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Language Interpreters as Cultural Brokers in Music Therapy

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Abstract

In an increasingly linguistically diverse society, music therapists in the United States are working with individuals who may not speak the dominant English language (Davenport, 2024). It is important that music therapists collaborate with language interpreters when language discordance occurs, that is, when the music therapist and patient do not have a shared proficiency of the same language. There are many ways of working with interpreters, but the topic is not widely researched in the music therapy profession. In this reflection paper, I discuss the ways in which music therapists and language interpreters can collaborate, highlighting the importance of the cultural broker stance and inviting interpreters into the therapeutic space.

Keywords: language; interpreter; music therapy

Introduction

As a graduate student, I completed my master's thesis with an interpretative phenomenological study on the experiences of music therapists' delivering music therapy services with language interpreters (Davenport, 2024). Throughout my music therapy education and training, the topic of language discordance was never discussed and working with interpreters was an unfamiliar concept. As I conducted my thesis, I learned more about the cultural broker stance in the language interpretation world. When working with an interpreter from the cultural broker stance, the interpreter "interprets not only the spoken word but also relevant cultural and contextual variables" (Tribe & Morrissey, 2004, p. 131). In my own clinical practice, I have been able to embrace this way of working. I will define the cultural broker stance in greater detail and share clinical examples from my own practice. Additionally, I invite fellow monolingual English-speaking music therapists to consider their own linguistic privilege and the ways in which they can address the topic of language discordance in music therapy.

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Location of Self

I was motivated to complete my thesis research on the collaboration between music therapists and language interpreters and felt personally connected to the topic. Although I do not identify as a bilingual individual, I relate to the pains of everyday microaggressions as a person of color. Additionally, I am a transracial adoptee (TRA), which means I was adopted by parents of a different racial group than my own. As a TRA, I was separated and uprooted from everything I knew as an infant—my birth family, culture, and language. I see my own ancestors in some of my non-English speaking patients, and as a result, I feel a heightened sense of responsibility and emotional investment to this research.

At the same time, I was raised in a small Midwest town and was often shielded from outside harm with my white adoptive parents. Even though I was foreign-born, I grew up speaking English and I never had to sit with the discomfort of not speaking the dominant language. I hold a different sense of privilege and power by being a POC raised by upper-middle class white parents. My intersecting identities of both privilege and subjugation influence the ways in which my original thesis research was conducted and analyzed, as well as how the current reflection paper was developed.

Language Statistics

According to the 2019 U.S. Census, 67.8 million people spoke a language other than English, and of those, 13% indicated that they spoke English not well and 6% not at all (Dietrich & Hernandez, 2022). The U.S. Census also collects information on languages other than English spoken in the home, which nearly tripled in size from 1980 to 2019, suggesting an increase in non-English speakers (Dietrich & Hernandez, 2022). In the context of healthcare, language discordance occurs when patients and providers lack proficiency of a shared language (John-Baptiste et al., 2004).

Language discordance may “lead to provider miscommunication, lack of overall patient understanding and comprehension, and dismissal of patient needs, ultimately resulting in poorer care, inadequate use of medication, increased adverse outcomes, increased length of stay, and higher hospital readmission rates” (Davenport, 2024, p. 1). According to Title VI of the 1964 Civil Rights Act, discrimination is prohibited based on national origin and language and “individuals cannot be denied access to education, health care, or legal services because they do not speak English” (Searight & Searight, 2009, p. 445).

Defining Cultural Brokers

It is important to distinguish between interpreters and translators, as they are often referred to interchangeably. Interpreters deal with spoken language whereas translators deal with written language. Both interpreters and translators do more than convert language and text; they “relay concepts and ideas between languages … and must be sensitive to the cultures associated with their languages of expertise” (Jones, 2002, p. 1).

According to Tribe and Morrissey (2004), there are four basic models of interpreting: 1) Linguistic mode: The interpreter interprets “word-for-word and adopts a neutral and distanced position”; 2) Psychotherapeutic or constructionist mode: “The interpreter is primarily concerned with the meaning to be conveyed rather than word-for-word interpretation”; 3) Advocate or community interpreter: “The interpreter takes the role of advocate for the client, either at the individual or wider group or community level, and represents their interests beyond interpreting language for them”; and 4) Cultural broker/bicultural worker: “The interpreter interprets not only the spoken word but also relevant cultural and contextual variables” (p. 131).

Many psychotherapy researchers (Gerskowitch & Tribe, 2021; Hunt & Swartz, 2017; Martin et al., 2020; Tribe & Thompson, 2009a) endorsed the cultural broker stance, "recognizing that important cultural, social, and political information can be interpreted and can enhance the therapist's overall understanding of their client" (Davenport, 2024, p. 1). One of the advantages of working with interpreters as cultural brokers is an enhancement of therapists' overall understanding of their client's culture and context (Gerskowitch & Tribe, 2021). Music therapists cited cultural, communicative, and musical benefits when working with interpreters as cultural brokers (Davenport, 2024). When the interpreter is viewed as a cultural broker, there is a "powerful and unspoken acknowledgment of acceptance ... shifting the perspective from 'You use an interpreter' to 'The interpreter is here for us'" (Hamerdinger & Karlin, 2019, p. 2).

Therapeutic Relationship

Bruscia (2014) illustrated *The Client-Music-Therapist Constellation* to depict the varying relationships between client, music, therapist, and ecology (p. 174). Music is shown as its own entity existing "in and by itself, apart from the client and therapist," implying that the music can serve as therapist apart from the music therapist (Bruscia, 2014, p. 175). In this model, both client and therapist have intramusical relationships, that is, their own personal relationships to music, that eventually form together to create the intermusical relationship between client and therapist.

Bruscia (2014) also acknowledged the need for a *Client-Music-Therapist-Other Constellation*, in the case of significant others or other professionals working with the client (p. 175). Related psychotherapy research outlines this three-way relationship between client, therapist, and interpreter (Hunt & Swartz, 2017; Miller et al., 2005; Pugh & Vetere, 2009; Tribe & Morrissey, 2004; Tribe & Thompson, 2009b). It seems then that a four-way relationship exists in music therapy between client, therapist, music, and interpreter (Davenport, 2024).

When working with interpreters from a cultural broker stance, Bruscia's (2014) constellation becomes even more applicable. The music therapist, client, and interpreter each have intramusical relationships that may intersect with one another. At times, the intermusical relationship between client and interpreter may exist without the music therapist. A skilled music therapist utilizes the *Client-Music-Therapist-Other Constellation* to better understand the dynamics at play when working with interpreters (Bruscia, 2014, p. 175). Through this cultural broker collaboration, music therapists can engage in richer practice, taking "a step away from the so-called expert role and engaging in a more collaborative, culturally reflexive approach" (Davenport, 2024, p. 7).

I will provide three case examples from my own practice, highlighting some of the ways in which music therapists may work with interpreters as cultural brokers. The patient names and clinical information have been altered to ensure anonymity and privacy.

Clinical Example #1 – Mr. Martinez

I received a music therapy referral for Mr. Martinez, a 50-year-old Mexican patient whose primary language was Spanish. I first met Mr. Martinez when he was in the intensive care unit (ICU) with a tracheostomy tube (commonly referred to as a *trach*). I found myself feeling nervous prior to meeting him for the first time. I was unsure of how we would communicate with the presence of language discordance as well limited verbal communication due to having a trach. I introduced myself and music therapy services with the assistance of a live remote Spanish interpreter (i.e., video interpreter). In attempts to learn Mr. Martinez's music preferences, I handed him my iPad to type a specific song or

artist. He selected a song in Spanish on YouTube and throughout the 5-minute song, he closed his eyes, lifted his hand up, and swayed back and forth. I noticed the interpreter was also singing along quietly on the screen. After the song ended, the patient appeared calm with his eyes closed and hands raised. I turned to the interpreter and asked if she would be willing to provide some cultural background and context of the song. She interpreted the name of the song, the lyrics of the chorus, and the overall meaning of the song. The patient nodded in agreement as I reflected how important it appeared his faith was to him. It was a beautiful moment because this sharing felt so natural and the interpreter really seemed pleased to be involved in this way, thanking me at the end of the session for such a meaningful interaction.

Prior to this session, I had never turned to an interpreter to ask about the patient or the musical content of a session. I simply had never thought to do this. As I read more about the cultural broker stance, I started to explore the ways in which I could bring the interpreter into the music therapy session and cultivate a space of cultural humility, learning, and collaboration. Here, the interpreter's intramusical relationship assisted me in understanding more about the patient's intramusical relationship, thereby strengthening our intermusical and interpersonal relationship. I continued to work with Mr. Martinez for several months and was able to connect him with our chaplain for additional spiritual care and support.

Clinical Example #2 – Mom and Baby Joseph

In addition to working with adults in a public safety net hospital, I also work with infants and families in the neonatal intensive care unit (NICU). I received a music therapy referral for Baby Joseph, a premature infant with feeding difficulties and respiratory distress whose family's primary language was Haitian Creole. When I arrived for the initial music therapy assessment, Baby was in the isolette, and Mom was present on the other side of the room. I introduced myself to Mom with a live remote Haitian Creole interpreter and asked if I could sit with her and tell her more about music therapy. She was open to speaking with me about music therapy and as I explained my role and purpose, she nodded and smiled, demonstrating understanding. I asked Mom if she would like to get Baby out of the isolette and hold him for a family music therapy session. Mom said she would excuse herself so that I could work with Baby. I quickly tried to correct myself and explain my role in a different way because I wanted to provide an opportunity for Mom and Baby to bond and experience the music together, not for me to work with Baby alone. The interpreter went back and forth between interpreting our verbal exchanges and explaining to me some cultural differences. He shared that music therapy is not well known in Haiti and the idea of music therapy for bonding and relaxation was difficult for him to interpret and for Mom to understand in this context. Even though I had worked successfully with other Haitian Creole families, this time was different. I had to change the way I described my role and my purpose in the NICU. I relied on the interpreter to assist me in my word choice and in bridging our cultural differences.

In this example, the interpreter played an active role in the music therapy session. He went beyond simply interpreting on a word-for-word basis. He provided an overall cultural context and collaborated with me to help give Mom the greatest understanding possible. Without the interpreter present and without the interpreter acting as a cultural broker, Mom may have left the room entirely to allow me to work with Baby by myself. Another scenario may have been Mom declining music therapy services altogether due to lack of understanding of the service. I continued to work with Baby and Mom until they were safely discharged.

Clinical Example #3 – Ms. Nguyen

I received a music therapy referral for Ms. Nguyen, a 70-year-old Vietnamese patient whose primary language was Vietnamese. I first met Ms. Nguyen when she was in the ICU. Her communication was limited as she was intubated, sedated, and on a ventilator. After several weeks, her orientation status and communication level changed, so I thought it was a good time to reassess. Initially, I was not working with an interpreter because she had demonstrated English proficiency in our previous sessions by nodding and shaking her head. I remember co-treating with another therapist to facilitate diaphragmatic breathing with live music. When we instructed Ms. Nguyen to place one hand on her chest and one hand on her belly, she smiled and nodded her head, but did not follow the instruction. We said it a few times, and still nothing, just smiles and nods. I called the live remote Vietnamese interpreter, and we were able to continue with the session. Later, the interpreter helped me find popular and traditional Vietnamese music that I could offer to the patient for music listening and relaxation. I wrote and highlighted in my progress note that an interpreter should be utilized for all patient interactions for optimal communication and success, as this had not yet been documented by anyone on her care team.

Through collaboration with a language interpreter, I was able to better assess Ms. Nguyen's overall communication and functioning, as well as strengthen our interpersonal relationship. Additionally, I was able to advocate for the patient by urging all other providers to include language interpreters in their interactions with Ms. Nguyen. In sharing these real-life clinical examples, I hope to emphasize a reflexive practice when working with interpreters. Any music therapist or provider may find themselves guilty of assuming a patient's English as "good enough." It is important to never assume a patient's English proficiency, while also never assuming lack thereof. In my experience, the best way to know is simply by asking: "It is appropriate for music therapists to ask the patient directly if they want an interpreter present for the session. If they are unable to answer this question when asked in English, then clearly an interpreter is indicated" (Davenport, 2024, p. 8).

It is important to remember that interpreters do not always have music backgrounds or even share the same culture or country of origin as the patient. It is also important not to overgeneralize or assume shared culture in these instances. However, just as psychotherapy researchers assert that cultural, social, and political information can be interpreted and shared, so too can musical information. When operating from a cultural broker stance, we as music therapists can strengthen the intermusical and interpersonal relationships with our patients, ultimately providing greater culturally reflexive care.

Call to Action

Music therapists are called upon to increase their knowledge and experience when working with interpreters. If not, we run the risk of providing inadequate care or disregarding certain patients altogether. Before we can embrace the cultural broker stance, we must first confront our own privilege and biases regarding language and linguistics in music therapy. As a society and as individuals, we create dominant narratives about ourselves and others that become eventual truths in our own minds (Hadley, 2013). We are born into a "socio-cultural historical matrix of dominant narratives;" some serve to oppress and others to empower (Hadley, 2013, p. 374). Over time, dominant narratives have placed the English language at the top of the hierarchy, with all other languages falling as less than (Gallagher-Geurtsen, 2007). From a feminist perspective, Hadley (2013) wrote that "individual problems are related to the social and political context of the person" (p. 376). Therefore, to combat these issues, it is important that music therapists confront their own

social and political contexts. To enact change, music therapists are "expected to recognize the impact of our feelings, attitudes, and actions, in fact our very embodied being, on the client and the therapy process" (Hadley, 2013, p. 376). Here are some thoughtful questions to reflect upon:

- How do music therapists privilege the English language over other languages in the U.S.?
- In what ways does living in an English-dominated society privilege the English-speaking patient and oppress the non-English speaking patient?
- How do I "cash in on unearned privileges," especially those of linguistic privilege for the monolingual English-speaking music therapist? (Hadley, 2013, p. 379)

The best way to combat language bias and prevent further harm and discrimination is to open the door for conversations surrounding working with interpreters, linguistic privilege, and language bias. Additionally, music therapists are invited to reflect upon the following questions:

- "Have I ever neglected to work with an interpreter out of my own convenience?"
- "Are my patients with limited English proficiency being offered the same music therapy services and opportunities as my English-speaking patients?"
- "Have I ever avoided or overlooked a patient simply because of their natal language?"
- "How do I feel when delivering music therapy services with the additional presence of an interpreter in the room?" (Davenport, 2024, p. 8)

Conclusion

I hope music therapists will consider the cultural broker lens when working with interpreters in music therapy. By inviting language interpreters into the therapeutic space and actively collaborating with one another, we can strengthen the intramusical, intermusical, and interpersonal relationships with our patients. However, first and foremost, it is vital that music therapists confront the ways in which their linguistic privilege and language bias play a role in delivering music therapy services and working with patients with limited English proficiency.

About the Author

Victoria (Tori) Davenport (she/her) is a board-certified music therapist currently practicing in Indianapolis, IN, USA. She primarily works with adults in the acute medical setting, as well as infants and families in a Level III NICU. She is passionate about cultivating an anti-oppressive practice with a critical humanism foundation, challenging the social and historical inequities that are weaved into healthcare systems and society.

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