Looking for ghosts everywhere: the effects of vicarious traumatization on mental health interpreters who work with refugees

Sophie Anna Lembeck

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ABSTRACT

This study aimed to add to the available literature on vicarious traumatization among mental healthcare interpreters who work with refugees. I attempted to further this research by interviewing 12 mental health interpreters who work with refugee clients in order to ascertain their experiences with vicarious traumatization. All participants interviewed presented with physical and/or psychological symptoms associated with vicarious traumatization, although they were unfamiliar with the concept of vicarious traumatization itself. Participants’ reactions to working with traumatized clients manifested in various physical and psychological ways and ranged in severity. Previous literature suggests that symptoms of vicarious traumatization are exacerbated when interpreters use certain interpretation methods, are unable to debrief with supervisors or peers, and/or have difficulty separating their personal and professional lives. The interpreters surveyed expressed dissatisfaction in each of these areas. These findings have strong implications for the field of interpreter education and agency policies regarding supervision and support for interpreters.
LOOKING FOR GHOSTS EVERYWHERE:
THE EFFECTS OF VICARIOUS TRAUMATIZATION ON MENTAL HEALTH
INTERPRETERS WHO WORK WITH REFUGEES

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2017
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FIGURE 1: EXAMPLE OF THE USE OF THE GENERAL INDUCTIVE APPROACH……16
Mental health interpreters are some of the most important yet underappreciated workers in the helping professions. Their job is vital—they are responsible for literally “transmitting meanings correctly from one language to another,” thus acting as a conduit from patient to professional and vice versa (Björn, 2005, p. 516). Without their help, millions of patients would be unable to access adequate healthcare.

The purpose of this study was to add to the growing canon of literature on vicarious traumatization among mental healthcare interpreters. I aimed to add to this research by ascertaining whether or not mental health interpreters experience vicarious traumatization when working with refugee clients. It has been suggested by multiple researchers that this phenomenon exists, but very little work has been done to credit or discredit this claim (Cohen & Collens, 2013; Garcés, 2015; Hseih & Nicodemus, 2015; Lai, Haydon, & Mulayim, 2015; Mehus & Becher, 2016). In order to add to this effort, I interviewed 12 interpreters who currently work with refugee clients in mental healthcare settings about changes that have occurred in their personal and professional lives since they began their careers.

Vicarious traumatization, also referred to as vicarious trauma or secondary post traumatic stress, refers to the “transformation of the [helper’s] inner experience as a result of empathic engagement with survivor clients and their trauma material” (Saakvitne & Pearlman, 1996, p. 25). This transformation can lead to physical and emotional symptoms in helpers that mimic traumatic reactions of clients. Although little research has been conducted, it has been theorized that mental health interpreters are at high risk for vicarious traumatization for a number of
reasons, including the professional codes of ethics of the interpreter’s role, the use of the first-person when conducting interpretation services, and sociogeographical origins similar to that of the client (Bontempo & Malcolm, 2011; Mehus & Becher, 2016). Because refugees have often been exposed to intense trauma, many non-native English speakers utilize the aid of mental health interpreters in order to seek therapeutic services in a way that is linguistically and culturally sensitive. Thus, interpreters are thrust into the lives of those who they have been assigned to help—a role which has both positive and negative impacts on the interpreters themselves.

Each interpreter who participated in this study mentioned a degree of satisfaction in their work, with one mentioning that he felt “grateful to be able to help [his] countrymen through a difficult time.” However, each interpreter who participated in this study also mentioned impairments to their personal lives directly as a result of their work interpreting for refugees. These hardships ranged in severity from mild (irritability, minor psychosomatic complaints) to grave (depression, night terrors). Halima, an interpreter who works with Arabic-speaking refugees, explained the effect working with her clients has had on her life: “Before, I was fine. But now I look for ghosts everywhere.”

In the next chapter, I will discuss a review of literature on vicarious trauma, interpreter training, and other relevant topics. In Chapter III, I will explain the methodology by which I conducted interviews with participants. In Chapter IV, I will present the results of the study, as well as an analysis of my findings. Finally, in Chapter V, I will provide recommendations for future research.
CHAPTER II
LITERATURE REVIEW

The aim of this study was to add to the limited literature available on vicarious traumatization among mental healthcare interpreters who work with refugees. I attempted to add to this research by interviewing mental health interpreters regarding their experience with vicarious traumatization when working with refugee clients. A secondary goal of this study was to learn about the interpreter education process, and think of ways in which interpreter education can play a role in diminishing the effects of vicarious trauma through education.

This chapter addresses previously written literature on vicarious traumatization, both among mental health interpreters and others in helping professions. It is important to provide a common definition of vicarious traumatization that will be used throughout this paper; therefore I will use the words of Saakvitne & Pearlman as a standard (1995): “Vicarious traumatization…refers to the cumulative transformative effect on the helper [due to their experiences] of working with survivors of traumatic life events” (p. 18).

The literature on vicarious traumatization among mental health interpreters is surprisingly scarce. Vicarious traumatization is a relatively new concept; the idea was first identified by McCann and Pearlman in 1990. While ample research has gone into the ways other helping professionals (such as social workers (Bride, 2007; Newell & MacNeil, 2010; Ruben, 2015) and doctors (Meadors, et al., 2009; Nimmo & Huggard, 2013; Woolhouse, Browne, & Thind, 2012) experience vicarious trauma, the plights of interpreters have been essentially ignored (Garcés, 2015; Sande, 1997). It is of the utmost importance that researchers begin to investigate the plight
of healthcare interpreters, particularly mental health interpreters, who often work with the most vulnerable members of society.

As stated previously, vicarious traumatization is the theory that “psychological distress affects not only those who have been personally traumatized, but also the healthcare professionals who work with such clients” (Lai, Heydon, & Mulayim, 2015, p. 5). These healthcare professionals, a category in which I include mental health interpreters, in turn, are presumably more likely to develop physical, emotional, and mental health symptomology consistent with acute stress. Common examples include headaches, back pain, insomnia, chronic fatigue, avoidance and emotional withdrawal, irritability, hypervigilance, anxiety, and depression (Bontempo & Malcolm, 2011; Lai, Heydon, & Mulayim, 2015; van Dernoot Lipsky & Burk, 2009).

Mental health interpreters are among the healthcare workers who are likely to develop vicarious traumatization due to the particular hazards of their profession. According to Laub (1992):

the listener to trauma comes to be a participant and a co-owner of the traumatic event: through his very listening, he comes to partially experience trauma in himself…the [hearer] comes to feel the bewilderment, injury, confusion, dread and conflicts that the trauma victim feels…The listener, therefore, by definition partakes in the struggle of the victim with the memories and residues of his or her traumatic past. The listener has to feel the victim’s victories, defeats, and silences, know them from within, so that they can assume the form of testimony. (pp. 57-8)

In addition to being listeners, interpreters are also re-tellers, and many are expected to translate word for word; “verbatim translation of a client’s traumatic experiences increased [helpers’] involvement in the story and triggered an identification process” (Spelvins et al., 2010, p. 1709). Because the origin of vicarious traumatization is not an exact science, the specific reasons one
person may develop vicarious trauma as opposed to another person are unknown. However, there are many risk factors for development, including whether or not the interpreter uses the fidelity method of interpretation; whether or not interpreter training programs provide adequate training about identifying occupational risks; whether or not organizational support is present, and whether or not the interpreter and the client share a similar life history.

The Politics of Interpretation

The process by which a person becomes a mental health interpreter in the United States varies significantly on both a state and organizational basis. However, trainings consistently involve education in an interpretation method called fidelity interpretation. This method involves the interpreter using the first-person perspective and using the patient’s exact words when recounting the events of the patients’ experiences (Diabate, 2011). This method is best described by Björn (2005):

The interpreter should translate everything that is said in the room without changing the content and meaning. The interpreter must be neutral. Everything should be translated into first-person form according to instruction. The therapist speaks directly to and has eye contact with the patient and not with the interpreter. (p. 516)

Interpreter educators argue that the fidelity method is the only way to ensure that unfiltered information from interpreter to provider, and therefore the best way to communicate information is passed from patient to professional. They acknowledge that while sentence and syntax structure will inevitably differ between languages, it is “essential to keep the interpretation as close to the original communication as possible for effective diagnosis” (Diabate, 2011, slide 31).

However, many interpreters feel uncomfortable with this method from both a “professional and human point of view” (Sande, 1997, p. 405). Interpreters who take the time to
get to know their clients personally, build rapport, and provide empathy are those who are more likely to have clients who accept providers’ recommended course of treatment (Hsieh & Nicodemus, 2015). In the words of noted trauma psychiatrist and author Bessel van der Kolk, “I could not become their doctor unless they made me one of them” (2014, p. 18). The same, it seems, is applicable for interpreters.

It is not only interpreters who feel that the fidelity method has its drawbacks. In fact, many researchers feel that using the first-person when interpreting can increase the interpreter’s risk of vicarious traumatization (Bontempo & Malcolm, 2011; Hsieh & Nicodemus, 2015; Mehus & Beher, 2016). When interpreting in the first-person, interpreters are telling their clients’ tales; they are listening, processing, and transmitting their clients’ traumatic experiences, and thus telling their clients’ stories as if they were their own. In this way, mental health interpreters are coexperiencing the most horrifying scenarios in their clients’ lives.

**The Limits of Interpreter Education**

When student interpreters are being taught how to interpret in the professional world, training programs often focus on the ways in which information is transmitted, and do not spend time teaching their students about the impact this information may have on them. While teaching methodology is undoubtedly a priority, it is also important to provide students with methods for dealing with the less-overt duties and responsibilities of the profession. The lack of education on emotional stress, risks for developing vicarious traumatization, and self-care strategies can prove problematic when interpreters are unaware of the hazards of their professions and the options available for dealing with them. As reported by Lai, Heydon, & Mulayim (2015):

Interpreting requires an intense level of cognitive function and has been documented in the literature as demanding maximum cognitive-processing capacity
to maintain accuracy and conversational flow…Any additional load caused by the
cognitive shifts [due to reactions to traumatic content] will divert the brain’s finite
resources away from the task of rendering one language comprehensibly into
another and cause a decline in the interpreting performance, either in accuracy,
fluency, or completeness. (p. 15)

If these biological and psychological processes are not discussed as part of training curricula,
student interpreters are unable to fully gauge the unconscious operations that are going on in
their own minds.

Being an interpreter in a mental healthcare setting, particularly one that deals with trauma
on a regular basis, can be a stressful and lonely occupation. Due to the nature of the profession,
many interpreters feel isolated, emotional, and distressed over the lives of their clients. When
these emotions arise, symptoms linked to vicarious traumatization can begin to appear. If
student interpreters are not informed of these occupational hazards, they may begin to feel
particularly uneasy upon the onset of its symptoms when they are in the professional field, and
thus have difficulty dealing with their consequences.

In addition to failing to explain vicarious traumatization, interpreter educators rarely
teach their students strategies for self-care. While teaching about the importance of self-care is a
relatively standard practice in courses for doctors, social workers, and other helping
professionals, self-care is not prioritized in interpreting courses. In reviewing current practices
of interpreter education, a 2015 study stated that “the field lacks…reports of actual self-care
programs in interpreter education” (Crezee et al., 2015, p. 77). When student interpreters are left
“without an understanding of how to debrief…in ways that promote healthy processing of
traumatic material,” they are more likely to use negative coping mechanisms to deal with their
emotions (Mehus & Becher, 2016, p. 252).
The Similarities between Interpreters’ and Clients’ Life Histories

All of the above symptoms may be further exacerbated when interpreters and clients share “cultural, sociopolitical, ethnic, geopolitical, or life histories” (Hsieh & Nicodemus, 2015, p. 1477). Ironically, this sense of shared life experience is why many interpreters enter the field—due to a sense of kinship or even a sense of responsibility for those for whom they work.

Yet, research has shown that interpreters working with refugees may be “adversely impacted” (Bontempo & Malcolm, 2011, p. 105) by the “traumatic nature of certain assignments,” (Crezee et al., 2015, p. 76) particularly those who share the same country or geographical area of origin as the refugees for whom they interpret. According to a 1997 study, “refugee interpreters felt that their own traumatic experiences had been reactivated when they were interpreting during psychotherapy” (Sande, 1997, p. 407). When transmitting traumatic messages from one person to another, one can easily conflate one’s own experience with that of the client.

While the risk of vicarious traumatization is not limited to those who share a personal history with their clients, it is often easier for those who do not share a trauma story to maintain “useful distance” from their patients’ histories, and thus avoid the more acute effects of vicarious traumatization (van Dernoot Lipsky & Burk, 2009, p. 20). However, this does not exclude such interpreter from the risks of developing vicarious traumatization—even without a personal connection, the strong empathy required for a position of this caliber can prove to be an “occupational health concern” for anyone who is interpreting traumatic content (Mehus & Becher, 2016, p. 249).
CHAPTER III
METHODOLOGY

The primary motive of this study was to add to the literature on vicarious traumatization among mental healthcare interpreters who work with refugees. I attempted to add to this research by ascertaining whether or not mental health interpreters experience vicarious traumatization when working with refugee clients. The secondary aim was to learn about the interpreter education process, and theorize ways in which interpreter education can play a role in diminishing the effects of vicarious trauma through education.

In this chapter, I present the methods used to gather information relevant to this issue. I provide information about the methods of research; participant demographics and the sample set of interviewees; measures taken to ensure an ethical study; and data collection and analysis. The study was designed to gather information about mental health interpreters’ individual and shared experiences working with refugees. Over the course of three months, I interviewed 12 mental health interpreters from across the United States. I conducted these interviews via Skype, over the phone, and in one instance in person. The interviews were semi-structured; I prepared a list of questions in advance (such as “what is your country of origin?”, “how are the experiences of your clients similar or different to your own?”, and “do you ever dream about your clients and/or their experiences?”). However, I let each participant guide their interview in order to ensure that the interviewees were able to share the information they found the most important and relevant to the study.
Research Design

This study was organized as a 12-person “one-shot case study,” during which I interviewed each participant once, gathered information regarding their experiences, and evaluated their responses. The cases were relatively homogeneous; each of the participants was chosen due to their profession in order to “give a detailed picture of a particular phenomenon” (that of the ways interpreters are affected by vicarious traumatization) in order to gather the most accurate information possible (Ritchie, Lewis, & Elam, 2003, p. 79). However, some heterogeneity was present—such as differences in languages spoken, country of origin, and gender, in order to reflect the diversity of interpreters in the workforce, and also in order to properly adhere to the “primary defining features” of a multi-person case study which is rooted in a “multiplicity of perspectives,” (Lewis, 2003, p. 52).

When designing the study, I began with a few ideas about the likelihood of vicarious traumatization among people who work with refugees, and later narrowed the scope into looking at mental health interpreters. I knew from the beginning that I wanted to use in-depth interviews in order to get a detailed response of each participant’s perspective, which could then turn to “in-depth understanding of the personal context within which the research is located” (Lewis, 2003, p. 52).

The interviews were semi-structured; I prepared a list of questions in advance (some of which were listed earlier in this chapter; a full list can be found in Appendix C). However, I let each participant guide their interview, a purposeful choice that was intended to “combine structure and flexibility” and to allow participants to share the information they found the most relevant to the study (Legard, Keegan, & Ward, 2003, p. 138). I was also aware that language
has the power to “illuminate meaning,” which would make it easier for me, as an outsider, to understand the information related more fully (Legard, Keegan, & Ward, 2003, p. 138).

The research project was conducted using a phenomenological lens. I felt this was the research method most appropriate to answer the question at hand, as it “provides a deep understanding of phenomenon experienced by several individuals” (Creswell, 2007, p. 62). This method not only focuses on what participants experience and how they experience it, but also explores the meanings and repercussions of these experiences. I conducted my study in a fashion described by phenomenological researcher Linda Finlay (2009):

Phenomenological research characteristically starts with concrete descriptions of lived situations, often first-person accounts, set down in everyday language and avoiding abstract intellectual generalizations. The researcher proceeds by reflectively analyzing these descriptions...then by offering a synthesized account...identifying general themes about the essence of the phenomenon. (p. 10)

As phenomenology “involves both rich description of the lifeworld or lived experience;” I felt it was appropriate for working with a diverse group of people who had shared a similar experience (Finlay, 2009, p. 8).

Sample

The sample of interpreters interviewed consisted of 12 interpreters whose life circumstances and sociogeographical histories varied considerably. The diversity of the 12 participants was meant to reflect the diversity of a larger national context. For inclusion in this study, each of the participants were required to meet two criteria: they must currently provide interpretation services for at least one refugee client in a mental health setting, and they must be over the age of 18. In total, the interpreters who participated in this study worked in six different languages with clients who sought refuge in the United States due to conflicts in their home
countries in the Middle East, Western and Central Africa, South America, the Caribbean, and East Asia.

Table 1: Participant Demographics

<table>
<thead>
<tr>
<th>Interpreter*</th>
<th>Country of origin</th>
<th>Native language</th>
<th>Status</th>
<th>Time living in the United States</th>
<th>Time working as a professional interpreter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nour</td>
<td>Lebanon</td>
<td>Arabic</td>
<td>Refugee</td>
<td>25 years</td>
<td>16 years</td>
</tr>
<tr>
<td>Sabrina</td>
<td>Panama</td>
<td>Spanish</td>
<td>Immigrant (Child)</td>
<td>25+ years</td>
<td>1 year</td>
</tr>
<tr>
<td>Youcef</td>
<td>Algeria</td>
<td>Arabic/French**</td>
<td>Immigrant (Adult)</td>
<td>10 years</td>
<td>6 years</td>
</tr>
<tr>
<td>Halima</td>
<td>Egypt</td>
<td>Arabic</td>
<td>Immigrant (Adult)</td>
<td>20 years</td>
<td>4 years</td>
</tr>
<tr>
<td>Adnan</td>
<td>Jordan</td>
<td>Arabic</td>
<td>Immigrant (Adult)</td>
<td>13 years</td>
<td>13 years</td>
</tr>
<tr>
<td>Mya</td>
<td>Burma (Myanmar)</td>
<td>Burmese</td>
<td>Refugee</td>
<td>13 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Martine</td>
<td>United States</td>
<td>Haitian Creole/English</td>
<td>US-born (first generation)</td>
<td>30+ years</td>
<td>2 years</td>
</tr>
<tr>
<td>Mauricio</td>
<td>United States</td>
<td>Spanish/English</td>
<td>US-born (first generation)</td>
<td>35+ years</td>
<td>20+ years</td>
</tr>
<tr>
<td>André</td>
<td>Haiti</td>
<td>Haitian Creole/French</td>
<td>Immigrant (Child)</td>
<td>5 years</td>
<td>3 years</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>United States</td>
<td>English**</td>
<td>US-born</td>
<td>20+ years</td>
<td>&gt;1 year</td>
</tr>
<tr>
<td>Ibrahim</td>
<td>Lebanon</td>
<td>Arabic/English</td>
<td>Refugee</td>
<td>16 years</td>
<td>12 years</td>
</tr>
<tr>
<td>Jafaar</td>
<td>Afghanistan</td>
<td>Dari***</td>
<td>Immigrant (Adult)</td>
<td>28 years</td>
<td>16 years</td>
</tr>
</tbody>
</table>

*All names provided are pseudonyms.
**Additionally speaks fluent Spanish and works with Spanish-speaking refugees
***Additionally speaks fluent Farsi and Pashto and works with Farsi- and Pashto-speaking refugees

I conducted three additional interviews with interpreters; however, after the interviews were complete it became clear that the interviewees did not meet the criteria for participation: two were case managers who worked with refugees; the third only worked with English-speaking refugees, and was thus not an interpreter. Those interviews and the information gathered from
those three participants are not included in this paper. It should be noted that many of the interpreters interviewed worked with non-refugee clients as well as refugee clients, and additionally worked with clients in a number of nontherapeutic settings. During the interview, I specifically asked that their answers focus on refugee clients with whom they work in psychotherapeutic, psychiatric, and case management settings.

Participants were recruited mostly through online advertisements using social media platforms, such as Facebook, LinkedIn, Instagram, and Craigslist. Others were recruited via word-of-mouth—they were interpreters with whom my colleagues had worked, or other third-degree connections. I had not met any of the interviewees before the process began, although I attended a lecture given by one participant approximately four months before the interview took place.

Perhaps the most surprising challenge of this study was that of recruiting participants; after sending scores of e-mails, internet posts, and physical fliers, I still struggled to find the minimum 12 interpreters required to conduct a verifiable study. While I did not choose to delve into the explanations for this phenomenon, I imagine a number of reasons: for example, the inherent vulnerability in disclosing emotional or uncomfortable information to a stranger; feelings that discussion of one’s own experiences may violate clients’ privacy; fear of inadvertently giving up confidentiality. This issue is further explored in Chapter V of this paper.

**Ethics**

The plan and materials for this study were reviewed by the Smith College School for Social Work Human Subjects Review Committee. The application and approval letter can be found in Appendix A of this paper.
Before scheduling an interview, each participant was asked to read and sign an informed consent form, and was offered the opportunity to ask any questions or address any concerns with me (the researcher), and was given my phone and e-mail contact information. Additionally, each participant was asked if they had any questions regarding this form before interviewing began. The full informed consent form can be found in Appendix B. In the informed consent packet, it was made clear that all participation would be confidential. In order to maintain confidentiality, the only recorded mention of the interviewee’s name was their signature on the informed consent document. In all other places, the participant was assigned a case number or a pseudonym. Regardless of these protection protocols, all information was stored on password-protected devices. The information will be saved for the three-year time period required by the Smith College School for Social Work Human Subjects Review Committee; after which time it will be destroyed.

Interpreters were informed of the benefits and risks of participating in this study. Participants were warned that they may feel emotional discomfort after the interview due to its intense nature, but were also informed that they would be provided with education on vicarious traumatization, self-care practices, and resources for professional care in the community. Participants were given a $15 digital gift card upon completion of the interview as a token of appreciation for their time and effort.

Data Collection

I chose to use qualitative methods of data collection for this study, as I felt that the research “centers on understanding the lived experience” of those who have chosen the same life’s work, and thus may share similar experiences that are unbeknownst to them (Drisko, 2013, p. 7). All data for this study were collected from individual interviews with the aforementioned
mental health interpreters. Interviewees were given the option to interview over the phone, via Skype, or in-person if convenient.

Interviews were semi-structured, but ultimately each interview was driven by the participant and their experiences. In preparation for these interviews, I developed a list of guiding questions which drew from pre-existing surveys regarding professional and personal life satisfaction (Hundall Stamm, 2009), vicarious traumatization experience (Saakvitne & Perlman, 1996), and compassion fatigue (Compassion Fatigue Awareness Project, 2013). A full list of these guiding questions can be found in Appendix C of this paper.

Data Analysis

After I finished collecting data, I began to analyze using the general inductive approach, which aims to allow findings to emerge from “frequent, dominant, or significant themes” present in large amounts of raw data, without the constrictions often imposed upon the researcher when using more rigid, quantitatively-based methodologies (Thomas, 2003, p. 2). I began by consolidating hours of language gathered into “meaningful chunks” of content (Lichtman, 2010, p. 197). After this, I denoted major categories and subcategories in order to “remove redundancies and identify critical elements” that were present in multiple interviews (Lichtman, 2010, p. 199). Finally, I identified key concepts that “reflect the meaning” of the raw data collected in the aforementioned interviews (Lichtman, 2010, p. 200). To demonstrate this approach, I offer a visualization of the process by which I coded a quote from Nour:
I used the method shown above to code relevant information provided by all interviewees. It is important to note that all quotes have been edited for grammar and condensed for clarity (I removed repetitions and phrases like “um,” as is appropriate when recording such interviews). However, the quotes are the words of the interpreters; nothing was added, and nothing removed that would change the meanings.

It is important to note that there are many who believe that, due to the subjective nature of qualitative studies, reliability and validity are unable to be accurately measured; it has been suggested that without standardized or quantitative methods such issues that require precision are difficult to attain (Brink, 1993; Cresswell, 2007; Thomas, 2003). However, I made a strong
effort to ensure that the study was both reliable and valid. Reliability is defined as the “consistency, stability, and repeatability” of a study (Brink, 1993, p. 35). I took the following steps in order to ensure reliability: I ensured subjects were “clear on the nature of the research,” including methods of data collection and storage; building the best “trust-relationship” possible with subjects during the timeframe allotted; comparing results obtained from one informant with those obtained from others; and keeping accurate, detailed field notes throughout the process (Brink, 1993, p. 35). Validity ensures that the study is measuring what is intended to measure; a valid study “should demonstrate what actually exists” (Brink, 1993, p. 35). In order to ensure validity, I practiced internal consistency; all participants were sent the same information, same texts, and were interviewed using the same guideline of questions.

In the next chapter, I will introduce the findings that stemmed from these interviews. Afterward, I will discuss my recommendations for future research and the practical applications of the information gathered in this study.
CHAPTER IV

FINDINGS

The aim of this study was to discuss vicarious traumatization among mental healthcare interpreters who work with refugees. I attempted to add to the previous research by interviewing mental health interpreters about their experience with vicarious traumatization when working with refugee clients. The secondary goal was to learn about the interpreter education process, and come up with ways in which interpreter education can play a role in diminishing the effects of vicarious trauma through education. This chapter presents the findings of this study, which were gathered using the methods described in Chapter III.

If the foremost purpose of this study was to determine whether or not mental health interpreters experience vicarious traumatization when working with refugee clients. According to my findings, the answer is a resounding yes—each of the interpreters interviewed reported physical and/or emotional symptoms correlated with vicarious traumatization. According to van Dernoot Lipsky & Burk (2009), “exposure to the suffering of others takes a toll on us personally and professionally. The depth, scope, and causes are different for everyone, but the fact that we are affected by the suffering of others…is universal” (p. 4). This phenomenon is demonstrated in Table 2 (beginning on page 19).

There were four common threads woven throughout the interviews I conducted: first, that using the fidelity method of interpretation is extraordinarily difficult for a host of emotional and practical reasons; second, that the lack of organizational support was extremely problematic; third, that there was a profound struggle in separating one’s personal and professional life; and fourth, that there was a consistency among interpreters’ reported physical and emotional
symptoms. In this chapter, I will delve into the details of these conflicts and their effects on the interpreters interviewed.

### Table 2: Interpreters’ Experiences with Vicarious Traumatization

<table>
<thead>
<tr>
<th>Interpreter</th>
<th>Status</th>
<th>Time living in the United States</th>
<th>Time working as a professional interpreter</th>
<th>Experiences physical signs of vicarious traumatization?</th>
<th>Experiences emotional signs of vicarious traumatization?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nour</td>
<td>Refugee</td>
<td>25 years</td>
<td>16 years</td>
<td>Yes (frequent exhaustion, increased heart rate, lightheadedness)</td>
<td>Yes (irritability, isolation, hypervigilance, depression, intrusive thoughts of personal trauma, flashbacks, dissociation, night terrors)</td>
</tr>
<tr>
<td>Sabrina</td>
<td>Immigrant (Child)</td>
<td>25+ years</td>
<td>1 year</td>
<td>Yes (frequent exhaustion, tearfulness)</td>
<td>Yes (isolation, emotional numbing, dissociation)</td>
</tr>
<tr>
<td>Youcef</td>
<td>Immigrant (Adult)</td>
<td>10 years</td>
<td>6 years</td>
<td>None reported</td>
<td>Yes (isolation, cynicism, difficulty managing anger, emotional numbing, anxiety, depression)</td>
</tr>
<tr>
<td>Halima</td>
<td>Immigrant (Adult)</td>
<td>20 years</td>
<td>4 years</td>
<td>Yes (frequent exhaustion, headaches, chest pain)</td>
<td>Yes (guilt, overspending, depression, night terrors)</td>
</tr>
<tr>
<td>Adnan</td>
<td>Immigrant (Adult)</td>
<td>13 years</td>
<td>13 years</td>
<td>None reported</td>
<td>Yes (emotional numbing, depression)</td>
</tr>
<tr>
<td>Mya</td>
<td>Refugee</td>
<td>13 years</td>
<td>10 years</td>
<td>None reported</td>
<td>Yes (guilt, isolation, anxiety)</td>
</tr>
<tr>
<td>Martine</td>
<td>US-born (first generation)</td>
<td>30+ years</td>
<td>2 years</td>
<td>Yes (frequent exhaustion)</td>
<td>Yes (depression)</td>
</tr>
<tr>
<td>Name</td>
<td>Status</td>
<td>Years in US (first generation)</td>
<td>Years of Interpretation</td>
<td>PTSD Symptoms</td>
<td>Other Symptoms</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------</td>
<td>--------------------------------</td>
<td>-------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mauricio</td>
<td>US-born (first generation)</td>
<td>35+ years</td>
<td>20+ years</td>
<td>Yes (frequent exhaustion)</td>
<td>Yes (irritability, anxiety, depression, flashbacks)</td>
</tr>
<tr>
<td>André</td>
<td>Immigrant (Child)</td>
<td>5 years</td>
<td>3 years</td>
<td>None reported</td>
<td>Yes (fear, guilt, intrusive thoughts of personal trauma)</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>US-born</td>
<td>20+ years</td>
<td>&gt;1 year</td>
<td>Yes (frequent exhaustion, insomnia)</td>
<td>Yes (avoidance of personal responsibilities, guilt, anger, depression)</td>
</tr>
<tr>
<td>Ibrahim</td>
<td>Refugee</td>
<td>16 years</td>
<td>12 years</td>
<td>None reported</td>
<td>Yes (anger, guilt, hypervigilance, emotional numbing)</td>
</tr>
<tr>
<td>Jafaar</td>
<td>Immigrant (Adult)</td>
<td>25+ years</td>
<td>16 years</td>
<td>None reported</td>
<td>Yes (anger, depression)</td>
</tr>
</tbody>
</table>

**Dissatisfaction with the Fidelity Method of Interpretation**

When asked to describe the main lessons of their training curriculum, multiple interviewees stated that healthcare providers and interpretation companies wanted them to act as a “machine,” “robot,” “puppet,” or “mouthpiece.” This is corroborated in the literature; many providers “conceptualize and expect interpreters to assume a neutral conduit role, transferring information from one language to another in a word-for-word, machine-like fashion” (Hsieh & Nicodemus, 2015, p. 1475). However, this can create conflict for translators. When using the fidelity method, interpreters are expected to “listen, comprehend, process and reformulate” their clients’ traumatic experiences, and thus “the interpreter bears witness to their clients’ victimization” (Lai, Heydon, & Mulayim, 2015, p. 6). Mya shared that this was a consistent challenge for her:

It’s hard. When they have been through so much…they’re very descriptive sometimes. When I started as an interpreter, I was eager to interpret correctly, word
for word, so I listened very intently and kind of took it all in. And there’s a price for that—when you take it all in, it’s soaked into you. And when you say that back in another language, it’s your words, it’s you saying that, so it’s kind of like that happened to you.

For interpreters who actually went through the same or similar situations as a client for whom they are interpreting, retraumatization may occur. Retraumatization is a “reminder of past trauma that results in a re-experiencing of the initial trauma event” in either a conscious or unconscious manner (Zgoda, Shelly, & Hitzl, 2016, para. 3). Both Nour and Mauricio described occurrences of retraumatization in their interviews, Nour more generally (with multiple clients across multiple situations) and Mauricio more specifically (with a particular client in a particular situation):

> Working with refugees, working with people who’ve had the same experiences…it’s amazing how everything is coming out again now. I thought I did good all these years. But I realize now that every time I hear a loud noise I jump. Every time I hear an ambulance, it’s scary. I have a fast heartbeat. But I never connected these feelings [to my past] until I started working with these kids who are in therapy. (Nour)

One time, a client was discussing an experience in which he had been violated sexually. And I had to take a few deep breaths once the interview was over. I had gone through a similar trauma as a child, and this person brought that back up in me. And here I am, caught in it—interpreting something that sounds so much like my own situation. And if you’ve been in that situation, you’re going to feel it. It’s going to feel like it was you again. (Mauricio)

Regardless of how often these retraumatizing situations occur, they are often extremely difficult to deal with. Mauricio explained that he utilizes his own therapy to cope when these situations arise in his work, and that being able to unpack with his therapist has been helpful over the years.
Nour, on the other hand, prefers to keep things to herself—she doesn’t want to “burden” other people in her life with the feelings brought up by her work.

Such situations are not the only issues interpreters have with the fidelity method. Many interpreters I interviewed felt that, when interpreting word-for-word, cultural nuances are not translated appropriately. According to André, as an interpreter, “you’re not going to modify, embellish, take anything out. You just pass it back in a different language. So sometimes the real message doesn’t get across.” According to Sabrina, many of her Venezuelan and Colombian clients were reluctant to discuss mental health issues; she stated that “there is a big cultural difference in talking about mental health in Latin American countries versus established first world countries. Nobody talks about depression there.” Similarly, Halima stated that the cultural differences in discussions of mental health made disclosure difficult for some of her Arabic clients. Jafaar provided a poignant example:

In the US, if somebody is a victim of sexual assault, it’s difficult to come forward. But it is ten times more difficult for people who have lived in religious cultures [outside of the US] for both religious and cultural reasons. In Arabic cultures, if a man is raped, he is no longer seen as a man. If a woman is raped, she has lost her honor. So many people don’t tell anyone about their suffering. So sometimes I have to tell providers about the other person’s culture to make sure they understand.

But you have to have the guts to actually [break protocol and] tell the doctor. These conversations are perhaps more important in the mental health field than in any other; understanding the cultural conventions of a patient’s family or country of origin is integral in providing adequate and competent treatment. According to Ibrahim, cultural knowledge should be a requirement for all interpreters: “You can be great at language and know nothing about the culture your client is coming from.” This sentiment was shared among many of the interpreters interviewed.
Finally, many participants in this study expressed frustration with their inability to advocate for clients in a manner they found appropriate, or even necessary. Halima explained the consequence she once faced for advocating for a client instead of simply acting as a “mouthpiece:”

One time I lost my job because I tried to get my client services that the government didn’t want them to get. I really don’t care about the government; I care about the [client]. But [government organizations] see you as just an interpreter. You can’t do anything else. The interpreter should just be saying word for word what the client says and that’s it. That’s your job. Not to let [your client] know what’s available to them. But I wasn’t okay with that and it cost the government some money so I got fired from that agency.

While Halima was the only interpreter I spoke with who lost a job due to advocacy work, others expressed a fear of the same fate. According to André, “Sometimes I really feel like doing something for a client—helping them get a cab home from the hospital or something. But I can’t; I’d lose my job.” Nour, however, stated that she advocates anyway. In her view, “There’s a fine line between the ethics of the job and being a human being. At the end of the day, being a human being is more rewarding.”

Lack of Organizational Support

It has been stated that many interpreters “express a need” for individual and group supervision in order to deal with the emotional stress accrued while working in an interpreting session with trauma victims (Sande, 1997, p. 402). However, these services are often unavailable; “when asked about the availability of a support system or other services for interpreters…[the majority] reported that such a service did not exist” (Garcés, 2015, p. 91). In fact, when asked about options for either peer or supervisory support, Sabrina laughed before stating that it didn’t seem to be on the organization’s priority lists. According to Mauricio,
“when you talk about that support piece, it just isn’t there.” However, information on available services for those dealing with strong emotions following their interactions with traumatized clients is not often presented to student interpreters. This is exacerbated by the fear that others won’t understand the strong emotions an interpreter can feel after a difficult session—an experience mentioned explicitly by Nour, Sabrina, and Halima during their interviews.

In addition to the lack of information provided about seeking outside support from supervisors, peers, or professionals, the interpreters surveyed stated that no attention was given to teaching methods of self-care during the training process. Only 3 of the 12 interpreters were familiar with the concept of self-care before the interview; 2 of whom had individually sought out therapy for their own traumatic experiences before beginning work as an interpreter (Sabrina and Mauricio). The third (Mya) had worked as a case manager in the past, and learned about self-care techniques during her training for that role.

Regardless, “it is hard for interpreters to take time out for themselves, especially if working on a piecemeal basis or as a freelance interpreter,” as 11 of the 12 interpreters surveyed do (Bontempo & Malcolm, 2011, p. 121). According to Martine:

If I’m ever really upset about a situation I just interpreted, I’ll log off [interpreter recruitment websites] and take a break for a bit. I’ll lay down, call my son…but I can only take an hour—then I have to log back on. Otherwise I won’t make any money, and interpreting is my only source of income.

Despite Mya’s previous education in self-care, she faces a similar situation; but there are times in which she will prioritize her own mental health over material gain—instead of logging off for an hour, she will take “the rest of the day” to rest, relax, and recuperate from the traumatic session.

Others, like Nour, Halima, and Mauricio are parents to children who live at home, and have trouble finding time to process their own feelings due to parenting responsibilities. As
Nour says, “I have the twenty-minute ride home to myself, and that’s it. I get home. I’m a mom. I have to take care of everything. So I push my emotions aside until my children are asleep.”

**Difficulty Separating Personal and Professional Lives**

In their book *Trauma Stewardship: An Everyday Guide to Caring for Self while Caring for Others* (2009), van Dernoot Lipsky and Burke discuss how one’s personal history often greatly affects one’s experience as a helping professional: “What is our own history of hardship, pain, suffering, and trauma?...The more personal our connection to our work, the greater gifts we bring to it...[yet] the more we identify with the type of trauma we’re exposed to the greater its impact on us may be” (pp. 19-20). Eleven of the interpreters interviewed had either a personal or familial connection to immigration stories; seven of the twelve had personal or familial connections to refugee stories. These degrees of identification can be exemplified by the quotations below, taken from interviews with Nour, Martine, Adnan, and Elizabeth respectively:

In a setting like the [clinic where I work], these refugees…went through a lot of trauma, and I lived that trauma myself. I grew up in the Civil War in Lebanon, so I lived their experience before. I lived their fear, the anxiety. (Nour)

A lot of the refugee client situations are not similar to my own experience, but they’re similar to what I’ve seen people in my family go through. I’ve had aunts, uncles, cousins who took boats and makeshift rafts from Haiti to Miami just for the opportunity to live here. (Martine)

In my generation, we didn’t have war in [Jordan]…financial opportunity in my time wasn’t that great, which is why I moved. But most of my clients are refugees and they have issues—financial issues, health issues, other issues—stemming from the violence and discrimination they experienced there. (Adnan)
I can’t pretend that I’m not fortunate, that I’m not privileged, to have never gone through what so many of my clients have gone through. But even though I’ve never been through the same traumatic experiences, I’m not blind or ignorant to their struggles. (Elizabeth)

Regardless of the degree of separation from clients’ experiences, each interpreter expressed emotional difficulties when interpreting trauma stories.

Additionally, many interviewees described having issues separating their professional life from the personal. Halima and Mya described a feeling of responsibility toward their clients that was omnipresent:

It is very hard to separate between my personal and professional life—these are human experiences, these things really happened. These people lost their loved ones in front of their eyes. So no, I don’t separate. The other day, I received a call at midnight—a client needed help. And if you don’t help, who’s going to do it? (Halima)

When you’re working in person, they have your phone number, and they call you around the clock, 24/7. I once had to drive to the hospital at 2 in the morning for a client…there’s no off. There was a girl, two years younger than me—she was suicidal, and I didn’t want to turn her away. It was hard to deal with, because I would always pick up her calls because I was worried. But then you wind up encouraging it. It was really hard to draw a strict boundary. (Mya)

Later, Mya stated, quite bluntly, that she “was scared of the way [her] job was taking over [her] life.” When Mya began to feel as if she was unable to be productive in her work, she switched from in-person to telephonic interpreting, a move which she feels has been helpful for her emotional health.
Presence of Physical and Emotional Stress Symptoms

Not all interpreters have the same flexibility that Mya had, and are forced through circumstance to stay with jobs that cause physical and/or emotional harm. There can be both personal and interpersonal consequences of working with refugees that permeate the lives of the interpreter. It is important to remember that there is a profound “difference…between what might be described as typical job-related stress and the kind of occupational stress in which the characteristics of the work [that] generates intense or cumulative levels of stress that lead to physical or psychological ill health” (Bontempo & Malcolm, 2011, pp. 105-6). The five most common symptoms reported were disturbances in sleep patterns (exhaustion, insomnia, nightmares, night terrors); irritability or difficulty managing anger; depression; emotional numbing; and overwhelming feelings of guilt. Each of these symptoms will be discussed in further depth in this section.

Sleep Disturbances

According to van Dernoot Lipsky & Burk (2009), repeated exposure to trauma can be extremely tiring. They continue: “As exposure accrues, our bodies and minds will require extra attention in order to become fully rested and refreshed” (van Dernoot Lipsky & Burk, 2009, p. 82). Similarly, Yassen (1995) stated that “those involved in trauma work [may] find it difficult to relax;” and therefore one’s work may “interfere” with one’s sleep pattern—by causing overwhelming fatigue, insomnia, or a combination of the two (pp. 185-6). Martine admitted that she is often “physically and emotionally exhausted” after work; Nour stated that this is exacerbated on days where she sees clients with whom she shares a trauma history.

One reaction to interpreting particularly traumatic stories is to push the traumas heard in sessions into the unconscious, which then reemerges in the form of dreams, nightmares, or night
terrors. Both Nour and Halima suffer from frequent night terrors related to specific stories they hear from their clients. They described these experiences during their interviews:

One time I was working with a client who shared a very painful experience…and that night, I relived it. I woke up in the middle of the night crying and screaming, and my daughter had to come into my room to comfort me. It’s like I absorbed all of her energy and all of her pain, and I was reliving it during my sleep. (Nour)

A client lost two of her children in front of her eyes. One of them died as a baby. But a bomb struck one of her daughters and she lost limbs before she died. Now every night I dream of my own two daughters coming to me with bloody arms and legs, saying “collect me,” “collect me.” (Halima)

While Nour and Halima’s experiences with night terrors are severe, they are not the only ones with disturbed sleep; other participants interviewed stated that they experience intermittent nightmares that stem from work-related stressors.

Irritability/Anger

Crezee et al. (2015) state: “Interpreters can deal with ‘potentially debilitating anger’ as a result of overempathizing with the client;” this phenomenon was described at length by a number of interviewees (p. 77). Both Halima and Mauricio stated that the irritability they carried home from work impacted their relationship with their spouses; Nour stated that her relationship with her daughter has been strained due to her anger. Similarly, Elizabeth mentioned issues with her roommate that stemmed from her own work-related “mood swings.” According to van Dernoot Lipsky & Burk (2009), people who experience vicarious traumatization are often “unaware of our anger, even when all of our loved ones, colleagues, and clients have to tiptoe around us” (p. 102). However, none of the four became aware of the effect their work was having on the people in their lives until it was brought up by the person in question.
In her interview, Elizabeth described a dull, constant feeling of anger that started shortly after her interpreting work began. She was adamant, however, that this anger was not a reaction to “a particular instance in [her] head,” but a feeling of anger and tension that had swept over her life. This is not unusual; many people in helping professions “experience a sense of anger at other people and the world in general as they reflect on the potential malevolence of others” (McCann & Pearlman, 1990, p. 140). Ibrahim, Jafaar, and Youcef described similar states of internal anger that were sometimes difficult to control. Sabrina also mentioned anger at “the system” and the way it treats immigrants and refugees.

**Depression**

In the first work in which the term “vicarious traumatization” was coined, authors McCann & Pearlman (1990) stated that “conditions of depression and despair in one's clients…can be contagious” (p. 136). In her later work, McCann stated that it was not uncommon for a helper to “find his or her own view of human nature becoming…pessimistic” (McCann & Mac Ian, 1995, p. 140). The fact that people in helping professions are particularly prone to depression has been substantiated by previous research (McCann & Mac Ian, 1995; McCann & Pearlman, 1990; van Dernoot Lipsky & Burk, 2009).

Unsurprisingly, 7 of the 12 interpreters interviewed expressed that they often felt “depressed” or “extremely sad” as a result of their work (others, who stated that sometimes their work made them feel “sad,” were not included in this category.) Some interpreters (like Jafaar and Elizabeth) felt generally depressed due to their work, while others (like Mauricio and Adnan) felt particularly depressed when working with specific clients:

Every client affects me. I try to be very realistic…but then I think about how much my clients have suffered. It makes me feel depressed whenever I think about it. (Jafaar)
I feel very sad—sometimes I even feel depressed—especially when I’m in an encounter that brings up my own baggage. (Mauricio)

Other participants expressed that their feelings of depression were not strictly in either category; they felt that “things just come up sometimes” (Ibrahim).

**Emotional Numbing**

It is not unusual for those in helping professions to consciously or unconsciously numb themselves to the pain of their clients. “People who bear witness to a range of human experience may become increasingly inoculated to others’ pain. We may start out by being moved by each person’s story, but over time it may take more and more intense or horrific expressions of suffering to deeply move us” (van Dernoot Lipsky & Burk, 2009, p. 78). Conscious numbing techniques can include engaging in inane material (such as movies, television programs, or perusing the internet for hours), over-exercising, or even excessive use of drugs and/or alcohol. Ibrahim and Jafaar admitted to “binging” on Netflix, or watching comedic movies or shows in order to numb themselves after interpreting trauma stories. Halima admitted to engaging in a problematic behavior on difficult days—she chronically “overspends,” which leads to rifts in her personal relationships—and a hole in her pocketbook.

Unconscious numbing occurs gradually, and is more internalized. This type of numbing was reported frequently among the interpreters I interviewed. Youcef, who has been a mental health interpreter for six years, agreed: “After so many years of dealing with refugees and their stories, you end up having your own shield. You become numb and disaffected.” Many interpreters interviewed agreed with Youcef, stating that they, too, had created their own metaphorical armor to protect them from the effects of hearing trauma stories day after day. However, this did not consistently correlate to the number of years one worked as an interpreter; Sabrina, who had been working as an interpreter for just over a year at the time of our interview,
stated that she has started to feel unsympathetic toward her patients, whereas Mauricio, who had been working in the field for over twenty years stated that he still is affected emotionally by many of his clients.

**Guilt**

Van Dernoot Lipsky & Burk (2009) believe that “guilt is one of the strongest signs of a trauma exposure response” (p. 98). The interpreters interviewed mentioned many forms that their guilt took: from overgeneralization (André) to feelings that they could be doing more to help their clients (Halima) to survivor’s guilt (Jafaar). Elizabeth described a feeling of guilt that came with the knowledge that she had “resources to help people” that she was “unable to use.” That guilt led her to neglect personal responsibilities in order to better serve her clients:

There were moments when I felt like I became so invested that I went over my hours a lot of times, put in weekends…I called out of my paid job a couple of times, missed classes…I didn’t want to let anyone down. You feel like you’re someone’s mother, daughter, sister. You want to be a part of all of these experiences, the good, the bad. But most importantly I don’t want anything else to go wrong in their lives. They’ve gone through so much trauma. There’s a huge fear that’s always present…that if something went wrong it’s because I wasn’t there.

It is not uncommon for interpreters to wind up “taking on too many responsibilities, working overtime on a regular basis, constantly bringing work home or taking calls at home, and being unable to separate from the work emotionally;” this can be seen as a way of assuaging one’s guilt (Yassen, 1995, p. 192). Elizabeth, Halima, and Mya all described the ways that feelings of guilt effected the way in which they engaged with work, both during and after working hours.

In the next chapter, I will provide recommendations for action drawn from this research, as well as suggestions for further research on vicarious trauma among mental health interpreters.
CHAPTER V
DISCUSSION

The aim of this study was to add to the literature on vicarious traumatization among mental healthcare interpreters who work with refugees; the secondary goal was to learn about the interpreter education process and theorize ways in which interpreter education can play a role in diminishing the effects of vicarious trauma through education. I attempted to add to this research by ascertaining whether or not mental health interpreters experience vicarious traumatization when working with refugee clients.

My findings were consistent with the previous literature and research, and they confirmed my primary research question. In essence, I found that vicarious traumatization impacted the lives of each of the interpreters who were interviewed for this study. In the following chapter, I will compare my findings with the previous literature on vicarious traumatization among mental health interpreters. Afterward, I will discuss the resulting implications for social work practice, limitations of this study, and recommendations for future research.

Comparisons between Research Findings and Available Literature

Overall, the findings from this study agreed with the literature available regarding vicarious traumatization among mental health interpreters. While there are writings that praise the fidelity method of interpreting, literature on mental health interpreters states that the use of this method can be frustrating and even triggering (Crezee et al., 2015; Lai, Heydon, & Mulayim, 2015). This is in accordance with my findings that mental health interpreters are overall dissatisfied simply acting as conduits, due to the emotional effects and the inability to perform advocacy work that resulted from the use of the fidelity method. Similarly, my findings concur with the previous literature that the lack of organizational support provided to interpreters is
detrimental to their success. It is generally agreed upon in the literature that helpers should be aware of the effects of vicarious traumatization and self-care methods before they embark on their professional careers (Sande, 1997; Gannet-Sanchéz, 2013). Additionally, interpreters admitted to difficulties separating their personal and professional lives, a phenomenon that can affect people in all helping professions. In their description of vicarious traumatization among therapists, Pearlman & Mac Ian (1995) write:

This trauma-specific literature tells us that doing trauma therapy can affect therapists negatively and that its effects are different from those related to doing general psychotherapy. The research suggests that aspects of the therapist, such as personal trauma history, gender, and personal stress, may interact with exposure to trauma material to contribute to trauma-related symptoms in the therapist. (p. 559)

Although this quote is geared toward therapists, the theory is justifiably applied to the experiences of the interpreters interviewed in this study. Finally, my findings concur with the literature that the presence of physical and emotional symptoms related to vicarious traumatization occur frequently among mental health interpreters (Garcés, 2015; Mehus & Becher, 2016). The implications of these findings will be discussed in the sections below.

Implications for Social Work Practice

Implications for Interpreter Education Programs

None of the 12 interpreters I interviewed for this study had heard the term “vicarious traumatization” prior to our interview. Although some of them had a basic grasp of the concept, many were surprised to hear that there was a clinical term for their experience. According to previous research, this is not unusual; interpreter training programs do not usually include information about vicarious traumatization in their training programs (Bontempo & Malcolm, 2011; Crezee et al., 2015; Gannet-Sanchéz, 2013; Lai, Heydon, & Mulayim, 2015). Bontempo & Malcolm (2011) argue that if interpreters are educated about vicarious traumatization, the
knowledge of the possibility of this “normal emotional response” may help mitigate its effects (p. 118). Lai, Heydon, & Mulayim (2015) take this a step further; they feel that interpreter education programs have an “indispensable duty” to provide students with information about the risks of vicarious traumatization (p. 16). Mauricio believed that the knowledge of the possible effects of vicarious traumatization may have helped him recognize the effect interpreting was having on his personal life; in our interview, he stated that stress related to repeated trauma exposure “is cumulative and it can really set a person off…The better prepared an interpreter is for a situation, the better off everyone is.”

Similarly, few of the participants were aware of the concept of self-care before our interview took place. Although some interviewees had taken measures to engage themselves in stress-relieving and self-soothing activities, not all of these were healthy coping mechanisms (for example Halima’s overspending, and Ibrahim’s use of numbing television). However, most interpreter education programs do not teach about self-care, and those that do often adhere to the notion that “self-care is for the weaker set” (van Dernoot Lipsky & Burk, 2009, p. 3). According to Sabrina, “[our teachers] just say stay separated from it,” without providing resources for help or further action. Martine stated that the education she received was more “toward the interest of the client” than that of the interpreter, and that certain strategies that are in the realm of self-care (for example, assigning a potentially retraumatizing case to another interpreter, taking breaks in between difficult cases) were “frowned upon.” Bontempo & Malcolm (2011) believe that it is integral for interpreter education programs to “assist [students] in identifying positive, action-oriented coping strategies” so they do not engage in negative self-soothing methods that would be detrimental both to the interpreter and his or her clients (p. 118).
I agree with these authors and interpreters that knowledge about vicarious traumatization and self-care practices is integral to the lives of student interpreters. I believe that it is the responsibility of the educator to ensure that the student interpreter has all of the resources necessary to begin his/her career in professional interpreting. As per Bontempo & Malcolm (2011):

Formal learning about grief, loss, suicide, depression, neglect, mental health, abuse, and other emotionally difficult topics, when integrated into interpreter education programs, would help mitigate to an extent the powerful impact of these topics in a real crisis. Information is power, and effective coping in a traumatic situation will be enhanced by having a range of problem-solving strategies, practical information about what to expect, and tangible support networks. (p. 118)

Without a deep-seated knowledge of vicarious traumatization and an ample skill-set for self care, interpreters are left vulnerable to the physical and psychological effects of secondary posttraumatic stress.

**Implications for Agency Supervisory Practices**


Clinical supervision is another way that organizations can assist employees working in challenging environments or with traumatic material. The use of supervision may afford interpreters an opportunity to address challenges in their interpreting work, some of which could potentially be the root cause of vicarious trauma. (p. 123)

Interpreters who are affiliated with agencies will likely benefit from such clinical supervision. However, this may still pose a challenge for interpreters who are free agents or independent
contractors. For these interpreters, many researchers (Bontempo & Malcolm, 2011; Gannett-Sanchéz, 2013; Sande, 1997) suggest peer-supervision groups that are either sponsored by agencies or developed through personal networks. Nour lamented that she felt that there was “no one to talk to;” no one who could “understand” her work. She stated that this led her to “keep it all inside” and eventually exacerbated her symptoms. McCann & Pearlman (1990) state the importance of peer-groups:

> It is important to tap into potential sources of support in one's professional network. The helper should first avoid professional isolation by having contact with other professionals who work with victims. These contacts can provide opportunities for emotional support for one's work in addition to the professional and intellectual support they offer. Professionals within a geographical area might organize support groups for helpers who work with victims. These support groups can be facilitated by experienced professionals who are sensitive to the personal effects of working with victims. (p. 145)

**Limitations of the Study**

**Low Sample Size**

Although sample sizes in phenomenological research are highly variable, it is generally recommended that a small-scale phenomenological study should have no fewer than 25 participants and no more than 50 (Mason, 2010). However, due to the time and financial constraints commonly associated with Master’s-level studies, it was difficult to gather a sample of this size. Therefore, I included interviews from 12 participants—the minimum allowed for a phenomenological study conducted through the Smith College School for Social Work. While some of this was due to financial and time limitations of this study, it was also affected by difficulty in finding interested interviewees. In Chapter III, I discussed possible reasons for this
struggle, including a fear of accidental disclosure of sensitive information regarding oneself or a client, despite the promise of confidentiality provided in the informed consent form.

**Lack of Mental Health Screening**

Another limitation of this study was that participants were not asked about their mental health histories prior to (or during) their interview. While one participant disclosed a history of hypochondriasis and social anxiety that predated his interpretation work, and others showed signs that indicated diagnosable posttraumatic stress disorder from events dating back to the traumas that led them to pursue interpreting in the first place, there were no explicit questions asked about clients’ histories of mental health disorders. Additionally, the term “depression” is used both medically and colloquially; thus when many interpreters stated that certain situations made them “depressed,” it was difficult to ascertain whether they were speaking about a mood state or a clinical condition. This made it much harder to tease out which symptoms were resultant of vicarious traumatization and which were due to an underlying mental health condition. I would encourage future researchers to add relevant exclusion criteria to their study in order to ensure that the symptoms reported are correlated with vicarious trauma as opposed to mental health conditions or personal trauma histories.

**Recommendations for Future Research**

In addition to making up for the previously mentioned limitations in my study, three topics of interest came up in the literature that I would like to see further explored. First is in the realm of demographics: I would be interested in a study that is controlled for gender and culture (for example, studying female interpreters from Arabic cultures). This is because “the danger for female [helpers] of overidentification with the victim and rage at the perpetrator. In contrast, male [helpers] may experience overidentification with the aggressor” (McCann & Pearlman,
1990, p. 135). Additionally, cultural norms play a role in which interpreters speak about mental health, which could impact the ways interpreters discuss their own experiences, as explained by Sabrina, Halima, and Jafaar. The second is in the area of translating methods: According to Crezee et al. (2015), “during traumatic interpreting assignments, interpreters [should] switch from first-person to third-person interpreting, to allow them to linguistically and psychologically distance themselves from the trauma story” (p. 79). I would be interested in a comparative study of those who use the first-person versus those who switch to the third-person. Finally, I agree with Mehus & Becher (2016) that there is a “broader need” to explore how interpreters are supported when dealing with trauma (p. 253). This hole in the research could be filled by another phenomenological study looking specifically at interpreters experiences with supervisory practices.

**Summary**

It is impossible to change a person’s life experiences; it is difficult to change widely accepted methods in the fields of translation and interpretation. However, I propose that by improving interpreters’ education programs to introduce general information about vicarious traumatization (including risk factors, signs, and common symptoms) and self-care (including methods of taking care of oneself and providing information on external resources in the community) it is possible to drastically reduce the impact of vicarious traumatization on the courageous mental health interpreters who dedicate their lives to working with refugees.
REFERENCES


APPENDIX A

HUMAN SUBJECTS REVIEW APPLICATION AND APPROVAL LETTER

2016-2017
Smith College School for Social Work
Human Subjects Review Application

Project title: Mental Health Interpreters’ Experiences with and Understanding of Vicarious Traumatization
Is this a joint project (more than one researcher working on this study)? No
Name of researcher(s): Sophie Anna Lembeck
Check one: MSW
Phone (include contact researcher for joint projects): (REDACTED)
Email (include email for contact researcher for joint projects): (REDACTED)
Research advisor: Jim Drisko

The signature below testifies that I, as the researcher, pledge to conform to the following: As one engaged in research utilizing human subjects, I acknowledge the rights and welfare of the participants involved. I acknowledge my responsibility as a researcher to secure the informed consent of the participants by explaining the procedures and by describing the risks and benefits of the study. I assure the Committee that all procedures performed under the study will be conducted in accordance with those federal regulations and Smith School for Social Work policies that govern research involving human subjects.

Any deviation from the study (e.g.: change in researcher, research methodology, participant recruitment procedures, data collection procedures, etc.) will be submitted to the Committee by submitting a Protocol Change Form for which you MUST receive approval prior to implementation. I agree to report all deviations to the study protocol or adverse events IMMEDIATELY to the Committee.

Researcher: Electronically signed by Sophie Lembeck, MA on 2/6/17
Name(s) (Date)

Research Advisor/Committee
Chair ____________________________________________________________
(Date)

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IN THE SECTIONS BELOW WHERE DESCRIPTIONS ARE REQUESTED, BE SURE TO PROVIDE SUFFICIENT DETAIL TO ENABLE THE COMMITTEE TO EVALUATE YOUR PROCEDURES AND RESPONSES.

1. DESCRIPTION OF RESEARCH PROJECT INVOLVING HUMAN PARTICIPANTS
Briefly summarize the purpose of the study, the over-arching research question, the specific research design you will use and why you have chosen it for this study, and the planned use of human participants, and a brief synopsis of relevant literature that points to need for further study (NO MORE THAT A HANDFUL OF ARTICLES) with sufficient detail and in clear, concise language (space will expand in all sections as you enter your information):

For my thesis, I will be studying the effects of vicarious traumatization on mental health interpreters who work with refugees who have sought asylum in the United States. Vicarious traumatization, also referred to as vicarious trauma or secondary post traumatic stress, refers to the “transformation of the [helper’s] inner experience as a result of empathic engagement with survivor clients and their trauma material” (Saakvitne & Pearlman (1996), 25). This transformation can lead to symptoms in helpers that mimic traumatic reactions of clients. Unfortunately, these reactions can lead to mental and physical health issues among helpers, which in turn may lead to high rates of compassion fatigue, burnout, and turnover. Despite recent political stalls, it is expected that more refugees will seek asylum in the United States when the current ban is lifted. As this number increases, so will the number of mental health interpreters needed to address the overwhelming traumatic experiences lived by thousands of new potential clients. The aim of this thesis is to examine current practices in training and organizational support for mental health interpreters in order to discover best practices for those working with displaced and traumatized clients.

While vicarious traumatization is a relatively new concept in the realm of social work (the concept was first written about by McCann and Pearlman in 1990), there has been ample research on the ways that people in helping professions, particularly therapists, experience secondary posttraumatic stress (Cohen & Collens, 2013; Iliffe & Steed, 2000; Pearlman & Maclan 1999; Schauben & Frazier, 1995). However, there has been very little work done studying mental health interpreters who experience this phenomenon. It is imperative that, as the demand for interpreters increases, researchers and professionals come together to create a list of practices that will support mental health interpreters in the important and specific work they do.

To add to this effort, I will conduct interviews with mental health interpreters who currently work with refugees in effort to answer the following questions:

- Do mental health interpreters experience vicarious traumatization when working with refugee clients?
- When in training to become a mental health interpreter, is the concept of vicarious traumatization addressed specifically?

2. PARTICIPANTS: if you are only observing public behavior, skip to question d in this section.
a). How many participants will be involved in the study?
Twelve.
b). List specific eligibility requirements for participants (or describe screening procedures), including exclusionary and inclusionary criteria. For example, if including only male participants, say so, and explain why. If using data from a secondary de-identified source, skip to question e in this section.

Each participant must be a mental health interpreter who works with refugee clients.

c). Describe how participants will be recruited. Be specific: give step-by-step description of the entire recruitment process, including getting permission to post flyers or post messages on internet sites. Attach all flyers, letters, announcement, email messages etc. that will be used to recruit. Include the following statement on any/all recruitment materials/emails/internet postings, etc: This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Participants will be recruited via word-of-mouth and internet posting. I will post on my own personal Facebook page, as well as the Smith School for Social Work group forums for class A17, class A18, and alumni, a group for western Connecticut wellness professionals, and other groups to which I am referred. Some groups may require permission by an administrator; for these groups I will contact administrators directly with my proposal and a request to include it in the group page. I also plan to post on forums such as Craigslist and websites such as Indeed.com. Additionally, I will be in contact with agencies in New York and New Haven, Connecticut (with which I am already familiar) that I know work with mental health interpreters who may be willing to take the survey. I will also reach out to previous colleagues who currently work with refugees, an agency that works closely with the Yale Child Study Center (where I am placed for my second year internship), and current colleagues.

Is there any relationship between you as the researcher and the participants (e.g. teacher/student, superintendent/principal/teacher; supervisor/clinician; clinician/client, etc.) that might lead to the appearance of coercion? If so, what steps will you take to avoid this situation. For example: “I will not interview individuals who have been direct clients.”

There is no relationship between myself and those I will ask to participate in interviews.

e). Are the study target subjects members of any of the following federally defined vulnerable populations? (ONLY check if the study focus area is SPECIFICALLY based on any of the listed groups. For instance, if your study is about how persons who are economically disadvantaged access services, you DO check ‘Economically disadvantaged’ category below. DO NOT CHECK IF SOME OF THESE FOLKS MAY BY CHANCE BE IN A MIXED SAMPLE – EXCEPT IF THERE ARE CHILDREN/UNDER 18 YEAR OLDS. Thus: if you are asking about how individuals who live in inner city locations get to services, you DO NOT check any of the categories below, because there is a range of types of people who live in these environments who may wish to participate, and you do not define the population as ‘economically disadvantaged). Be aware that checking ‘yes’ automatically requires the HSR Full Review.

No federally defined populations are intentionally sought for this study. However, please note that there may be participants who are pregnant, live with disabilities, or who are economically or educationally disadvantaged who choose to participate in interviews.

3. RESEARCH METHODS:

- Interview
a). Please describe, with sufficient detail, the procedure/plan/research methodology to be followed in your research (e.g. this is a quantitative, survey based study; tell us what participants will do; etc).

This is a qualitative study in which participants will be asked questions about their lives and experiences as mental health interpreters. A copy of predicted questions is attached (see Appendix B.)

b). How many times will you meet/interact with participants? *(If you are only observing public behavior, SKIP to question d in this section.)*

I will interact with participants two or three times: once via e-mail to introduce the project (or via internet posting), once to obtain consent, and once via phone or Skype for the interview.

c). How much total time will be required of each participant?

Approximately 45-60 minutes.

d). Where will the data collection occur (please provide sufficient detail)?

The data collection will occur on my personal computer, which is password protected. I will take notes during interviews and then transcribe them in MS Word.

e). If you are conducting surveys, attach a copy of the survey instrument to this application. If you are conducting individual interviews or focus groups, including ethnographies or oral histories, attach a list of the interview questions as an “Attachment”. Label attachments alphabetically, with descriptive titles (e.g.: *Attachment A: Interview Questions*).

N/A

4. INFORMED CONSENT: *(If you are only observing public behavior, SKIP to next section)*

a). What categories of consent documentation will you be obtaining from your participants? (Check all that apply)

Participant consent will be obtained before the interview via e-mail.

b). Attach original consent documents. *note: be advised that, electronic signatures and faxed, signed consents ARE allowed. Please describe how you will gain consent.

Please see Appendix A: Informed Consent.

5. COLLECTION /RETENTION OF INFORMATION:

a). With sufficient detail, describe the method(s) of recording participant responses (e.g., audiotape, videotape, written notes, surveys, etc.)

I will use written notes in a notebook in order to record my participants’ responses. I will then transfer notes to my password-protected computer, and shred the notebook pages.

b). Include the following statement to describe where and for how long will these materials will be stored and the precautions being taken to ensure the security and safety of the materials:

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period.

c). Will the recordings of participant responses be coded for subsequent analysis? *(If you are only observing public behavior, SKIP to next section.)*

No

6. CONFIDENTIALITY:
a). What assurances about maintaining privacy will be given to participants about the information collected?
Anonymity is assured (data cannot be linked to participant identities)
b). If you checked (2) above, describe methods to protect confidentiality with sufficient detail. Describe how you will maintain privacy of the participant as well as the data
N/A
c). If you checked (3) above, explain, with sufficient detail, why confidentiality is not assured.
N/A
d). If you checked (3) above, provide sufficient detail that describes measures you will take to assure participants understand how their information will be used. Describe and attach any permissions/releases that will be requested from participants.
N/A

7. RISKS:
a). Could participation in this study cause participants to feel uncomfortable or distressed?
Potentially
If yes, provide a detailed description of what steps you will take to protect them.
At the end of the interview, I will provide participants with online resources that describe self-care practices.
b). Are there any other risks associated with participation (e.g. financial, social, legal, etc.)?
No

8. COMPENSATION: (If you are only observing public behavior, SKIP to the next section)
Describe any cash or ‘gifts’ (e.g.: coffee shop gift card) that participants will receive for participating in this research (see guidance about payment/gift compensation in the Smith School for Social Work Human Subjects Review Guideline, at the HSR site in the SSW website). Participants will be given a $15 Amazon gift card to thank them for their cooperation.

9. BENEFITS:
a). Describe the potential benefits for you, the researcher, in conducting this study.
First, conducting this study will serve as a capstone project, without which I will not be able to get my MSW degree. Second, my current internship asked that I conduct this particular study.
b). Describe the potential benefits for individuals who participate as subjects, EXCLUDING payment/gift compensations.
Participants will learn that vicarious traumatization is a potential phenomenon, not a singular event that only affects them.
c). Describe the potential benefits to the field of clinical social work from this research?
Although literature about vicarious traumatization is abundant when looking at clinicians and their reactions to clients who have suffered trauma, here is currently very little literature on the topic of mental health interpreters’ experiences of this same phenomenon. Therefore, this research has the potential to inform the social work community of the effects vicarious traumatization on mental health interpreters, which could inform future training and best practice standards.

10. FINAL APPLICATION ELEMENTS:
a. Include the following statement to describe the intended uses of the data:
The data collected from this study will be used to complete [include which is applicable: my Master's in Social Work (MSW) Thesis; my Doctoral degree]. The results of the study may also be used in publications and presentations.
b. If there are Co-Researchers, cooperating departments, and/or cooperating institutions, follow the following instructions:
If you are working with/conducting your research with a researcher working at another institution or organization, include a letter of approval from that institution’s IRB or agency administrator. If there are multiple researchers, indicate only one person on the Documentation of Review and Approval as the researcher; others should be designated as “Co-Researcher(s)” here.
N/A
c. TRAINING: Include the following statement to describe training:
I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at the SSW and was completed within the past four years.
March 27, 2017

Sophie Lembeck

Dear Sophie,

You did a very nice job on your revisions. Your project is now 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.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, EdD
Co-Chair, Human Subjects Review Committee

CC: James Drisko, Research Advisor
Title of Study: Mental Health Interpreters’ Experiences with and Understanding of Vicarious Traumatization (TENTATIVE)

Investigator(s): Lembeck, Sophie (slembeck@smith.edu)

You are being asked to be in a research study of mental health interpreters’ experiences of vicarious traumatization. You were selected as a possible participant because you responded to a request for participants you saw on a flier or heard about via word-of-mouth. We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

The purpose of the study is to examine the effects of vicarious traumatization on mental health interpreters who work with refugees who have sought asylum in the United States. This study is being conducted as a research requirement for my master’s in social work degree. Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

If you agree to be in this study, you will be asked to participate in one 45-60 minute interview, during which you will be asked about your experiences working as a mental health translator. This interview will be conducted in person or via Skype or other video conferencing software.

Risks/Discomforts of Being in this Study

The study has the following risk: Participants may experience emotional discomfort after discussing distressing experiences. There are no other reasonable foreseeable (or expected) risks to participating in this study.

Benefits of Being in the Study
The benefits of participation are educational—participants will learn that vicarious traumatization is a phenomenon, not a singular event that only affects them. This will hopefully allow participants to gain insight into their own lives.

The benefits to social work/society offer implications for practice—this research has the potential to inform the social work community of the effects vicarious traumatization on mental health interpreters, which could inform future training and best practice standards.

Confidentiality
Your participation will be kept confidential. Only the researcher and participant will know about the participant’s role in this study. In addition, the records of this study will be kept strictly confidential. If the participant agrees to audio recording, it will be via password-protected audio recording software. If the participant declines, I will use written notes in a notebook in order to record my participants’ responses. I will then transfer notes to my password-protected computer, and shred the notebook pages.

All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift
You will receive the following payment/gift: one $15 Visa gift card.

Right to Refuse or Withdraw
The decision to participate in this study is entirely up to you. You may refuse to answer any question or withdraw from the study at any time (up to the date noted below) without effecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. If this is an interview and you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by seven days from the time of your interview. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns
You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Sophie Lembeck, at slembeck@smith.edu or by telephone at (xxx) xxx-xxxx If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent
Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

…………………………………………………………………………………
APPENDIX C

GUIDING INTERVIEW QUESTIONS

Interview Questions:
These questions are meant to serve as a guideline for a discussion of vicarious traumatization with mental health translators who work with refugees.

1. How long have you been working as a mental health interpreter?
2. What is your native language?
3. What is your country of origin?
4. How are your clients’ life experiences similar/different from your own?
5. Are there clients with whom you particularly enjoy working? Why may this be?
6. Are there clients with whom you have difficulty working? Why may this be?
7. What is the most difficult part of your job?
8. What is the most rewarding part of your job?
9. Did you complete your mental health translation certificate in person, online, or both?
10. Do you feel like you had the appropriate training for your current position? Why/why not?
11. During your training/certification period, were you introduced to the concept of self-care?
12. During your training/certification period, were you introduced to the concept of vicarious traumatization?
13. Do you find it difficult to separate your personal and professional lives?
14. Does your work with refugees cause you to feel “on edge” when not in the workplace?
15. Do you feel “worn out” because of the work that you do?
16. Do you ever feel sad or depressed about the traumatic experiences your clients have faced? How does this affect your personal life?
17. Do you ever feel as if you are experiencing the trauma of someone you are helping/have helped?
18. Do you ever dream about your clients and/or their experiences?
19. Do you believe you make a difference through your work?