

CUSTOMER HAS REQUESTED:  
**Electronic Delivery (ELDEL)**

[docdel@ahsl.arizona.edu](mailto:docdel@ahsl.arizona.edu)

**Document Delivery/ILL**  
Arizona Health Sciences Library  
520-626-6840  
[ahsill@ahsl.arizona.edu](mailto:ahsill@ahsl.arizona.edu)



Friday, October 07, 2011

TN: 215530



Call #: **W1 AM529 v.24 1970**

Location:

Request #:215530



Patron: Jones, Desiree

Pages: 677-85

Journal Title: American journal of  
psychotherapy

Volume: 24  
Issue: 4  
Month/Year: 10 1970

Article Author: Wolman C

Article Title: Group therapy in two languages,  
English and Navajo.

Notes:

Paging History:

NOS LAC INC OTHER \_\_\_\_\_

Re-Page by -/-/-

Charge:

This is not a bill. Please do not pay from this  
slip.

Initials \_\_\_\_\_

Need by: 12/05/2011



**CUSTOMER INFORMATION:**

Desiree Jones (djones)  
2550 West Ironwood Hill Drive  
#833  
Tucson, AZ 85745

College of Public Health

Method of Payment:

[djones1@email.arizona.edu](mailto:djones1@email.arizona.edu)  
520-429-2746  
Fax:

# Group Therapy in Two Languages, English and Navajo

CAROL WOLMAN, M.D.\* | Philadelphia, Pa.

## INTRODUCTION

It is widely believed that psychiatric techniques are culture-bound, and that a therapist cannot help people who speak a language different from his own. This paper will describe a year's experience to the contrary. Navajo problem drinkers participated in group therapy led by an English-speaking physician with the aid of an interpreter. The therapist did not understand Navajo, the language most frequently used by his patients. Both the difficulties and the bright spots of this arrangement will be discussed.

The Navajo Tribe is the largest in North America, comprising about 130,000 people. After being subdued by Kit Carson a century ago, the Navajos abandoned their life of robbing and raiding, and devoted themselves to raising sheep, weaving rugs, and working silver. Today, the men often earn some cash income by railroad labor, fruit picking, and other types of seasonal employment.

The Navajo reservation, about the size of West Virginia, is a beautiful but barren land, located mainly in Arizona, but overlapping New Mexico and Utah. It is scarred by arroyos and canyons that rapidly carry away the little rain that falls. The altitude of 4,000 to 10,000 feet makes for a short growing season. It is estimated that, in a good year, the reservation land cannot support more than 35,000 people at a subsistence level. As a result, even with the seasonal cash supplements, most Navajo incomes fall well below the poverty level and many families receive some public assistance.

Unlike some other poverty groups, however, the Navajos have retained much of their traditional culture. Family structure, as with most Southwestern Indians, is matrilineal, matrilocal, and, some might add, matriarchal. The old Navajo religion, based on the healing of sick individuals through solemn ceremonies, is still very much alive and many young Navajos choose it over Christianity. They see no inconsistency, though, in using modern medicine in situations where the latter has shown its superiority (1).

Alcoholism, a disease introduced by white men, is resistant to "traditional" cures and the white doctor is expected to treat it. Excessive drinking has been called by one Navajo leader "the number one health problem threatening our people today." In 1966, the tribe estimated that there were 3,000 alcoholics and another 10,000 problem drinkers among the Navajo. Other

\* Mailing address: 3924 Delancey St., Philadelphia, Pa. 19104.

leaders guess that as many as one-third of the adult population have this difficulty. Men are affected much more than women. In Gallup, New Mexico, an off-reservation town with over 40 bars, about 700 Indians per month are arrested for drunkenness.

The most common drinking pattern is spree drinking. No liquor is permitted on the reservation, so families pile into their pick-up trucks on week ends, and drive to Gallup, Farmington, or Flagstaff. Once there they sociably meet their friends at the bars. The man with wine in his hand or on his breath automatically belongs to a far-flung drinking fraternity, and might not drop out for a week or two, to the detriment of job and family. The occasional drinkers become brothers of the chronic down-and-outers, those who revolve from bar to alley to jail and back. Of course, a fair amount of drinking also takes place illicitly on the reservation, especially at rodeos, religious ceremonies, and other occasions where many people gather. The one pattern seldom seen is controlled social drinking in moderation.

As might be expected, many Navajos lose life and limb from alcoholism and its consequences. Most reservation car accidents are alcohol related. At least 50 Navajos per year freeze to death in the below-zero winter nights, having fallen drunkenly asleep outdoors. Most homicides and suicides involve alcohol, and cirrhosis and delirium tremens are commonly seen disorders.

The economic effects of drinking are equally devastating. Of course, the few available jobs are quickly lost and not so easily regained. Saving money is difficult when one is expected to spend one's paycheck treating others to wine. The skid row types can stay intoxicated for months on other people's money. Many people tell of how they were robbed of all their cash and clothes while drunk in the streets of Gallup. Eventually, a man may pawn his jewelry and even sell his sheep to keep himself in wine.

Liquor is a strong solvent for the cement of Navajo society. Navajo marriages are somewhat informal, and excessive drinking leads to promiscuity and irresponsibility, and thence, to breakup of the family. When both parents are drunk, children may be neglected and unfed. The cliché of the "drunken Indian unable to handle firewater" cannot explain the devastating effect of alcoholism among the Navajos. Metabolic studies fail to show any difference between red and white man that would account for it. Rather, the reasons are historical, cultural, and social.

The life of a young male Navajo is full of frustration. He has been in school from the age of six, often at a boarding school far from home. He does not care to spend the rest of his life in a small mud-and-log hogan, without heat and electricity. Yet his family ties are strong, and he does not want to leave the Navajo region. His English is often poor, and his grasp of the white world unsophisticated, so he cannot compete successfully for

white-collar jobs. Laboring jobs are seasonal and undependable. In the old days, when a young man married, he moved in with his wife's family. There he was watched for several years to see if he was a good warrior and provider before being accorded high status. Today, all he can do to gain recognition is to share his paycheck, a poor substitute for stolen sheep and horses. In winter, there is often no paycheck to bring home and to him are given the menial tasks of the household. His role in both white and traditional Navajo society is marginal; in some ways, he belongs to neither. Inevitably, he feels useless, emasculated, and very angry. Navajo culture proscribes the show and even the sensation of anger. No wonder he sometimes escapes through drunkenness!

The society he lives in condones this escape route. Since fermented beverages were unknown to the Southwest before Europeans came, wine has in no way been tamed by the local Indian cultures as it was, for instance, by Judaism. Indians drink to get drunk rather than for ceremonial or social purpose. To an Indian, actions of a drunk individual are not really his own and thus are somewhat excusable. A man can, for instance, display hostility while intoxicated, and not be held accountable. Moreover, the act of drinking is not disapproved of until it becomes chronic and hurtful to the family. In fact, children are sometimes given wine for the fun of watching them stagger (2).

The aforementioned drinking fraternity makes it very hard for a man to become a teetotaler. Negative sanctions for behavior among Navajos are external rather than internal. Navajos respond to shaming rather than to the voice of conscience. The fraternity will coax and threaten an abstainer, accuse him of deserting his friends and turning Christian. This sort of pressure is very hard for a Navajo to resist, even when there is strong counter-pressure from his family. Often an outside force, such as the peyote religion or some sort of medical treatment, can help him to stay sober (3).

#### METHOD

A program to combat Navajo problem drinking was begun in 1965, under a National Institute of Mental Health Grant. This grant lapsed in 1967, but that year the Navajo tribe received a sum from the Office of Navajo Economic Opportunity (ONEO) and hired 25 Navajo ex-alcoholics as Community Alcohol Workers (CAW). In September 1968, ONEO and the United States Public Health Service jointly established an alcoholism treatment ward at the Gallup Indian Medical Center along the lines of the earlier National Institute of Mental Health program (4).

The ward had beds for ten patients, each of whom was admitted for one week. He or she (about 10 per cent were women) was examined physically, and with appropriate laboratory tests, and started on disulfiram if not medi-

cally contraindicated. At the end of his stay, he could, if he wished, take a "wine test." This consisted of imbibing five ounces of wine under medical supervision, to see for himself the effect of drinking while on disulfiram. After discharge from the hospital, the patient was closely followed by the CAW's, who also referred most of the drinkers for treatment (5).

Daily group meetings, an hour in length, were held on the ward. Many of the patients were bilingual to some degree, but some knew no English. Translation was performed by any of five or six staff members, who varied greatly in outlook and ability. Occasionally, if none of them was available, one of the patients would take on this task.

Two therapists conducted the groups, working alternate weeks. Sometimes they attended one another's meetings. A Public Health Service psychiatrist provided supervision and advice.

Most discussion stayed close to the topic of drinking. The stated purpose of the meetings was to explore the reasons for each individual's drinking, and help him find other ways to solve his problems. Obviously, this goal could not be reached in a week. We did feel that the discussions promoted a cohesiveness among the patients, and that each one benefited from publicly acknowledging his problem. In addition, some were able to develop increased self-confidence and speaking ability. Some of the discussions dealt with mutual problems, such as how to handle friends who press drinks on one. Others were used to discharge ward tensions, as when a patient left without permission. In short, the therapy aimed at encouraging verballity and self-assertiveness, rather than attempting to be analytic. We feel that these limited goals, were accomplished, and several patients told us the same.

## RESULTS

Both the Navajo and English languages were used, but Navajo predominated, since English was the second language for all the patients. The style and pace of group meetings was greatly affected since everything had to be translated; thus, only half as much as normal could be said in an hour. Spontaneity often gave way to formality, and quick comments to long speeches addressed to the interpreter. Sometimes the action rested long in one language, at other times it flew back and forth like a ping-pong ball. There were few interruptions, since it is hard to interrupt someone speaking a language one does not understand.

At any moment, there was someone not comprehending the words spoken. Implicitly, a choice was always available—to stop and translate, or to proceed in the same language. Anyone in the room could make that choice, but the responsibility for seeing that all were included, and that communication did not break down, lay ultimately with the leader. Whether the interpreter also felt responsible varied with the individual. As for the patients, their

attitude toward the communication problem often reflected their feelings about therapy. A discussion of the communication problem could sometimes be used to deal with resistance to treatment.

The language situation accentuated the distance between the group and the leader, especially when the group was short on English. Each time a bilingual patient spoke, his choice of language made it artificially clear to whom he was addressing his remarks. This could also prove useful. Misunderstandings and poor translations of course occurred. These tended to reflect cultural differences. For instance, a leader once asked sarcastically, of a man who insisted that his drinking days were over, what magic transformation had taken place. The word "magic" has a rather more serious and sinister meaning in Navajo than in English, and confusion reigned for a while.

On another occasion, two single women in the group said that liquor helped them with dating. When the leader tried to discuss dating further, several of the men became indignant. After a great deal of embarrassment, it became clear that the Navajo word used to translate "dating" implies "sexual intercourse," and that such things are not usually discussed in mixed company. Despite such mishaps, most translation went smoothly, and very little affect seemed to be lost in the process. Misunderstandings that seemed purely linguistic often reflected deeper antagonisms between group and leader that surfaced by this means.

The interpreter plays a crucial role in such a therapy group. Ideally, he is a paid professional who not only knows both languages, but is familiar enough with both cultures to smooth out difficulties like those just mentioned. Equally important, he is not surprised or offended by anything said. He translates everything, no matter how trivial. He seldom adds anything, and always translates his own additions. Not hypersensitive, he does not bridle at being corrected or double-checked. With a good sense of timing, he makes language switches appropriately and deftly, without being asked. He shares the leader's goals, and can rehash the meetings with the leader in a helpful way.

We had no such paragon to help us, and became very aware of how the translator could interfere with therapy. The "dating-sex" session will serve as a good example. In this meeting, the two women who introduced the subject were speaking Navajo, and "dating" was the translation used by Mrs. A., a middle-aged Navajo translator. The leader tried to pursue the matter, in English, naturally. Before Mrs. A. could translate, an objection was raised in Navajo by a man who understood English. Mrs. A. translated the objection. The leader asked what was wrong with discussing the topic of dating. Mrs. A. replied, "I won't interpret such bad things—nobody wants to talk about them." Obviously, she did not recognize the difference in

meaning between the Navajo and the English word she was using. Moreover, she could not tolerate a discussion of sex. The story also illustrates how the interpreter can block communication between the leader and the group. Once she had balked, the leader had no way of discussing the problem with the patients. There was no way to talk to them. In general, the interpreter can, at any time, halt the conversation by answering the speaker himself instead of translating his thought.

Another way in which the interpreter can wreak havoc is by abandoning his role for another. If he decides to play leader, he can shut out the therapist entirely, and since the latter does not understand Navajo, he may not realize for a while what is happening. Conversely, the interpreter may decide to discuss his own problems (some of our staff are ex-alcoholics). This may be done so as to help the group, but more often is just a way for him to gain inappropriate attention.

The interpreter, of course, is always Navajo, and his loyalty is therefore divided between the staff, to which he belongs professionally, and the patients. He often perceives his role to be that of explaining the patient's viewpoint to the doctor, and is, therefore, peculiarly amenable to group pressure. In the example given above, Mrs. A. yielded to the desire of some patients to avoid the topic of sex. Another day, a new patient gave his name in Navajo as "penis." This was a test of the young female interpreter, to see how far she would go in translating his comments.

Another common instance: a passive patient objects to discussing his own problems, and asks that the expert doctor explain the dangers of drinking. The therapist responds by saying that this patient must have some familiarity with these dangers himself. The interpreter, instead of translating this reply, says to the leader, "What this patient means is . . ." and rephrases the passive statement. He thus not only breaks up the dialogue, but also shields the patient from the therapist's demand that he be more active.

This type of problem grows even worse when a patient acts as interpreter. Usually, he will only translate what the group wants the leader to hear. To illustrate, on one occasion Lucy, a new patient who spoke no English, spent 15 minutes introducing herself. The patient-translator said that Lucy denied drinking, and described in detail her recent DT's, which she claimed were caused by witchcraft. The leader asked the group if she were making sense. Although the group included several bilingual patients, none was willing to answer the question. Lucy kept interrupting in Navajo, and was either ignored by the group or greeted with laughter. No one would translate her remarks nor would anyone take the responsibility of asking her to be quiet. It was later learned through a patient that she had been insulting the leader, asking why he talked so much, and the like. The leader had been saying similar things about her all the while. No patient was willing to take the onus of bearing such evil messages, and communication failed.

There are several good reasons why a patient should not serve as interpreter. He is extra vulnerable to group pressure, and much less likely to respond to leader pressure. As a patient, he has the right to speak for himself at any point instead of translating. The difficulties of this situation have already been pointed out. He becomes very powerful and can easily monopolize the meeting if he chooses. On the other hand, translating is hard work, and affords the patient a ready-made defense against treatment. The translation problem can be very difficult to deal with, but it is largely a technical one. If good interpreters, trained in the techniques of group therapy had been always available to us, our task would have been much easier.

Special problems are posed for the therapist with a bilingual group. He must be able to listen to long speeches in a strange tongue without irritation. Above all, he must give all patients equal attention, whether he can speak with them directly or not. He may have a tendency to ignore the non-English speakers, especially since the bilingual group members are often less shy and more verbal.

The leader must see to it that the lines of communication are constantly open. It is often easier to let Navajo comments slip by than to insist on translation. The therapist may feel that his incessant demands for translation are annoying to the patients and detrimental to their free-flowing discussion, or he may feel angry and hurt at being left out. He must learn to recognize and deal with his own feelings on these matters. On the other hand, he is unusually free to observe nonverbal behavior. He seldom misses a speaker's affect, or the reaction of the group members to him. It is not difficult to put these together with the translation when it arrives.

A special form of nonverbal behavior is available for observation in such a group. That is the choice of language, and the timing of language switches. Of course, the amount of English a patient uses partly depends on his ability to speak it, and the leader must have some idea of each patient's language ability. He is then in a position to use language switches to fathom group dynamics. If a group speaks mainly in English, translating little for the non-English speakers, the members are showing poor cohesiveness. They are not looking out for each other. The therapist can attempt to correct this omission by urging translations into Navajo, and thus also demonstrate his own concern for all the patients.

The attitude of the group toward treatment and toward the therapist is often clearly expressed in the amount of translation it allows and encourages. One week, a lot of resistance to treatment was evident. A patient was serving as interpreter one day, and often the only response he would give, when asked by the leader to translate the Navajo conversation, was "They're not talking about you." Nothing could have indicated more thoroughly the hostility being expressed in Navajo. The next day, when the staff interpreter returned, the previous meeting was discussed, and the group members were

able to verbalize their unwillingness to trust others with parts of themselves. Another group, which had freely and openly discussed the problems of many members, took the initiative in asking that all Navajo comments be translated. In this way, they expressed their warmth toward the therapist.

Thus, the presence of two languages can be used to intensify and clarify group tensions. It can open up a discussion of group feelings toward the leader, by the use of questions like, "Were you talking about things you didn't want me to hear?" A discussion of group communications is a good way to illustrate the handling of a difficult reality situation.

#### CONCLUSIONS

Group therapy can be conducted in two languages, one of which is unknown to the therapist. The interpreter plays a crucial role. He should not be a group member, nor take over leadership, and he must understand and resist group pressures. Which language is used at any moment tends to reflect the dynamics of the group. Language switches are, in effect, a form of nonverbal communication. Breakdowns in translation may indicate resistance to treatment, and the therapist can exploit this parameter to help the patients understand their behavior. This experience in group therapy challenges the widespread belief that a member of one culture cannot aid the people of an alien culture and language through psychotherapy. Many difficulties lie in the way, but techniques can be developed to overcome them.

#### SUMMARY

This paper has examined the effect on group therapy of the presence of two languages, one of which the leader did not understand. Daily therapy on an alcoholic rehabilitation ward involved about ten voluntary Indian patients at a time, with an average stay of five days. Most were bilingual, but a few knew no English, and the leader understood no Navajo. Translation was done mainly by a staff member.

Both languages were used, but Navajo predominated. The interpreter could complicate matters in different ways. The group exerted various pressures on the interpreter. Special problems were posed for the leader. Group dynamics were expressed via language switches in ways that have been discussed in detail. Certain techniques were developed, using talk in Navajo, to intensify and clarify group tensions. Which language was used at any moment would tend to reflect group feelings and tensions. The leader can turn the bilingual situation to positive advantage.

#### REFERENCES

1. Kluckhohn, C. and D. Leighton. *The Navaho*. Harvard University Press, Cambridge, Mass., 1946.

2. Ferguson, F. N. Navaho Drinking: Some Tentative Hypotheses, *Human Organization*, 27:159, 1968.
3. Henderson, N. B. Community Treatment Plan for Navaho Problem Drinkers. Gallup Indian Hospital, 1965.
4. *Preliminary Report of the Indian Health Service Task Force on Alcoholism*. DHEW, HSMHA, IHS. January 1969.
5. Savard, R. J. Effects of Disulfiram Therapy on Relationships within the Navaho Drinking Group. *Quart. J. Stud. Alcohol*, 29:909, 1968.