and interpreters. Women may be referred to psychology to address this distress or the rape directly, or adjustment to HIV contracted as a result of rape.

The use of interpreters

If rape is to be discussed, the interpreter needs to feel as comfortable and confident doing this as the therapist. This might be problematic if intimate discussions about sexual behaviour or abuse are difficult or embarrassing for the interpreter (Ravel, 2003) or therapist. Much as survivors of rape may see the world as 'unsafe, unjust, unpredictable and without meaning' (Connor *et al*., 2003), therapists and interpreters might be similarly affected. Research has found that therapists who work with clients who have survived traumatic events can experience profound psychological effects including 'vicarious

traumatisation' (McCann & Pearlyman, 1990), which might present as emotional burnout and fatigue, Post Traumatic Stress-type symptoms, depression and somatic symptoms (Lansen, 1993). When working with women who have been raped in conflict, the additional complexity of asylum claims, language barriers, health issues and multiple losses can compound professional burnout (Lansen, 2001). The impact of this work on interpreters has not been investigated in this level of detail.

The majority of psychologists and interpreters who work in the NHS are women, which might impact upon hearing female clients' experiences of sexual violence. Griffin (1971) suggests that all women fear rape, which results in them constricting and constraining their behaviour, such as not walking alone late at night.

The emotional impact of interpreting

Acting as a bridge between the therapist and client may mean the interpreter faces any emotional impact more directly than the therapist (Ravel, 1996). The interpreter is certainly in a better position to assess the emotional significance of utterances made by the client by being privy to the cultural meanings embedded in the language (Putsch, 1985). Messent (2003) suggests that such emotional impact has the potential to become 'intensified by the repetition involved in translation' (pg. 143). Tribe (1998) found that interpreters working with victims of torture sometimes over-identified with

clients' accounts; it was common for them to feel overwhelmed, concluding in concern about the effect this would have on both the therapist and client.

The current study

This study explored how female interpreters made sense of the stories of sexual violence they interpreted, as well as how this understanding influenced their ways of coping with the emotional impact of their work. The study was described at a monthly interpreters' meeting and participants requested; three interpreters volunteered. Participants had been working in NHS sexual health services ranging from 4-10 years, were between 25-55 years old, all were white but of different ethnicities (European, North American and Central American). Between them, participants spoke English, Spanish, French, German and Portuguese. None of the participants had been raped but all had experience of interpreting stories of wartime sexual violence. The interviews were transcribed, participants allocated pseudonyms, and data analysed using Interpretive Phenomological Analysis (Smith, *et al*., 1999).

The emotional impact of the work

All the participants described difficulties in coping with the emotional impact of interpreting for women who had been raped in war:

"*I just started to cry … I was mortified, I couldn't believe that had happened to me*" Anna.

"*it's very hard all day long to speak other people's words, and they are charged with emotions, and none of them are yours…it kind of pushes you to the back of you*" Carla.

"*I would feel upset, I would say 'Imagine if this happened to me"* Beth.

Understandings of clients' responses to rape

There was a pattern of alternating between distancing from and identification with clients. Identification involved drawing on their own life experiences to try to understand clients' presentations:

"*I have so much to deal with, and so much pain, that I do understand what these people have gone through*" Beth.

Distancing involved drawing on professional explanations:

"*an assessment was done of PTSD and she had everything: flashbacks, she wasn't functioning*" Anna.

"*this is where you store these memories , and what the therapist is trying to do is to make these memories transform into ordinary memories and then you can live with them and they won't keep popping up in flashbacks or nightmares*" Carla.

Understandings of why rape happens

A pattern of alternating between distancing and identification was also involved. Participants identified as women vulnerable to assault:

"*it can happen to anyone, it's not just in war, you could be walking home at night, or even your husband can inflict those things on you… you have to be careful, you are vulnerable*" Carla.

Distancing was achieved in how the client's story was listened to:

"*I find it almost surreal sometimes, difficult to relate, it's not my experience, and so I think about it in an abstract way*" Carla.

Differences from participants' lives and those of the client created distance, such as viewing rape as happening in war:

"*it is used as a weapon in some countries. It's almost every female refugee who's here*" Carla.

"*they would do it for the sake of doing it [rape]… it's wrong, but they think it's right in Africa, and they will continue doing it*" Beth.

Rape was conceptualised as something that happened in other people's countries. Such ideas might serve as a defence for these participants, in that

they can view themselves as safe from rape in Britain. These discourses reflect age-old racist ideas of 'savage' Africa and connect to anti-asylum and racist responses from wider society. Indeed, participants highlighted the ethnic and cultural differences between themselves and the clients:

"*I read a lot of their reports on women and sexual violence in Africa… there is a lot of taboos relating to sexual abuse in Africa*" Anna.

As well as directly expressing anti-asylum discourses:

"*there are refugees that come here and take the piss*" Beth.

"*these people are so ungrateful, you break your back, you run around the whole of London and all these people are working for them and then they spit on the system and it makes me feel very angry*" Carla.

In understanding this anger, Herman (1992) proposes that by being in the witness position of listening to a client's story, therapists (and interpreters) are caught between the positions of victim and perpetrator. A therapist could identify with the feelings of both through a process of counter-transference, and so in identifying with the perpetrator, the therapist (or interpreter) can experience contempt, hatred and disgust for the client. Wilson and Lindy (1994) suggest such identification might also result in denying or

intellectualising the client's experience, while identifying with the victim the professional risks becoming fatigued, over-involved and a loss of boundaries.

If distancing is the coping strategy being employed by interpreters, minimisation and distortion could easy happen through the process of interpretation, as the client's words are subtly altered in the translation given to the therapist. However, if the interpreter is coping by identifying with the client, they risk being overwhelmed in the session or they might spend their free time reading country political reports to the client's story.

Both Herman (1992) and Wilson and Lindy (1994) emphasise the importance of regular and structured supervision and support to prevent oscillation between these two poles. With no formal supervision arrangements, using anti-asylum discourses to create distance between the interpreter's and client's lives goes unchecked and unchallenged. In addition, when discussing such sensitive topics as rape, it is essential that clients feel in a safe and judgement free environment to form a trusting therapeutic relationship (Wilson & Lindy, 1994). The interpreter therefore also needs offer unconditional positive regard, use respectful words and allow the formation of such a relationship. Drawing on anti-asylum discourses might disrupt this process.

Avenues of support

Of concern is that all the participants reported a lack of support from their employer:

"*it's all supposed to be a certain way when you study interpreting, then when you are in the field it's not at all as thorough as that because of time constraints or people just can't be bothered or they just don't know*" Carla.

Because of this lack of official support, participants made informal arrangements to try and cope with the emotional impact of the work:

"*my best friend is a psychotherapist, I don't get any formal supervision as such but if things are really horrible I can talk to her*" Anna.

In addition, participants had developed practical techniques such as:

"*if I have something that really bothers me I write it down on a piece of paper after the session and then throw it away before I go home*" Carla.

Conclusion

This study demonstrated that interpreters develop an understanding of both the session content (i.e. rape) and clients (i.e. asylum seekers). This understanding may influence their presentation in sessions and the words they use in translation and so the understanding and therapeutic relationship

generated between the clinician and client. These participants had no access to formal support to shape this understanding or deal with the emotional impact of the work. As a result, participants found their own ways to cope and understand, most notably to distance themselves from clients or over-identify with them. These strategies are likely to impact on the therapy session as well as the interpreter's emotional wellbeing.

Recommendations

- **The structure of therapy**

  Pre and post session meetings are crucial for preparation and debrief. These should include a conversation about the cultural ease of discussing rape for the interpreter and how to continue or pause the session if the client or interpreter becomes distressed; eliciting techniques the interpreter has developed that might be employed to prevent their distress. The therapist should check for any signs of identification or distancing. Ultimately, if these ways of coping are felt to be interfering in the work, this should be feedback to the interpreting agency and an alternative interpreter booked in future.

- **Training**

  Therapists should be trained to work with interpreters in a supportive and facilitative way, acknowledging their personhood and not just their language skills. Interpreters may value training from experienced interpreters on strategies to cope with the emotional impact of the

work and training from therapists about psychological explanations of clients' responses to trauma.

- **Policy**

  Local services should develop a 'code of practice' to ensure that such training is implemented and pre and post sessions are standard practice. Good practice guidelines for working with interpreters are available from sources such as Tribe (2005).

- **Funding**

  Adequate funding is essential to provide supervision/support that is based on interpreters' individual needs and level of experience. Training interpreters has cost implications, most interpreters are sessional workers, and so being paid for their training time would encourage attendance.

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