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Interpreting trauma : exploring the experience of compassion fatigue among professional medical interpreters : a project based on responses from the voluntary participation of professional medical interpreters at several major urban health care facilities

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Interpreting Trauma: Exploring the
Experience of Compassion Fatigue
among Professional Medical Interpreters

ABSTRACT

The nature and breath of the work of professional medical interpreters routinely exposes them to traumatized patients in both medical and psychiatry settings. The literature suggests that such exposure increases their risk for developing compassion fatigue. The aim of this pilot study was to determine if professional medical interpreters (PMI) are at risk for developing compassion fatigue (CF). Methods. An innovative designed was developed to explore possible risk and protective factors associated with the development of CF. Well-validated measures were employed to assess the presence or absence of compassion fatigue in a cohort of professional medical interpreters working in large metropolitan hospitals in the Northeast. Risk and protective factors were also explored, including: risk exposure, interpersonal reactivity (empathy), support characteristics of the work environment, and personal factors such as age, gender, and work experience. Convenience sampling recruited 26 participants, 15 of whom completed the survey. Findings. Findings align with the extant literature on compassion fatigue among health care workers, indicating that this is an important issue for medical interpreters as well. The unique characteristics involved in the personal and work life of PMIs suggests that they, their employers and colleagues, would benefit from recognizing the risks inherent in these front line jobs. The practice environment for PMIs should be carefully crafted to minimize development of CF. Social work colleagues can play an important role in helping to craft such environments, and in responding to their colleagues.

INTERPRETING TRAUMA: EXPLORING THE EXPERIENCE OF COMPASSION

FATIGUE AMONG PROFESSIONAL MEDICAL INTERPRETERS

A project based on responses from the voluntary
participation of professional medical interpreters at
several major urban health care facilities, and
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

Professional medical interpreters are on the front lines of trauma work with medical professionals. The nature and breath of the work of medical interpreters routinely exposes them to patients who have experienced traumatic events, which the literature suggests increases their risk for developing compassion fatigue. While compassion fatigue has been widely documented and studied among first responders, mental health professionals, and animal care workers, there is virtually no research on this phenomenon among professional medical interpreters. This study seeks to identify the risk and protective factors at play in the development of compassion fatigue among this population (Sprang, Clark, & Witt-Woosley, 2007; Figley 1995, 2002; Tehrani, 2007; and Craig & Sprang, 2010).

The aim of this pilot study was to determine if professional medical interpreters are at risk for developing compassion fatigue. Additionally, the study was designed to examine possible risk and protective factors related to the development of compassion fatigue, examining factors in both the individual and the work environment that may be associated with developing signs of the phenomena. Risk and protective factors considered in this study include exposure risk (such as routine exposure to severe trauma cases), interpersonal reactivity or empathy, support characteristics of the work environment, and personal factors such as age, gender, and number of years worked in the field.

The research literature suggests that both risk and protective factors play a role in the development of compassion fatigue in other populations. This study seeks to understand the influence of both risk and protective factors through the use of a 79-item online survey which collected information in several domains: demographic information, work environment, personal empathy (Interpersonal Reactivity Index, Davis, 1990), and the constructs of compassion satisfaction, burnout, and secondary traumatic stress (ProQOL 5, Stamm, 2009).

This researcher has a personal interest in this topic based on work done in my second year internship at MGH Chelsea, where the use of professional medical interpreters was crucial, providing access to mental health support for approximately half of my caseload. Among the patients who would not have otherwise been able to access support, many had suffered trauma and spoke about it in therapy with the use of an interpreter. Furthermore, in a community as diverse as that of Chelsea, MA, every mental health, medical, and other professional on staff requires the aide of interpreters with some frequency. Mental health and wellbeing of the professional medical interpreter staff is of utmost importance to the overall functioning of a clinic such as MGH Chelsea, and as social workers, I believe we are in a unique position to identify and respond to compassion fatigue in our interpreter colleagues. Furthermore, the data from this study may be used as a starting point for further research into this important subject, with the aim of creating better inform, evidenced-based practices when working with the aide of professional medical interpreters.

CHAPTER II

Literature Review

Professional medical interpreters are on the front lines of trauma work with medical professionals. The nature and breath of the work of medical interpreters routinely exposes them to patients who have experienced traumatic events, which the literature suggests increases their risk for developing compassion fatigue. While compassion fatigue has been widely documented and studied among first responders, mental health professionals, and animal care workers, there is virtually no research on this phenomenon among professional medical interpreters. This study seeks to identify the risk and protective factors at play in the development of compassion fatigue among this population (Sprang, Clark, & Witt-Woosley, 2007; Figley 1995, 2002; Tehrani, 2007; and Craig & Sprang, 2010).

Compassion fatigue: Definition and impact

Compassion fatigue, as used in this study, is interchangeable with the experience of Secondary Traumatic Stress (STS), and is operationalized using Figley's definition (1995):

> "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other [or patient] – the stress resulting from helping or wanting to help a traumatized or suffering person [or patient]." (p. xiv)

Figley and others studied the phenomenon of compassion fatigue for decades, and measured the experience of compassion fatigue among various populations (Sprang, Clark, & Witt-Woosley, 2007; Figley 1995, 2002; Tehrani, 2007; and Craig & Sprang, 2010).

The signs of compassion fatigue include: episodes of sadness and depression, sleeplessness, general anxiety, and other forms of suffering (Figley, 1995). Others have suggested that symptoms of compassion fatigue also may include: expressing complaints about administrative functions; poor self-care (i.e., hygiene, appearance); apathy; lack of pleasure in activities; difficulty concentrating; mental and physical fatigue; and preoccupation (http://www.compassionfatigue.org/pages/symptoms.html).

It is important to differentiate between CF and PTSD, as the relative symptom pictures share many characteristics but are not identical. The main difference is that PTSD is a result of direct trauma, or the trauma of someone very close to you (family member or loved-one) while CF (aka: vicarious trauma, secondary traumatic stress or ST) is the result of learning of another person's trauma. In short, "compassion Fatigue is a more user friendly term for Secondary Traumatic Stress Disorder, which is nearly identical to PSTD, except it affects those emotionally affected by the trauma of another (usually a client or a family member)," (http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html). For the purpose of this study, it was important to attempt to differentiate between the subject's experience of the more personal and immediate diagnosis of PTSD and their experience of work-related compassion fatigue.

Noreen Tehrani argues for the, "need to provide support to all professionals undertaking caring work with distressed or traumatized clients," (p. 325), in her 2007 study, "The cost of caring – the impact of secondary trauma on assumptions, values and beliefs." She further asserts

that, "if the trauma narrative touches upon any personal history the carer may become numb and not able to 'hear' the client." (p. 328) Although Tehrani's study focused on care workers, the implication for professional medical interpreters losing the ability to "hear" the client is of obvious and significant importance. (Tehrani, 2007)

Factors influencing CF: Now that the consequences to the quality of work of individuals suffering from CF have been examined, the need to identify both risk and protective factors becomes the focus of this study. In their 2007 study, "Compassion Fatigue, Compassion Satisfaction, and Burnout: Factors impacting a professional's quality of life," Sprang, Clark, and Whitt-Woosley examine the relationship between CF, CS, and burnout. Their study examines how individual, occupational, and environmental factors may impact an individual's response to vicarious exposure to trauma. The study sample universe was comprised of 5,752 licensed or certified behavioral health providers in a rural state. 1,121 subjects responded to the 102-item mail-in survey sent to their homes. The survey captured "providers' practice methods, their use of evidence-based practices, their knowledge of event-specific responses in various populations (rural, children, and elderly), barriers to effective treatment, and levels of compassion fatigue, compassion satisfaction and burnout," (pp. 263 & 264) using the Professional Quality of Life Scale (ProQOL 5: Stamm, 2009). As justification for their study, Sprang, et al. composed an extensive review of the literature listing the following as empirically proven protective and risk factors among various populations: *Protective factors:* increased age, higher levels of education, years of professional experience; specialized training, and supportive work environment and adequate supervision. *Risk factors:* female gender, personal trauma history, long work hours and heavy caseloads, and rural location. (G. Sprang, et al., 2007)

The most notable findings in this study were: 1) specialized training was shown to increase CS and reduce CF and burnout, 2) a high caseload of PTSD clients increased levels of CF and burnout, and 3) specialized trauma training proved as a protective factor. The authors of the study suggest that educating this population about relevant risk and protective factors and providing protective resources could reduce instances of CF and burnout in behavioral health providers.

Risk Factors: Several risk factors have been identified in the development of compassion fatigue, including: 1) repeated exposure to secondary trauma, 2) past history of personal trauma, 3) similar cultural history to the traumatized person, and 4) the necessity of delivering bad news to the traumatized person (Tribe & Raval, 2003). Emergency medical technician teams, hospitals, and mental health clinics have been identified in prevention literature as being at highest exposure risk to CF (Catherall, 1995).

The literature states that empathy, based on over-identification with a patient's situation or history, can act as a risk factor by which means the interpreter internalizes the patient's trauma as his or her own (Tribe & Raval, 2003). However, there is some suggestion that witnessing the successful recovery of a traumatized patient can prove to be a protective factor for the interpreter in the form of vicarious growth (McDowell, Messias, & Estrada, 2011).

Protective Factors: The literature suggests that training, supervision, support, being alerted to potentially difficult content before a session, being allowed an opportunity to debrief after a session, and interpersonal respect may have a buffering effect on job stress and influence interpreter functioning (Tribe & Raval, 2003). The following four aspects of interpretive work were found to be directly influenced by either the presence or lack of supportive characteristics of the work environment: 1) complex and invisible mental work, 2) enabling communication, 3)

negotiating blurred role boundaries and conflicting role expectations, and 4) the physical and emotional toll of health care interpreting work (McDowell et al, 2011). McDowell concludes that, "All individuals directly engaged in health care interpretation work, including bilingual dual-role interpreters, need formal training, supervision, and support" (p. 146). McDowell's study paves the way for this study, and leaves an opportunity to include the influence of empathy as a variant on the experience of CF in this population.

The next section describes the methodology adopted for this study to examine the presence or absence of compassion fatigue among professional medical interpreters and to identify protective and risk factors that may be implicated in CF outcomes.

CHAPTER III

Methodology

The purpose of this study is to explore the experience of compassion fatigue among professional medical interpreters. As such, the research asks: Do professional medical interpreters experience compassion fatigue? And, if they do, can we identify both protective and risk factors that affect development of the problem? The following domains were examined: exposure to trauma, interpersonal reactivity or empathy, support characteristics of the work environment, and personal factors such as age, gender, and years worked in the field. It is hypothesized that: 1) positive personal characteristics, and support characteristics in the work environment will act as protective factors or buffers against the development of compassion fatigue (CF), and 2) high exposure to trauma will act as a risk factor in the development of CF.

With the collaboration of the research advisor for this project, and the input of several professional medical interpreters obtained in personal communications (A. Spiro, personal communication, January 4, 2012; J. Vincente, personal communication, November 16, 2011; F. Gargano, personal communication, October 11, 2011), several urban hospitals with large interpreter staffs were identified and invited to participate in the study. The department heads at each hospital was sent an invitation email (Appendix A), followed by an email to forward to their staff, inviting participation in the study (Appendix B). Participation was voluntary and

anonymous. Potential participants were asked to click on a link to an online questionnaire hosted on SurveyMonkey (Appendix C).

Due to an initially low response rate, the invitation email to the department heads was resent several times, and the researcher reached out with personalized emails and phone calls explaining the purpose of the study and asking for the participation of their staff. After the initial recruitment effort, an additional facility was identified based on personal knowledge of the research advisor and was invited to participate. A one week extension was granted for the data collection period in hopes of reaching the minimum 50 participant suggested for a quantitative study.

Research Design

This exploratory study utilized quantitative methods with the aim to produce generalizable findings. Furthermore, based on the literature, enough work has been done on the topic of compassion fatigue as to provide a base understanding of CF, therefore the aim of the study was not to look deeply into the individual experiences of each participant, but to try to understand if the phenomenon exists in this population, and if so, what characteristics may prove protective or risk to the development of CF. In this way, a quantitative exploratory study may provide enough data to suggest further and more detailed research on this phenomenon among professional medical interpreters. The discussion in this paper will reflect on how protective and risk factors in the development of compassion fatigue among this population can be applied to training and systems that affect professional medical interpreters to improve evidence-based practices.

Sample: Non-probability convenience sample was used to recruit professional medical interpreters from a pool of individuals who work at regional area hospitals and community health centers. Twenty-six potential participants visited the online survey and attempted the screening questions. Seventeen of those 26 met the eligibility requirements as determined by the initial screening questions (Appendix D). Two were eligible to participate but did not answer questions beyond the screening questions, and were therefore excluded. Fifteen participants signed the informed consent and completed the study (N=15).

Inclusion criteria: Eligibility to participate in the study was determined by the following criteria: participants needed to be 1) be 18 years of age or older, 2) be employed as a professional medical interpreter in a hospital or community health center setting, 3) have worked at least 1 year as a professional medical interpreter, 4) interpret in person (as opposed to via phone), and 5) be a willing participant in the study as indicated by agreeing to the letter of informed consent.

Exclusion criteria: Those not meeting inclusion criteria were excluded from participating. Specifically, anyone who did not agree to participate by signing the informed consent was excluded from the study. Department heads and managers of interpreter services were asked not to participate in the study as well as other professional medical interpreters not working in the target settings or who do not otherwise meet inclusion criteria.

Recruitment Procedures

A non-probability convenience sample was initially taken from ten facilities in and surrounding a medium-sized city in the northeast United States. Directors of interpreting services at these urban hospitals and community health centers were contacted about the study through an

invitation email (Appendix A). Directors who expressed interest in the study were asked to forward an email (Appendix B) to their employees containing a link to the online survey (Appendix C).

This recruitment technique was chosen based on feedback from several professional interpreters. The consensus feedback was that the participants would be most likely to respond if they could take the survey at their convenience - as professional medical interpreters have ever changing schedules and are rarely able to meet as an entire staff - and in the privacy of their own homes - as some of the questions ask for honest feedback about the participants work environment which they may find difficult to answer while in the workplace. Those consulted also emphasized the importance on anonymity for potential respondents, as they are asked to give feedback about their employment experience. The preference for anonymity as well as all of the advice received from experts was employed in the design of this study. As a practical matter, there is no central registry of professional medical interpreters who meet study criteria, and requesting the assistance of managers in area hospitals was the only feasible means of obtaining a sample.

Recruitment began upon receipt of the HSR approval letter (Appendix E). Data collection was initially accepted between March 14, 2012 and April 14, 2012 but, due to low response rates, the data collection period was extended an extra week, and another facility was identified by the research advisor and included in the invitation. Department heads were sent an email explaining the extension and including the invitation email to participants. Ultimately the data collection ended on April 20, 2012.

Ethics and Safeguards

Risks of participation: The nature of the survey was to examine the experience of compassion fatigue. Participating in this survey could raise awareness about the participants' work conditions or highlight emotional responses of working with patients. This heightened awareness could be experienced as distress by some participants. A list of online educational resources and supports relating to compassion fatigue, symptoms of CF, and self care suggestions were provided to respondents, listed on the printable letter of informed consent (Appendix F). Additional resources including directions to access counseling support within each facility and a suggestion to discuss any issues with their supervisor are also included in the informed consent.

Participants' directors and department heads forwarded the "recruitment email," and it is therefore possible that the respondents felt compelled to participate in this study. To address this possibility, care was taken to assure participants of the voluntary and anonymous nature of participation in both the recruitment email and the letter of consent, specifically indicating that their department managers would not know if they choose to participate or not.

Benefits of participation: Participants did not receive any tangible benefits, including money or goods, for participating in this study. Participants in this study may have benefitted from the insight gained by completing the self-reflective survey and by being asked about their experiences. Participants may have gained satisfaction in the knowledge that the data collected in this study would be used to justify further research in improving the experience of professionals in the interpreter field, and in publications and presentations for the purpose of educating many professions about compassion fatigue.

Voluntary nature of participation: Participation in this study was entirely voluntary. The participant was able to choose not to open the survey which was linked to the recruitment

email, they may have chosen to not agree to the letter of consent, may have skipped any question they wished, and may have chosen to not submit the finished survey. Once the participant chose to submit the survey and letter of consent, they were no longer able to remove their participation as the data is anonymous and it would have been impossible to identify their individual responses. These protocols were explained to participants in the letter of consent.

Informed consent procedures: The Informed Consent was presented in an electronic format. Participants could enter the study after agreeing to participate. Agreement was indicated by clicking on the "I agree" button on the form.

Once the participants agreed to participate they were routed to the beginning of the survey. Those who declined the informed consent did so by clicking "I do not agree" and were routed to an exit screen. Parental and guardian signatures were not sought as inclusion criteria dictates that the participants must be 18 years or older, and translations were not offered as participants must be able to read and write in English in order to meet inclusion criteria.

Precautions taken to safeguard confidential and identifiable information: In order to provide the most protection of each participant's identity, the data for this study was collected anonymously through SurveyMonkey. I configured the survey's settings such that participants access the survey and their answers were gathered without tracking names, e-mails or IP addresses. In the survey settings, I enabled Secure Sockets Layer (SSL) encryption. SSL encryption technology protects respondent information using both server authentication and data encryption, ensuring that user data is safe, secure, and available only to authorized persons as it moves along communication pathways between the respondent's computer and SurveyMonkey servers (SurveyMonkey, 2012).

SurveyMonkey (2012) describes the following physical security: The data center is located in a SAS70 Type II certified facility. The data center is staffed at all times and secured by security guards. Visitor logs, and entry requirements included pass cards with biometric recognition. Servers are kept in a locked cage; digital surveillance equipment monitors the data center around the clock; environmental controls for temperature, humidity and smoke/fire detection are in place. All customer data is stored on servers located in the United States.

Participants' responses were associated with an automatically generated code number, therefore the data gathered through this survey preserved anonymity even to the researcher. The Smith College School for Social Work faculty advisor and data analyst handled the same anonymous data, and per thesis guidelines have signed a confidentiality agreement in order to protect the rights of participant anonymity. In all future use of this data, be it in presentations, publications, or MSW thesis, anonymity will be preserved, as the already anonymous data will be presented in aggregate.

All electronic data will be stored for three years in a password protected document on a personal, password protected, laptop, accessible only to the researcher, until which time it will be destroyed according to Federal guidelines. Furthermore, the laptop has antivirus, antispyware software meeting government standards of protection of electronic data. Any physical documents such as data printouts are stored in a secure and locked file cabinet and will be kept for the minimum three years as required by Federal guidelines and then destroyed. If the data are needed for a longer period of time, they will be kept securely as described above and destroyed when no longer needed.

Human subjects review board: The Human Subject Review Board (HSRB) at Smith College, Northampton, MA. approved this study after assuring that all materials met Federal and

college standards for protection of human subjects. A copy of the HSRB approval letter is provided in (Appendix E).

Data Collection

 Overview: The data collection instrument was offered online through the data collection tool SurveyMonkey. After reading the recruitment email (Appendix B), participants click on the link to the survey and are lead to a welcome screen. As the participant clicks the next button, they are led to the screening questions to determine eligibility for participation in the study.

 Informed consent procedures: Ensuring that individuals were fully informed about the research study and their participation in it was a critical component of the research design. Potential participants meeting inclusion criteria were next presented with the informed consent letter (Appendix F). The letter includes information about the study, an emphasis on both the voluntary and anonymous nature of participation, and includes several educational and mental health resources available to participants.

 Quantitative measures: After answering six screening questions to determine eligibility (Appendix D), and agreeing to the letter of consent described above, participants entered into a five section, 79-item questionnaire including open-ended, multiple choice questionnaire (Appendix C), including: two previously validated Likert-type measures; 15 demographic questions; eight questions about support in the work environment, and with five questions about the participant's experience of PTSD. All of the questions in the first two sections (demographic and work environment) were formulated by the researcher and were based on the literature.

Demographic data: Demographic information collected included: age; sex; number of languages the respondent interprets for; the specific languages the respondent interprets for; level of education and amount of training specific to interpretation; number of years worked as a professional medical interpreter; hours a week providing face-to-face interpretation; whether the participant interprets at one facility or more than one; which medical settings the subject interprets in and percent of time spent in each setting; percent of time working in inpatient mental health, outpatient mental health, and emergency medicine; does the subject interpret for children, adults, or both, which method of interpretation does the subject most often use; and finally, the subject is asked to identify different aspects of their professional role.

Work Environment: Questions about work environment were formulated by this researcher in order to gauge whether the subject has a positive work environment (implying a perception of comfort and support) or a negative work environment, and are used as indicators of protective or a risk factor in the work environment that may potentially contribute to the development of CF. Questions about work environment focus on physical comfort, supervisory support, reasonable wok expectations, and perception of professional respect.

Previously validated measures: Sections three and four utilize two previously validated scales. The construct of compassion fatigue is operationalized using ProQOL 5: The Professional Quality of Life scale (Stamm, 2009), a 30-item self-report measure that measures the constructs of compassion satisfaction, burnout, and secondary traumatic stress (available through http://proqol.org/Compassion_Fatigue.html). An empathy rating was obtained for each participant using the Interpersonal Reactivity Index (Davis, 1980), with revisions as recommended by (Pulos, Elison, & Lennon, 2004). The revised version contains 21 self-report

items. The final section of the survey contains five questions aimed at understanding if the subject experienced PTSD or trauma unrelated to their role as a professional medical interpreter.

Data Analysis

Responses were examined to explore: (a) whether professional medical interpreters experience compassion fatigues, (b) whether empathy scores act as a protective or risk factor in the development of CF, (c) how characteristics of the work environment relate to the presence or absence of CF, and (d) how demographic characteristics may act as a protective or risk factor in the development of CF. At the end of data collection period, the survey data were downloaded into an Excell spreadsheet, checked for errors, and submitted for analysis. Each respondent was given a unique identifier and demographic and quantitative data were coded and organized.

Demographic data: Demographic data for participants were analyzed using descriptive statistics. The plan to interrogate the data using relational statistics was not feasible due to the small sample size. Given the large number of data points, it was determined that the sample of 15 subjects did not provide enough data to run correlations.

Fifteen subjects completed the questionnaire successfully. The age of respondents ranged from 28 to 63 (n=14, m=41.5 years). Two thirds of the sample were women (n= 9), and 1/3 were men (n=5). One subject did not respond to age and gender questions.

Subjects reported interpreting 1 to 4 languages; 80% interpreted for two or fewer languages (n= 15), with 7 distinct languages used by respondents in their daily work. All subjects reported having interpreter training, including eight subjects with 40-60 hour training (53%); six subjects have certificates specifically for medical interpreting (40%), and four have hospital training (27%).

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Two subjects report having a college certificate in interpretation and two who have a degree in professional medical interpretation. In terms of general education, 33% reported some college experience (n = 5), 27% have a graduate degree (n = 4), and the remaining 40% hold either an AS or a BA (n = 1, n = 5 respectively).

The median number of years subjects worked as a professional medical interpreter is seven, ranging from a minimum of three (n = 2) to a maximum reported 17 (n = 1) years in the field. Subjects worked between one (n = 1) and 70 (n = 1) hours each week with a median of 32 hours per week. In response to questions about the location subjects (n = 15) interpret in, 40% report they work in one facility and 60% work in two facilities and subjects identify a wide range of departments with subjects spending the most time in emergency medicine, oncology, and primary care (n = 15).

Quantitative data: Responses to the IRI (empathy), ProQOL 5, and work environment sections of the survey were scored using scoring strategies specific to each scale. Individual scores for the domains of compassion satisfaction (CS), secondary trauma (ST is interchangeable with CF), and burnout (BO) scored using scoring strategies for the ProQOL 5. Totals were computed for the IRI and work environment portions of the survey creating ratings for empathy (IRI) and perceived support in the work environment. In both cases, the higher the score, the greater the presence of either empathy or perceived support.

Strengths and limitations of the methods

Strengths: A primary aim of the study was to develop and pilot a methodology for examining protective and risk factors in the development of compassion fatigue among medical interpreters. In this regard, the study was innovative and successful. The methodology that was

piloted in this study was based on a thorough review of relevant literature, made use of standardized measurement tools where available, and pioneered social networking media as a recruitment tool.

Limitations: The primary limitation of this study is the small response size, which prohibited in depth interrogation of the data. The five weeks allotted to collect data was insufficient for reaching a statistically viable sample.

Methodological bias: The study's methodology had bias. First, selection bias was generated by the fact that the sample for this study was relatively small in size and nonrandomized. Further, only those with access to a computer with internet, who were able to navigate SurveyMonkey, and who could read and write in English could participate. Additionally, the participants were introduced to the survey through their Department chair, possibly creating concerns about anonymity. The research design attempted to mediate this form of bias by clarifying in the informed consent and survey instructions that the survey was anonymous, so that neither the names, e-mail addresses, nor the IP addresses of participants were known.

Other aspects of researcher's identity: Other aspects of the researcher's identity, such as being a white woman, also needed to be considered as the study was planned, conducted, and data was scrutinized. Furthermore, the researcher's limited experience with the population being studied may have led to the possibility of neglecting to ask questions about certain aspects of the participants' experiences out of bias caused by her own personal experiences and identity. With this in mind, the researcher contacted several professional medical interpreters during the development of the survey to gain a deeper understanding of what questions would be most relevant to this population.

CHAPTER IV

Findings

This was an exploratory study using a quantitative methods design. The purpose of the research was to determine whether professional medical interpreters experience compassion fatigue, and to add to the knowledge base about both protective and risk factors in the individual and work environment that may influence the development of CF among this population. The study surveyed professional medical interpreters working in urban hospitals and community health care clinics.

This chapter contains a demographic description of the sample and summaries of the quantitative data, including several scales created to help explain the data. Due to the small sample size in this pilot study, the external and internal validity of the findings are not reliable and should not be read as such. However, some observations and inferences can be made for further exploration, as will be discussed in the following chapter.

Table 1

Gender, (n =15)

Sex	f	%
Female	9	60.0
Male	5	33.3
Missing	1	6.7

Table 2

Age, (n = 14)

Mean	m	Range
43.4	41.5	28 - 63

In previous studies on CF on different populations, females were shown to be more at risk of developing CF, while increasing age acted as a protective factor.

Table 3

Number of Languages interpreted, (n = 15)

Number of languages	f	%
1	9	60
2	3	20
3	1	6.7
4	2	13.3
Total	15	100

Subjects identified seven languages in total that they use in their work. Listed in the order of most common to least common: Spanish (n=12); Portuguese (n=6); French, Russian, and Cape Verdean Creole (n = 2); and Italian and Nepali (n=1).

Table 4

Professional experience, (n = 15)

Mean	SD	Range
7.53	3.93	3 - 17

46.7% of subjects reported having 6 years or less in the field of professional medical interpretation. All subjects reported using consecutive interpretation as their primary method, while two noted an occasional use of simultaneous interpretation.

Table 5

Hours worked per week, (n = 15)

Mean	SD	Range
32.7	17.4	1 – 70

This data is remarkable with regard to the range of hours worked per week as a professional medical interpreter. This information may speak to the vastly different experiences of the work that individuals in this field may experience.

Also notable is that, in a separate question, 60% of subjects (n= 9) reported that they split their time between two facilities while 40% (n = 6) reported working in one location.

Table 6

Specialized training, (n = 15)

Training	F
40 – 60 Hours of Training	8
Medical Interpreter Certificate	6
Hospital Training	4
College Certificate in Medical Interpreting	2
Degree in Professional Medical Interpreting	2
Written exam in Medical Interpreting	1

In Table 6, training is listed from least to most credentialed. Medical interpreting is still evolving is credentialing and professional standards and it can be difficult to capture accurately levels of education and training within the field. With that said, none of the subjects reported "No training." However, less that half reported training beyond the minimum 40 – 60 hours of training.

Figure 1

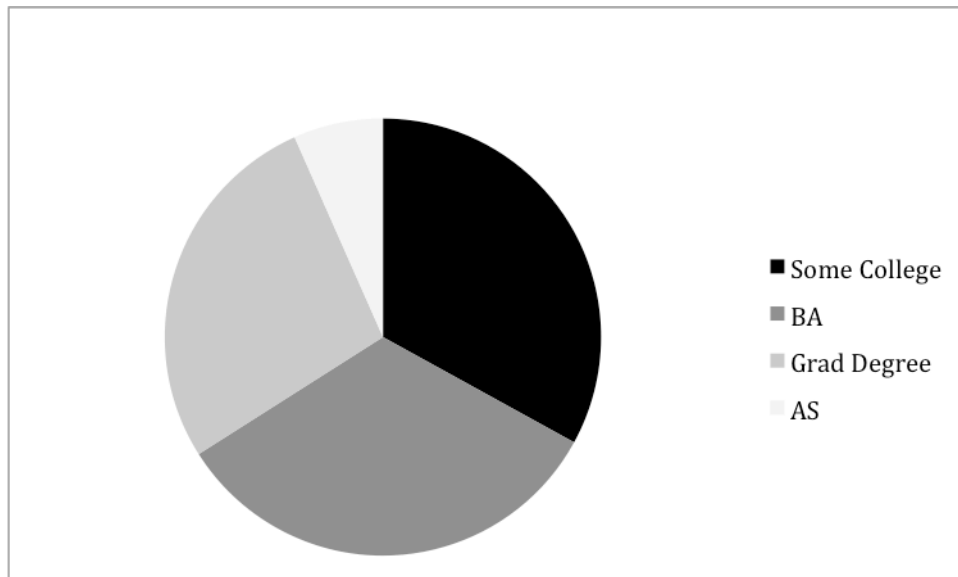*Highest level of education completed, (n = 15)*

Figure 1 shows a pie chart illustrating the highest level of general education completed by the subjects.

Table 7

Role perception, (n = 15)

Perceived Role	F
Cultural Broker	15
Language Translator	14
Enabling Communication	13
Advocate on behalf of the patient	12
Mediate the relationship between patient and practitioner	10
Navigator for Patient	9
Negotiating role expectation about your work for the patient and/or practitioner	6
Social support/ friend to patient	5
Complex and invisible mental work	4
Convince the patient to follow the practitioner's recommendations	2

Table 7 reflects the range of roles the cohort reported in their role as a professional medical interpreter. The literature suggests that individuals in other fields have an increased experience of compassion fatigue based on a misunderstanding of role and role boundaries. While a professional medical interpreter's role may vary depending on the facility in which they work, the literature suggests that the roles of "friend to patient" (n = 5), and those who feel they must "mediate the relationship between practitioner and patient" (n = 10) are taking on responsibilities outside of their profession.

Table 8 displays responses to seven questions developed to gauge perceived support in the work environment (WE). A high WE score indicates a perception of support and respect at work, as well as a satisfaction with the physical demands of the job. The empathy scale, also

included in Table 8, shows the total scores from the Interpersonal Reactivity Index (Davis, 1980)

for which a high score demonstrates a higher empathy rating.

Table 8

Work Environment Scale and Empathy (IRI) Scale, (n =15)

Domain	*n*	Mean	SD	Range
Work environment	15	5.27	1.58	1 - 7
Empathy	15	42.2	3.79	37 - 50

Table 8 demonstrates that the subjects in this study showed a strong positive perception

of the support within their work environment, which is considered a protective factor against the

development of CF in other populations. The Empathy Scale reflects average to low empathy

ratings. A high empathy rating was hypothesized to be a risk factor in the development of CF in

this population.

Table 9

Work setting: Percent of time worked in various hospital settings by

number of responses, (n = 15)

Percent of time	Emergency Department	Outpatient Mental Health	Inpatient Mental Health
0%	4	3	8
10%	2	6	3
20%	1	3	3
30%	2	3	-
40%	2	-	-
50%	-	-	-
60%	1	-	-
70%	-	-	-
80%	1	-	-
90%	2	-	-
100%	-	-	-
Missing	-	-	1
Total	15	15	15

The goal in collecting work settings was to infer a trauma exposure index from the data. That is, it was hypothesized that there would be an association between exposure to setting where trauma stories or events are more likely (inpatient psychiatry, ED). This sample was most experienced in the ED, with less exposure to inpatient mental health settings. Given the size of the data pool, it was not possible to explore the hypothesis. However, this remains an important domain of information for development in future research.

Table 10

ProQOL 5: Compassion Satisfaction, Burnout, and Secondary Trauma (CF), (n = 15)

Domain name	Mean	Range
Compassion Satisfaction	28.4	18 - 36
Burnout	27.1	23 - 33
Secondary Trauma	34.2	26 - 38

The PROQOL 5 (Stamm, 2005) is a survey instrument containing 30, likert scale questions and covering three domains: compassion satisfaction (pleasure derived for doing your work well), burnout (feelings of hopelessness about doing your job effectively), and secondary traumatic stress (CF) (the reaction to work related, secondary exposure to trauma). (http://www.proqol.org/ProQol_Test.html). As shown in Table 10, the subjects mean scores on each domain fell within the mid-range of possible scores.

Table 11

Preexisting PTSD, (n = 15)

Question	Yes	No
In your life, have you ever had any experience that was so frightening, horrible or upsetting that you had nightmares or unwanted thoughts about it?	8	7
In your life, have you ever had any experience that was so frightening, horrible or upsetting that you had to try hard not to think about it? Or did you go out of your way to avoid situations that reminded you of it?	6	9
In your life, have you ever had any experience that was so frightening, horrible or upsetting that you were constantly on guard, watchful, or easily startled?	6	9
In your life, have you ever had any experience that was so frightening, horrible or upsetting that you felt numb or detached from others, activities or your surroundings?	7	8
Have you ever been treated for symptoms of PTSD?	2	13

The final five questions on the survey inquired about the presence or absence of preexisting PTSD in subjects as shown above in Table 11. Preexisting PTSD was considered a confounding variable. While only two subjects reported receiving treatment for symptoms of

PTSD, it may be important to note that between six to eight subjects endorsed experiencing each of four listed symptoms of PTSD.

CHAPTER V

Discussion

Summary of previous findings

The literature reveals that, although there has been significant research examining compassion fatigue in health and other professions, there is a dearth of research on the experience of this phenomenon among professional medical interpreters. Furthermore, although some work has been done to investigate risk and protective factors, it stands to reason that the unique characteristics involved in the personal and work life of this population deserves a focused examination.

Previous work: Compassion fatigue has been widely documented and studied among first responders, mental health professionals, and animal care workers. There is virtually no research on this phenomenon among professional medical interpreters. Studies have documented that increased exposure survivors of trauma in the capacity of care worker leads to an increased risk for developing signs of compassion fatigue (CF). Some protective and risk factors relevant to these populations have been identified, including characteristics of both the individual and the work environment. The authors of one study (G. Sprang, et al., 2007) on behavioral health providers suggests that educating this population about relevant risk and protective factors, and providing them with protective resources could work to reduce instances of CF and burnout. (Figley 1995, 2002; Tehrani, 2007; and Craig & Sprang, 2010).

The research of Tribe and Raval (2003) resulted in the publication of *Working with Interpreters in Mental Health.* This important work suggests framework for mental health practitioners to consider when working with the aide of an interpreter. Although the book is aimed at mental health professionals, the implication that interpreters would benefit from practice regulations around working with complex and sometimes traumatized populations is latent in the text.

Strengths and limitations

Strengths: The strengths of this study lie in its aim and the methodology that was developed to explore this important question. The study examines compassion fatigue among a sample that has previously been unexplored, and the study conceptualizes a framework for identifying risk and protective factors important to this specialized population. Both are strengths.

The study undertook to shine a light on a critical member of the care giving team; a growing number of non-native English speakers living in the United States receive medical services with professional medical interpreters as critical components in the process. The methodology proposed in the study could be replicated or built upon to produce investigate this important topic. In particular, the tailored focus on protective factors and risk factors for this particular work force is innovative.

Limitations: Feasibility issues encountered in implementing the study proved to be the greatest limitation. Due to the smaller than expected sample, inferences cannot be drawn from the data that were collected. The data collection period was much too short and, in hindsight, the professional work of a medical interpreter is a constant and often hectic schedule which may

have rendered participation during the workday impossible, for some. Although the online nature of the survey would allow participants to complete the survey from work or from home in theory, this is overlooking the fact that a participant may not have a computer or Internet services at home. Furthermore, casual discussions with interpreters reveal that often times they may not have time to eat lunch at work, much less complete a 79 item online survey in one sitting. A focus group was considered during the conception of this study and may have been a helpful way to ascertain the most effective methodology for answering this study's questions.

Implications for Social Work

It is estimated that nearly 20 million people in the U.S. require an interpreter in order to access health services (www.migrationinformation.org). This staggering number highlights the fact that social workers have a vested interest in the health and wellbeing of medical interpreters. Beyond this, social workers have both an opportunity and an obligation to support our interpreter colleagues, as we are uniquely positioned as a profession to recognize the phenomenon of compassion fatigue, and to facilitate interventions and to collaborate with interpreters to improve and support the systems in which interpreters train and work. The aim of this study included the hope that findings of this study would be used to support further research to inform social workers' evidence-based practice as a protective measure in their continuing work with interpreter services. The fact that the sample was too small for significant findings does not alter the importance and relevance to social work; it simply illuminates the importance of continuing this work.

Recommendations for future research

The failure of this study to gather a sufficient sample, and subsequent lack of significant findings leads this researcher to recommend several objectives for future research. It would be valuable to convene a focus group to identify effective ways to survey this group of workers. This could lead to revisions in the methodology, including sampling protocols or the survey tool itself. Furthermore, a closer collaboration with the department heads - perhaps asking for dedicated time for individuals to complete the survey – might make a difference in interpreters ability to compete the survey, to say nothing of their interest. Greater buy-in by the interpreters themselves would also likely boost participation. As this study was both anonymous and voluntary, this researcher did not interact personally with the potential participants.

Aside from addressing feasibility issues with gathering a sample, future research in this area would benefit from creating an *exposure index* by assessing which work situations (emergency, mental health, pediatrics) embodies the greatest exposure to patients' trauma. By identifying the departments or work situations in which professional medical interpreters are most exposed to their patients' trauma, preventative measure may be taken to help protect against the development of compassion fatigue.

A recent study emphasizes the value of strengths-based approaches in examination of interpreting for survivors of trauma and finds reason for optimism (Splevins, Cohen, Joseph, Murray, & Bowley, 2010). "Vicarious posttraumatic growth among interpreters," offers an alternate perspective to the study of the implicitly negative *compassion fatigue* by examining the experience of growth reported by some interpreters when working with survivors of trauma. It is important that future research put a proportional emphasis on the gains that can be experienced

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when working with trauma as well as the risks to promote and sustain the valuable work of professional medical interpreters, interpreting trauma.

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Appendix A

Invitation Email

SUBJ: Research project about professional medical interpreting

TO: [Insert email address of Interpreter Services Departments Head]

Dear _____,

My name is Jenny White. I am a master of social work candidate at Smith College School for Social Work and am contacting you to explore the possibility of inviting members of your Department to participate in a research project involving medical interpreters that looks at an aspect of their work known as compassion fatigue. I am writing to department heads at area hospitals [health centers] to ask if you would be willing to pass on information about the study to your staff. My goal is to get the word out to as many professional medical interpreters as I can, and your assistance would be invaluable.

Professional medical interpreters work on the front lines with their medical colleagues and are routinely exposed to patients who have experienced significant traumatic events. We know from studies undertaken about first responders and trauma workers that working with patients who present with major medical and/or psychological trauma puts first responders at risk of developing a type of secondary PTSD know as "compassion fatigue." While a great deal is known about compassion fatigue among first responders and medical personnel, virtually no research has been undertaken to explore this phenomena among professional medical interpreters.

Understanding more about how compassion fatigue and secondary trauma develop in various allied and medical professions is important because it allows workers and managers to develop training programs that promote protective strategies the educate and support workers. Such strategies improve worker retention, well being, and work satisfaction.

If you are willing to forward an email to your staff about the study, please let me know by replying to this email and I will forward a copy of the invitation email for you to distribute. The staff invitation email will tell your staff about the study and give them a web address where they can read the study questions and answer anonymously online if they wanted to participate. Their participation, of course, is entirely voluntary. You would not know which individuals, if any, from your department agreed to participate in the study.

This research has been approved by the Human Subject Committee at Smith College School for Social Work in Northampton, MA.

I would be pleased to present the study findings at a staff meeting or other forum that you might suggest. While I would not be discussing your particular hospital, the finding would describe what we learned from a cohort of professional medical interpreters across a number of settings. We hope that study results will provide information that is useful to interpreters and their managers and help to inform the systems in which interpreters train and work.

If you are willing to forward an email to your staff about this important study, please reply to this email (mailto:interpreterstudy@gmail.com) and I will send the recruitment email to

you right away. If you cannot participate in the study at this time, it would also be helpful to hear from you so that I know you received this invitation.

If you have any questions regarding this research please email your questions (or a phone number and a good time to reach you) and I will get back to you immediately.   Thank you so much for your time and interest.

Sincerely yours,

Jenny White, MSW Candidate
Smith College School for Social Work
Northampton, MA
interpreterstudy@gmail.com

Cc: Human Subjects Committee, Smith College School for Social Work

Appendix B

Recruitment Email

SUBJ: Research project about professional medical interpreting

TO: [Insert email address of Interpreter Services Departments Head]

Dear _____,

   My name is Jenny White. I am a master of social work candidate at Smith College School for Social Work and am contacting you to explore the possibility of inviting members of your Department to participate in a research project involving medical interpreters that looks at an aspect of their work known as compassion fatigue. I am writing to department heads at area hospitals [health centers] to ask if you would be willing to pass on information about the study to your staff. My goal is to get the word out to as many professional medical interpreters as I can, and your assistance would be invaluable.

   Professional medical interpreters work on the front lines with their medical colleagues and are routinely exposed to patients who have experienced significant traumatic events. We know from studies undertaken about first responders and trauma workers that working with patients who present with major medical and/or psychological trauma puts first responders at risk of developing a type of secondary PTSD know as "compassion fatigue." While a great deal is known about compassion fatigue among first responders and medical personnel, virtually no research has been undertaken to explore this phenomena among professional medical interpreters.

   Understanding more about how compassion fatigue and secondary trauma develop in various allied and medical professions is important because it allows workers and managers to develop training programs that promote protective strategies the educate and support workers. Such strategies improve worker retention, well being, and work satisfaction.

   If you are willing to forward an email to your staff about the study, please let me know by replying to this email and I will forward a copy of the invitation email for you to distribute. The staff invitation email will tell your staff about the study and give them a web address where they can read the study questions and answer anonymously online if they wanted to participate. Their participation, of course, is entirely voluntary. You would not know which individuals, if any, from your department agreed to participate in the study.

   This research has been approved by the Human Subject Committee at Smith College School for Social Work in Northampton, MA.

   I would be pleased to present the study findings at a staff meeting or other forum that you might suggest. While I would not be discussing your particular hospital, the finding would describe what we learned from a cohort of professional medical interpreters across a number of settings. We hope that study results will provide information that is useful to interpreters and their managers and help to inform the systems in which interpreters train and work.

   If you are willing to forward an email to your staff about this important study, please reply to this email (mailto:interpreterstudy@gmail.com) and I will send the recruitment email to

you right away. If you cannot participate in the study at this time, it would also be helpful to hear from you so that I know you received this invitation.

If you have any questions regarding this research please email your questions (or a phone number and a good time to reach you) and I will get back to you immediately. Thank you so much for your time and interest.

Sincerely yours,

Jenny White, MSW Candidate
Smith College School for Social Work
Northampton, MA
interpreterstudy@gmail.com

Cc: Human Subjects Committee, Smith College School for Social Work

Appendix C

SurveyMonkey Questionnaire

Interpreter Survey

Welcome

Welcome to this study for professional medical interpreters. I appreciate that you are taking the time to participate.

Starting on the next screen, you will be asked to answer 5 questions to determine if you are eligible to participate this study. If you are not eligible then you will be directed out of the survey. If you are eligible you will be asked to read and agree to a letter of consent before entering the survey.

The survey should take about 30 minutes to finish and you may skip any questions.

As many professional medical interpreters work at more than one facility, it is possible that you will receive the invitation to participate in this study more than once. Please only respond once to this survey, as only one of your responses can be counted.

Please feel free to contact me at any time about this study.

Thank you,

Jenny White, MSW Candidate
Smith College School for Social Work

Interpreter Survey

Please answer the following questions to verify that you are eligible to participate in this study.

1. You may have received more than one notice inviting you to participate in this research. Have you already completed this study?

○ Yes

○ No

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Interpreter Survey

* 1. Are you 18 years of age or older?

○ Yes

○ No

✱1. Are you able to read and write in English?

○ Yes

○ No

* 1. Are you currently employeed as a professional medical interpreter in a hospital or community health care center?

- ○ Yes
- ○ No

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Interpreter Survey

＊1. Have you worked for more than one year as a professional medical interpreter?

○ Yes

○ No

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*1. Do you interpret in person (as opposed to over the phone interpretation)?

○ Yes

○ No

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Dear Participant,

I am a second year graduate student at Smith School for Social Work. As part of my degree, I am conducting research toward a Master's thesis. The focus of my thesis study is to explore the experiences of professional medical interpreters. I am interested in the impact of interactions with patients who have experienced suffering on individuals in your profession. The data collected in this study will be used in my thesis, and may be used in publications and presentations on this subject.

*1. In order to participate in this study you must be 18 years or older, and you must work as a professional medical interpreter. As a participant of this study you will be asked to read and agree to this letter of consent, and then to complete and submit an online survey. The survey should take approximately 30 minutes to complete. The survey must be completed in one sitting, as it cannot be saved and finished at a later time, although you may exit the survey at any time and begin it again at your convenience. Once you have completed and submitted the completed survey, it will not be possible to know which answers are yours so there will be no way of removing your data.

The nature of the study examines the potential effects of your experience of working with patients who have experienced suffering, and therefore there is a risk that your participation may elicit emotional discomfort or stress. A list of referral sources for local informational or mental health resources can be found at the bottom of this letter of consent, should you need them. The potential benefits of participation in this study include: contributing to the development of research knowledge about your profession and the opportunity to share elements of your personal and professional experience. Your profession may also benefit from further research that comes out of this exploratory study in terms of increased support, specialized training, and professional development around working with populations who have experienced suffering.

Participation in this study is anonymous. Safeguards have been taken so that I will not be able to identify any individuals who participate in this study. Furthermore, only three people will have access to the anonymous data before it is put in aggregate: the thesis advisor, the professional data analyst, and this researcher – all of who have signed confidentiality pledges to protect participant information. The data collected will be kept in secure locations for a period of three years as required by Federal guidelines at which time it will be destroyed. Any data stored electronically will be in locked documents and also destroyed after the three years. Information needed beyond the three-year period will continue to be stored in a secure location and destroyed when it is no longer needed.

Interpreter Survey

Participation in this study is voluntary. You may choose not to complete the survey, you may choose not to agree to this letter of consent, skip any question you wish in the survey, and you may choose not to submit the finished survey. If you do chose to submit the survey, you will be asked to do so electronically by clicking the "Submit button." After submitting the survey your answers will not be identifiable as yours and therefore there will be no way of removing your data. If you have any questions or concerns about your rights or any aspects of this study, you should contact me at ████████ or the Chair of the Smith College School for Social Work Human Subject Review Committee at (413) 585-7974.

Researcher: Jenny White's phone: ████████████████████████

Educational Resource: http://www.giftfromwithin.org/html/ for information on compassion fatigue

Mental Health Resources:

Contact your facility HR and ask for Employee Assistance Program (EAP) for free Mental Health services

Visit the following websites for a list of mental health resources:

http://www.psych-net.com/hotlines.html

http://www.dbsaboston.org/DirectoriesResources.html

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

○ "I AGREE"

○ "I DO NOT AGREE"

Interpreter Survey

About you:

Please answer the following 15 questions about you.

1. Please state your age in years (numbers only):

[   ]

2. Sex:

- ○ Female
- ○ Male

3. How many languages do you interpret for as a medical interpreter?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6+

4. Which language(s) do you interpret for professionally? Please check all that apply.

☐ Albanian	☐ Haitian Creole	☐ Portuguese
☐ American Sign Language	☐ Hindi	☐ Russian
☐ Arabic	☐ Italian	☐ Somali
☐ Bosnian (Serbo-Croatian)	☐ Japanese	☐ Spanish
☐ Cantonese	☐ Khmer	☐ Vietnamese
☐ Farsi	☐ Mandarin Chinese	
☐ French	☐ Nepali	

Other (please specify)

[   ]

Interpreter Survey

5. What interpreter training/ education have you completed? Please check all that apply.

- No interpreter education/ training
- 40-60 hours of interpreter training
- Certificate/training specific to medical interpretation
- Hospital based training/certification
- College based interpreter certificate
- University degree in interpretation

Other (please specify)

6. What is the highest level of school you have completed or the highest degree you have received?

- Less than high school degree
- High school degree or equivalent (e.g., GED)
- Some college but no degree
- Associate degree
- Bachelor degree
- Graduate degree

7. How many years have you worked as a medical interpreter? Please type the number below.

8. In the past six months, on average, how many hours a week would you say you spend providing face-to-face interpretation? Please write the number of hours in the box below.

9. Are you currently employed at one facility in your role as a medical interpreter, or are you contracted to work in more than one?

- I am employed at one facility
- I am employed at more than one facility

Interpreter Survey

10. As a medical interpreter you may work in many different settings in your facility, or you may specialize in one or two settings. Think about your work over the past 6 months and do your best to list the three departments where you have spent the most time. (examples: pediatric outpatient, oncology, dentistry)

Department 1 [   ]

Department 2 [   ]

Department 3 [   ]

11. Consider your response to the previous question. Try to estimate what percentage of your time you spend on each of the departments you identified above.

	Department 1	Department 2	Department 3
% of time in the above named departments:	[▼]	[▼]	[▼]

12. Consider the past six months of your work as a medical interpreter. Do your best to estimate the percent of time you spent interpreting in the following departments:

check off correct %

inpatient mental health [▼]

outpatient mental health [▼]

emergency medicine [▼]

13. Are the patients you interpret for children? Are they adults? Or do you interpret for both child and adult patients?

◯ The patients I interpret for are all children

◯ The patients I interpret for are all adults

◯ The patients I interpret for are sometimes children and sometimes adults

14. Which method of interpretation do you most often use?

◯ Consecutive interpretation

◯ Simultaneous interpretation

Other (please specify)

[   ]

Interpreter Survey

15. Which of the following do you consider part of your role as interpreter? Please check all that apply.

☐ Cultural Broker

☐ Language translator

☐ Navigator for patient

☐ Enabling communication

☐ Negotiating role expectations about your work for the patient and/or practitioner

☐ Social support/ friend to patient

☐ Mediate the relationship between patient and practitioner

☐ Advocate on behalf of the patient

☐ Convince the patient to follow the practitioner's recommendations

☐ Complex and invisible mental work

Other (please specify)

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Interpreter Survey

Questions about your work environment as a Professional Medical Interpreter...

Please answer "Yes" or "No" to the following 8 questions about your work environment.

1. Would you describe your work environment as physically comfortable?

- ○ Yes
- ○ No

2. Do you feel that your job description matches the actual functions of your daily work?

- ○ Yes
- ○ No

3. Is it difficult to complete your work in the time allotted?

- ○ Yes
- ○ No

4. Do you clearly understand the responsibilities and expectations of your job as an interpreter?

- ○ Yes
- ○ No

5. Would you consult your supervisor about a difficult work situation?

- ○ Yes
- ○ No

6. Do you meet regularly with your supervisor to discuss your work?

- ○ Yes
- ○ No

7. Do you feel that you are appropriately respected for your professional work?

- ○ Yes
- ○ No

Interpreter Survey

8. Are you ever asked to do work that makes you feel uncomfortable? If so, how often?

○ Never

○ Rarely - less than once a month

○ Once a month

○ Once a week

○ Several times a week

Other (please specify)

[   ]

Interpreter Survey

Interpersonal Reactivity Index

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by checking off the appropriate number 1, 2, 3, 4, or 5. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can.

1. I daydream and fantasize, with some regularity, about things that might happen to me.

- ○ 1 - Does not describe me
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me well

2. I often have tender, concerned feelings for people less fortunate than me.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

3. I sometimes find it difficult to see things from the "other guy's" point of view.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

4. Sometimes I don't feel sorry for other people when they are having problems.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

5. I really get involved with the feelings of characters in a novel.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

6. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

7. I try to look at everybody's side of a disagreement before I make a decision.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

8. When I see someone being taken advantage of, I feel kind of protective towards them.

- ○ 1 - Does not describe me well
- ○ 2
- ○ 3
- ○ 4
- ○ 5 - Describes me very well

9. I sometimes try to understand my friends better by imagining how things look from their perspective.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me well   very well

10. Becoming extremely involved in a good book or movie is somewhat rare for me.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me   very well

11. Other people's misfortunes do not usually disturb me a great deal.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me well   very well

12. If I'm sure I'm right about something, I don't waste time listening to other people's arguments.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me   very well

13. After seeing a play or movie, I felt as though I were one of the characters.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me well   very well

14. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me   very well

15. I am often quite touched by things that I see happen.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me   very well

16. I believe that there are two sides to every question and try to look at them both.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me   very well

17. I would describe myself as a pretty soft-hearted person.

   ○ 1 - Does not describe   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me
me   very well

18. When I watch a good movie, I can very easily put myself in the place of a leading character.

  ○ 1 - Does not describe me   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me very well

19. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

  ○ 1 - Does not describe me   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me very well

20. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

  ○ 1 - Does not describe me   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me very well

21. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

  ○ 1 - Does not describe me well   ○ 2   ○ 3   ○ 4   ○ 5 - Describes me very well

Professional Quality of Life Survey (ProQOL 5)

When you interpret for people, you have direct contact with their lives. As you may have found, your compassion for those you interpret for can affect you in positive and negative ways. Below are some questions about your experience, both positive and negative, as an interpreter. Consider each of the following questions about your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.
1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, 5 = Very Often

1. I am happy.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

2. I am preoccupied with more than one person that I interpret for.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

3. I get satisfaction from being able to interpret for people.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

4. I feel connected to others.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

5. I jump or am startled by unexpected sounds.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

6. I feel invigorated after working with those I interpret for.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

7. I find it difficult to separate my personal life from my life as an interpreter.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I interpret for.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

9. I think that I might have been affected by the traumatic stress of those I interpret for.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

10. I feel trapped in my job as an interpreter.

- 1 = Never
- 2 = Rarely
- 3 = Sometimes
- 4 = Often
- 5 = Very Often

11. Because of my work as an interpreter, I have felt "on edge" about various things.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

12. I like my work as an interpreter.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

13. I feel depressed because of the traumatic experiences of those I interpret for.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

14. I feel as though I am experiencing the trauma of someone I have interpreted for.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

15. I have beliefs that sustain me.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

16. I am please with how I am able to keep up with interpreting techniques and protocols.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

17. I am the person I always wanted to be.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

18. My work makes me feel satisfied.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

19. I feel worn out because of my work as an interpreter.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

20. I have happy thoughts and feelings about those I interpret for and how I could help them.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

21. I feel overwhelmed because my interpreting work seems endless.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

22. I believe I can make a difference through my work.

○ 1 = Never   ○ 2 = Rarely   ○ 3 = Sometimes   ○ 4 = Often   ○ 5 = Very Often

23. I avoid certain activities or situations because they remind me of the frightening experiences of the people I interpret for.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

24. I am proud of what I can do to help through interpretation.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

25. As a result of my work as an interpreter, I have intrusive, frightening thoughts.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

26. I feel "bogged down" by the system.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

27. I have thoughts that I am a "success" as an interpreter.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

28. I can't recall important parts of my work with trauma victims.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

29. I am a very caring person.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

30. I am happy that I choose to do this work.

  ◌ 1 = Never   ◌ 2 = Rarely   ◌ 3 = Sometimes   ◌ 4 = Often   ◌ 5 = Very Often

History of PTSD

This is the final page of questions in this survey. These questions are meant to determine if you may have suffered from PTSD before you became a professional medical interpreter.

In order to help assess for this, please answer the following questions. If you are still experiencing these symptoms tell your doctor and they can help you access appropriate treatment.

1. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you had nightmares or unwanted thoughts about it?

    ○ Yes

    ○ No

2. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you had to try hard not to think about it? Or did you go out of your way to avoid situations that reminded you of it?

    ○ Yes

    ○ No

3. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you were you constantly on guard , watchful, or easily startled?

    ○ Yes

    ○ No

4. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you felt numb or detached from others, activities or your surroundings?

    ○ Yes

    ○ No

5. Have you ever been treated for symptoms of PTSD?

    ○ Yes

    ○ No

Interpreter Survey

Thank You

Thank you for taking the time to participate in this study. Please feel free to contact me with any questions or comments about the study. Please click "Done" to submit the completed survey.

Sincerely,

Jenny White, MSW Candidate
Smith College School for Social Work

Appendix D

Screening Questions

1. You may have received more that one notice inviting you to participate in this research. Have you already completed this study?

2. Are you 18 years of age or older?

3. Are you able to read and write in English?

4. Are you currently employed as a professional medical interpreter in a hospital or community health care center?

5. Have you worked for more than one year as a professional medical interpreter?

6. Do you interpret in person (as opposed to over the phone interpretation)?

Appendix E

Smith College SSW: HSR Approval Letter

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

March 2, 2012

Jennifer White

Dear Jenny,

You have given great feedback. This is wonderful work and a very interesting study indeed! Your project is now officially approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Best of luck to you!

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Elizabeth Irvin, Research Advisor

Appendix F

Letter of Informed Consent

Dear Participant,

I am a second year student at Smith School for Social Work, pursuing my master's degree. As part of my degree, I am conducting research toward a MSW thesis. The focus of my thesis study is to explore the experiences of professional medical interpreters. I am interested in the impact of interactions with patients who have experienced suffering on individuals in your profession. The data collected in this study will be used in my MSW thesis, and may be used in publications and presentations on this subject.

In order to participate in this study you must be 18 years or older, and you must work as a professional medical interpreter. As a participant of this study you will be asked to read and agree to this letter of consent, and then to complete and submit an online survey. The survey should take approximately 30 minutes to complete. The survey must be completed in one sitting, as it cannot be saved and finished at a later time, although you may exit the survey at any time and begin it again at your convenience. Once you have completed and submitted the completed survey, you may not withdraw from the study.

The nature of the study examines the potential effects of your experience of working with patients who have experienced suffering, and therefore there is a risk that your participation may elicit emotional discomfort or stress. A list of referral sources for local mental health resources can be found at the bottom of this letter of consent, should you need them. The potential benefits of participation in this study include: contributing to the development of research knowledge about your profession and the opportunity to share elements of your personal and professional experience. Your profession may also benefit from further research that comes out of this exploratory study in terms of increased support, specialized training, and professional development around working with populations who have experienced suffering.

Participation in this study is anonymous. Safeguards have been taken so that I will not be able to identify any individuals who participate in this study. Furthermore, only three people will have access to the anonymous data before it is put in aggregate: the thesis advisor, the professional data analyst, and this researcher – all of who have signed confidentiality pledges to protect participant information. The data collected will be kept in secure locations for a period of

three years as required by Federal guidelines at which time it will be destroyed. Any data stored electronically will be in locked documents and also destroyed after the three years. Information needed beyond the three-year period will continue to be stored in a secure location and destroyed when it is no longer needed.

Participation in this study is voluntary. You may choose not to complete the survey, you may choose not to agree to this letter of consent, skip any question you wish in the survey, and you may choose not to submit the finished survey. If you do chose to submit the survey, you will be asked to do so electronically by clicking the "Submit button." After submitting the survey you can no longer be withdrawn from the study. If you have any questions or concerns about your rights or any aspects of this study, you should contact me at ███████ or the Chair of the Smith College School for Social Work Human Subject Review Committee at (413) 585-7974.

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATIE IN THE STUDY.

"I AGREE" ☐   "I DO NOT AGREE" ☐

Researcher: Jenny White's phone: ███████████

Educational Resources:

http://www.compassionfatigue.org/pages/symptoms.html

http://www.giftfromwithin.org/html/

Resources at your facility:

If you are in emotional distress, please contact your Human Resource Department and ask about the Employee Assistance Program (EAP).