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Not Lost in Translation

How to Perform Competent Cross-Cultural Consultation

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The development of a rich cross-cultural consultation relationship between an agency social worker and a community program is enhanced when it has elements making for a good fit. When the consultant acts authentically, there develops an atmosphere of safety, a relationship parallel to the therapeutic relationship, and a cross-cultural transitional space.

I chose my field of study, my graduate school, and my job, but the consultation experience I am about to describe seems to have chosen me. It brings to mind the Buddhist who said, "When the student is ready, the teacher will appear." During my 3½ years as a clinical supervisor and consultant to Right from the Start (*Desde El Principio*), a community-based program for young Latino families, I have continually wondered who is learning more, the staff or me? It is probably a tie.

When cultural differences are involved in consultation, the history and customs of all participants become an integral part of the focus, as well as the currency of communication. Factual knowledge about each other's backgrounds, however, is not enough. It takes a solid commitment on the part of the program staff and a consultant who is willing to take risks and live with the possibility of making embarrassing mistakes to create a clinical space strong enough to hold everyone's differences.

This article explores the development of a rich, cross-cultural consultation relationship between an agency social worker and a community program. Beginning with the history that preceded this collaboration, it illustrates the elements of a *good fit* between a consultant and a community program and how group members were engaged to participate in creating it. I hope to provide the reader with examples of the vital concerns that are woven into a consultation experience like this one. Language is an ever-present theme that needs to be addressed at all stages of the consultation relationship. The structure of the consultation, requiring both clear boundaries and a looseness of hierarchy, helps teach staff members about their roles in their work with clients. Authenticity on the consultant's part helps create both an atmosphere of safety and a two-person relationship, parallel to the therapeutic relationship described in relational theory. There is also the *cross-cultural transitional space* that evolves from the consultation, enabling staff members to take what they have learned in meetings and use it to deepen their relationships with their clients. Finally, throughout the entire consultation experience, issues of immigration and loss need to be encouraged to surface freely and frequently.

THE HISTORY OF AN IMPORTANT LIAISON

Right from the Start (RFTS) is a program of Family Network in Highland Park, IL, an agency that has been providing preventive services for young families in the community since 1982. Parents and their children, from birth to age 4, come to the site for social contact with other parents while participating in a variety of activities. Family Network was the lead agency in a consortium with four other local social service agencies[1] that created RFTS almost 12 years ago in response to the unmet needs of new and at-risk mothers, with a focus on the growing Latino population. Paralleling the nation's population shift between 1980 and 2000 in which "the population of races other than White non-Latino grew by 88%, while the White non-Latino population grew by 7.9%" (Lim, Cruz, Pumariega, & Cutler, 2005, p. 505), a similar phenomenon was occurring in the northern suburbs of Chicago. Over time, the program has evolved to include both preventive and therapeutic services to the Latino population in Highwood and other surrounding communities.

In establishing a consultation relationship with another agency, it is not always possible to build upon past history. In this case, the fact that Family Network and Jewish Child and Family Services (JCFS) are both members of the founding consortium and have had a long history of collaborating with one another is important, because I, as the long-standing liaison between the two agencies, originated this consultation. When Family Network requested a clinical supervisor from JCFS to help the RFTS coordinator meet the requirements for social work licensure, as a JCFS staff member I happily offered my services. The RFTS coordinator then invited me to become the clinical consultant for her staff. Thus, we began an important collaboration in a comfort zone, which helps us weather the occasional storms that normally arise in collaborative work (Sheridan, 2000).

RIGHT FROM THE START PROGRAM COMPONENTS

Home visits to families by family support workers form the hub of the RFTS program. Highland Park Hospital, a member of the founding consortium, refers to the program women who have just given birth. In certain cases, visits by a family worker may begin while a mother is still in the hospital, but most occur after mother and baby are home. It is not unusual for a family to receive this service until their youngest child is 4 years old.

In addition to home visits, many services are offered to families at the program site in the church basement that houses Family Network. A major service is the weekly, bilingual drop-in group attended by mothers and children from all parts of Family Network and RFTS. Other RFTS services include classes for parents in English as a Second Language, art, sewing, and exercise, as well as swimming activities for both parents and children. A van is also provided for parents who have no transportation to activities. This list of activities is by no means exhaustive.

Over the course of the consultation, the program staff has included four family support workers and the program coordinator. Two group members have MSW degrees, two have bachelors degrees, and one has considerable experience as a nurse. All group members take turns presenting case material and clinical questions. During our 90-minute staff meetings, which are held twice monthly, we also discuss child development, therapeutic interventions, our reactions to the material, our group dynamics, and any personal experiences that further the sense of safety and cohesion in the group.

[1]The other agencies are Jewish Child and Family Services (formerly Jewish Family and Community Service), Highland Park Hospital, Family Service of South Lake County, and the Josselyn Center.

ELEMENTS OF A GOOD FIT IN CONSULTATION

Whose Language Do We Speak?

The role of language in our consultations has been a curious thing. The countries represented by the RFTS staff are Ecuador, Spain, Bolivia, Mexico, and the United States. One would think that, for me to be truly useful to the staff, the least I could do is learn Spanish (Meyer, 1977). The truth is I do not speak Spanish and have often wondered to what degree this language deficit on my part damages a good fit between us. What I have found is that knowing the language is not a bottom line for forgiving consultees. Nonetheless, open discussions about this language barrier are of key importance.

Sometimes during meetings the staff discussion takes off in Spanish. In part, I experience this as a sign that the Latino staff members are so comfortable with me that they forget about the language difference. At the same time, it serves as a reminder to me that they are constantly stretching themselves to understand and express complex concepts and feelings in a language that is not their mother tongue, and they are doing so for my benefit.

Often, feelings evoked in clinical consultation are uncomfortable, and although "the uncomfortable zone is at the same time a fruitful zone for learning" (Brinkman & de Groot, 2004, p. 517), I believe that discomfort can be magnified by having to express oneself in a foreign language. I can only hope that my close attention to possible feelings of loss each time a Latino staff member has to address me in English, which is a constant reminder that she no longer lives in her native land, will serve as an antidote to my lack of Spanish. I also wonder if I express enough appreciation to the staff members for their willingness to make this effort in discussions of such emotionally sensitive material.

A Delicate Balance

Another important element of a good fit is a consultant's ability to maintain a delicate hierarchical balance. On the one hand, a consultant must understand the concept of frame and provide a structure in which boundaries are kept. This framework is clinically necessary because of the diagnostic information that comes to light when a family support worker breaks either clinical or consultation boundaries. In a process that is parallel to the therapist's breaking of boundaries in treatment, when a worker oversteps boundaries in our consultation or with her clients, it generally reveals the nature of the client projections she is struggling with and carrying into the consultation space.

On the other hand, within the structure of this consultation experience, one of the most important tasks I have had to do is reduce or, at times, eliminate the hierarchical atmosphere of our meetings (Sheridan, 2000). A successful consultation experience across cultures requires the maintenance of the delicate balance between monitoring clinical issues closely and at the same time loosening other parts of the consultation structure.

An example of the use of the frame in consultation occurred with a family support worker who had done long-term work with the mother of a 7-year-old. This client was separated from the child's father and would not allow her son to visit him. She also said very negative things about his father in front of the son. The worker was extremely frustrated, and we all agreed that the situation was destructive for the 7-year-old. Soon, he began slipping into a noticeable depression. Even the school social worker talked to both parents in an effort to help them settle their differences enough to allow the son to visit his father freely.

After a few months, the son was injured in a serious bicycle accident and had to be hospitalized. This accident brought the parents together at the hospital; but, as soon as her child was back home, the mother once

again refused to allow visitation between father and son. On a home visit, the family support worker became so enraged at the mother's lack of cooperation that she told her client she would stop seeing her unless the client complied with her recommendations for visitation.

It took courage for the worker to share her angry reaction in our consultation meeting. In fact, by threatening to withhold services to her client, she had replicated the family pattern of impulsivity and withholding. But when she told us about her angry reaction, no one in the group judged her, and all of us could identify with her extreme frustration. At the same time, the consultation frame required that I help the group and the family support worker see that she had crossed the line by acting out her rage and threatening to abandon her client. As we explored what was behind this threat, the worker began to understand that it was evoked, in part, by her client's serious abandonment issues. The client was testing to see if her worker would give up on her; once she understood this dynamic, the family support worker was able to go back and reassure her client that she would not leave her and would continue to help both parents work on this visitation problem.

Although the clinical frame of the consultation has to be monitored closely, I have also had to pay close attention to decreasing the power differential, particularly between the consultees and me. To accomplish this objective, I have encouraged informality in our group discussions, shared personal information about myself, and left room for group members to make important choices. The staff members choose topics for discussion, make necessary changes in schedule, and decide whether my clinical guidance is useful or not. For example, in my culture, spouses who have been sexually abused as children are often encouraged to share this information with their partner as a means of increasing their comfort with intimacy. When I suggested this to one worker whose female client had told her about being sexually abused as a child, the group quickly vetoed this as a therapeutic response. In many Latino cultures, sharing past experiences with sexual abuse may cause a woman to be seen as damaged and less worthy. Consequently, it would threaten the intimacy of the partnership and, in some cases, the integrity of the family. It has been important for me to defer to the group on many issues and understand the cultural implications of my suggestions.

In this regard, one can never be too careful. Because of my previous work with clients from other cultures, including Jewish refugees from the former Soviet Union, I was reasonably confident that I would be able to create a nonjudgmental atmosphere, another important element of a good fit in consultation, where nothing would be frowned upon or assumed. Yet, despite my years of experience and *presumed* wisdom, I managed to make a significant *faux pas* fairly early in our consultation relationship.

The coordinator had asked me to make a presentation to the group about disciplining young children, because staff members are always searching for ways to help their families structure family life in a new culture. I eagerly brought in a video on the topic, which we enjoyed together, and then proceeded to give a talk on setting limits. My first example was how to get children to stay in their own beds at bedtime. As I talked, I sensed a growing tension in the room. Fortunately, I had the presence of mind to ask if anyone had a question or concern about what I was saying. The response? Silence. Then, one of the staff members told me that most of her clients shared beds with their children, partly because of cultural norms and partly because there are not always enough beds to go around.

So there I was, reflecting back on all of the sleepless nights I had endured when my own children would not stay in bed, when, suddenly, I had to switch gears and address my presumptuousness. I recognized my false assumption that RFTS family members all had their own beds. Perhaps out of embarrassment, I burst out laughing and

soon we were all laughing—at me. My hard-learned ability to laugh at my own mistakes shifted the discussion to the more pressing issue of how it feels for staff members to open up in consultation when we are all from different cultures and when their consultant did not check out this important detail of their clients' lifestyles.

Like the therapist, a consultant represents authority, because he or she is seen as a source of guidance and important clinical information. I am also aware of the fact that, in our consultations, I represent the dominant culture in our country. Consequently, my sensitivity to this power differential is crucial, especially because some of the staff and their clients have suffered oppression, whether in their mother country or here. If I unwittingly communicate negative bias or unconscious negative attitudes, I replicate this oppression (Dyche & Zayas, 2001).

Over time, I have witnessed the importance of a consultant's ability to suspend judgment over basic differences and tolerate the discomfort of putting her foot in her mouth. A little humor goes a long way. In the last example, my laughing showed the staff I could handle any slings and arrows they might shoot my way. It also increased the group's awareness of individual differences and gave permission for group members to reveal their mistakes. Following this experience, our discussion broadened, and each staff member shared details about her own lifestyle. Likewise, I shared information about mine, including parenting issues at bedtime when my children were young. In the end, the trust level in the group took a leap forward. As stated by Young, "Regardless of the apparent 'sameness,' at some point in all supervision, and preferably early in the process, multicultural issues must be explored" (2004, p. 41).

Professionals or Paraprofessionals?

I have heard many professionals express heartfelt doubts about the ability of a worker without a college or professional degree to learn real clinical work. I do not share the doubts of many of my colleagues, but perhaps this is not the issue. The real issue is that *projections do not discriminate.*

It is important for a consultant to have equal respect for all consultees, regardless of educational level, and never to underestimate their ability to learn clinical work. Workers without formal degrees can learn the important clinical skills and understanding necessary to make therapeutic interventions. Possessing these skills and understanding is crucial if they are to sustain the painful projections of their clients and recognize their own internal reactions to their clients' nonverbal communications.

I have the utmost respect for the importance of licensure. Yet, the fact remains that there is none for the job of *family support worker*, and there *are* pressing needs in this underserved, immigrant Latino population. I believe that, with the help of consultation, family support workers out in the community can learn to give therapeutic responses and function as professionals.

The tension over professional status is often reflected in the group. For example, I might encourage a staff member to make a challenging intervention, such as scheduling a session with a couple experiencing domestic violence. Understandably, the staff member is reluctant to do this. She might say, "I'm just a family support worker. I don't know how to do this." I absolutely understand her fears, and I express directly both my empathy and my wish that she at least consider it. Then, as a group, we discuss how to intervene, as well as the fact that domestic violence generally takes place in the *absence* of a support person. In addition, someone in the group usually points out that the clients have very few people to turn to for help.

Toward the end of the discussion, I make a case to the worker for her valuing her own expertise, especially if she has been in her job for a number of years. She has laid the foundation for such a session, because she already has a strong relationship with the

family. And I encourage the whole group to value themselves as professionals.

There is no question but that the enormous impact of the immigration experience bonds the RFTS clients very closely to their workers. In today's language, the family support worker at RFTS is the *first responder* in the resettlement process, and we have all seen how first responders hold a special place in the heart of someone who is navigating either a life-threatening or life-changing experience. In immigration, there appears to be a certain imprinting that takes place—particularly if the worker has had a similar experience—whereby the first person to help the immigrant make the transition is of utmost importance. It often takes a long time before someone new can fill those shoes.

As RFTS staff members have found, it is often hard to get their clients to go to another professional, say, a therapist at a mental health clinic. The bond to the second professional often simply does not form or what remains is a longing to talk to the original family support worker. This normal phenomenon in immigration increases the importance of family support workers, as well as the urgency of valuing them in a professional role.

CONSULTATION AND THE TWO-PERSON RELATIONSHIP

In relational theory, it is in the here-and-now, two-person relationship between the therapist and the client that the actual therapeutic work takes place. Similarly, "a relational supervisor does not view him- or herself as the expert authority or as the final arbiter of truth. Instead, what is 'true' about the supervisee, his or her work with clients, and the relationship between supervisee and supervisor, is negotiated and co-constructed by the supervisor and supervisee based on their mutual but different expertise" (Ornstein, 2006, p. 2).

This relational concept also applies to consultation, when considering the consultant as one person and the consultation group members as the collective other person. In my work with RFTS, I have been both impressed and touched by the evolution of our relationship. As mutual trust has increased, it has been accompanied by significant cognitive and conceptual learning. Within this two-way relationship, I believe the authenticity of our interactions has far outweighed the importance of any intellectual knowledge I have gained about our cultural differences specifically or about the consultation process in general. It has increased the emotional safety of the consultation space and loosened the normal resistance to bringing things up in consultation (Gabbard, 2000).

Although sharing my own struggles may diminish what some may view as my authority, doing so has been intrinsically involved in equalizing what might have been an uncomfortable power differential. My being "real" with the group often helps us avoid impasses. In addition, I have a genuine passion for helping other professionals identify the elements of their therapeutic interventions, painful or otherwise, and this passion probably comes across in my excitement when a staff member catches on to her clients' projections and develops an effective response.

An important icebreaker in our discussions has been my own sharing. Let me give an example. I could have increased the group's cognitive learning by handing out articles on the effects of immigration and how to intervene. What has felt more relevant is my sharing of personal information to which the group can relate, in this case, the impact of immigration on my own family. My mother and her parents emigrated from Turkey to the United States when she was a baby. She was affected by her parents' frequent emotional unavailability while adjusting to a new country, her father's loss of self-esteem when he could not reestablish himself in his previous occupation, and by the anti-Semitism she experienced in this country. This story, and its impact on me, has come out in bits and pieces, causing me unwittingly to express my wish to be under-

stood by the group, both in regard to who I am as a person and to the material I am trying to help them master. I believe this has also freed them up to share their wish to be understood by me.

My honesty and use of self have also helped increase the trust level in the group, because discomfort on the part of a consultant is always palpable. Sometimes, I am deeply aware of an indescribable cultural chasm between us. If I am not willing to address my feelings of being left out during a conversation in Spanish at our consultation table, or my sense of not having understood the cultural context of a very poignant interaction between a worker and her client, then how can I expect the staff to put their struggles on the table? Foster captures this fact when she writes, "The ultimate goal of . . . these interventions would of course be a real collaborative interaction between two human psyches [my own and the collective psyche of the staff] who together are struggling to understand how they impact on each other" (Foster, 1998, p. 266).

A CROSS-CULTURAL TRANSITIONAL SPACE

Robert Winer (1991), a family therapist, writes about the role of transitional experience in healthy development. The very first *transitional space* in life is the space surrounding mother and child wherein the child learns to function independently while still developing an internal sense of mother's presence. Winer was innovative in referring to family treatment as a transitional space. It is within this space that the family takes in the guidance of the therapist and changes its patterns of relating.

Similar in concept is the *cross-cultural transitional space* existing in our consultation relationship. The cross-cultural transitional space encircles our relationship and includes the entire journey of information and guidance from me to the RFTS staff—integrating the impact of our group interactions and cultural differences—and from the staff members to the therapeutic space between the family support workers and their clients. Of course, the journey goes both ways. Perhaps the best way to help clarify this journey is to share the most recent developments in our consultation.

During the past several months, staff members have been asking for help in dealing with some very complex marital issues, including alcoholism, domestic abuse, and communication problems. Although they have expressed doubts about being able to respond therapeutically to a troubled couple, I have reassured them about their ability to learn the skills necessary to do so.

I consistently encourage family support workers to meet with both the mother and father and sometimes even the whole household of the families with whom they are working. This is true especially when relationship difficulties exist between parents. We use consultation meetings to prepare the staff for these sessions, looking at the frame of marital treatment and how to maintain an alliance with both members of a couple. As a first step, we focus on getting each member of the couple to listen while the other speaks, something even very conflictual couples will do if they trust the staff member with whom they are working and if it is for the benefit of their children. We also regularly address the problem of forming an alliance with a difficult-to-engage father or a reluctant mother in order to begin the work.

Initially, the prospect of facing an angry mother and father seemed both overwhelming and a bit frightening to the staff members, but to their amazement, they have received very positive responses from their clients. Both partners in most of the couples approached have been willing to participate in marital sessions, all held during home visits. In addition, these couples are actually making changes! It has taken a lot of courage for staff members to step into these deep waters, and they are having significant success with it.

As a way to conceptualize the phenomenon of cross-cultural transitional space, I

ask the reader to envision a fluid environment surrounding the consultation experience, in which the family support worker is free to go back and forth between her consultant and her clients—all of whom may be from different cultures—while continuously transforming the therapeutic learning from consultation into a culturally attuned intervention that can be helpful to her clients. My acceptance and encouragement of each worker's creative version of what will work make the cross-cultural transitional space safe for learning and for operationalizing the learning. In addition, the growth that results in this context is tri-fold and is found among the consultant who is developing a deeper cultural understanding of her consultees' cultures, the family support worker who is learning new therapeutic concepts and feels validated by the positive outcome of her interventions, and the clients who feel understood and, consequently, make real changes in their coping skills.

One example of this kind of learning occurred with a staff member who conducted a marital session during a home visit with a very argumentative couple. Our entire consultation group was both amazed and thrilled that she succeeded in getting both partners to attend, which speaks to the couple's trust in her and their genuine wish for help.

The family support worker described the husband's sharp "put-downs" of his wife each time she would speak. In spite of the fact that his wife was a beautiful woman and that he was somewhat unattractive, the husband continued to berate his wife for being homely. Although we might understand these criticisms as the husband projecting his feelings of inadequacy onto his wife, it would be difficult to provide a verbal intervention that would persuade the couple to look at this projection. In fact, the repetitiveness of this negative communication pattern could have easily created an impasse in the work, given most couples' anxieties about changing long-term relationship patterns. Instead of feeling defeated, however, the worker asked both partners to look together into the mirror they had on their wall. As they looked at their reflection, the worker asked them what they saw. At that moment, the husband was able, amazingly enough, to say that he saw the pretty face of his wife and that he also saw his "ugly" face. This moment was a turning point that seemed to break through the impasse in their relationship and eliminate the husband's disparaging comments, at least temporarily. For this husband and wife, it was the first time in a very long period that they were able to experience a positive moment together.

While allying with both couple members, something we had discussed in consultation, this staff member recognized intuitively the cultural importance of the husband's pride. The couple needed an experiential rather than a verbal response from her, and she factored in their cultural background, especially given that she was familiar with the lifestyle of the small town from which they had emigrated. She also understood their intense need for a nurturing response. In this intervention, the family support worker was truly able to translate what she had learned in consultation, not just from English to Spanish but also from my culture to her culture. I believe the whole group was astounded by this caring intervention and what it accomplished.

SUMMARY AND CONCLUSION

During the time I have worked with the RFTS staff as a clinical consultant, I have been both impressed and touched by the staff's willingness to share their struggles and by the resulting emergence of their clinical skills. These skills evolved over time and were facilitated by the creation of a good fit between the staff members and me, their consultant. This fit became possible, in part because of the positive relationship that already existed between my agency (JCFS) and Family Network, and in part because of the program coordinator's request for my clinical consultation as an adjunct to our supervisory relationship. Other

factors that have enhanced our work together include my careful efforts to suspend judgment about cultural customs and rituals different from my own, as well as my willingness to face our misunderstandings, including my own *faux pas* in my work with the group. In addition, the group's willingness to open up and learn was influenced by my belief in their ability to learn therapeutic skills and psychodynamic process.

The staff has been very responsive to our joint effort in building an authentic two-way relationship between us, parallel to the two-person treatment relationship described by relational theory. My own authenticity and use of self through sharing personal experiences have helped create an atmosphere of safety and continue to maintain a reciprocal openness. In addition, the equitable sharing of power has been both necessary and important because of the cultural differences among group members, some of whom come from situations in which they have experienced oppression, and particularly because I represent the dominant culture in this country.

Finally, the clinical understanding and skills of the staff have blossomed within the *cross-cultural transitional space* of our consultation. This space consists of the consultation relationship and the entire journey of guidance and information from consultant to staff member to the treatment relationship between family support workers and their clients. The fluid environment surrounding the consultation experience provides a space in which the worker is free to go back and forth between her consultant and her clients, allowing the therapeutic learning from consultation to be transformed into a culturally attuned intervention.

The family support workers at RFTS have learned to receive their clients' material with an increasing understanding of boundaries and a growing ability to identify and hold the complex and often painful projections of their clients. As a result, the Latino families they serve are getting the support and counseling they need.

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