UNIVERSITÉ DE GENÈVE

Archive ouverte UNIGE

https://archive-ouverte.unige.ch

Master 2023

Open Access

This version of the publication is provided by the author(s) and made available in accordance with the copyright holder(s).

The psychological implications of interpreting for survivors: training as a tool for addressing vicarious trauma among interpreters

Pyke, Grainne Mary

How to cite

PYKE, Grainne Mary. The psychological implications of interpreting for survivors: training as a tool for addressing vicarious trauma among interpreters. 2023.

This publication URL: https://archive-ouverte.unige.ch//unige:170202

© This document is protected by copyright. Please refer to copyright holder(s) for terms of use.

Gráinne Mary PYKE

The psychological implications of interpreting for survivors: training as a tool for addressing vicarious trauma among interpreters

Mémoire présenté à la Faculté de Traduction et d'Interprétation

Pour l'obtention du MA en Interprétation de Conférence

Directeur de mémoire : Prof. Lucía Ruiz Rosendo

Juré : Manuela Motta

Mai 2023

STUDENT INFORMATION:

Gráinne Mary Pyke

grapyke@outlook.ie

Faculté de traduction et d'interprétation

Université de Genève

40, boulevard du Pont-d'Arve,

CH-1211 Genève 4, Suisse

Table of Contents

ABSTRACT 4

ACKNOWLEDGEMENTS 5

1. INTRODUCTION 6

1.1 Research question and objectives 7

1.2 Methodology 8

2. HEALTHCARE INTERPRETING AS A PROFESSION 9

2.1 Community interpreting 9

2.2 The role of the interpreter 12

2.3 Interpreting trauma 14

2.4 Burnout and compassion fatigue 15

2.5 Vicarious trauma 16

3. PREVENTION AND MANAGEMENT OF VICARIOUS TRAUMA 22

3.1 Coping strategies 22

3.2 Organisation-level coping strategies 23

3.3 Personal coping strategies 26

4. EDUCATING HEALTHCARE INTERPRETERS 29

4.1 Healthcare interpreter training 29

4.2 Addressing vicarious trauma through training 33

4.3 *Secondary Trauma and Fostering Wellness for Interpreters* 36

4.4 *Breaking Silence: Interpreting for Victim Services* 39

4.5 *Interpreting sensitively and effectively for migrants, refugees and asylum seekers who have experienced sexual violence* 41

5. DISCUSSION 42

5.1 Awareness 42

5.2 Debriefing 43

5.3 Collaboration 44

5.4 Diversification 44

5.5 Personal coping strategies 45

5.6 Role play and case studies 45

5.7 Self-reflection 48

6. CONCLUSION 51

6.1 Limitations 52

6.2 Vicarious post-traumatic growth 52

7. REFERENCES 54

APPENDIX A: Healing Voices Course Syllabus (2012) 60

APPENDIX B: Training Outline: Interpreting sensitively and effectively for migrants, refugees and asylum seekers who have experienced sexual violence (2022) 61

ABSTRACT

Interpreters play an important role in the health and social care system. This article reviews the phenomenon of vicarious trauma among interpreters, assessing its incidence and manifestations. The research focuses particularly on interpreters in healthcare and those working with trauma survivors. It is based on the hypothesis that the impact of vicarious trauma can be mitigated through tailored, appropriate training. While previous studies of the vicarious traumatization of interpreters have tended to highlight its prevalence and focus on coping strategies to prevent it, this research is specifically focused on training as a key contributor to protecting interpreters' mental health. This study compiles key coping strategies and uses these as a point of reference to conduct an analysis of several training programmes. Three widely accessible training programmes, designed for interpreters, are analysed. It is contended that, while the training programmes are a valuable tool for interpreters, more must be done to ensure that the training is made available to interpreters, and that service providers are au fait with working with interpreters.

Keywords: interpreting, vicarious trauma, burnout, training, psychological impact

ACKNOWLEDGEMENTS

A particular thank you must go to my thesis supervisor, Professor Lucía Ruiz Rosendo, for her consistent feedback and guidance, and for allowing me to work so autonomously on this essay.

My thanks also to Manuela Motta for agreeing to be on the jury.

1. INTRODUCTION

The International Organization for Migration notes that "[u]nderstanding changes in [...] shifting demographics related to global social and economic transformations, such as migration, help us make sense of the changing world we live in and plan for the future" (World Migration Report, 2022). The number of people living outside their country of birth has increased threefold in the last half-century. In response to increasingly multicultural societies arising from this population movement, the healthcare infrastructure in migrant and refugee host societies must account for language services and incorporate their provision into present and future resource planning.

Garnering increasing attention in healthcare research is the issue of vicarious trauma. This secondary traumatisation occurs in those working closely with survivors. Figures vary depending on study design and methodology, but can range from 15% (DeLucia et al., 2019) to 55.9% (Purakal et al., 2021). Similarly, mental health professionals working with survivors of trauma like sexual violence and torture are often exposed to harrowing narratives. The emotional impact of these caring professions can take their toll on mental health over time. Interpreters are no exception. These language professionals play a fundamental role in bilingual healthcare interactions. A key pillar of the patient-interpreter-physician communication triad, they have often been left by the wayside when it comes to institutional support (Bancroft et al., 2016; Berthold and Fischman, 2014; Costa, 2020; Green et al., 2012; Hsieh and Nicodemus, 2015; Lor, 2012; Zimány, 2010). For a long time, physical health trumped mental health when it came to preservation and protection. Yet the reality is that in healthcare contexts, emotive messages, negative content, or the fact of working with vulnerable patients, leaves interpreters susceptible to "a significant accumulation of occupational stress" (Bontempo and Malcolm, 2012, p. 105), which can have serious consequences.

Compounding this issue is the fact that consistently, interpreters in medical contexts are not professionals. Rather, they may be relatives or friends of the patient, untrained interpreters or bilingual staff members who act as ad hoc interpreters (Antonini, 2015; Diamond et al., 2009; Hale et al., 2009; Lee, 2006; Schenker et al., 2011). Rising numbers of migrants throughout the world creates challenges for healthcare systems, and interpreters are an invaluable intermediary to avoid linguistic and cultural barriers. Some countries or regions have implemented legislation to better define who is eligible to work as a healthcare interpreter[1]. However, use of

[1] For example, in the United States, medical interpreters must have completed a minimum of 40 hours of training (Roat and Crezee 2015).

untrained interpreters pervades in many societies and contexts. Despite legislative accommodations, physicians may continue to make use of non-professional interpreters for a variety of reasons, including time constraints and budgetary considerations (Hsieh, 2015; Jaeger et al., 2019; Schenker et al., 2011).

This research project is an exploration of the impact on and risks to the mental health of interpreters working in healthcare and with survivors, and notably a study of the phenomenon of vicarious trauma. In recent decades, there has been increasing awareness among healthcare professionals regarding the risks of secondary traumatisation derived from working in situations of clinical urgency or with traumatised patients[2]. It goes without saying that the health service involves a breadth of staff, in both hospitals and community care settings, and interpreters who mediate patient-physician interactions are fundamental players in the bilingual healthcare game. It is therefore pertinent to consider the impact of work on the mental health of interpreters too. Unfortunately, as Hsieh and Nicodemus note, "there are few structured resources in either organizational settings or the industry for interpreters to cope with their experiences of emotional exhaustion or vicarious trauma" (2015, p. 1477).

This research intends to build on current research about working with victims of violence and trauma in healthcare settings. It will focus on the training and education of healthcare interpreters for the protection of their mental health.

1.1 Research question and objectives

This paper is an analytical study of existing literature. This research intends to answer the following question: *What training can be provided to healthcare interpreters to help them to cope with the impact of vicarious traumatisation?*

The research question will be answered through careful analysis of the risk of vicarious trauma to healthcare interpreters (through conceptualising their role in interpreted interactions and considering risk of exposure to traumatic content in the workplace), and the coping strategies recommended for healthcare professionals can be taught to interpreters to protect against vicarious trauma/risks specific to the professional environment. Armed with a toolkit of coping

2 A comprehensive review of 24 studies by Matthews et al. (2022) found higher than average rates of PTSD, depression and anxiety in emergency department personnel when compared to the general population.

strategies, three training programmes will then be analysed.

1.2 Methodology

This essay is analytical research into vicarious trauma and its prevalence among interpreters. It is qualitative in nature. The goal is to conduct a critical evaluation of current research and the understanding of the phenomenon of vicarious trauma (VT), in order to draw conclusions about training opportunities. In this way, this research aims to act as a stepping stone for further research into training programmes on trauma for healthcare interpreters and service providers. Furthermore, it is hoped that this work will serve as a point of reflection for healthcare professionals working with interpreters. It is worth noting that as this research is interpretive in nature, it is likely that some bias exists, despite efforts to remain as objective as possible.

The writing of this essay had several stages. The first chapter analyses and compares the main relevant literature on this topic carried out to date. It began with the reading of existing academic articles and secondary sources addressing the impact and manifestation of vicarious trauma in people who work in caring professions. Articles and books were sourced almost exclusively from the University of Geneva's online library search tool. PubMed® was also a useful source of relevant scholarship. This chapter serves as an overview of current knowledge, recurrent topics and research trends, to understand the roles and workplace context of traumatisation before analysing the training programmes.

Subsequently, there was extensive reading on how trauma can be prevented and managed. By analysing academic content and discerning recurring ideas and themes, five key coping strategies were identified, which are outlined in the third chapter.

With this, the researcher could proceed to look further into training programmes offered to interpreters on the topic of vicarious trauma. Finally, all of this will be applied to analyse a sample of existing training programmes for interpreters on traumatisation. Ultimately, to understand their structure and contents, to consider their effectiveness in preventing professional burnout and vicarious traumatisation. This meant analysing whether the programmes a) inform students about how what they interpret may affect them, b) teach them about vicarious trauma and c) equip them with coping strategies from the literature to protect them.

2. HEALTHCARE INTERPRETING AS A PROFESSION

2.1 Community interpreting

This research considers the risks of secondary traumatisation of interpreters exposed to traumatic content in healthcare settings. Healthcare interpreting is a branch of community interpreting (CI) which is also referred to as public service interpreting or liaison interpreting. CI involves facilitating an individual's interaction with a public service, like in a hospital or police station. Interpreting in the courtroom is an academically grey area, with some authors not considering this CI, but legal interpreting. However, CI is generally considered to encompass legal interpreting in all its forms. Interpreters essentially give their clients a voice, allowing people who do not speak a language required for communication in a society to access basic services (Bancroft, 2015). CI usually uses a consecutive mode of interpreting, during which an utterance is rendered in its entirety only once the speaker has finished. Unlike conference or media interpreting, the work of community interpreters directly benefits a person, as opposed to an institution (Bancroft, 2013).

Scholarly research in both translation studies and medicine has largely concurred that successful communication is fundamental for adequate health care provision. Language barriers have been shown to adversely affect patient health outcomes (Cambridge, 1999; Flores et al., 2003; Flores, 2005; Hale, 2007; Hsieh, 2015; Jacobs, 2001; Parrilla Gómez, 2020; Timmins, 2002). Following any plan of care in order for it to be successful can be a complicated task, and this is manifestly all the more true for those who have limited proficiency in the most widely spoken language in a society. By acting as the cultural and communicative link, healthcare interpreters can help to ensure that there is concordance between a patient and physician to ensure quality of care.

Another argument in favour of employing qualified, competent language professionals is that the use of such interpreters has been shown to reduce the likelihood of readmission and the average length of hospital stays (Flores, 2005; Karliner, 2007; Lindholm et al., 2012). As Hsieh notes, allophone patients "receive less preventive care, fewer referrals, follow-ups and public health services, but show more resource utilization […] when they do visit healthcare institutions" (2015, p. 177). Professional language services ultimately alleviate strain on the healthcare system, a compelling argument for establishments constantly struggling with budgetary constraints (Roat and Creeze, 2015, p. 242).

Despite clear developments in the understanding of the value of interpreters, and the coinciding professionalisation of the occupation[3], a misconception prevails of interpreting as an activity that may be carried out by any half-skilled linguist. For a variety of reasons, medical practitioners may call on untrained interpreters, including bilingual medical staff or family members, to facilitate a consultation. Because of time pressure, or perhaps in spite of it, and misunderstandings about the role of the interpreter, different actors may be called upon to interpret for allophone patients.

Given the immense variation between clinical settings and medical encounters, this is understandable, even practical, occurrence. Studies have corroborated that many cross-linguistic medical encounters involve untrained interpreters, if any at all (Diamond, 2009; Lee, 2006; Schenker et al., 2011). Non-professional interpreters may include friends or family members of the patient, bilingual staff members, or even multilingual bystanders. This practice persists (Kindermann, 2017; Zimány, 2010) despite evidence that professional interpreters contribute to increased quality of care and health outcomes. Studies indicate that allied interpreters and physicians work together towards common health goals, and professional interpreters raise the quality of patients' clinical care to be on par with counterparts without language barriers, as well as reducing length of hospital stays and readmission rates (Hsieh, 2015; Karliner, 2007; Lee, 2006). That said, both types of language professionals occupy different communicative roles in an interaction, and there are merits and demerits to each (Mori, 2020).

In order to ensure appropriate provision for language discordant patients, service providers must naturally first understand the function of an interpreter, regardless of whether the latter be a trained professional or a bilingual friend or family member. Some national health services in Europe and North America have published concise and accessible guidelines on the use of interpreters[4]. But of course, even when service providers understand how to use language brokers, Hsieh (2015) concludes that there are four principal considerations affecting choice of interpreter:

[3] the 2016 Affordable Care Act in the US obliges healthcare institutions to provide qualified interpreters to patients of limited English proficiency, setting an interesting legal precedent on a federal scale which reinforces the importance and acceptance of competent healthcare interpreters. In the UK, while non-proficiency in English is not explicitly considered an obstacle to care, the NHS has a legal obligation to reduce inequalities of access and health outcomes of patients. This is often interpreted as encompassing the provision of language services to patients with limited English proficiency

[4] For example, 'On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision if Interpreting Services', the 2009 handbook from the HSE Irish health system

Time Constraints

This is perhaps the most major factor influencing the decision to call a professional interpreter or not. Time spent on the logistics of arranging an interpreter, introductions and explanations, as well as the consecutively interpreted consultation itself adds up in a work environment where every minute is precious. NHS guidelines on the use of interpreters advise healthcare providers that "[w]hen an interpreter is required, additional time will be needed for the consultation (typically double that of a regular appointment)" (2018, p.6).

Alliances of Care

Healthcare providers seek to strike a balance between providing the patient with sufficient information to permit autonomous decision-making and active participation in care, and "patient receptiveness (e.g., feeling comfortable and agreeing to accept the proposed treatment)" (Hsieh, 2015, p. 78). A professional interpreter allies with physicians in the interests of patient care. National health service guidelines on using interpreters recommend booking the same interpreter for follow-up appointments in the interest of continuity of care, allowing rapport-building between the physician and interpreters.

Therapeutic Objectives

Providers' perception of clinical complexity and confidentiality are also factors in their choice of interpreter. Patients may not be willing to share information with an unknown interpreter, or conversely may be more inclined to do so. In mental health interpreting, therapeutic objectives may be conveyed in extremely precise phrasing or tone. For example, Bot notes that there are times when "patients gave relevant answers to the questions they heard from the interpreter's mouth. These questions, however, differed in therapeutic intention from the original questions phrased by the therapists" (2015, p.257). This underscores the importance of understanding the interpreters' role as active, and not as conduit.

Organizational-level Considerations

Professional interpreters imply an additional cost to a healthcare institution, and while this may be a worthy investment for large clinics or hospitals in multilingual, metropolitan areas, it is often impractical for smaller establishments where the number of patients who would theoretically benefit from the service simply does not justify the expense. That said, as Roat and Crezee stress, interpreters are ultimately a worthwhile investment, "help[ing] a hospital avoid costs it would have otherwise incurred in caring for LEP patients" (2015, p.242).

It has even been suggested that the lack of attention paid to the emotional impact of interpreters' work may boil down to the fact that interpreters have "traditionally been trained to adopt an emotionless, passive, and robot-like style of interpreting" (Hsieh and Nicodemus, 2015, p. 1477). Traditionally, the role of interpreters in healthcare was considered merely functional, limited to assisting communication. In recent decades, however, studies have emerged which challenge this perspective and put forward several alternative ways of framing the communicative role of an interpreter in physician-patient interactions (Bancroft, 2015; Hsieh, 2017; Roat and Crezee, 2015). In fact, interpreters often exercise a far greater influence over interpreted interactions.

2.2 The role of the interpreter

It is increasingly understood that interpreters play an active role in communication, and are co-participants in the interaction, as opposed to "an invisible conduit" (Angelelli, 2019, p. 151). The interpreter as an additional element in this traditional patient-physician dyad has been conceptualised in different ways. For the purposes of this research, the four communicative functions as set out by the Cross Cultural Health Care Programme, a pioneer entity in healthcare interpreter training since the 1990s, and point of reference for researchers in the field of bilingual health communication, will be considered. These are: interpreter as conduit, clarifier, cultural broker and advocate. These roles are also set out in the California Standards for Healthcare Interpreters (CHIA) as: message converter, message clarifier, cultural clarifier, and patient advocate. This is a model of incremental intervention which acknowledges the flexibility of the interpreter role while positioning the default function as purely communicative.

Conduit

The role of interpreter as conduit corresponds to the model of communication set out by American linguist Michael Reddy in 1979, which is the most basic notion of language mediation. According to this model, interpreters do not exercise agency. Here, they simply facilitate the communication process, rendering the words from one language to another, without interfering with what the speakers say, nor co-constructing meaning (Leanza, 2005; Angelleli, 2019). The interpreter does not take risks and there are no "unnecessary additions, deletions, or changes in meaning" (CHIA, 2002, p.42). This ideology of interpreter-as-conduit is particularly relevant in court interpreting, where it is requested that interpreters *translate* the

message, as opposed to *interpreting* it (the latter incorporating analysis and understanding of the utterance) (Hsieh, 2016).

Clarifier

Interpreters assuming a clarifying role make inexplicit information explicit. This may involve seeking clarification from either party, flagging potential cultural misunderstandings, or describing a concept for lack of a direct linguistic equivalent. As the term suggests, interpreters occupying this role seek to clarify some part of the utterance in order to understand the message. They may interrupt or use analogies to explain a term or concept to speakers, thus facilitating clear and concise information.

Cultural broker

Community interpreters are often native speakers of minority languages in society. They may have immigrated to a new society as an adult or grown up in a household which did not share societal culture (for example, an Eritrean family in London, or a Kurdish family in Warsaw). This permits them a privileged, albeit complex, dual culture understanding, and their role as interpreters is valuable beyond understanding the nuances of healthcare discourse. The interpreter may act as a cultural interface between participants, when it is necessary or appropriate to share relevant cultural information. In addition to flagging any cultural discordance that hinders mutual understanding, the interpreter may also "explain the cultural custom, health belief or practice of the patient to the provider or educate the patient on the biomedical concept" (CHIA, 2002 p.44) to clarify communication.

Advocate

In assuming the role of advocate, healthcare interpreters elect to become visible by advocating for or establishing alliances with either patient or physician. The interpreter may elect to take sides if necessary and defend the patient against the institution (Hsieh, 2016). They actively participate in support of the patient, transcending the communicative function of interpreting in order to advocate for a patient's quality of care if they perceive this to be at risk. This role is contentious, and the issue of interpreters acting as advocates for vulnerable patients has been debated as infringing on the basic principles of impartiality and neutrality defended in most codes of ethics for interpreters. Roat and Creeze (2015, p. 248) observe that:

> Professionals rooted in healthcare disciplines argued that ALL healthcare workers, including doctors and nurses, are called upon to advocate for patients on occasion. And interpreters

> coming from a social justice viewpoint saw advocacy in the face of ill treatment as a human responsibility.

However, the US National Code of Ethics for Interpreters in Health Care recommends that this only be "undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem" (NCIHC, 2004, p.3).

Evidently, in bilingual healthcare, interpreters play a more active role than simply translating words. They are more than mere language moderators. In her 2016 book, *Bilingual Health Communication*, Hsieh sets out a theoretical framework for interpreter-mediated medical encounters. She argues that limiting the assessment of healthcare interpreter performance to linguistic analysis (comparing the source and target texts, quantifying errors, etc.) falls short of understanding the impact an interpreter has on such interactions. Rather, analyses of the communicative event and its actors should first consider the goals of the medical encounter. Hsieh believes that interpreters should be considered as part of the healthcare team and work accordingly towards shared goals. This is extremely pertinent when it comes to understanding why interpreters are impacted by their work.

In bilingual healthcare encounters, each actor (patient, physician and interpreter) has individual agency, and understanding this is pivotal to fulfil communicative goals. Individual agency varies institutionally (power structure, institutional hierarchy, access to resources and professionalism), individually (educational background, self-efficacy skills, communicative competence, emotional status and motivational relevance) and interpersonally (relationships, social obligations and interactional dynamics) but ultimately remains a feature of all encounters (Angelelli, 2004; Hsieh, 2016). These factors influence all three interlocutors and therefore the communicative act. The individual agency of interpreters may be challenged or compromised in the communicative act, but it can also be leveraged and enhanced by strong communicators in order to enhance communication. Considering this, it is fundamental not only for interpreters to be provided with adequate training, but also for healthcare staff to be trained on the appropriate use of interpreters with allophone patients.

2.3 Interpreting trauma

Interpreting in mental health is a specific healthcare interpreting context to be considered. In mental health interpreting, there are two main types of stressors: those associated with the

interpreting skills and those associated with the emotional impact of the sessions. Since psychological disorders involve thoughts, feelings and behaviours, language become the tool for diagnosis and treatment of many mental health conditions. The interpreters' role is of paramount importance, and they must be able to scale up and down their involvement as appropriate, as discussed in the previous section. Interpreters must pay attention to how a patient uses language at all time, even when speech is incoherent, so as to provide the therapist with as much material as possible to work with. The interpreter must remain "a language and communications expert, not a habit, values and norms expert" (Bot, 2015, p. 263). How a therapist manages a session varies based on their methods, experience and idiosyncrasies, meaning that it can be an ambiguous area of interpreting (Gómez, 2012, p. 10). It is important that interpreters and therapists have a strong working relationship and mutual understanding in order for a session to function. Roat and Crezee suggest that in the future, interpreters may be required to take specialised training on interpreting for mental health to hone their skill set (2015, p. 250).

Mental health interpreting presents several area-specific dilemmas. These may only be exacerbated when the patient is a migrant or refugee. As Royuela (2021, p.48) notes:

> Specifically, and as stressed by other authors, (Casillas et al, 2016; Dominicé Dao, 2018), I believe it is useful to take into account the patient's status as a refugee, and therefore the difficulties this implies for the patient. Beyond personal beliefs and personalities, distress, administrative issues and economic difficulties unique to the refugee's situation also affect the medical encounter.

Due to the nature of sessions, interpreters working in mental health may be particularly vulnerable to burnout and vicarious trauma. Indeed, much research into the impact of work on interpreters' mental health considers those working with clients who are refugees or asylum seekers. Several of these studies will be reviewed in the following section on burnout and the vicarious traumatisation of interpreters.

2.4 Burnout and compassion fatigue

As interpreters play a key role in healthcare encounters and may have to interpret in an environment which is "inherently stressful and sometimes quite traumatic" (Bancroft, 2015,

p.229), they are susceptible to becoming overwhelmed. Several terms may be used to describe the varying levels of stress experienced by interpreters, including: *burnout,* which is used to refer to protracted workplace stressors like unmanageable workload, inter-collegial conflicts and inconsistent working hours; and *compassion fatigue,* which refers more specifically to the exhaustion experienced when excessive emotional energy is expended on patients over a prolonged period of time (Mento et al., 2020; Zhang et al., 2018). This distinction is important, as the origins of these problems are very different. Burnout and compassion fatigue should be considered as separate risks and palliated accordingly. As Sultanić (2023) notes, interpreting for vulnerable populations is a form of emotional labour. Intense emotional engagement with patients is simultaneously an inherent part of caring professions, and an occupational hazard.

The impact of emphatic engagement of interpreters with patients is the area of focus for this research. Repeated exposure to traumatic information and an accumulation of stress and burnout, in particular untreated, risks morphing into the more serious issue of vicarious, or secondary, trauma.

2.5 Vicarious trauma

The British Medical Association defines vicarious trauma (VT) as:

> … a process of change resulting from empathetic engagement with trauma survivors [and] anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including doctors and other health professionals. (BMA, 2022)

Other terms such as second-hand trauma or secondary traumatic stress disorder may be employed to refer to similar phenomena. The term 'vicarious traumatization' was coined by Pearlman and McCann (1990). They described how consistent exposure to traumatic material has a cumulative harmful impact on psychological wellbeing. Fundamental psychological needs (namely safety, dependency/trust, power, esteem, and intimacy) are undermined when cognitive schemas are disrupted through trauma, perverting a person's understanding of the world. VT, according to Pearlman and Saakvitne, involves "profound changes in the core aspects of the [...] self" (1995, p. 152). It leads to a pervasive sense of discomfort which extends beyond the realm of the professional and has the potential to seriously impact practitioners'

personal lives.

VT can have cognitive, emotional, behavioural, spiritual, interpersonal and physical consequences (see Fig 1), and manifests as PTSD-like symptoms (Birck, 2001; Canfield, 2005; Ndongo-Keller, 2015; Pearlman and Saakvitne, 1995).

Personal Impact of Vicarious Trauma

Cognitive	Emotional	Behavioural	Spiritual	Interpersonal	Physical
• Diminished concentration • Confusion • Loss of meaning • Decreased self-esteem • Preoccupation with trauma • Trauma imagery • Apathy • Rigidity • Disorientation • Whirling thoughts • Thoughts of self-harm or harm toward others • Self-doubt • Perfectionism • Minimization	• Anxiety ▪ Guilt ▪ Survivor guilt ▪ Shutdown ▪ Numbness ▪ Fear ▪ Helplessness ▪ Sadness ▪ Depression ▪ Hypersensitivity ▪ Emotional roller coaster ▪ Overwhelmed ▪ Depleted ▪ Powerlessness	• Impatient • Irritable • Withdrawn • Moody • Regression • Sleep disturbances • Appetite changes • Nightmares • Hyper-vigilance • Elevated startle response • Use of negative coping (smoking, alcohol, other substance misuse)	• Questioning the meaning of life • Loss of purpose • Lack of self-satisfaction • Pervasive hopelessness • Anger at God • Questioning of prior religious beliefs	• Decreased interest in intimacy or sex • Mistrust • Isolation from friends • Impact on parenting (protectiveness, concern about aggression) • Projection of anger or blame • Intolerance • Loneliness	• Sweating • Rapid heartbeat • Breathing difficulties • Somatic reactions • Aches and pains • Dizziness • Impaired immune system

(Yassen, 1995)

Image 1. The Personal Impact of Secondary Traumatic Stress (Yassen 1995)

VT is a documented phenomenon among healthcare professionals. Due to the nature of their work, therapists, social and emergency workers and first responders are particularly prone to the long-term effects of trauma (Skogstad et al., 2013). In the United States, the prevalence of PTSD in adults is estimated to be 3.8%, although this figure varies greatly depending on study design and methodology. Recent research by DeLucia et al (2019) surveyed 526 emergency physicians and found the prevalence of PTSD to be 15.8% in this group. Similarly, Matthews et al.'s (2022) comprehensive review of 24 studies by Matthews et al. found higher than average rates of PTSD, depression and anxiety in emergency department personnel when compared to the general population. These patterns are replicated among therapists and other health professionals (Canfield, 2005; Creese, 2021). According to Bancroft (2016, p. 72), "the difference is that health professionals are trained to address the stress and trauma of their jobs, and most interpreters are not".

In certain contexts, and especially when it comes to minority languages, interpreters for refugees and asylum seekers may have once been in the shoes of their refugee clients. This is an exacerbating factor, as having unresolved trauma or having previously been a victim of trauma has been shown to increase a person's vulnerability to VT. Other risk factors include mental health disorders, being a woman, a lack of support structures, instability in non–work-related areas of one's life, negative coping strategies and working with patient populations who disproportionately experience trauma (Bontempo and Malcolm, 2012; Ndongo-Keller, 2015). A taxing professional environment can also increase vulnerability to VT, if issues such as excessive workload, unclear scope of work, and dissonance between institutional public-facing commitments to vulnerable populations and internal policies and incentives (Ravi et al., 2021) pervade. While physicians, therapists, and others working with traumatic material expressly work to improve patients' emotional and physical state, interpreters may experience a sense of powerlessness, as a mere spectator in the face of pain.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the standard in American psychiatric diagnosis, currently includes repeated secondary exposure to trauma as a risk factor for development of PTSD. Despite progress being made in certain regions, many physicians remain at risk, and many will experience PTSD from work at some stage. While it has been well-documented that physicians are at risk of developing trauma in their professional settings, this academic acknowledgement has yet to percolate down to training institutions. Interpreters work alongside medical professionals, sometimes on a daily basis (depending on role/training/profession) and form part of a carefully orchestrated communication triad of patient-interpreter-physician. They facilitate interactions which may involve grief, pain, suffering, abuse and/or trauma. Interpreters find themselves in a predicament whereby if they try to emotionally detach from a scenario, "minimisation and distortion could eas[ily] happen through the process of interpretation, as the client's words are subtly altered in the translation given to the therapist", but, on the other hand, if they seek to identify with the client as a means of managing distressing information, "they risk being overwhelmed in the session" (Butler, 2008, p.8). Another factor contributing to the risk of VT in interpreters is the common use of the first person in interpreting, which only exacerbates the psychological impact of highly emotional content (Berthold and Fischman, 2014; Bontempo and Malcolm, 2012).

It is important for both trainers and interpreters themselves to be cognizant of the association between exposure to traumatic material and cumulative stress, and for the topic to be addressed

in education programmes. This would allow students to develop coping strategies, mitigating harmful effects. Research and development often emerge in response to a problem, not predicating one. While research into the phenomenon of VT has developed in recent decades, it has been noted that little research has been done regarding VT as an occupational hazard in the field of interpreting (Gomez, 2012; Lor, 2012; Bontempo and Malcolm, 2012; Ndongo-Keller, 2015). Research into interpreter-mediated encounters between refugees, asylum seekers and victims of torture and mental health professionals and interpreters in criminal tribunals has evidenced the serious consequences the repeated exposure to traumatic content has on the mental health of interpreters and highlighted the lack of formal support structures to deal with the emotional impact of work (Bontempo and Malcolm, 2012; Butler, 2008; Kindermann et al., 2017; Lai and Heydon, 2015; Lor, 2012; Ndongo-Keller, 2015). The work of Bontempo and Malcolm (2012) particularly contributed to shedding light on the issue of VT among interpreters, and their work has been an especially valuable source of information for this essay.

Bontempo and Malcolm published a comprehensive book chapter on the emotional impact that healthcare interpreting has on sign language interpreters. Their paper defines VT and outlines the particular challenges of interpreting in healthcare settings (for example, specific jargon, environmental factors, etc.). They outline both personal and organizational strategies to ensure that interpreters employ positive coping techniques. It is noted that education and training is a fundamental part of protecting interpreters, and in particular, role play, reflective journalling, and peer network-building are encouraged.

On her part, Ndongo-Keller (2015) details how, following several years of work listening to survivor stories and witness accounts, interpreters lives and thoughts became severely disrupted. Ndongo-Keller surveyed four colleagues on the psychological, emotional, physical, professional, and spiritual impact of hearings at the International Criminal Tribunal for Rwanda. Again, this author notes that the vulnerability of interpreters must be recognised and responded to through positive coping mechanisms and organisational support, and highlights that “this situation must be addressed, for it would be preposterous, not to say tragic, if interpreters […] set out to save lives, yet ended up losing their own” (2015, p. 349).

Numerous other studies conducted on the issue of VT among interpreters corroborate this data and underscore the real-life impact of working with survivors. These include Kindermann’s 2017 study involving psychometric surveys and the assessment of interpreters for symptoms of anxiety and depression. 64 interpreters for refugees were surveyed, and showed a 21%

incidence of secondary traumatisation, and comparatively higher scores for depression and anxiety than among normal population.

Similarly, a qualitative study by Lai and Heydon collected data from 271 community interpreters in Australia. The online survey revealed that "68% of Victorian community interpreters have to confront traumatic client material about an hour per week of their interpreting assignments, and a third of these are experiencing exposure averaging 3.5–10 hours per week in their interpreting assignments" (2015, p.9). The study found that 78% feel some degree of distress when they encounter traumatic client content.

This echoed results from Splevins et al. (2010) and Lor (2012). Both of these qualitative studies considered the impact of working with survivors on interpreters. Splevins et al. found that "all participants in the current study described intense emotional reactions and symptoms of distress in the early stages of their job" (2010, p. 1712). However, the study notes that working with survivors had an overall positive impact on interpreters' lives. Lor conducted interviews with four interpreters in Minnesota, working in mental health settings with trauma survivors found that they "struggl[e] to manage the emotional, psychological, and cognitive impact that comes from working with traumatic client material" (2012, p.44).

These findings were corroborated by a qualitative review by Rajpoot et al. of 18 studies into the experiences of interpreters when working with survivors of domestic violence, abuse or other trauma. It identified the "psychological and emotional impact of interpreting" (2020, p.9) as a key theme in all the studies. The review found that interpreters suffer from fatigue and burnout due to consistently listening to and recounting stories of extreme violence and having to break bad news. The studies reviewed use a variety of terms, including vicarious trauma, PTSD and secondary PTSD, to describe a similar phenomenon.

These studies offer an extremely valuable insight into the impact of trauma on interpreters, and it is increasingly evident that community interpreters are prone to VT. Turning a blind eye to stress among interpreters in healthcare and for survivors means compromising interpreter wellbeing. On the one hand, this may lead to poor professional performance or errors which erodes patients' quality of care and ultimately risks undermining the integrity of the entire profession. On the other hand, unchecked stress may accumulate and lead to VT, with serious psychological and even physical impacts on an interpreter. The right investments must be made to equip interpreters with tools to identify stressors and potential triggers for VT. In an interview conducted by Korpal & Mellinger, one interpreter stated that "...I think that [I] just

constantly [remind] myself that I have the training and the skills to deal with conflict" (2022, p. 283). This sentiment is precisely the driver behind this research. Language skills are just one of the many factors that can influence an interpreter's performance and confidence. As Tedjouong and Todorova note, many challenges faced by interpreters in conflict boil down to "a lack of adequate, real-life, and context-specific training" (2023, p.102). It is critical to provide interpreters across the board with the right tools through training and preparation for assignments, including mental and emotional support mechanisms. This is fundamental to protect interpreters' sense of self-efficacy, which in turn protects their sense of self and confidence, and ultimately serves to maintain the integrity of the profession. The following section will consider methods of dealing with VT, and later we will consider how these may be incorporated into teaching curricula for interpreters.

3. PREVENTION AND MANAGEMENT OF VICARIOUS TRAUMA

3.1 Coping strategies

In order to prevent and manage post-traumatic stress disorder (PTSD) and vicarious trauma (VT), coping strategies, mechanisms or behaviours are employed. The American Psychological Association (APA) defines these as “an action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation or in modifying one’s reaction to such a situation. [They] typically involve a conscious and direct approach to problems” (APA, 2022). These behavioural and cognitive tactics employed by individuals seek to re-establish a sense of wellness following disruptive events. Although a variety of terms and techniques exist, for the purposes of this research they will be grouped into four system-, or organisation-level strategies: awareness, debriefing, collaboration, diversification; and personal coping strategies (Bontempo and Malcolm, 2012; Costa 2020; Hsieh and Nicodemus, 2015; Ndongo-Keller, 2015; Pearlmann and McCann, 1995; Ravi et al., 2021). More weight is deliberately given to organisation-level coping strategies, considering that even if an individual adopts healthy coping strategies, this can only partially contribute to curbing the problem, and positive impact will be minimal “if an employer does not address the work environment and conditions that put workers at risk of traumatisation” (Bontempo and Malcolm, 2012, p. 117).

In one survey, Canfield (2005) found that the likelihood of VT developing in psychotherapists ultimately comes down to the implementation of protective measures, rather than the prevalence of risk factors. This highlights the importance of developing robust coping strategies in order to preserve mental health, both in the face of, and before, exposure to adversity. If the problem of VT is neglected among healthcare professionals, major risks of long-term damage to psychological well-being and recourse to negative coping strategies, like substance abuse or social isolation, prevail. This is evidenced in statistics documenting higher rates of substance abuse and PTSD among healthcare professionals than other demographics (Cottler et al., 2013; DeLucia et al., 2019; Matthews et al., 2022; Purakal et al., 2021).

While it would be unscrupulous to extrapolate this data to interpreters, and some studies have found that interpreters are impacted by their work with trauma victims to a lesser extent than physicians and therapists (although still affected) (Birck, 2001; Kindermann, 2017), it is important to be cognizant of the environment in which interpreters are working. It has also been noted that as the interpreter speaks in the first person, there is a major impact on their cognitive schema (Bontempo and Malcolm, 2012; Hsieh, 2015; Ndongo-Keller, 2015), and

evidence of VT among language professionals is indisputable. Working in healthcare and with trauma survivors is taxing by nature, requires mental agility and resilience, and involves working with vulnerable patients. Ultimately, the risks of cumulative stress and VT form an integral part of healthcare and trauma interpreting. It is therefore appropriate to equip interpreting students with adequate resources to identify, understand and cope with these phenomena.

3.2 Organisation-level coping strategies

The following section compiles techniques and strategies that may be implemented by employers or service providers in order to protect interpreters from the emotional impact of assignments with survivors. They do not come from the interpreters themselves, but rather are in place as support mechanisms. In this way, the burden of protecting and preserving mental health does not fall exclusively to the interpreters themselves.

Awareness

Here, the term awareness refers to all types of formal learning and education, as well as information obtained from peers or through autonomous research. In order to protect themselves in the face of adversity, all professionals, regardless of their field, must first have an understanding and awareness of occupational hazards, and be informed about VT (Korpal & Mellinger, 2022; Ndongo-Keller, 2015). This is the first step to addressing and alleviating the problem. When it comes to caring professions, being informed about the impact of stress and trauma on the mind and body is of key importance, in order to develop an arsenal of prevention and coping strategies. As Bontempo and Malcolm explain, "[f]ormal learning about grief, loss, suicide, depression, neglect, mental health, abuse, and other emotionally difficult topics, [...] would help mitigate to an extent the powerful impact of these topics in a real crisis" (2012, p. 125). These emotional experiences are commonplace in the lives of emergency physicians, nurses and the interpreters working alongside them.

While international recommendations[5] exist regarding the training and instruction of workers manually transporting loads, with a view to safeguarding health and accident prevention, considerations of occupational hazards to psychological wellbeing health tend to lag behind. A

[5] In 1967, the International Labour Organization adopted the Maximum Weight Convention on with regard to maximum permissible weight to be carried by one worker.

lack of awareness regarding VT can be problematic, as “[i]ndividuals experiencing vicarious trauma may not recognize that their difficulties are related to their occupational trauma exposure, potentially leading to defensiveness or embarrassment” (Ravi et al., 2021). This is in addition to the withdrawal which often accompanies development of VT. As well as compromising professional performance, these reactions can make it especially complicated for well-meaning peers to intervene, and ultimately provoke a downward spiral of compromised mental health.

Awareness develops over time. In certain studies, length of service is frequently cited as a factor contributing to developing resilience and learning to deal with the impact of exposure to trauma (Lor, 2012; Splevins, 2010). In others, even seasoned interpreters continue to be affected by things that they hear and say (Lai and Heydon, 2014). However, it would be preferable to introduce the topic of mental health and VT very early on in an interpreter’s career, and ideally during training, prior to taking on potentially injurious work.

Debriefing

Debriefing is a tool which may be used formally (such as in an organised session with a psychologist) or informally (with team members). A formal debriefing session following an adverse or traumatic situation may be a useful tool for combatting the harmful effects of exposure to trauma. Debriefing is intended to prevent trauma from taking root and festering, by giving individuals a space to review the traumatic event, share their feelings, and consider useful coping strategies for the future. In one study of 222 sign language interpreters, debriefing was the most utilised strategy for coping with symptoms of VT (Knodel, 2018). On an institutional level, through regular debriefing sessions “supervisors may monitor the interpreter’s well-being and provide psychological interventions if necessary” (Crezee, 2015, p. 79).

It must be noted, however, that debriefing for therapists, and indeed their interpreter counterparts, is contestable, by virtue of the nature of their work. As Pearlman and McCann observe, the sense of isolation derived from the psychological distress is “compounded by the requirement for confidentiality in psychotherapy, which precludes one’s ability to reveal the disturbing traumatic material” (1990, p. 141). Interpreters may struggle with a similar discordance with their ethical standards, which emphasise confidentiality and maintaining boundaries. However, the code of ethics does not prohibit interpreters from speaking about an assignment entirely, as long as a client’s identity is not revealed (Bontempo and Malcolm, 2012).

The effectiveness of debriefing has been contradicted in numerous recent studies over the past two decades. It has been identified that a single debriefing session may have no effect at all, or even a compounding impact on PTSD (Rose et al., 2002). It is therefore advisable to avoid compulsory debriefing sessions, and rather to make them available as an optional resource.

Collaboration

Collaboration encompasses tools like "collegial support systems" (Canfield, 2005, p.98), "[keeping] up with connections" (Fawcett, 2003, p. 7), "efforts to create a supportive, communicative work environment" (Somville, 2016 p.8), and working with colleagues to balance workloads and schedules. For healthcare professionals and their interpreters, collaborating with colleagues can serve as a valuable coping strategy when it comes to exposure to material that may negatively impact mental health. Figley (2002) and McCann and Pearlman (1990) advocate for talking openly to other professionals, who can offer professional, intellectual and emotional support, and a valuable "chance to offload" (Costa et al., 2020). In addition to peer support, there is clear evidence to suggest that having "a supportive and empathic supervisor" (Canfield, 2005) plays a major role in offsetting the impact of VT and stress. Buddy, or mentoring, programmes between experienced and inexperienced employees may be a useful option for interpreters starting out. These can be helpful in high-pressure situations and make staff feel less alone and isolated.

Healthcare interpreters are exposed to a diverse range of actors. It is therefore necessary to expand this strategy of collaboration beyond the interpreting team, and include administrative staff, nurses, physicians, and patients themselves. National healthcare system guidelines on the use of interpreters often recommend that, where possible, the same interpreter be used for follow-up sessions with a patient. This provides the interpreter with the valuable opportunity to construct a working relationship with a patient. Accompanying a patient along a journey can be immensely satisfying for interpreters, and the compassion satisfaction derived from the experience can quell the harmful effects of trauma exposure.

Collaboration can also comprise mutual support and assistance between the healthcare professionals in the patient-interpreter-physician triad. Having a healthy working relationship with physicians is essential when it comes to confidence and competence in an interpreter's workplace (Butler, 2008; Leanza, 2005; Miller et al., 2005; Zimány, 2010), but alas, is often overlooked. It is recommended that physicians be trained to work with interpreters, "in a

supportive and facilitative way, acknowledging their personhood and not just their language skills" (Butler, 2008, p. 10).

Diversification

It is important to diversify cases in order to deter the cumulative negative effect of exposure to trauma. With the appropriate professional support, interpreters may be able to take this into account when planning their work. Pearlman and McCann describe this as "balancing victim with nonvictim case" (1990, p. 146) for therapists, and Ravi et al. label it as "strategic scheduling…[to anticipate and limit] the number of emotionally challenging cases during a clinic session and deliberately scheduling such visits at times when the physician feels the most equipped with emotional reserve and ability to focus" (2021, p. 572). Similarly, Crezee recommends that interpreters "limit workload and the number of stressful cases to ward off possible burnout" (2015, p. 77).

In a survey of 259 therapists, Bober and Regehr (2006) found a direct correlation between number of hours spent working with victims of trauma per week and increased levels of traumatic stress symptoms. This underscores the importance of diversification and taking on clients from a variety of clinical backgrounds.

Nonetheless, the workload of physicians and therapists is conditioned by a vast range of factors: type of healthcare establishment, clinical speciality, geographical location, etc. The workload of interpreters working alongside these physicians is further delineated by language combination. Considering these external factors, diversification could be perceived as somewhat of a luxury, a strategy which can only be applied in a limited number of circumstances.

3.3 Personal coping strategies

While in an ideal world, adverse events in the professional sphere would not contaminate one's private life, reality is quite different. The pandemic, which gave rise to a widespread increase in remote working, compounded this predicament, as bedrooms, living rooms and kitchens were transformed into offices and classrooms overnight. Developing the ability to emotionally detach from the professional sphere outside working hours is valuable for any professional, and this is all the more salient when it comes to caring professions and working with traumatised clients.

In conjunction with structural and workplace supports, it is recommended that individuals in healthcare apply strategies on a personal level to curb the risk of VT. Healthcare interpreters may make a conscious decision to seek coping strategies, upon experiencing adverse reactions to cases at work, or may do so under the auspices of a colleague or superior. "[A] combination of external support and personal coping techniques" (Splevins et al., 2010, p. 1711) is advisable to cope with the impact of difficult or overwhelming material.

Healthcare interpreting is a demanding task, and it is therefore advisable that interpreters, just like other healthcare professionals, invest time in their wellbeing. This includes efforts to incorporate routines or activities in their personal lives to counter the impact of trauma. Self-care has become a real buzzword over the past few years. The term denotes the rituals and practices designed a) to prevent illness from developing and b) to promote relaxation and to avoid and reduce stress (Cambridge English Dictionary, 2023).

Self-awareness and self-care are fundamental for workers who emphatically engage with clients, in order to "attend to [...] emotional, spiritual, psychological and physical needs" (Pearlman and Saakvitne, 1995, p.153), and for healthcare interpreters to "maintain their physical, mental, or emotional health, as well as stay robust enough to carry out and fulfil their work and responsibilities" (Costa et al., 2020 p.40), ultimately ensuring motivation and career longevity. Personal coping strategies usually include things like good sleeping patterns, meditation and/or spiritual practices, leisure time and physical activities, etc.

However, despite the emphasis placed on developing personal coping strategies, in their cross-sectional design study, Bober and Regehr note that "there was no association between time devoted to leisure, self-care, research and development, or supervision and traumatic stress scores" (2006 p.7), which subverts the prevailing assumption that these practices are a useful tool for reducing symptoms of traumatic stress. When it comes to dealing with work-related stress and VT, the onus tends to be placed on the individual, and how they manage their work and personal life. A pilot study conducted by the NGO Colleagues Across Borders and Madrid's University of Alcala offered asylum interpreters remote, formal support to investigate whether it was effective at increasing "resilience, self-care, confidence, and professionalism" (Costa et al., 2020, p.37). While results of this pilot training scheme were positive, it is not appropriate to lay the burden of responsibility predominantly on the individual. Bober and Regehr found that "the primary predictor of trauma scores is hours per week spent working with traumatized people, the solution seems more structural than individual" (2006, p. 8).

Therefore, it would be of greater benefit to offer a programme to decision-makers and management in clinical settings, educating them about workplace stressors and the impact of traumatic material.

Professional competence is, of course, the primary factor in successful healthcare provision. However, it is clear that the scope of competence goes beyond theoretical knowledge and practical skills, and must take the mental and physical health of workers into account. Only this allows the optimisation of working conditions, for the benefit of all. In the following section, consideration will be given to the training of healthcare interpreters, to establish if the coping strategies set out in this chapter are included in interpreter education.

4. EDUCATING HEALTHCARE INTERPRETERS

This next section will focus on interpreter education and training. Scholars note that the right training is key to protecting interpreters from emotional and psychological strain. Therefore, three programmes, which have been designed for interpreters working with traumatic content, will be analysed, in order to determine whether they align with the literature on preventing vicarious trauma (VT).

As established, VT can have a profoundly negative, often insidious, effect on an interpreter's personal and professional life, and numerous studies have corroborated the incidence of VT among interpreters. A widespread lack of appropriate training has also been highlighted (Bontempo and Malcolm, 2012; Ndongo-Keller, 2015; Zimány, 2010). Yet, strategies do exist to curb the harmful effects of working with traumatised clients. By understanding VT as an occupational hazard, resources and funding may be made available for further research and the development of training programmes. Adequate training, including basic awareness-raising among students, protects the interpreter by equipping them with the resources to understand and process information in an objective, professional capacity, which improves professional performance and overall wellbeing (Bontempo and Malcolm, 2012; Butler, 2008). It would therefore appear to be a necessary step towards preserving interpreters' mental health. As research into burnout and VT among interpreters progresses, it follows that over time, it will become increasingly prevalent in interpreter education. This would not only reap rewards for the interpreters themselves, but a host of ensuing benefits will also exist for healthcare staff and patients.

In order to understand how this research may be applied to training programmes, let us first set out an overview of education and training opportunities for healthcare interpreters. This is useful for understanding the pedagogic environment.

4.1 Healthcare interpreter training

In recent decades, there has been a rise in demand for language professionals to bridge emerging communication gaps in increasingly plurilingual societies, and with this, rapid developments in the field of interpreter education. This is a heterogeneous domain, in that courses and programmes come in a wide variety of formats. What's more, despite the evident importance of healthcare interpreters, their increasing relevance in today's globalised societies, and the clear challenges presented in this line of work, formal training and education opportunities specific to this domain remain exiguous. It is not unusual for community

interpreters to have no formal training (Hale et al., 2009; Tiselius, 2022), although some may graduate with a community or public service interpreting degree or follow a certificate course. Although there has been an increase in accredited, formal training programmes, the situation varies greatly between countries (Angelelli, 2019). In the United States, minimum training requirements to become a medical interpreter include having a high school diploma and having followed a 40-hour accredited programme, although the structure of these programmes varies enormously. Currently in Europe, no universal minimum training requirements exist (Sultanić, 2021).

Evidently, content and learning formats vary enormously from programme to programme. That said, most professional development for community interpreters comprises training opportunities, which are "task-oriented and skill-focused" and involve "learning specific job-related skills" (Angelelli, 2019, p.7). Education opportunities, offering a broader, more comprehensive acquisition of knowledge relating to the profession, are rarer. The latter allows scope for critical thinking and problem-solving, which is essential in bilingual healthcare encounters (Angelelli, 2019; Hseih, 2016). Though relevant, acquiring terminology should not become the exclusive focus of training and education, because this undermines the importance of the cultural, professional and sociocultural context of interpreted events - something which even more extensive training programmes may overlook (Angelelli, 2019). Without a broad, comprehensive education, interpreters may lack certain critical thinking skills, and tools for the contextualisation and comprehension of nuanced healthcare discourse. Such skills are key in understanding both their role in the patient-interpreter-physician communication triad, and how their interlocutors perceive their role. Extensive, ongoing education allows interpreters to understand macro and micro issues at play for healthcare interpreters. However, due to a lack of resources or demand, such education may not always be readily available. Therefore, training is the next best option, and it comes in diverse forms.

Higher education

While growing interest in this area has led to a boom in Masters programmes in North America, Europe and China, these are often focused on Conference Interpreting[6], or combine Translation and Interpreting studies. To our knowledge, there are currently no university degree

[6] Notably in the European Union, the EMCI is a consortium of 16 member universities, established in 2001 with the aim of producing high-quality professional interpreters to meet the EU's demands. EMCI programme curricula cover the theory of interpreting, its practice, consecutive mode, simultaneous mode and the EU institutions and international organisations.

programmes dedicated exclusively to healthcare interpreting, because this tends to be considered a sub-category of community, or public service, interpreting (Angelelli, 2019; Sultanić, 2021). University degree programmes may include a module specific to healthcare interpreting. For example, the MA in Interpreting at Queen's University Belfast in Northern Ireland includes a 20-credit module on public service interpreting, which "prepares students for practice in the voluntary sector, and judicial and health environments" (Queen's University Belfast, 2023).

Online training

Little research on training in this post-pandemic era would be complete without acknowledging the boom in online learning. The International Medical Interpreters Association (IMIA) offers a plethora of Internet-based courses. A search on their website generates 20 results for in-person training sessions, and an impressive 424 for online workshops. This trend of increasing digitisation constitutes a real paradigm shift for education. Advantages are clear, including increased accessibility, decreased travel costs for students and educators, continuity in times of disruption, and content that may be reused and upcycled. That said, the shift is not without its demerits. For example, online learning demands greater self-discipline of its learners, and risks creating a sense of isolation. Particularly for addressing topics like mental health, peer support and networks are hugely beneficial. The interpersonal experience of being together in a room is near impossible to recreate in a virtual learning environment, although increasingly, virtual platforms offer a breakout room feature, which allows participants to discuss in smaller groups. Hybrid or blended courses may also offer a practical solution to this problem, with learners benefitting from both in-person interactions and online activities (Bao, 2015, p.250).

Seminars, conferences

A further option for training is seminars, conferences and symposiums, about topics related to interpreting. One-day events might also be useful. Seminars and conferences, although brief, are usually run by experts. They may therefore be an opportune forum for teaching interpreters about burnout and VT, by providing healthcare interpreters with specialised knowledge and the latest research in the field. Furthermore, conferences offer participants the chance to build peer support and to network. The CHIA's annual conference even includes a networking lunch and breakfast. CHIA's 2023 edition included two-hour workshops on 'Interpreting Consents for Clinical Trials' and sight translation, and one-hour breakout sessions on diverse topics, including vaccine types and mental health interpreting.

Short courses

There are an abundance of short courses, workshops and certifications on offer for interpreters (Bao, 2015). These have become popular globally as opportunities for continued professional development and upskilling. They come in diverse forms and abound in the field of healthcare interpreter education. The most common programmes include refresher courses (for example, on note-taking skills), basic interpreting courses for a specific field, and customised, highly contextualised courses by specific organisations. Such programs may be offered by:

- Universities, such as ISIT in Paris, which offers a one-day course for interpreters on 'Stress management and emotional resilience for interpreters'. This is divided into three parts, namely the physiology of stress and stressors in interpreting, honing reactions to stress and simulations of stressful situations. Similarly, Monash University in Victoria has created a four-hour virtual course on stress management for interpreters, which covers the topics of 'professional interactions, stress management, self-care and mindfulness'. Assessment involves completing practical tasks throughout the course;
- Government agencies, such as the Office of Victim Services and Justice Grants of Washington DC, who pay for interpreters to participate in *Breaking Silence: Interpreting for Victim Services*. Similarly, following an influx of Ukrainian migrants, Ireland's Department of Health launched three pilot microcredential courses for 'people working as interpreters or planning to do so in the future, as well as advocacy workers, social workers, migrant activists, clinicians and healthcare planners with a level 8 qualification in any area' (University of Limerick, 2022). These are six-week, part-time courses, on Communication and Interpreting in the Irish Healthcare System, ethics and interpreting practice;
- Charity organisations, like the Dublin Rape Crisis Centre or the Irish Refugee Council;
- Interpreting agencies or private companies.

Short courses allow interpreters to learn, grow, and build skills throughout their career. For certified courses, entry requirements may be more stringent, and the interpreters' skills are officially validated and recognised. Short courses and workshops may be accredited and offer the convenience of allowing participants to dedicate a set amount of time to a topic, meet peers (although these courses are increasingly offered online) and acquire knowledge quickly. Some courses offer follow-up activities or subsequent sessions to consolidate and further learning.

However, "short programs often leave little time for reflection, practice and improvement" (Bao, 2015, p. 406). They may also only be offered once, or annually, in which case scheduling

conflicts are hard to avoid.

4.2 Addressing vicarious trauma through training

In order to address the problem of VT among interpreters, it is important to consider how this subject matter may be incorporated into training. Several researchers have proposed training curricula which address the emotional engagement of interpreters.

For example, Image 2 below is taken from research by Berthold and Fischman (2014) on interpreters working with social workers. They stress the need for the adequate training of interpreters working with refugees, and ongoing organizational support. Point four considers informing interpreters about challenges in the field on mental health interpreting, "with an emphasis on trauma and secondary trauma" (awareness-raising). Point seven focuses on self-care. These are both useful strategies for protecting interpreters' mental health.

Table 1: Proposed Curriculum Components for Training of Interpreters
1. Interpreter skills and techniques
2. Interpreter codes of ethics (for example, for health care interpreters, for community interpreters, for legal interpreters)
3. Interpreter's roles and responsibilities when working with traumatized individuals
4. Special challenges for the interpreter in the mental health field, with emphasis on trauma and secondary trauma
5. Basic information on the nature of symptoms in traumatized patients
6. Dynamics of the psychological or legal interview and the specific roles and ethics of interpreter and interviewer
7. Self-care techniques
8. Role of culture in mental health
9. Stigma of mental illness in different cultures
10. Cross-cultural communication and special stressors for refugees and immigrants
11. Importance and benefits of professional supervision

Image 2. Proposed Curriculum Components for Training of Interpreters
(Berthold and Fischman, 2014, p.104)

This curriculum is in line with training recommendations from the Voice of Love Project (2012) (see http:voice-of-love.org), a not-for-profit US-based organisation which produced training and resources to support interpreting for survivors of torture, trauma and sexual violence. A prevailing recommendation of their 2012 needs assessment was the creation of a three-day training programme for interpreters. Similarly, it was suggested that training include

information about secondary trauma, and interpreter self-care techniques to combat this and other workplace stressors. The authors proposed the following components for a training programme:

> A glossary of relevant terminology (perhaps an appendix); Information about torture and trauma services and sexual assault; Background on mental health interpreting, including the concept of the therapeutic alliance; [...] Information on key areas of mental health, including trauma, symptoms of trauma, torture, PTSD, dissociation, etc.; **Secondary trauma**; Interpreter roles and boundaries; Advanced flow management skills specific to torture and trauma services; Strategies to safely address cultural barriers to communication; **Interpreter self-care** specific to this area, including resources, references and support systems; Pre- and post-conferences; Strategies to prevent interpreter burnout; Resources for professional development. (Bancroft et al., 2012, p 47, emphasis added)

It is interesting to note that the Voice of Love needs assessment also recommends a half-day training programme for providers and staff working with allophone patients and their interpreters, to include: "Guidelines for working with trained interpreters; Guidelines for working with untrained interpreters; Interpreter ethics [...]; Secondary trauma for interpreters; Pre- and post-conferences; Debriefing for interpreters" (Bancroft et al., 2012, p 47). This once again underscores the importance of raising awareness and implementing collaboration on an institutional level, strategies which significantly contribute to preventing VT.

Similar elements can be found in Sultanić (2023), who notes that training programmes for interpreters working with vulnerable minors include

> (1) background information and knowledge, (2) procedural knowledge, including understanding of the interview structure and techniques, (3) interpreting knowledge, (4) terminology knowledge, **(5) emotional strength built on trauma-informed training with special strategies learnt for coping prior to, in-process, and post assignment**, and (6) interprofessional training and collaboration (Sultanić, 2023, p.124, emphasis added)

Evidently, professional competencies and knowledge are hugely important when it comes to working as an interpreter, but these are just one side of the coin. A plethora of other competencies should fortify an interpreter's skillset (cultural knowledge, appropriate conduct,

etc). In arming healthcare interpreters with knowledge to protect themselves in adverse situations, these professional capabilities are reinforced. Well-trained, competent interpreters are confident, know what they need to perform best, and know how to request it (Hale, 2007). Ultimately, high-quality professional interpreting guarantees the precision of information being provided to the medical professional (Cambridge, 1999; Flores et al., 2003; Hale, 2007; Jacobs, 2001; Parrilla Gómez, 2020; Timmins, 2002) and inspires confidence in both practitioner and patient (Zimány, 2010).

While ideally the concepts of VT and burnout would be introduced during an initial, comprehensive education provided to all healthcare interpreters, the pedagogic landscape is not so analogous. Community interpreting remains a domain in which qualifications and training requirements vary enormously. The question thus remains about how exactly to train interpreters with a view to preventing burnout and VT. Considering that not all of them will be working with survivor patients, or indeed may do so for a very limited number of hours a week, it is not necessary for them to receive extensive training on VT. Rather, as proposed by Bancroft (2012), Berthold and Fischman (2014) or Sultanić 2023 existing pedagogical formats could be adapted.

The following section of this essay will analyse three training programmes currently available to interpreters. These are:

1) MCIS Language Solutions online training *Secondary Trauma and Fostering Wellness for Interpreters* based on a programme by the charity The Voice of Love. With its accompanying manual 'Healing Voices', this is a flagship programme on vicarious trauma in interpreters. This course is available online following a simple registration process and takes approximately two hours to complete.

2) The training manual, *Breaking Silence: Interpreting for Victim Services* which Sultanic claims to be the "most comprehensive, free trauma-informed interpreting curriculum developed in the US to date" (2023, p.120). It was developed by Bancroft et al. (2016), for Ayuda and Cross-Cultural Communications with funding from the DC Office of Victim Services and Justice Grants. It is a training program on trauma-informed interpreting with a focus on "interpreting for victims of violent crime, domestic violence, sexual assault and child abuse" (Ayuda, 2016).

3) The Dublin Rape Crisis Centre (DRCC) two-day course for interpreters on working with rape victims. The course, entitled *Interpreting sensitively and effectively for migrants, refugees*

and asylum seekers who have experienced sexual violence took place on November 22nd and 23rd 2022. The DRCC team kindly provided a copy of the training outline, as access to full course content is restricted.

These programmes were selected based on their relevance to the research question. All of these programmes are designed specifically for interpreters who will be working with emotionally challenging content in the field. They have been designed by organisations working with trauma survivors, and in particular, for interpreters working with refugees and asylum seekers. Two of the courses are particularly well-reputed in the field (Roat and Crezee, 2015; Sultanić, 2023). They could be followed (where possible) and analysed within the timeframe of this research paper. All three courses are free of charge, requiring a simple registration process. This was considered an important point, in that VT should be considered an occupational hazard and a health matter. Therefore, access to information should be open to all, as a right and not a privilege. Furthermore, many interpreters who are most vulnerable to VT through their work with migrants may be refugees themselves who may be economically disadvantaged. Finally, it was considered of interest to include three programmes which, although similar, differ slightly in their formats – *Secondary Trauma and Fostering Wellness for Interpreters* is available permanently online, and upon registration, users have up to one month to complete it, whereas *Breaking Silence* took place over six days across several weeks, and the DRCC training was condensed into two days.

The following section will review the content of the training programmes. Our research objective is to establish what training is currently available, in order to evaluate its utility and shortfalls. Through the analysis of the above training programmes, gaps can be identified, which is useful in paving the way for the development of more comprehensive programmes catering to the needs of healthcare interpreters.

4.3 *Secondary Trauma and Fostering Wellness for Interpreters*

MCIS Language Solutions course called *Secondary Trauma and Fostering Wellness for Interpreters* is based on training developed by The Voice of Love (2012) to support interpreters working with survivors of extreme trauma. The training is available online, free of charge, at https://training.mcislanguages.com/. The course objectives (see Appendix) are:

- Identify factors related to job stress and how they can affect one's work
- Define and explain secondary trauma that interpreters may experience
- Apply strategies to identify, prevent or minimize secondary trauma for interpreters

- Review self-care strategies and create a personal wellness plan

The course includes questions and opportunities for self-reflection throughout. For example, learners are invited to propose ways to deal with trauma, or things to include in a wellbeing plan. These activities must be completed in order to move on to the next slide, but not evaluated. The learner earns their certificate upon viewing of all modules and completing the post-training survey.

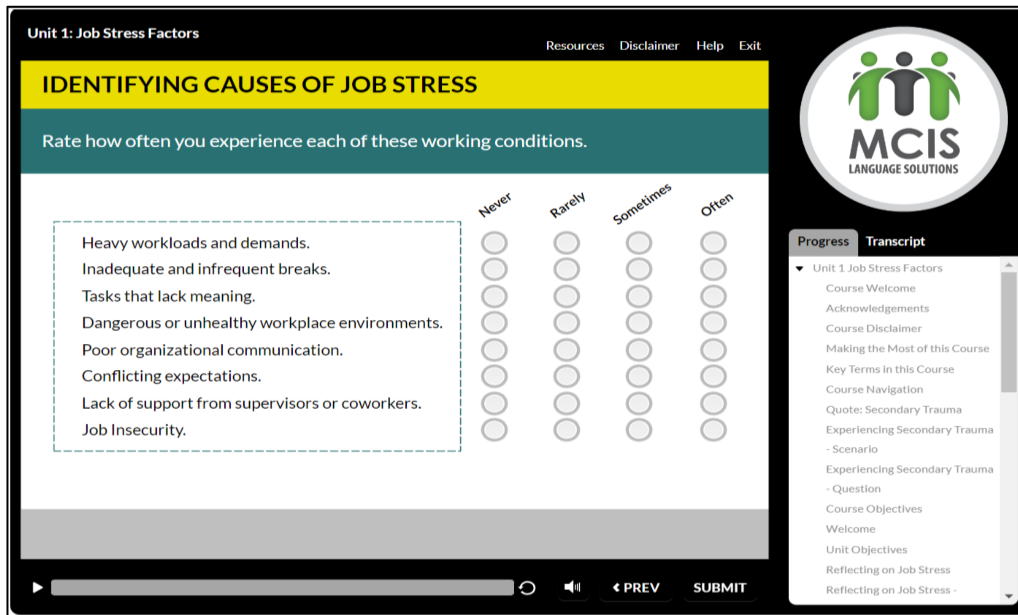

Image 3: sample slides from Unit 1: Job Stress Factors

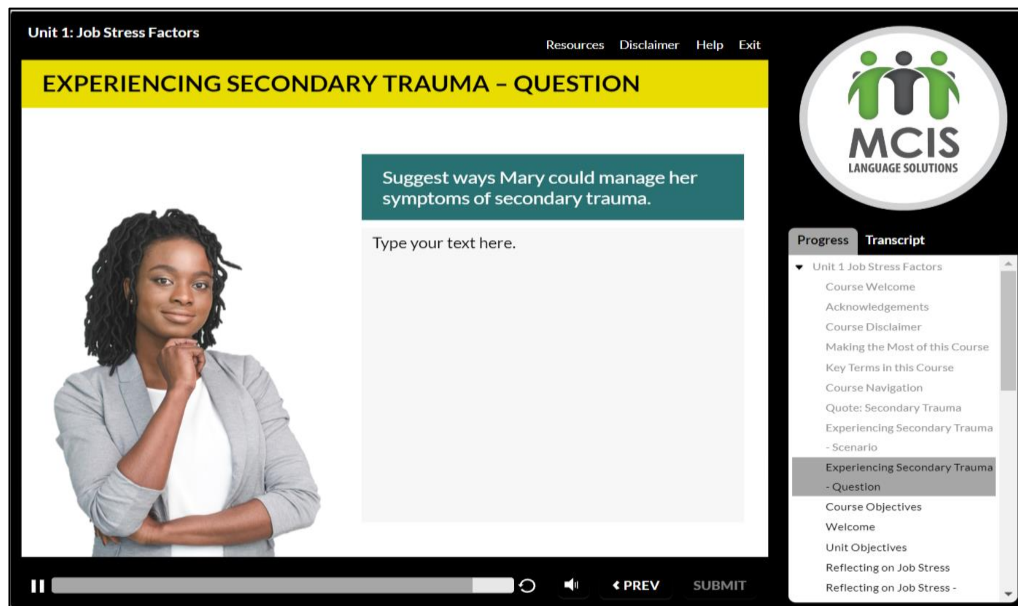

Image 4: sample slides from Unit 1: Job Stress Factors

Each slide is accompanied by a comprehensive audio description (a transcript is also available),

providing more information than what actually appears on the slides.

Unit 1 begins by talking about job stress, which is a key factor in burnout. The symptoms of job stress are outlined, and two key strategies to combat it are mentioned.

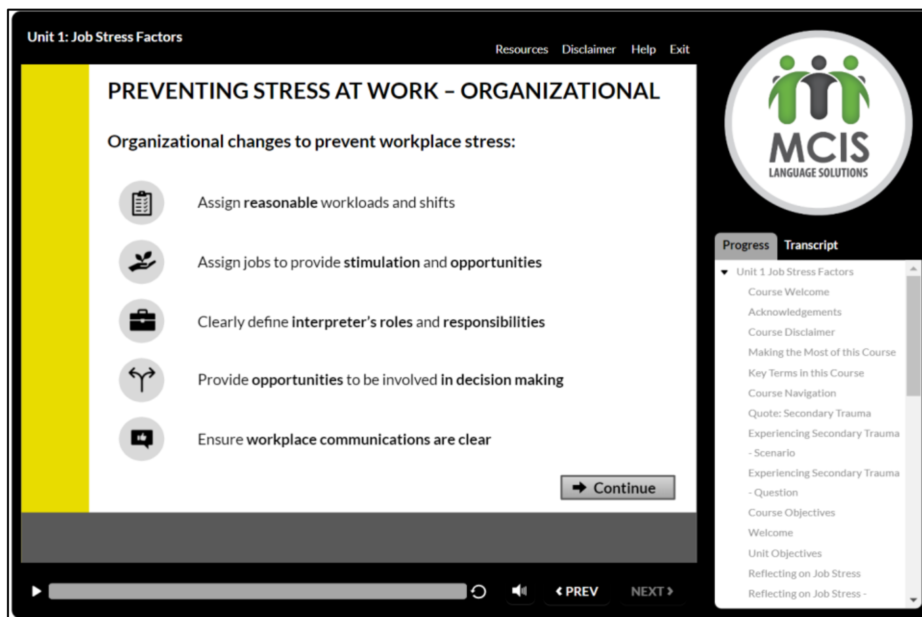

Image 5: sample slide from Unit 1: Job Stress Factors

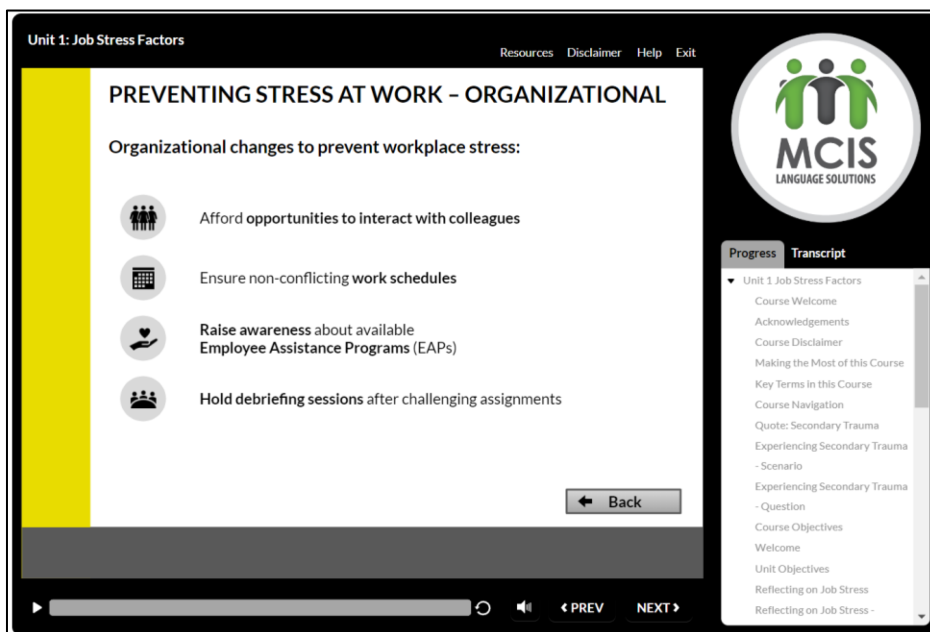

Image 6: sample slide from Unit 1: Job Stress Factors

Firstly, stress management, and secondly, organizational change (identification of stressful aspects of work together with employer, the design and implementation of strategies that reduce stressors e.g clarity on role, feedback from interpreters). The course outlines several ways in which employers can offset the risks of workplace stress (see above).

Unit 2 details what secondary trauma is, its manifestations and how people react to trauma. In this section, there is also a brief mention of vicarious post-traumatic growth, and how immensely gratifying the experience of "watching someone heal before your eyes" (Unit 2, 2012) can be.

Unit 3 is dedicated to coping strategies. This unit also delves into the cognitive, physical, emotional and behavioural responses to VT. It also covers coping strategies for *during* the interpreting job (for example, focusing your gaze on a particular spot on the wall), which has not been considered in this research. The unit addresses short, medium and long-term strategies to prevent secondary trauma. These are, respectively, strategies to be used during the interpreting session, strategies to be used when you get home after the assignment and the coming days, and strategies to be employed in future similar assignments.

Unit 4 is entirely dedicated to personal wellness. It builds on the foundation of the preceding units to create a plan for learners to refer to as required in the future. The plan is personal, and learners are encouraged to focus on strategies that work for them. They are also reminded that they can seek support from employers in the form of "counseling, debriefing after sessions, peer supervision or [taking a break]" (2012, Unit 4).

This training is a very comprehensive, yet accessible, source of information on VT. It does not overdevelop on the psychology and physiology of traumatisation, but rather provides practical strategies and advice to learners. This course covers each of the coping strategies set out in this paper.

4.4 *Breaking Silence: Interpreting for Victim Services*

This is a free, online training course for experienced interpreters. It was most recently held in March 2023 over six days, with a total of 24 hours of live instruction. Furthermore, participants must complete tasks prior to each live session. The objective of the course is to "[prepare] interpreters to gain the skills necessary to work directly with crime victims" (Ayuda, 2023). Although access to the live training is limited, Ayuda has the full training manual and accompanying workbook available online. Each training module, of a total of eight, comprises three learning objectives. Module 2 is entirely dedicated to vicarious trauma and self-care. It's learning objectives are:

- Compare and contrast stress and vicarious trauma for interpreters.
- Practice wellness techniques to manage the interpreter's emotional responses before, during and after victim services encounters.

- Write a self-care plan for interpreting in victim services.

The introduction to the module concludes with a powerful message to interpreters. “Please do not underestimate the importance of this module [...] you *will* be affected emotionally [by certain assignments]” (p.71). This interesting addition would suggest that this module on VT may be perceived by some as superfluous.

The module is divided into three parts. Firstly, participants are taught about the difference between good and bad stress, the signs and symptoms of burnout and the manifestation of VT. The information is extremely comprehensive, covering the process of feeling empathy, and aggravating factors making interpreters susceptible to VT. As noted in this research, it is of pivotal importance to obtain information about the risks of VT in order to prevent it from developing. Therefore, Part 2.1 does a thorough job of creating *awareness* among participants, before moving on ‘Techniques for Reducing Stress and Trauma’ (p. 86).

This part looks at what to do about the stress and VT which participants learned about in the previous section. Participants are taught exactly why interpreters are vulnerable to traumatisation, (due to cognitive processes involved in interpreting and use of the first-person narrative). Just as in *Secondary Trauma and Fostering Wellness for Interpreters*, this training breaks down coping strategies into before (p. 86-91), during (p. 92-94) and after (p. 94-96) an assignment. In terms of *collaboration*, interpreters are encouraged to coordinate with the service provider to prepare for the assignment, and to create a ‘[discreet] pre-arranged hand signal’ to indicate to the provider if they need to take an urgent break from interpreting, due to being overwhelmed by content or the victim’s delivery. Furthermore, an emphasis is placed on the importance of social support systems outside the professional environment. Interpreters are encouraged to *debrief* with service providers, noting that ‘[c]ase managers, therapists, medical providers and even law enforcement typically have formal mechanisms established in their workplaces to debrief staff who have been exposed to traumatic events’ (p.94), although it can be a challenge to have service providers understand the importance of interpreters having access to debriefing mechanisms too. The manual also warns participants against taking debrief sessions as personal therapy.

The final part of Module 2 teaches interpreters how to write a self-care plan. Here, the difference between a self-care plan and a wellness plan is denoted as follows: “Your self-care plan will focus on interpreting and strategies to help you remain calm while interpreting and also reduce or prevent VT. A wellness plan is more generalized and addresses self care in all areas of your life” (p. 97). The manual notes that four key elements (sleep, physical activity,

good nutrition, relaxation) comprise the pillars of long-term wellness. However, this training particularly seeks to prepare interpreters for work with survivors, and particularly focuses on how to create a precise self-care plan to be implemented immediately around these challenging assignments. The manual suggests a lot of personal coping strategies, for example, "I'll engage three times in my favorite nasal deep breathing exercise in my car before going in" and "I might take a hot shower when I get home to 'wash away the thoughts'" (p. 100).

4.5 *Interpreting sensitively and effectively for migrants, refugees and asylum seekers who have experienced sexual violence*

This two-day online training course by DRCC is "designed to prepare and support interpreters providing services for migrants, refugees and asylum seekers who have been affected by sexual violence" (DRCC, 2022). Participants are not evaluated but do receive a certificate of attendance. According to the DRCC website, this training addresses

- the social beliefs around sexual violence
- the impact of sexual violence on a person
- key points in the legal process when a person reports an experience of sexual violence
- the principles and ethics of interpreting
- the impact of vicarious traumatization on the interpreter and strategies for self-care

Specific content could unfortunately not be shared; however, a training outline was provided by DRCC (see Appendix). On VT, the training addresses 'Self-support techniques while working with trauma' on Day 1. It is probable that this refers to coping strategies that may be implemented *during* the interpreting job, which has not been a focus of this research. On Day 2, 'Vicarious trauma and self-care' is one of the six points addressed. Interpreters participating in the training are also taught about potential issues when working with various services providers, like in sexual assault treatment units (SATU), with the police, and in court.

Considering the lack of comprehensive data available, the analysis of this programme will be complemented by the DRCC handbook produced for interpreters working with trauma survivors in 2008, and information from the DRCC website (drcc.ie).

5. DISCUSSION

In light of the research question of this thesis: *What training can be provided to healthcare interpreters to help them to cope with the impact of vicarious traumatisation?*, this section will consider the commonalities and differences of the three programmes, and how they align with the literature on vicarious trauma (VT).

The literature highlights the profoundly negative, often insidious, effect that VT can have on an interpreter's personal and professional life. Numerous studies have corroborated findings of the development of VT in interpreters and have highlighted the lack of appropriate training (Bontempo and Malcolm, 2012; Knodel, 2018; Ndongo-Keller, 2015; Zimány, 2010). Despite this, many interpreters are entirely unfamiliar with the concept.

Dealing with the problem of VT requires a multifaceted approach. As established, coping strategies can be divided into the following categories: awareness, debriefing, collaboration, diversification, and personal coping strategies. These are employed as a framework of reference for analysis. This analysis demonstrates that each programme incorporates elements of each coping strategy, although with some exceptions.

5.1 Awareness

When it comes to personal health, knowledge is power. Awareness includes being informed about the impact of stress and trauma on the mind and body. While a lack of understanding of the phenomenon of VT can be immensely problematic for interpreters, mere awareness of the risk is already an important step towards protecting mental health.

The function of these three training programmes is to create this awareness among participants. This is evident from course objectives. Learners are further reminded that they will "learn what secondary trauma is…[and] how to become aware of secondary trauma that you may experience" and that "it is important to be aware of its early warning signs" (2012, Unit 1).

Breaking Silence learners are explicitly made aware that stress and trauma are workplace concerns that affect both healthcare staff and interpreters (2016, p.72). A primary objective of the DRCC short course is considering "the impact of vicarious traumatization on the interpreter" (DRCC, 2022). Through case studies (see 5.6) and self-reflection (see 5.7), students are encouraged to consolidate their learning, and contextualise their newfound understanding of VT in real life.

The courses inform students about the distinction between stress and traumatisation. This is a relevant distinction to make, in that although not strictly chronological, unchecked stress can lead to burnout and fatigue. Over an extended period of time, interpreters can begin to experience the "same kinds of trauma responses that the survivors [they] interpret for display" (Bancroft et al., 2016, p. 79). By initially making interpreters aware of the development and progression of workplace stress and VT, these courses create the necessary foundation for interpreters to create robust coping strategies to prevent and deal with the problem. These courses also outline the symptoms and manifestations of VT. In this way, they align with curricula recommendations from Sultanić (2023), Berthold and Fischman (2014) and Bancroft (2012).

5.2 Debriefing

Debriefing is a technique for coping with trauma exposure that emerges time after time in the literature, including Bontempo and Malcolm (2012), Crezee (2015) and Sultanić (2023). Miller et al. (2005) found that being able to discuss an emotional assignment was extremely valuable to interpreters, although a minority had access to this service. It is therefore noteworthy that both *Secondary Trauma and Fostering Wellness for Interpreters* and *Breaking Silence* emphasise the usefulness of debriefing after a stressful assignment. The former also notes that after particularly emotionally charged sessions, some service providers may follow up with interpreters to see how they coped (2012, Unit 3). It is generally recommended, however, that debriefing takes place with a different professional to the one with whom the interpreter was working (Gomez, 2012; Miller, 2005). Although interpreters may be concerned about breaching confidentiality (Knodel, 2018), when implemented correctly, debriefing is a useful support mechanism which does not necessarily fly in the face of ethical standards. Even informal debriefings with colleagues can be a "good avenue for releasing stress", and "reduce or even prevent the onset of psychological distress and fatigue" (Crezee, 2015, p. 79).

Breaking Silence stresses that "[d]ebriefing is such an important part of your self care", and notes that the benefit is twofold, in that sessions also serve as an opportunity to "address cultural mediation issues that may have come up" (2016, p.95).

The third programme from the DRCC does not expressly mention debriefing in its training outline. That said, it is likely one of several recommendations at the end of the final day, as part of the segment on VT and self-care. As noted in their handbook, Dublin Rape Crisis Centre offers a debriefing session to interpreters after each counselling session (2008, p.36).

5.3 Collaboration

This study highlights that collaboration is encouraged with other interpreters and service providers in all three programmes. *Secondary Trauma and Fostering Wellness for Interpreters* learners are told that they "must trust the [...] service provider working with the survivor" and are encouraged to "turn to your employer [...] and seek counseling, debriefing [...], peer supervision…" (2012, Unit 3). Similarly, *Breaking Silence* suggests that learners contact interpreter colleagues who have taken on similar assignments to discuss self-care (2016, p.101). On the DRCC course, interpreters are taught about "issues […] when working in SATU [sexual assault treatment units], reporting to Gardaí, Courts, etc" (see Appendix B).

The fact that collaboration, and collegial and employer support are included in all three programmes acknowledges that they are critical ways of offsetting the impact of trauma. This further underscores the importance of strong institutional support and is closely linked to the coping strategies of debriefing and diversification. Furthermore, adequate training for therapists and physicians working with interpreters is a key element of collaboration.

5.4 Diversification

This study revealed that diversification, a strategy widely recommended by scholars, is not emphasised in these programmes. These training programmes did not expressly recommend that participants limit their exposure to stressful cases or create a pattern of work juxtaposing difficult assignments with less taxing ones to balance emotional load. This might indicate an omission or oversight. However, a more plausible explanation is that the interpreters taking these courses inevitably work, or will be working, with survivors. Therefore, the premise of these courses is to teach them how to protect themselves in these situations, and not to focus on how to avoid overexposure.

That said, this diversification is encouraged to a certain extent in both *Secondary Trauma and Fostering Wellness for Interpreters* and *Breaking Silence* by advising interpreters with a similar adverse experience or unresolved trauma to avoid interpreting for survivors. This is noteworthy, as the literature notes that people with past personal experiences of trauma are particularly vulnerable to secondary traumatisation (Green, 2012). Furthermore, *Secondary Trauma and Fostering Wellness for Interpreters* tells learner that if they are struggling emotionally, they should contact their employer to find a replacement interpreter. Of course, it is important that interpreters have the ability to introspect and understand their own triggers

when these situations arise, in order to react appropriately before their mental health is compromised. This is connected to awareness of what VT is and its manifestation.

5.5 Personal coping strategies

Finally, these programmes all strongly emphasise personal coping strategies and self-care as a method of preventing VT. Modules three and four of *Secondary Trauma and Fostering Wellness for Interpreters* focus on coping strategies and personal wellness. The course suggests a wide range of personal coping strategies, from deep breathing to taking a break to connecting with friends., and learners are taught how to create wellness goals. Part 2.3 of the *Breaking Silence* module on VT and self-care similarly outlines how to prepare a self-care plan. The training manual suggests a wide range of personal coping strategies, including visualisations, breathing and relaxation techniques and physical activity. It is indeed of note that the DRCC course includes self-support and self-care as key components of a training course on sensitive and effective interpreting.

Scholars like Bancroft (2015), Bontempo and Malcolm (2012) and Crezee (2015), encourage the implementation of personal care techniques to fortify mental health and prevent its demise in the face of emotionally challenging content. While these personal coping strategies are an immensely useful tool, over the course of this research it has become evident that employers and institutions must also step up and promote appropriate working conditions and collegial relationships if the problem of VT is truly to be curbed. Splevins et al. (2010), Bontempo and Malcolm (2012) and Ndongo-Keller (2015) note that a combination of both personal and institutional strategies would be optimal for mental health protection and preservation.

These three training programmes are comprehensive in that they are not limited to personal coping strategies. However, they all stress the importance of self-care, more than any other coping strategy. Further emphasis must be placed on organisational support, and the major role it plays in preventing vicarious trauma.

5.6 Role play and case studies

It is interesting to note that each of the three trainings include an element of case-based learning. In *Secondary Trauma and Fostering Wellness for Interpreters*, participants are invited to “consider the consequences” (2012, Unit 3) of a scenario in which an interpreter encourages

a client to give more thorough answers and later offers to bring tea for everyone, deviating from their role. Participants must select which answers are true on the slide below, before learning that they "must allow the service provider to take the lead at all times" (2012, Unit 3).

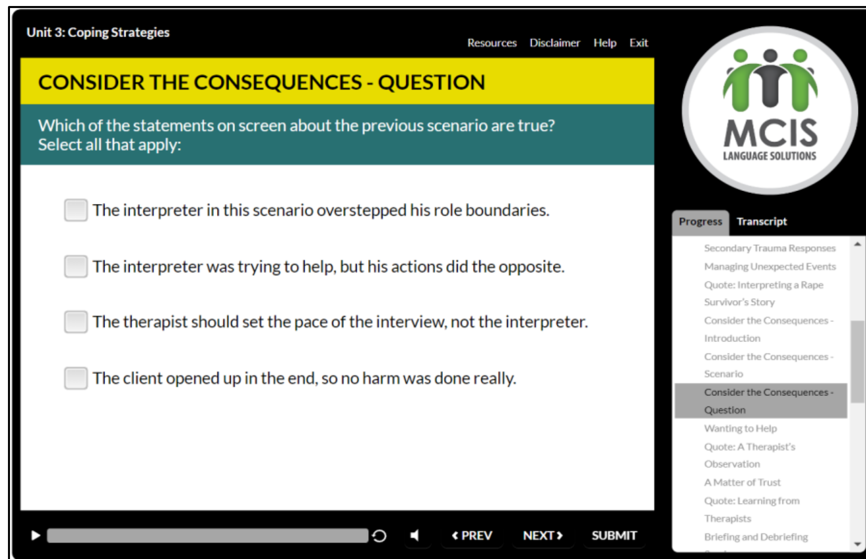

Image 7: sample slides from Unit 3: Coping Strategies

Similarly, participants in the *Breaking Silence* training are provided with a workbook that contains various role plays and dialogues. Module 2 on Vicarious Trauma and Self-Care (pp. 11-20) includes several activities for interpreters involving distressing content. Participants are invited to act out a scenario with a sexual assault therapist, survivor and interpreter, to identify whether symptoms are associated with stress or VT.

STRESS vs. VICARIOUS TRAUMA		
	STRESS	**VICARIOUS TRAUMA**
Heart pounding		
Flashbacks of the story		
Irritation		
Nausea		
Tuning out/spacing out		
Anger		
Taking your feelings out on colleagues (*snapping, being irritable*)		
Dizziness/light-headedness		
Shakiness		
Emotional numbness		
Disruption of eating patterns		
Inability to continue interpreting		
Reporting problems to supervisor		
Intrusive thoughts		
Insomnia		
Frustration		

Image 8: Stress vs. Vicarious Trauma activity, Breaking Silence workbook (2016, p.15)

There is also a story of a teenage rape which one participant reads out while another interprets. Participants then “discuss what self-care strategies [they] could do before, during and after a session like this one” (p. 16).

The DRCC training also includes two case studies, one at the end of the first day, which focuses on sexual assault and violence, and the other halfway through day two. The second day of training focuses more on legal and ethical points when interpreting for survivors of sexual violence.

This sort of case-based learning present students with real-life scenarios that draw the students deeper into the learning experience. Students may be given information on the scenario in advance, and prepare accordingly, or may be given a relevant scenario directly after learning specific material. They will often work in small groups, with an educator who guides the session with minimal intervention. Case-based learning is interactive and an extremely versatile method, suitable for use in a wide variety of educational environments. It allows a deep level of learning by inducing more critical thinking skills, reifies theory and allows opportunities for error.

For interpreter trainers, CBL may offer a valuable opportunity to expose students to scenarios incorporating “grief, loss, suicide, depression, neglect, mental health, abuse, and other emotionally difficult topics”, as recommended by Bontempo and Malcolm (2012, p. 125). If carefully and appropriately managed, this provides a safe, controlled environment for exposure to traumatic content. For healthcare interpreter training, there need not be tailored scenarios for each new group of students, but rather a variety of cases that provide for diverse learning objectives.

Among other factors, CBL exercises are shaped by learning objectives and time constraints, but also through guided reflection and group discussion. The idea is to raise awareness and introduce students to debriefing activities and impart information about personal coping strategies. Through discussion and collaboration, they work to find pragmatic solutions to significant, contextualised dilemmas. Exposure to real-world problems, compared to those manufactured for pedagogic purposes, can be an immensely helpful tool in teaching students how to proactively and pragmatically manage professional situations.

In this sort of interactive classroom, students are invited to share their skills, knowledge and

creative thinking with a team. This allows for greater scope of exploration of concepts, dilemmas and lexicon which come up time and time again, and problem-solving among learners. Comprehensive analysis and discussion pre- and post- exposure to the scenario aid learning. Case studies and role plays should be created based on recurring dilemmas and common situations that are difficult to handle. They are a useful pedagogic tool for introducing both novice interpreters and their seasoned counterparts to the type of material that has the potential to have an adverse impact on the mental health of interpreters. For example, VOL's needs assessment of 169 interpreters for survivors of torture, trauma and sexual violence found that "[o]ver one-quarter of interpreters in the survey (27%) had already interpreted for [clients] who became verbally abusive or physically violent during the session" (2012, p. 40). A scenario could involve a scenario in which an interpreter feared for their safety. Another example might involve interpreting for a patient who has suffered sexual violence.

Regardless of the pedagogic method used to impart learning, it is always advisable to take student feedback into consideration. This contributes to protecting student interpreter wellbeing, creating strong trainer-student relationships and strengthening support networks (Bontempo and Malcolm, 2012).

5.7 Self-reflection

It is of note that these training programmes, in various ways, invite learners to engage in this reflective practice in order to develop a way of thinking that is deliberate and meditative. Opportunities for professional and personal reflective practice may be a useful addition to training programmes (and not exclusively those devoted to mental health). This creates interpreters who can continually contemplate, analyse, and ultimately better their skills and professional performance (Costa et al., 2020). Bao (2015, p. 406) acknowledges that many intensive short courses for interpreters cannot facilitate adequate time for "reflection, practice and improvement", but this would not appear to be the case for the three analysed programmes.

Incorporating reflective practices or time for reflective discussion into training about burnout and VT provides students with a space to analyse events and reactions, and can be a powerful tool in helping students identify and understand "their own responses to stressful scenarios and […] traumatic realities in their own lives by helping them consider how they plan to manage such personal material in a professional setting" (Bontempo and Malcolm, 2012, p.125). A 2020 pilot project by Costa et al. noted an improvement in confidence and self-awareness

among non-professional interpreters interpreting for refugees, who were provided with three sessions of remote, professional support, during which self-reflection was encouraged. Interpreters may easily find self-care tips and personal coping strategies from a quick online search, but it is through self-reflection and peer support that they become cognizant of the need to seriously apply these strategies.

According to Hetherington, "[s]elf-reflection complements rather than replaces supervision, because the opportunity to discuss work with a supervisor allows for the identification of issues the supervisee may not recognize, nor, indeed, wish to acknowledge" (2012, p. 51). This relates to ensuring that the onus is not on interpreters to deal with problems of burnout and VT alone. Appropriate organisation-level strategies (specifically raising awareness among interpreters, providing opportunities for debriefing, promoting collaboration, diversification) are a major factor in preventing interpreter burnout and VT, and should therefore be prioritised over educating interpreters about personal coping strategies.

Data from this research indicates that these training programmes are comprehensive and indeed employ coping strategies recommended in research. When used correctly, these strategies that are ultimately effective. These courses fulfil their learning objectives. As noted by Bontempo and Malcolm, "education programmes for interpreters need to address the issue of vicarious trauma with students" (2012, p. 123). It can be considered a very positive development that programmes have been created in the meantime which have indeed been designed to tackle the issue. However, they must be used as one tool in an entire toolbox of mechanisms, structures and information designed to create a safe and secure working environment for interpreters.

Unfortunately, despite the evident challenges of working with trauma survivors, training is still often lacking. While the programmes analysed for this research are thorough, just *Breaking Silence* covers the topic of VT and self-care as part of a broader training programme, which also includes an overview of victim services, note-taking skills and terminology, etc. The other two programmes specifically focus on the challenges to mental health of working with survivors. For example, *Breaking Silence* is a comprehensive training programme which include information on interpreting mechanics (note-taking, etc). *Secondary Trauma and Fostering Wellness for Interpreters* is designed for "those who have already completed core interpreter training and who wish to continue their professional development" (see Appendix A and exclusively addresses the impact of interpreting for trauma survivors on interpreters.

The DRCC training is a mixture of both, covering both the context of interpreting for survivors of sexual violence (including outlining the legal and medical process in Ireland), and its impact on interpreters' mental health. The course does not include information on the mechanics of interpreting. Some of these differences may be attributed to the lengths, formats and learning objectives of these training programmes.

As this research has developed, it has become clear that the research question, about training *for healthcare interpreters* is slightly flawed. A review of recurring coping strategies established that when it comes to protecting the mental health of interpreters, it is, in fact, far more pertinent to focus on organisation-level strategies than personal ones. It may therefore be more appropriate to consider what training can be provided to *healthcare providers working with interpreters* to aid the prevention of professional burnout and VT. By framing the question in this way, healthcare interpreters are not burdened with the sole responsibility of developing coping strategies. Management and coordinators of interpreter teams should embrace an active role in promoting employee wellbeing. This may be indirect, by incorporating strategies of collaboration and diversification into human resource management, or direct, by organising debriefing sessions and actively raising awareness about burnout and VT among interpreter employees.

6. CONCLUSION

This essay was an analysis of training programmes for interpreters on preventing vicarious trauma. This phenomenon poses a significant threat to the wellbeing of language professionals working in healthcare and particularly with trauma survivors. Interpreters are exposed to trauma in a very real way, which can have serious repercussions in various areas of their lives, with socioemotional and physical manifestations. Research has indicated that vicarious trauma can be effectively tackled through the implementation of positive coping strategies which must involve both the interpreter themselves, the service provider and the employer. Above all, a safe working environment which supports its interpreters and affords them the same support mechanisms as other staff members is fundamental to reduce the risk of secondary traumatisation (Bontempo and Malcolm, 2012; Ndongo-Keller, 2015; Splevins, 2010; Todorova and Tedjouong, 2023).

Based on the analysis of three programmes, it is clear that training is a pivotal mechanism for teaching interpreters about workplace stress and burnout, and vicarious trauma. Positive coping strategies in the literature can be broadly grouped into awareness, debriefing, collaboration, diversification, and personal coping strategies. The best form of defence against secondary traumatisation involves a combination of all of these.

In this way, this analysis of training on VT indicated that it compiles various strategies in one place, and contextualises them with, for example, the triggers and symptoms of trauma. Essentially, training encompasses a lot of what the literature recommends. The right training programme provides interpreters with the knowledge they need to understand the risk posed by trauma, and then to protect themselves. This research found that programmes are comprehensive and effective. Yet it has also become evident that the balance between personal and organisation-level coping strategies remains skewed. Greater emphasis must be placed on organisational support, and healthcare providers and institutions working with interpreters must be trained accordingly.

Of course, VT as an occupational hazard should be mitigated on both a professional and personal level. There is no shortage of material for interpreters keen to read up about vicarious trauma, In addition to the training courses, there is comprehensive information about interpreting for survivors available online in the form of articles and handbooks. For example, DRCC published ‘Interpreting in Situations of Sexual Violence and other Trauma’, a handbook for community interpreters, in 2008. Furthermore, Ayuda’s training manual and workbook of exercises from the *Breaking Silence* programme are available online. California Healthcare

Interpreting Association's YouTube channel has a free webinar on 'Vicarious Trauma and Professional Interpreters' and an abundance of other useful content.

6.1 Limitations

The reliability of the data from the course analyses is impacted by the lack of access to the full content of the DRCC training programme. This meant that the analysis could not be as in-depth as for the other two programmes.

Furthermore, this research has been conducted as part of an MA degree programme, which limited the length of the paper. It is hoped that this project will serve a platform for further, more comprehensive analyses and development of training programmes on vicarious trauma. Indeed, in order to truly understand how effective these programmes are, it would be required to carry out a more comprehensive study asking interpreters to follow a training programme and then following up to establish how effective what their learning was according to whether they experience symptoms of VT or not. This is beyond the scope of the current study.

6.2 Vicarious post-traumatic growth

This research did not explore the phenomenon of vicarious post-traumatic growth, which has also been documented among interpreters. Vicarious post-traumatic growth is defined as "the experience of growth as a result of indirect trauma exposure" (Deaton et al., 2023). This has been shown to occur in interpreters too. For example, Splevins et al. (2010, p. 1706) acknowledge that despite the lack of evidence in this area, related literature on the field suggests that interpreters are both negatively and positively impacted as a result of trauma work. Lor (2012) found that several interpreters experienced elements of positive change and helpful growth from their work in mental health, and Ndongo-Keller (2015) found that interpreters working at the UN International Criminal Tribunal for Rwanda ultimately became stronger and started valuing their own lives more. In a study by Gomez (2012) on vicarious post-traumatic growth, six interpreters spoke of their overall positive experience in psychotherapy. They acknowledge the importance of training, support systems and self-care strategies in being able to learn and grow from their work.

Further research into vicarious post-traumatic growth is recommended. It would be interesting for interpreters to be able to understand both the negative and positive impact of working with

emotionally difficult content. This would allow them to be fully informed when it comes to making decisions around which assignments they accept.

Finally, although this research is centred on interpreted encounters in healthcare, it may be applied beyond this realm. Much of the content in the training programmes can be extrapolated to other contexts, like interpreting in conflict zones, or in courtrooms, where interpreters supporting survivors are inevitably susceptible to vicarious traumatisation. It is only by framing and understanding VT as an occupational hazard that the resources and funding may be made available for further research and the development of training programmes. Adequate training, including basic awareness-raising among students, protects the interpreter by equipping them with the resources to understand and process information in an objective, professional capacity, which improves professional performance and overall wellbeing. This is a necessary step in the preservation of healthcare interpreters' mental health. Baseline, compulsory training also places all interpreters on a level playing field and acts as a safeguard against workplace stress, burnout and VT. And crucially, this learning should take place during initial training before interpreters are exposed to trauma. When it comes to secondary traumatisation, discretion is the better part of valour.

7. REFERENCES

Angelelli, C. (2004) Medical Interpreting and Cross-cultural Communication. London: Cambridge University Press.

Angelelli, C. (2019). Healthcare Interpreting Explained. London: Routledge.

Antonini, R. (2015b). Child language brokering. In F. Pochhacker (Ed.), Routledge Encyclopedia of Interpreting Studies (48-49). London: Routledge.

APA Dictionary of Psychology (2023): https://dictionary.apa.org/coping-strategy

Ayuda (2020): https://ayuda.com/language-services/interpreters/

Bancroft, M. A., Bendana, L., Bruggeman, J., & Feuerle, L. (2013). Interpreting in the gray zone: Where community and legal interpreting intersect. *Translation & Interpreting, 5*(1), 94-113.

Bancroft, M. A. (2015). Community interpreting: A profession rooted in social justice. In H. Mikkelson, & R. Jourdenais (Eds.). *The Routledge Handbook of Interpreting* (217-234). London: Routledge.

Bancroft, M. A., Allen, K., Green, C. E., & Feuerle, L. M. (2016). *Breaking Silence: Interpreting for Victim Services. A workbook of role plays and exercises.* Washington DC: Ayuda.

Bao, C. (2015). Pedagogy. In H. Mikkelson, & R. Jourdenais (Eds.). *The Routledge Handbook of Interpreting* (400-416). London: Routledge.

Birck, A. (2001). Secondary traumatization and burnout in professionals working with torture survivors. *Traumatology*, *7*(2), 85-90.

Berthold, S. M., & Fischman, Y. (2014). Social work with trauma survivors: Collaboration with interpreters. *Social work*, *59*(2), 103-110.

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief treatment and crisis intervention*, *6*(1), 1-9.

Bontempo, K., & Malcolm, K. (2012). An ounce of prevention is worth a pound of cure: Educating interpreters about the risk of vicarious trauma in healthcare settings. In L.Swabey and K. Malcolm (Eds.). *In our hands: Educating Healthcare Interpreters* (105-130). Gallaudet University Press.

Bot, H. (2015). Interpreting in mental health care. In H. Mikkelson and R. Jourdenais (Eds.). *The Routledge handbook of interpreting* (254-265). London: Routledge.

British Medical Association: https://www.bma.org.uk/advice-and-support/your-wellbeing/ vicarious-trauma/vicarious-trauma-signs-and-strategies-for-coping

Butler, C. (2008, December). Speaking the unspeakable: Female interpreters' response to working with women who have been raped in war. *Clinical Psychology Forum*, *192*, 22-26.

California Standards for Healthcare Interpreters (2002). At https://chiaonline.org/resources/ Pictures/CHIA_standards_manual_%20March%202017.pdf (accessed 10

Cambridge English Dictionary (2023) https://dictionary.cambridge.org/us/dictionary/english/self-

care

Cambridge, J. (1999). Information loss in bilingual medical interviews through an untrained interpreter. *The translator*, *5*(2), 201-219.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work*, *75*(2), 81-101.

Casillas, A., Paroz, S., Dory, E., Green, A., Vu, F., and Bodenmann, P. (2016) Building the Diversity Bridge Abroad: The Journey to Implement Cultural-Competent Health Care in Lausanne, Switzerland. *Journal of Education and Training Studies*, *4*(2)

Costa, B., Lázaro Gutiérrez, R., & Rausch, T. (2020). Self-care as an ethical responsibility: A pilot study on support provision for interpreters in human crises. *Translation and Interpreting Studies*, *15*(1), 36-56.

Cottler L.B., Ajinkya S., Merlo L.J., Nixon S.J., Abdallah A.B., Gold MS. (2013). Lifetime psychiatric and substance use disorders among impaired physicians in physicians health program: comparison to a general treatment population. *Journal of Addiction Medicine, 7*(2), 108.

Creese, J., Byrne, J. P., Conway, E., Barrett, E., Prihodova, L., & Humphries, N. (2021). "We all really need to just take a breath": composite narratives of hospital doctors' well-being during the COVID-19 pandemic. *International journal of environmental research and public health*, *18*(4), 2051.

Crezee, I. (2015). Teaching interpreters about self-care. *International Journal of Interpreter Education*, 7(1), 7.

Cross Cultural Health Care Program, 1999

Deaton, J. D., & Ohrt, J. H. (2023). A preliminary validation of the vicarious Posttraumatic Growth Inventory across helping professions and investigation of construct validity. Traumatology. At ://doi.org/10.1037/trm0000434 (accessed 01 May 2023).

DeLucia, J. A., Bitter, C., Fitzgerald, J., Greenberg, M., Dalwari, P., & Buchanan, P. (2019). Prevalence of post-traumatic stress disorder in emergency physicians in the United States. *Western journal of emergency medicine*, *20*(5), 740-746.

Diamond, L. C., Schenker, Y., Curry, L., Bradley, E. H., & Fernandez, A. (2009). Getting by: underuse of interpreters by resident physicians. *Journal of general internal medicine*, *24*, 256-262.

Dominicé Dao, M., Inglin, S., Vilpert, S. and Hudelson, P. (2018) The relevance of clinical ethnography: reflections on 10 years of a cultural consultation service. *BMC health services research*, *18*, 1-11.

Dublin Rape Crisis Centre (2023) : drcc.ie

Dublin Rape Crisis Centre (2008) *Interpreting in Situations of Sexual Violence and other Trauma: A handbook for community interpreters.* At https://www.drcc.ie/assets/files/pdf/drcc_2008_interpreting_leaflet_2008.pdf

Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric

encounters. *Pediatrics*, *111*(1), 6-14.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical care research and review*, *62*(3), 255-299.

Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., & Hardt, E. J. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*, *111*(1), 6-14.

Gomez, A. (2012). *Vicarious trauma and posttraumatic growth: A study of how interpreters working in psychotherapy are impacted by their work*. Doctoral dissertation, Dublin Business School.

Green, H., Sperlinger, D., & Carswell, K. (2012). Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services. *Journal of Mental Health*, *21*(3), 227-235.

Hale, S. (2007). *Community interpreting*. Hampshire: Palgrave Macmillan.

Hale, S. B., Ozolins, U., & Stern, L. (2009). *The critical link 5: Quality in interpreting: a shared responsibility.* Amsterdam: John Benjamins.

Harvey, M. A. (2015). Reaping the benefits of vicarious trauma. *International Journal of Interpreter Education*, *7*(2), 3.

Hetherington, A. (2012). Supervision and the Interpreting Profession: Support and AccountabilityThrough Reflective Practice. *International Journal of Interpreter Education*, *4*(1), 5.

Hsieh, E., & Nicodemus, B. (2015). Conceptualizing emotion in healthcare interpreting: A normative approach to interpreters' emotion work. *Patient education and counseling*, *98*(12), 1474-1481

Hsieh, E. (2015). Not just "getting by": factors influencing providers' choice of interpreters. *Journal of general internal medicine*, *30*, 75-82.

Hsieh, E. (2016). *Bilingual health communication: Working with interpreters in cross-cultural care*. Routledge.

Hsieh, E. (2017). Conceptualizing bilingual health communication: a theory-based approach to interpreter-mediated medical encounters. *Providing Health Care in the Context of Language Barriers*, 35.

International Organization for migration https://worldmigrationreport.iom.int/wmr-2022-interactive/

Jacobs, E. A., Lauderdale, D. S., Meltzer, D., Shorey, J. M., Levinson, W., & Thisted, R. A. (2001). Impact of interpreter services on delivery of health care to limited-English-proficient patients. *Journal of general internal medicine*, *16*, 468-474.

Jaeger, F. N., Pellaud, N., Laville, B., & Klauser, P. (2019). The migration-related language barrier and professional interpreter use in primary health care in Switzerland. *BMC health services research*, *19*, 1-10.

Jeffery, A. J., & Salt, R. J. (2022). Voices of the community: Exploring the experiences of resettled refugee interpreters at a refugee clinic in a large multicultural city in Texas, United States of America. *Health & Social Care in the Community*, *30*(5), 1951-1959.

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health services research*, *42*(2), 727-754.

Kindermann, D., Schmid, C., Schell, T., Bozorgmehr, K., Thalheimer, M., Daniels, J., Herzog, W. & Nikendei, C. (2017). Prevalence of and risk factors for secondary traumatization in interpreters for refugees: a cross-sectional study. *Psychopathology*, *50*(4), 262-272.

Knodel, R. K. (2018). Coping with vicarious trauma in mental health interpreting. *Journal of Interpretation*, *26*(1) 2.

Korpal, P., & Mellinger, C. D. (2022). Self-care strategies of professional community interpreters: An interview-based study. *Translation, Cognition & Behavior, 5*(2), 275-299.

Lai, M., & Heydon, G. (2015). Vicarious trauma among interpreters. *International Journal of Interpreter Education, 7(*1), 3.

Leanza, Y. (2005). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. *Interpreting*, *7*(2), 167-192.

Lee, K. C., Winickoff, J. P., Kim, M. K., Campbell, E. G., Betancourt, J. R., Park, E. R., Maina, A.W., & Weissman, J. S. (2006). Resident physicians' use of professional and nonprofessional interpreters: a national survey. Jama, 296(9), 1049-1054.

Lindholm, M., Hargraves, J. L., Ferguson, W. J., & Reed, G. (2012). Professional language interpretation and inpatient length of stay and readmission rates. *Journal of General Internal Medicine, 27*, 1294-1299.

Lor, M. (2012). Effects of client trauma on interpreters: An Exploratory study of vicarious trauma. Master of Social Work Clinical Research Papers. Paper 53.

Matthews, L. R., Alden, L. E., Wagner, S., Carey, M. G., Corneil, W., Fyfe, T., ... & Krutop, E. (2022). Prevalence and predictors of posttraumatic stress disorder, depression, and anxiety in personnel working in emergency department Settings: A systematic review. *The Journal of Emergency Medicine*.

Mento, C., Silvestri, M. C., Merlino, P., Nocito, V., Bruno, A., Muscatello, M. R. A., ... & Kawai, T. (2020). Secondary traumatization in healthcare professions: A continuum on compassion fatigue, vicarious trauma and burnout. *Psychologia*, *62*(2), 181-195.

Miller, Miller, K., Martell, Z. L., Pazdirek, L., Caruth, M. and Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: an exploratory study. *American Journal of Orthopsychiatry,* 75(1), 27-39.

Mori, A. (2020). *The Influence of Different Kinds of Interpreter on a Mental Health Care Encounter*. Masters dissertation, University of Geneva.

NCIHC A National Code of Ethics for Interpreters Working in Healthcare (2004). At https://www.ncihc.org/assets/z2021Images/NCIHC%20National%20Code%20of%20Ethics.pdf.

NHS Guidance for commissioners: Interpreting and Translation Services in Primary Care. At https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners interpreting - and-translation-services-in-primary-care.pdf

Ndongo-Keller, J. (2015) ‘Vicarious trauma and stress management’ Mikkelson, H., & Jourdenais, R. (Eds.) *The Routledge Handbook of Interpreting* (349-363). New York: Routledge

Parrilla Gómez, L. (2020) *La interpretación en el contexto sanitario: aspectos metodológicos y analisis de interaccion del interprete con el usuario*. Oxford: Peter Lang.

Pearlman and McCann (1990) ‘Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims’ *Journal of Traumatic Stress*, 3 (1).

Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (150–177). New York: Brunner/Mazel.

Purakal, J.D., Venkatesan, S., Natesan, S., Staton, C.A., Kozhumam, A., Vissoci, J.R. (2021). 35 Prevalence and Predictors of Post-Traumatic Stress Disorder Symptoms Among Emergency Physicians in the United States During the COVID-19 Pandemic, *Annals of Emergency* Medicine, *78*(2), 17-19.

Rajpoot, A., Rehman, S., & Ali, P. (2020). Emotional and psychological impact of interpreting for clients with traumatic histories on interpreters: A review of qualitative articles. *WikiJournal of Medicine, 7*(1), 1-15.

Ravi, A., Gorelick, J., & Pal, H. (2021). Identifying and addressing vicarious trauma. *American Family Physician*, *103*(9), 570-572.

Roat, C. E., and Crezee, I. (2015). Healthcare interpreting. In H. Mikkelson and R. Jourdenais (Eds.). *The Routledge Handbook of Interpreting* (319-336). London: Routledge

Royuela Sanchis, C. (2021) *Cultural differences in interpreter-mediated cross-cultural care: The case of the HUG in Geneva.* Masters dissertation, University of Geneva.

Schenker, Y., Pérez-Stable, E. J., Nickleach, D., & Karliner, L. S. (2011). Patterns of interpreter use for hospitalized patients with limited English proficiency. *Journal of general internal medicine*, *26*, 712-717.

Skogstad, M., Skorstad, M., Lie, A., Conradi, H. S., Heir, T., & Weisæth, L. (2013). Work-related post-traumatic stress disorder. *Occupational medicine*, *63*(3), 175-182.

Somville, F. J., De Gucht, V., & Maes, S. (2016). The impact of occupational hazards and traumatic events among Belgian emergency physicians. *Scandinavian journal of trauma, resuscitation and emergency medicine*, *24*(1), 1-10.

Splevins, K. A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010). Vicarious posttraumatic growth among interpreters. *Qualitative health research*, *20*(12), 1705-1716.

Sultanić, I. (2021). Interpreting traumatic narratives of unaccompanied child migrants in the United States: Effects, challenges and strategies. *Linguistica Antverpiensia, New Series–Themes in Translation Studies, 20*, 227-247

Sultanić, I. (2023). Interpreting for vulnerable populations: Training and education of interpreters working with refugee children in the United States. In L. Ruiz Rosendo & M. Todorova (Eds.), *Interpreter Training in Conflict and Post-Conflict Scenarios* (114-128). Oxon: Routledge.

Timmins, C. L. (2002). The impact of language barriers on the health care of Latinos in the United States: a review of the literature and guidelines for practice. *Journal of midwifery & women's health*, *47*(2), 80-96.

Tiselius, E. (2022). Conference and community interpreting: Commonalities and differences. In H. Mikkelson, H., & R. Jourdenais (Eds.). *The Routledge Handbook of Conference Interpreting* (49-63). Oxon: Routledge.

Tedjouong, E., & Todorova, M. (2023). Interpreters' training needs in refugee humanitarian crises: Perceptions from Cameroon. In L. Ruiz Rosendo & M. Todorova (Eds.), *Interpreter Training in Conflict and Post-Conflict Scenarios* (pp. 101-113). Oxon: Routledge.

Voice of Love (2012). *Interpreting Compassion: A Needs Assessment Report on Interpreting for Survivors of Torture, Trauma and Sexual Violence.* At http://voice-of-love.org/wp-content/uploads/2014/11/VOL-Needs-Assessment-Report-final1.pdf

World Migration Report: https://worldmigrationreport.iom.int/wmr-2022-interactive/

Yassen, J (1995). 'Preventing secondary traumatic stress disorder' In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (150–177). New York: Brunner/Mazel.

Zhang, Y. Y., Zhang, C., Han, X. R., Li, W., & Wang, Y. L. (2018). Determinants of compassion satisfaction, compassion fatigue and burn out in nursing: A correlative meta-analysis. *Medicine*, *97*(26). doi: 10.1097/MD.0000000000010819

Zimány, K. (2010). Training for interpreting in mental healthcare in Ireland. *International Journal of Interpreter Education*, *2*(1), 3-13.

APPENDIX A: Healing Voices Course Syllabus (2012)

Secondary Trauma and Fostering Wellness for Interpreters – Online Training

Course Description:

This course explores how interpreting for trauma survivors may affect an interpreter, by identifying factors related to job stress, learning about how to differentiate between secondary trauma and stress, as well as how to become aware of secondary trauma and strategies to prevent or minimize its effect. Lastly, the course reviews self-care techniques, including how to develop wellness goals.

This course is intended for those who have already completed core interpreter training and who wish to continue their professional development.

This online course will take about 2 hours to complete.

Course Objectives:

- Identify factors related to job stress and how they can affect one's work.
- Define and explain secondary trauma that interpreters may experience.
- Apply strategies to identify, prevent or minimize secondary trauma for interpreters.
- Review self-care strategies and create a personal wellness plan.

Module Description:

Module
Module 1: Job Stress Factors *explores what job stress is; its causes; its impact on health, including early physical warning signs; as well as approaches for addressing and preventing stress at work.*
Module 2: Understanding Secondary Trauma *explores what secondary trauma is, as well as trauma reactions interpreters may experience.*
Module 3: Coping Strategies *presents and discusses strategies interpreters can apply to prevent or minimize secondary trauma.*
Module 4: Personal Wellness Plan *presents tools to create wellness goals and an individual plan, by building on what was presented in previous units.*

Course Completion Requirements

To receive a certificate of completion, students must have viewed all the slides within the modules and have received a minimum of 70% on the course quiz.

Once the student have completed the course as per the above requirements, they will be able to download the course completion certificate through the training portal.

Contact training@mcis.on.ca for support.

APPENDIX B: Training Outline: Interpreting sensitively and effectively for migrants, refugees and asylum seekers who have experienced sexual violence (2022)

Interpreting sensitively and effectively for migrants, refugees and asylum seekers who have experienced sexual violence

A Dublin Rape Crisis Centre Training Programme

Day One: 9.30am – 1.30pm

- Introductions, housekeeping, focusing and resourcing
- Sexual violence as a global issue: the impact of cultural attitudes and beliefs
- Self-support techniques while working with trauma: supporting yourself in the moment
- The impact of rape, sexual assault, and other trauma
- The window of tolerance
- Guidelines on interpreting for a person disclosing an experience of sexual violence
- Case study

Day Two: 9.30am – 1.30pm

- Check in, focussing and resourcing
- Points of impact in the legal and medical process
- Issues for interpreters when working in SATU, reporting to Gardai, Courts, etc.
- Principles and ethics of interpreting: pressure points when working with distress and trauma
- Case study
- Interpreting in a counselling setting
- Vicarious trauma and self-care