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Vicarious Trauma: Effects on Visual Language Interpreters Professional Quality of Life

by

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Honors Thesis

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Abstract

The primary aim of this study was to examine visual language interpreters' experiences of vicarious trauma and its effects on their professional quality of life. This study used a sample of 85 Canadian visual language interpreters and examined their experiences of vicarious trauma and professional quality of life by studying their responses on secondary traumatic stress, burnout and compassion satisfaction measures. Responses demonstrated that the majority of the visual language interpreters involved in this study had secondary traumatic stress scores that were moderate, burnout scores that were moderate to low and compassion satisfaction scores that were moderate to high. Results revealed a significant relation between secondary traumatic stress and burnout and a marginally significant relation between secondary traumatic stress and compassion satisfaction. These results indicate that mental health agencies should consider how visual language interpreters working within trauma-related fields are being trained and supported.

Vicarious Trauma: Effects on Visual Language Interpreters Professional Quality of Life

"The problem is not that the students do not hear. The problem is that the hearing world does not listen." This quote by Jesse Jackson, an American civil rights activist, illustrates the marginalization and oppression of deaf students and can be extended to encompass the entire deaf communities' marginalization and oppression within mainstream society. Deaf individuals are often left out of conversation, talked down to and falsely labelled as having a mental disability (Harvey, 2003). One setting which is often overlooked and requires increased attention is the disproportionate number of deaf individuals seeking mental health services. A number of studies estimate a three to four times prevalence rate of mental health disorders among deaf adolescents and adults compared to the general public (van Eldik, Treffers, Veerman & Verhulst, 2004; van Gent, Goedhart, Hindley & Treffers, 2007). The heightened presence of deaf individuals seeking mental health services certainly has many variables, but one fact remains undisputable, those serving the deaf within the mental health setting must remain in the best capacity to do so.

To maximize therapeutic effectiveness within the mental health setting it is essential that communication between the mental health professionals such as psychologists, psychiatrists and social workers, and their clients is clear and concise (Farooq & Fear, 2003). When the client seeking mental health services is deaf and uses sign language, the communication facet becomes much more complicated and requires the use of a visual language interpreter. A visual language interpreter's role in the mental health setting is to facilitate the conversation between the deaf client and the mental health professional. Consequently, the mental health setting shifts from being a dyad to a triad which has several implications on the overall functioning of the clinical sessions (Chovaz 2013; De Bruin & Brugmans, 2006). Chovaz (2013) suggests that a critical

point of intersection must occur within the triad between mental health professionals, visual language interpreters and deaf clients for therapeutic change to occur. Specifically, because each member of the triad contributes differently to the mental health context, each must consider and define each other's contributions. Both the visual language interpreter and mental health professional must evaluate and improve the relationship to reach this 'sweet spot' within the triad.

When working in the mental health settings, the mental health clinician and visual language interpreters assume very different roles and responsibilities. The mental health professional must have a comprehensive background in mental health knowledge and the visual language interpreter must thoroughly understand contextual, inter and intrapersonal dynamics and be fluent in two languages (Chovaz, 2013). A similarity within their responsibilities is the helping role that both professions perform through their empathetic support for the deaf clients. However, a large body of research on 'helping' professions suggests that there may be a cost to caring, such as experiences of vicarious trauma which is known to occur in professions that help those who are facing or have faced a traumatic event or experience (McCann & Pearlman, 1990). The effects among helping professions can manifest within the helpers overall professional quality of life (Sprang, Clark, & Whitt-Woosley, 2007).

Mental health professionals such as psychologists, psychiatrists and social workers are not immune to the painful images and thoughts that result from their exposure to clients' trauma. However, mental health professionals are given comprehensive training to prepare them for the various negative consequences they may face as a part of their professions such as vicarious trauma. In contrast, visual language interpreters are trained to perform their responsibilities in a variety of settings but are not required to complete specialized training to work within mental

health settings in Canada (Association of Visual Language Interpreters Canada), which they often work within. Training geared towards identifying potential issues and challenges within working in mental health settings would likely be useful for visual language interpreters (Anderson, 2011). Additionally, teaching effective self-care methods may provide visual language interpreters with protection from vicarious trauma and the effects it may have on their professional quality of life. The goal of this study is to determine if visual language interpreters are experiencing the effects of vicarious trauma due to working within the mental health setting. Further, this study will examine whether their experience of vicarious trauma is affecting their professional quality of life. Past research on vicarious trauma has largely overlooked its effects on visual language interpreters. Specifically, in Canada, the effect of vicarious trauma on one's professional quality of life has not been studied among visual language interpreters working in the mental health setting.

Understanding vicarious trauma and how it occurs requires an explanation of the terms countertransference and secondary traumatic stress. The term countertransference was first defined by Freud (1910) who stated that “countertransference arises in [the analyst] as a result of the patient's influence on his unconscious feelings”. More recent works describes countertransference generally as a therapist's emotional entanglement with a patient (Etchegoyen, 2005). When working with a trauma victim, countertransference can cast the therapist into one or more of the roles associated with the client's original trauma and the therapist may begin to feel symptoms that are often associated with the client's trauma. Overall, countertransference is a temporary response to a particular client (Sexton, 1999). Another term that helps define vicarious trauma is secondary traumatic stress. Secondary traumatic stress is defined by Figley (1995) as the emotional distress experienced by persons having close contact

with a trauma survivor. The symptoms are nearly identical to vicarious trauma and post-traumatic stress disorder, which include feelings of alienation, irrational fears, withdrawal and sleep disorders.

To describe how vicarious trauma develops, McCann and Pearlman (1990) present the constructivist self-development theory. This theory utilizes Piaget's (1971) idea of schemas to illustrate how individuals develop cognitive structures, such as their assumptions and expectations about the world and themselves, which are used to shape their realities. When an individual directly or indirectly experiences their environments, their cognitive schemas become more complex and strengthen which allows them to make sense out of their experiences. Consequently, if an individual is repeatedly exposed to another person's trauma, their cognitive schemas begin to change and in turn their worldview becomes altered both positively and negatively (McCann & Pearlman, 1990).

To illustrate how an individual exposed to trauma may experience a change within their worldview, McCann and Pearlman (1990) build on work done by Epstein (1989). Epstein (1989) suggested that there are four basic assumptions that humans hold which include viewing the world as benign, life as meaningful, seeing the self as worthy and seeing others as trustworthy. Vicarious trauma can disrupt each of these basic assumptions within individuals exposed to another person's trauma. Additionally, there are five psychological processes that are affected when one experiences vicarious trauma which include their sense of safety, dependency and trust, power, esteem and intimacy (McCann & Pearlman, 1990). For example, if a visual language interpreter working within the mental health setting is exposed to a client's past involving cruel and deceitful treatment by trusted guardians the visual language interpreter may begin to distrust other individual's within their own lives. The constructivist self-development

theory also suggests that an individual's memory system may be affected due to vicarious trauma, making their memory difficult to control, particularly their memories related to their clients trauma (McCann & Pearlman, 1990).

To study the relationship between vicarious trauma and professional quality of life an individual's experiences of compassion satisfaction and burnout can be examined. Compassion satisfaction refers to the pleasures or gratifications that one receives from their profession (Simon, Pryce, Roff, & Klemmack, 2005). In contrast, burnout is a syndrome that occurs as a result of interpersonal stressors within ones job (Leiter & Maslach, 2004). Mismatches between a person's expectations and the actual job they are performing are proposed to be predictors to burnout. Specifically, mismatches within ones workload, sense of control, rewards, their sense of community, fairness and the values within their workplace may result in burnout (Maslach & Leiter, 1997). Further, burnout is due to chronic stress within the workplace and not necessarily due to specific kinds of client problems such as trauma (Schauben & Frazier, 1995).

A study by Sprang, Clark and Whitt-Woolsey (2007) examined burnout and compassion satisfaction within a large sample of mental health professionals. The results demonstrated that those with specialized training had a greater score on compassion satisfaction and lower scores on burnout than those without specialized training. This study illustrates that specialized training does indeed enhance the professional quality of life of those working in the mental health setting.

The effects of vicarious trauma are dependent upon the degree of the client's traumatic experiences, the amount of exposure one has to these experiences, and the helpers existing schemas about the world (McCann & Pearlman, 1990). Additionally, vicarious trauma must also be dependent upon the individual's role and responsibilities within the mental health setting and their degree to which they have been effectively trained to be exposed to sensitive information

such as a deaf client's traumatic experience. So what then is the visual language interpreter's role within the mental health setting and why are they particularly vulnerable to the effects of vicarious trauma within the mental health setting? To examine visual language interpreter's profession, Dean and Pollard (2001) apply the Demand Control schema which was originally designed by Karasek & Theorell (1990).

The Demand Control schema (Karasek & Theorell, 1990) proposed that professions that have a combination of high demands and low control (Ex. High strain jobs) were the worst job contexts for a worker. Dean and Pollard (2001) apply the Demand Control schema to visual language interpreters stating that they face high demands and have little control within their profession. Visual language interpreters are responsible for establishing an interpreter/ client relationship which includes establishing rapport and remaining non- judgemental. They are often overwhelmed with linguistic and cognitive demands which include having to fully understand the client and accurately conveying their meaning, content and feelings. Additionally, emotional challenges within the interpreting profession include containing their own responses, having to block out subjective feelings and having no outlet for their own emotional distress (Dean & Pollard, 2001). Visual language interpreters have to go beyond merely hearing about the traumatic experiences of the deaf clients but they have to verbally convey the traumatic information to those within the mental health setting with the same meaning, and feelings (Macdonald, 2015). An empirical study done by Loutan, Fairnelli and Pampallona (1999) studied visual language interpreters who worked with refugees and asylum seekers, the majority of which had experienced major traumatic events and or had been exposed to violence. The results revealed that interpreter's painful feelings and feelings of distress increased as the number of interpreting sessions with victims increased. Additionally, the majority of visual language

interpreters expressed a need to share their feelings with the medical doctors involved. This study illustrates how as the demands increase, the more visual language interpreters are affected.

The control aspect of the demand control schema refers to the skills and resources that a visual language interpreter has to cope with the demands of their job and their authority over decision making (Dean & Pollard, 2001). Interpreters are expected to remain neutral by restricting themselves from being impacted by the material that they are interpreting (Harvey, 2003) but yet, Pealman and Sakvitne (1995) illustrate that an individual can 'act' neutral but they can't feel neutral within high stress situations. Finally, Anderson (2011) found that interpreters working within a mental health setting who attempt to deal with their struggles alone face a greater risk to experiencing vicarious trauma. The interpreter's professional code of ethics, clearly states that they have a responsibility to keep client information confidential (Association of Visual Language Interpreters Canada, 2000). The contradiction that exists is that the vicarious trauma a visual language interpreter experiences is a result of their client's original trauma, and discussing the client's trauma would go against confidentiality.

A study done by Doherty, MacIntyre and Wyne (2010) examined the well-being of interpreters. These interpreters were specifically dedicated to mental health interpreting with refugees. The results from their study revealed that 56% of the visual language interpreters had been emotionally affected by their work and 67% reported that they sometimes found it difficult to get their clients off of their minds. These results indicate that mental health interpreting is clearly affecting visual language interpreter's well-being in their personal lives. To examine visual language interpreter's professional quality of life, a recent study by Mehus and Becher (2015) looked at visual language interpreters who worked in a variety of settings, including the mental health setting. This study utilized the professional quality of life scale (ProQOL) to

measure secondary traumatic stress, burnout and compassion satisfaction. The results demonstrated that visual language interpreters are experiencing significant levels of secondary traumatic stress and compassion satisfaction.

In summary, in this study, vicarious trauma was described using McCann and Pearlman's (1990) constructivist self-theory, and the effects of vicarious trauma on professional quality of life were outlined using the terms compassion satisfaction and burnout. Next, visual language interpreter's profession and unique risk to vicarious trauma was analyzed through the use of demand control schema which illustrated that interpreters face many demands within their profession but do not possess the proper controls. Maslach and Leiter (1997) illustrated the demand control theory showing that mismatches between ones workload and sense of control can result in burnout. Additionally, the code of ethics for visual language interpreters, specifically their responsibility to keep information confidential was argued to be a barrier for them to practice effective self-care methods. Previous empirical research has shown that vicarious trauma effects professional quality of life in multiple professions (Sprang, Clark & Whitt-Woolsey, 2007) and can also occur among visual language interpreters working within the mental health setting (Doherty, MacIntyre & Wyne, 2010; Mehus & Becher, 2015)

This study hypothesizes that the more secondary traumatic stress a visual language interpreter experiences, the lower their professional quality of life will be, as measured through their ratings on compassion satisfaction and burnout scores. Additionally, it is hypothesized that the less experience an individual has within the interpreting profession; the higher their scores will be on the secondary traumatic stress questionnaire and the professional quality of life scale. The unique contribution of this study is that the experience of vicarious trauma among visual language interpreters working within the mental health setting in Canada has not been studied.

Specifically, the effect of vicarious trauma on professional quality of life has not been studied among visual language interpreters in Canada.

Method

Participants

Participants involved in this study were visual language interpreters gathered throughout Canada. Participants were selected on the basis of being registered as interpreters in Canada through various interpreting organizations and also through their involvement in the LEADS interpreter information and training Conference at King's University College. Participants were included in the study on the basis of being a visual language interpreter in Canada and all other participants were excluded if they did not meet this criterion. Visual language interpreters were asked to volunteer using Western University's survey database called Qualtrics. There was no compensation for participants who agreed to complete the study. A demographic questionnaire was included asking questions related to the participants interpreting background. All participants were coded anonymously. There were 110 responses but 25 of the participants started the study and did not finish. Participants who did not complete the full questionnaire package were excluded from the study. There were 85 participants involved in this study ($M=11$, $F=74$). The age range was from 18-65+ ($M= 35-44$). The years spent interpreting ranged from 0-50 years ($M= 11-15$). Participants worked in a variety of settings including Medical (84%), Mental Health (77%), Emergency (74%) and Legal (55%).

Materials

Participants completed three questionnaires, one being the demographics questionnaire which examined participant's demographics and their interpreting background. The second questionnaire used was a secondary traumatic stress questionnaire which measured experiences

of vicarious trauma. The third questionnaire used was a professional quality of life questionnaire which measured participant's professional quality of life.

Secondary Traumatic Stress Questionnaire. Participants completed a 17 item self-report scale measuring Vicarious Trauma or Secondary Traumatic Stress (Bride, Robinson, Yegidis and Figley, 2004). To measure secondary traumatic stress three subscales which were intrusion, avoidance, and arousal were examined. Five items measured the subscale of intrusion (2, 3, 6, 10 and 13). A sample question that measured intrusion asked "My heart started pounding when I thought about my work with clients". Seven items measured the subscale of avoidance (1, 5, 7, 9, 12, 14 and 17). A sample question that measured avoidance asked "I felt emotionally numb". Five items measured the subscale of arousal (4, 8, 11, 15 and 16). A sample question that measured arousal asked "I had troubles concentrating". This questionnaire was scored based on a list of statements in which participants were asked to indicate how frequently each statement was true for them in the past 7 days. These responses were scaled with 1 being never and 5 being very often. The scores were added up to indicate an overall score of secondary traumatic stress.

Raw scores could range from 17 to 85. Any score over 38 indicated experiences of secondary traumatic stress. A reliability analysis of the scale for the present sample of visual language revealed a Chronbach Alpha of .90. A reliability analysis for the subscales of avoidance, intrusion and arousal for the present sample of visual language interpreters revealed Chronbach Alphas of .74, .77 and .76. A normed reliability analysis of this scale revealed a Chronbach Alpha of .93. Also, the normed reliability analysis on the subscales of intrusion, avoidance and arousal revealed Chronbach Alphas of .80, .87 and .83 (Bride, Robinson, Yegidis and Figley, 2004).

Professional Quality of Life Questionnaire. Participants filled out a 30 item self-report scale measuring professional quality of life (Stamm, 2009). To measure professional quality of life, three factors which were burnout, compassion satisfaction and secondary traumatic stress were examined. Ten items measured burnout (1, 4, 8, 10, 15, 17, 19, 21, 26 and 29) and five items were worded in the opposite order (1, 4, 15, 17 and 29). A sample question that measured burnout asked “I am not as productive at work because I am losing sleep over traumatic experiences of a person I (help)”. Ten items measured compassion satisfaction (3, 6, 12, 16, 18, 20, 22, 24, 27, and 30). A sample question measuring compassion satisfaction asked “I like my work as a (helper)”. Ten items measured secondary traumatic stress (2, 5, 7, 9, 11, 13, 14, 23, 25, 28). A sample question measuring secondary traumatic stress asked “I feel depressed because of the traumatic experiences of the people I (help)”. This questionnaire was scored based on a list of statements in which participants were asked to indicate how frequently each statement was true for them in the past 30 days. These responses were scaled with 1 being never and 5 being very often.

Each factor was added up separately to indicate a score for burnout, compassion satisfaction or secondary traumatic stress. Raw scores ranged from 10 to 50 on burnout, compassion satisfaction or secondary traumatic stress questions. Scores in the lower quartile of compassion satisfaction and the upper quartile of secondary traumatic stress or burnout may be cause for concern. Specifically, scores on compassion satisfaction questions under 22 called for concern and scores on burnout or secondary traumatic stress over 42 called for concern. A reliability analysis on compassion satisfaction, burnout and secondary traumatic stress questions for the present sample of visual language interpreters revealed Chronbach Alphas of .91, .75, .80.

A normed reliability analysis on compassion satisfaction, burnout and secondary traumatic stress questions revealed a Chronbach Alpha of .88, .75, .81 (Stamm, 2009).

Procedure

This study was carried out by selecting questionnaires, which were located online, that measured secondary traumatic stress and professional quality of life. The researchers used Qualtrics, to post the questionnaires online for the participants to complete. Qualtrics is Western University's survey database. Included in the Qualtrics documents was an informed consent which was approved by the Board of Ethics, a demographics form, a secondary traumatic stress questionnaire, a professional quality of life questionnaire, a life satisfaction questionnaire, an empathy questionnaire and an anxiety questionnaire which made the questionnaire package a total of seven items. The participants were notified in the informed consent that the results of the study would be posted on the Center for Deaf Education and Accessibility Forum (CDEAF) and that there would be no compensation for their participation. Participants were coded using numbers and their identities were kept anonymous. Upon completing the questionnaires the participants were not given a debriefing form.

Participants were recruited during a three day interpreter information and training LEAD's Conference at King's University College. Participants collected at the LEAD's Conference were approached and asked to participate in a study that measured Vicarious Trauma among visual language interpreters. Upon agreeing, participants were instructed to fill out the survey by accessing a link to the Qualtrics document on the Center for Deaf Education and Accessibility Forum's (CDEAF) website. Participants were also recruited through interpreting organizations across Canada which were contacted by the advisor. The interpreting organizations contacted included the Association of Visual Language Interpreters Canada, Canadian

Association of the Deaf, Ontario Association of the Deaf, Westcoast Association of Visual Language Interpreters, Association of Sign Language Interpreters and the Ontario Interpreting Services. Visual language interpreters who were members of these interpreting organizations in Canada were given a letter of information which described the studies purpose and asked them to participate using Qualtrics. Upon agreeing, participants were instructed to fill out the survey by accessing a link to the Qualtrics document on the Center for Deaf Education and Accessibility Forum's (CDEAF) website.

Results

This study examined the relation between visual language interpreter's experiences of secondary traumatic stress and professional quality of life. The two facets of professional quality of life examined were burnout and compassion satisfaction. The secondary traumatic stress variable was measured using a 17-item scale. A reliability analysis revealed a Cronbach Alpha of .90. The secondary traumatic stress score was obtained by averaging the 17 items on the scale. A reliability analysis was conducted on the 10-items of the professional quality of life scale that measured burnout (see Table 1). The Cronbach Alpha was .75. The burnout score was obtained by averaging the 10 items measuring burnout on the professional quality of life scale. A reliability analysis was conducted on the 10-items of the professional quality scale that measured compassion satisfaction. The Cronbach Alpha was .91. The compassion satisfaction score was obtained by averaging the 10 items measuring compassion satisfaction on the professional quality of life scale (see Table 2)

The descriptive statistics conducted for the three variables revealed secondary traumatic stress ($M=1.94$, $SD=.83$), compassion satisfaction ($M=4.02$, $SD=.63$), and burnout ($M=2.12$, $SD=1.02$) (see Table 3). The mean scores were summed for participants responses on secondary

traumatic stress ($M= 33.10$, $SD= 14.1$) which revealed an average score that was just below the clinical range for moderate secondary traumatic stress (> 38). 30% of the participants scored above the cut off for secondary traumatic stress. The mean scores were summed for participants responses on compassion satisfaction ($M=40$, $SD= 6.47$) which demonstrated an average score that was within the moderate to high range for compassion satisfaction (23-41). 98% of the participants scored within the moderate to high range for compassion satisfaction. The mean scores were summed for participants responses on burnout ($M= 21.5$, $SD=5.53$) which revealed an average score that was within the low range for burnout (< 23). 100% of the participants scored within the moderate to low range for burnout (see Table 4)

Table 1

Cronbach Alpha's for Secondary Traumatic Stress (STS) and the subscales of avoidance intrusion and arousal.

<u>STS</u>	<u>Avoidance</u>	<u>Intrusion</u>	<u>Arousal</u>
.90	.74	.77	.76
(17 items)	(7 items)	(5 items)	(5 items)

Table 2

Cronbach Alpha's for Professional Quality of Life scale and the burnout and compassion satisfaction (CS) questions

<u>PQL</u>	<u>Burnout</u>	<u>CS</u>
.88	.75	.91
(30- items)	(10- items)	(10- items)

Table 3

Mean Scores for Secondary Traumatic Stress (STS), subscales of Avoidance, Intrusion and Arousal, Compassion Satisfaction (CS), Burnout

<u>STS</u>	<u>Avoidance</u>	<u>Intrusion</u>	<u>Arousal</u>	<u>CS</u>	<u>Burnout</u>
1.94	1.98	1.72	2.12	4.02	2.12
(.83)	(.87)	(.83)	(1.02)	(.63)	(1.02)

The descriptive statistics conducted for these three subscales revealed avoidance (M=1.98, SD=.87), intrusion (M=1.72, SD=.83), and arousal (M= 2.12, SD=1.02).

Table 4

Mean Scores Summed for Secondary Traumatic Stress (STS), Compassion Satisfaction (CS) and Burnout

<u>STS</u>	<u>CS</u>	<u>Burnout</u>
33.10	40	21.5
(14.1)	(6.47)	(5.53)

A correlational analysis was conducted to determine the relations between the three variables (see Table 5). The correlation between secondary traumatic stress and burnout revealed a strong, positive and significant correlation, $r(83) = .54, p < .001$. This relationship indicated that the more secondary traumatic stress a visual language interpreter reported, the more burnout they experienced. The correlation between secondary traumatic stress and compassion satisfaction demonstrated a weak, negative and marginally significant correlation, $r(83) = -.20, p = .071$. This relationship indicated that visual language interpreters who reported higher scores on secondary traumatic stress tended to report lower scores on compassion satisfaction.

To further investigate the relationship between secondary traumatic stress and compassion satisfaction, as well as the relationship between secondary traumatic stress and burnout, the secondary traumatic stress scale was split into three subscales which included avoidance, intrusion and arousal. The descriptive statistics conducted for these three subscales revealed avoidance ($M = 1.98, SD = .87$), intrusion ($M = 1.72, SD = .83$), and arousal ($M = 2.12, SD = 1.02$) (see Table 3).

A reliability analysis was conducted on the 7 items of the secondary traumatic stress scale that measured avoidance. The Cronbach Alpha was .74. The avoidance score was obtained by averaging the 7 items measuring avoidance (see Table 1). The correlation between avoidance and compassion satisfaction indicated a moderate, negative and significant correlation, $r(83) = -.22, p < .05$. This relationship indicated that visual language interpreters who reported higher scores on avoidance had lower scores on compassion satisfaction. The correlation between avoidance and burnout was moderate, positive and significant, $r(83) = .53, p < .001$. This relation indicated that visual language interpreters reported higher scores on avoidance also had higher scores on burnout.

A reliability analysis was conducted on the 5 items of the secondary traumatic stress scale that measured intrusion. The Cronbach Alpha was .77. The intrusion score was obtained by averaging the 5 items measuring intrusion on the secondary traumatic stress scale (see Table 1). The correlation between intrusion and compassion satisfaction was weak, negative and non-significant, $r(83) = -.17, ns$. The correlation between intrusion and burnout was moderate, positive and significant, $r(83) = .43, p < .001$. This relation revealed that visual language interpreters who scored higher on intrusion also scored higher on burnout.

A reliability analysis was conducted on the 5 items of the secondary traumatic stress scale that measured arousal. The Cronbach Alpha was .76. The arousal score was obtained by averaging the 5 items measuring arousal on the secondary traumatic stress scale (see Table 1). The correlation between arousal and compassion satisfaction was weak, negative and non-significant, $r(83) = -.14, ns$. The correlation between arousal and burnout was moderate, positive and significant, $r(83) = .52, p < .001$. This relation indicated that the higher scores on arousal that the visual language interpreters reported, the higher the burnout scores were.

A correlational analysis was conducted to investigate the relationship between select demographic questions, compassion satisfaction, burnout, secondary traumatic stress and its subscales of avoidance, intrusion and arousal (see Table 5). The correlation between the demographic question “what is your age?” and compassion satisfaction revealed a weak, positive and significant relation, $r(83) = .28, p < .01$. This relation demonstrated that the older a visual language interpreter was, the higher their compassion satisfaction scores were. The correlations between “what is your age?” and burnout demonstrated a weak, negative, marginally significant relation, $r(83) = -.20, p = .064$. This relation indicates that the older a visual language interpreter was, the lower their burnout scores tended to be. The correlational analysis revealed that no other

relations were significant or marginally significant with the demographic question “what is your age?”

The correlation between the demographics question “how many years have you been working as an interpreter?” and compassion satisfaction revealed a weak, positive and significant relation, $r(83) = .26, p < .05$. This relationship indicated that the longer a visual language interpreter had been working in the profession, the higher their compassion satisfaction scores were. The correlation between the demographic question “how many years have you been working as an interpreter?” and burnout revealed a weak, negative and significant correlation, $r(83) = -.24, p < .05$. This relation demonstrated that the longer a visual language interpreter had been working in the profession, the lower their scores on burnout were. The correlation between the demographic question “how many years have you been working as an interpreter?” and the subscale of intrusion on the secondary traumatic stress scale indicated a weak, negative and marginally significant relation, $r(83) = -.20, p = .073$. This relation revealed that the longer a visual language interpreter had been working in the profession, the lower their scores on intrusion were.

A multiple regression analysis was conducted using burnout, compassion satisfaction, gender, and the demographics questions “what is your age?” and “how many years have you been working as an interpreter?” as predictor variables of secondary traumatic stress which was the criterion variable (see Table 6). The $R^2 = .37$ revealed that a significant amount of variation in secondary traumatic stress was accounted for by burnout, compassion satisfaction, gender, age and years interpreting as predictor variables. Burnout was found to be the only predictor variable that independently predicted the variance in secondary traumatic stress $F(6,78) = 6.57, p < .001$.

Table 5

Correlations among Secondary Traumatic Stress (STS), Compassion Satisfaction (CS), Burnout, Age, Years Interpreting and the subscales of Avoidance, Intrusion and Arousal of the STS scale.

	1	2	3	4	5	6	7	8
1. STS	1							
2. CS	-.20(M)	1						
3. Burnout	.54**	-.59**	1					
4. Age	.87**	.28*	-.20(M)	1				
5. Years Interpreting	-.13	.26*	-.24*	.87**	1			
6. Avoidance	.95**	-.22*	.53**	-.03	-.40	1		
7. Intrusion	.87**	-.17	.48**	.80	-.80	.72**	1	
8. Arousal	.93**	-.14	.52**	-.90	-.90	.84**	.71**	1

** Correlation is significant at the .001 level (2-tailed)

* Correlation is significant at the .005 level (2-tailed)

Table 6

Regressions for Burnout, Compassion Satisfaction (CS), Gender, Training Program, Age, and Years Interpreting as predictor variables of Secondary Traumatic Stress as a criterion variable

Variable	
Secondary Traumatic Stress	
Burnout	$\beta = .62, p < .001$
CS	$\beta = .17, ns$
Gender	$\beta = .50, ns$
Training Program	$\beta = .16, ns$
Age	$\beta = .21, ns$
Years Interpreting	$\beta = -.12, ns$

Discussion

When compared to the normed scores, the descriptive statistics conducted in this study indicated that majority of visual language interpreters were not experiencing levels of secondary traumatic stress, compassion satisfaction or burnout that called for concern. This studies first hypothesis was that the higher visual language interpreters scored on vicarious trauma, the lower their professional quality of life would be. A correlational analysis confirmed this hypothesis by revealing that the more secondary traumatic stress visual language interpreters reported the more burnout they experienced and the lower their compassion satisfaction scores tended to be. This studies second hypothesis was that the longer visual language interpreters were involved in the profession, the lower their professional quality of life would be. A correlational analysis disproved this hypothesis by revealing that the longer the visual language interpreters were in the profession, the higher their compassion satisfaction and the lower their burnout scores were. A regression analysis indicated that burnout was the only predictor variable that independently predicted the variance in visual language interpreters secondary traumatic stress scores.

Upon summing the visual language interpreters mean scores on secondary traumatic stress, burnout and compassion satisfaction, it was found that 30% of the visual language interpreters scored above the moderate range for secondary traumatic stress, 100% scored in the moderate to low for burnout and 98% scored in the moderate to high range for compassion satisfaction. One possible explanation for the visual language interpreters experiencing low to moderate burnout rates may be that those experiencing high rates of burnout may not have participated in this study. The participants in this study were largely collected on the basis of being a registered interpreter within various interpreting organizations in Canada. Perhaps, the visual language interpreters who would have scored high on burnout were experiencing

symptoms such as chronic job stress (Maslach & Leiter, 1997) and didn't want to participate in a study related to their professions. Additionally, the visual language interpreters in this study may have felt pressured to provide responses that were socially desirable. Research conducted by Kilburg, Nathan & Thoreson (1986) proposed the double standard of adjustment theory which explains that mental health professionals may underreport their symptoms of vicarious trauma due to the societal expectation that they must personally function at higher levels than their patients. Although the anonymity of each participant involved in this study should have damped the effects of social desirability, the visual language interpreters may have still provided answers that were socially desirable because of the double standard of adjustment that exists between themselves and the deaf individuals and communities they work with.

This current study's findings relate to a study completed by Mehus & Becher (2015) who used a sample of 119 visual language interpreters who had similar rates of involvement within the mental health setting (79%) to this current studies sample (77%). The authors measured visual language interpreters' scores on secondary traumatic stress, burnout and compassion satisfaction using the same Professional Quality of Life scale developed by Stamm (2009). The authors found that 71% of the visual language interpreters had scores above the moderate level for secondary traumatic stress, 61% that were in the high range for compassion satisfaction and only 14% in the high range for burnout.

One possible explanation behind the differences in secondary traumatic stress scores compared to this current study is that Mehus & Becher (2015) chose visual language interpreters on the basis of whether or not they had "heard tragic, difficult, or traumatic stories as an interpreter". Therefore, the author's sample of visual language interpreters indicated prior to their participation in the study that they were experiencing symptoms of secondary traumatic stress,

which may have inflated the scores on secondary traumatic stress. However, there were notable similarities in Mehus and Becher's (2015) study and this study, particularly the relation between the visual language interpreters high scores secondary traumatic stress, high scores of compassion satisfaction and low scores on burnout. These similarities indicate that visual language interpreters are experiencing secondary traumatic stress but yet are still deriving much pleasure from their work and avoiding burnout which is also consistent to work done by Splevins, Cohen, Joseph, Murray & Bowley (2010).

Research conducted by Samios, Abel and Rodzik (2013) offers an explanation for these findings which suggests that despite high scores on secondary traumatic stress, the high scores on compassion satisfaction may act as a protective factor against burnout. Further, Samios et al. (2013) studied 61 therapists who worked with trauma survivors and examined their experiences of compassion satisfaction. Specifically, these authors looked at whether positive emotions and techniques such as positive reframing could build compassion satisfaction among the sample of therapists. The results demonstrated that positive emotionality worked through positive reframing to cause greater compassion satisfaction which protected against burnout. This explanation suggests that the high compassion satisfaction scores among the visual language interpreters in this current study may have protected them from scoring high on burnout. This finding reveals the importance of studying the positive aspects of visual language interpreters working in trauma related setting in the future.

A correlational analysis demonstrated results that correspond with existing literature on vicarious trauma and professional quality of life. The first hypothesis of this study stated that the more vicarious trauma a visual language interpreter experiences the lower their scores would be on professional quality of life. The results supported this hypothesis by revealing that the more

secondary traumatic stress a visual language interpreter reported, the more burnout they experienced and the lower their compassion satisfaction scores tended to be. Similar results were revealed in research conducted by Mehus & Becher (2015) who found a relation between visual language interpreter's scores on secondary traumatic stress, burnout and compassion satisfaction. Specifically, they found that higher secondary traumatic stress scores were related to higher scores on burnout among their sample of visual language interpreters. Interestingly, these authors did not find a marginally significant relationship between higher scores on secondary traumatic stress and lower scores on compassion satisfaction as this study reported.

The correlational analysis also revealed results that are supported by existing literature on an individual's experience in a helping profession and the effects on their professional quality of life. Results demonstrated findings that were opposite of predictions made in this studies second hypothesis which was that the longer visual language interpreters were involved within the profession, the lower their professional quality of life would be. The rationale behind this prediction was that experiences of vicarious trauma would accumulate over time as suggested by the constructivist self- development theory (McCann & Pearlman, 1990). Additionally, the constant high demands and low control within the interpreting profession (Dean & Pollard, 2001) was expected to take a toll on the visual language interpreters over time. Consequently, the visual language interpreter's professional quality of life was proposed to steadily decrease over time. However, it was found that the longer a visual language interpreter was in the profession, the higher their compassion satisfaction scores were and the lower their burnout scores were. These findings are consistent with a study conducted by Imai, Nakao, Tsuchiya, Kuroda, & Katoh (2004) who studied a sample of public health nurses involved in mental health care and found that nurses who were new to the profession were more likely to experience burnout.

Additionally, Anderson (2011) studied a sample of 16 visual language interpreters who were working with refugees and people seeking asylum. The qualitative analysis in Splevins et al. (2010) study demonstrated that interpreters “found a way to deal with the negative effects of working with a traumatized population”. These findings offer an explanation for the relation found between age and compassion satisfaction in this current study suggesting that older visual language interpreters found their own personalized ways to derive pleasure in their work and avoid burnout but less experienced visual language interpreters may not have established their own personalized ways to do the same.

To further investigate the secondary traumatic stress variable, this study assessed correlations between its subscales of avoidance, intrusion and arousal and their relations with burnout and compassion satisfaction. The correlational analyses demonstrated that the higher visual language interpreters scores on intrusion were, the higher their scores were on burnout. Commonly reported symptoms of intrusion are the inability to get a client off of one’s mind and the identification with clients (Bride, 2007). Interestingly, Doherty, MacIntyre and Wyne (2010) studied 18 visual language interpreters who worked within mental health settings and found that 67% indicated that they sometimes found it difficult to get their clients off of their minds. Additionally, Doherty et al. (2010) found that many of the visual language interpreters were experiencing feelings of hopelessness and powerlessness towards their clients.

A potential explanation for the consistency of these findings among the positive relation between visual language interpreters scores on intrusion and scores on burnout may be linked to visual language interpreter’s lack of specialized training to work within trauma related fields. Butler (2008) argues that due to visual language interpreter’s lack of training specific to working in the mental health setting, they may be more vulnerable to identifying with their clients. In

contrast, mental health professionals who are given extensive training to work in the mental health setting would be more likely to recognize and manage symptoms of intrusion developing within them. Therefore, this current studies sample of visual language interpreters may be over identifying with their clients which could be increasing their scores on burnout.

Additionally, this study found that visual language interpreters who reported higher scores on avoidance had higher scores on burnout and lower scores on compassion satisfaction. A commonly reported symptom of avoidance is emotional numbing and detachment from others. Butler (2008) suggested that visual language interpreters often distance themselves from the situation as a way of coping with their desire to identify with clients. This finding suggests the importance of self-awareness among visual language interpreters working within trauma related settings as a means of improving their compassion satisfaction scores which has been found to be effective for therapists working with traumatized clients (Sexton, 1999).

The multiple regression analysis in this current study revealed that burnout was the only predictor variable that significantly predicted the variance in visual language interpreters experiences of secondary traumatic stress which was the criterion variable. One explanation for these findings is that visual language interpreter's chronic stress at work may be affecting their vulnerability to secondary traumatic stress. Additionally, this study found that when burnout, compassion satisfaction, gender, age and years interpreting were entered into a regression equation together, they only accounted for 34% of the variance in visual language interpreters secondary traumatic stress scores. This finding suggests that further research must be conducted to determine other variables that may account for the remaining 66% of variance in visual language interpreters secondary traumatic stress scores that was unaccounted for in the regression model used in this study.

There are two main practical implications of these findings. First, mental health agencies should consider how visual language interpreters working within trauma related fields, such as the mental health setting, are being trained and supported. This current study found that 30% of visual language interpreters who participated were experiencing above the moderate level of secondary traumatic stress which calls for concern. Research by Anderson (2011) found that providing peer support, opportunities to debrief, and education on vicarious trauma significantly reduced visual language interpreter's symptoms of vicarious trauma. The second practical implication of these findings is that more experienced visual language interpreters should be involved in the training and support of novice interpreters. Specifically, more experienced visual language interpreters may teach novice interpreters the skills they personally established to avoid burnout and derive pleasure from interpreting.

There were three main limitations present within this study. First, this study would have benefited by including more background information on factors that may influence secondary traumatic stress, burnout and compassion satisfaction scores such as a visual language interpreters experiences of personal trauma or their personal belief systems. For example, Pearlman and MacIan (1995) found that personal history with trauma was a significant predictor of vicarious trauma among a sample of therapists. Additionally, Pearlman and Saakvitne (1995) found that counselors with a "larger sense of meaning and connection" were less likely to experience vicarious trauma. The second limitation in this study was that ranges were used for the age and years interpreting questions which reduced the questions power. The third limitation was that a secondary traumatic stress scale was used to study vicarious trauma. A secondary traumatic stress scale can measure a wide variety of symptoms that relate to both constructs but vicarious trauma extends further into how an individual's worldview is affected (Figley, 1995).

Therefore, this study would have benefited by including scales that assessed a visual language interpreter's worldview by examining their cognitive schemas or scales that assessed psychological processes that are affected when one experiences vicarious trauma such as their sense of safety, dependency and trust (McCann & Pearlman, 1990).

Future research must further refine the construct of vicarious trauma and the measures used to assess it. The current literature on vicarious trauma and secondary traumatic stress is inconsistent in how these constructs are defined which largely impacts how they are currently conceptualized. Additionally, more research examining visual language interpreters' experiences of vicarious trauma is needed to provide a broader scope of understanding this understudied population. Specifically, qualitative research on factors that impact individual visual language interpreter's ability avoid secondary traumatic stress, burnout and increase compassion satisfaction such as their beliefs or support networks would be useful to the literature.

In conclusion, this study was the first to examine a Canadian sample of visual language interpreters' experiences of vicarious trauma and the effects it had on their professional quality of life. This studies overall aim was to highlight visual language interpreters need for support and training to work within settings where they are exposed to traumatic material, such as in the mental health setting. Currently, in Canada, specialized training for visual language interpreters working in trauma related settings is not required and the results of this study indicate a need for more support for this understudied population.

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