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The Effects of Vicarious Trauma on Life Satisfaction in Visual Language Interpreters

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Honors Thesis

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Abstract

The purpose of this study was to investigate the effect that vicarious trauma (VT) has on the life satisfaction of visual language interpreters working with Deaf consumers in mental health settings. Experiencing an accumulation of traumatic interactions with Deaf consumers can produce deleterious effects on the mental and physical health of interpreters, increasing the risk of developing VT. To examine these effects, a sample of 85 visual language interpreters (females = 74, males = 11) across Canada were contacted through various relevant agencies and websites. The age range of participants was 18 to 65+ years with majority of interpreters between the ages 35 to 44 (n=29). Three questionnaires were hosted on Qualtrics including: a demographic questionnaire, The Satisfaction with Life Scale, and the Secondary Traumatic Stress Scale. Results demonstrated that VT negatively relates to life satisfaction $r(83) = -.40, p < .001$. These findings suggest that when visual language interpreters experience symptoms of VT, their quality of life is negatively impacted. Implications for interpreter training programs are discussed.

The Effects of Vicarious Trauma on Life Satisfaction in Visual Language Interpreters

Vicarious trauma (VT) affects approximately 40-85% of people working in a “helping profession” (Mathieu, 2012). Used interchangeably with “compassion fatigue” and “secondary traumatic stress” it can best be described as the accumulation of empathetic engagement with another person’s traumatic experiences (Harrison & Westwood, 2009; Hook & Rothenberg, 2009; McCann & Pearlman, 1990; Newell & Macneil, 2010). The impact of VT on those who develop it is not only detrimental to their career, but it also affects their values and beliefs, interpersonal relationships, and their mental and physical well-being (American Counselling Association, 2011). The majority of research on VT has looked at its effects on social workers, nurses, first responders and clinicians. To date, very little research has focused on how VT affects visual language interpreters working with Deaf consumers. Before discussing the effects, it is important to understand the signs and symptoms associated with VT. Some of the most common symptoms include: difficulty falling/staying asleep, feeling trapped by their work, anhedonia, and feelings of hopelessness toward their job (American Counselling Association, 2011). Lacking the proper training for interpreting in mental health settings, daily challenges faced by interpreters, and the restraint on the code of ethics for interpreting are several reasons why visual language interpreters begin to experience these invasive symptoms.

Visual language interpreters working with Deaf consumers, a marginalized and oppressed population, are often exposed to the traumatic material experienced by the Deaf consumers (Barnett, 2002). Encountering even one traumatic interaction with a Deaf consumer can cause major problems for the interpreter (Harvey, 2001). Therefore, it comes as no surprise that an accumulation of traumatic interactions with Deaf consumers may have harmful effects on the mental health of the interpreter. In a clinical setting, the visual language interpreter’s role as a

passive third link requires the interpreter to place him or herself in the role of the client while refraining from adding to the dialogue of the therapeutic session. At some point in their career, 56% of interpreters working in a mental health setting have experienced emotional strain and 33% of interpreters felt that it had a negative impact on their life (Doherty, MacIntyre, & Wyne, 2010). VT is emotionally devastating and if left untreated, can characterize all aspects of a person's life including their relationships, careers, and home life. Therefore, the lack of research on the effects of VT in visual language interpreters demands attention. It is necessary to discover if there is a relationship between VT and life satisfaction in order to provide evidence to support the need for more formal mental health training in interpreting programs. This training may include self-care for interpreters as well as better preparation for the potential consequences of interpreting in mental health settings. In order to examine this relationship, the present study requested visual language interpreters to complete three questionnaires including a demographic questionnaire, a secondary traumatic stress questionnaire and a life satisfaction questionnaire.

One theory that provides an explanation for VT is the Constructivist Self-Development Theory created by Lisa McCann and Laurie Anne Pearlman in 1990. The cognitive portion of this theory focuses on psychological needs, cognitive schemas, and the memory system while relying on the underlying premise that through the development of schematic structures, people construct their own interpretation of reality. Schematic structures consist of beliefs, assumptions, and expectations which allow individuals to better understand their environment (Piaget, 1971). In previous literature, five psychological needs have been established including: safety, dependency/trust, power, esteem, and intimacy (McCann & Pearlman, 1990). The cognitive manifestations of these psychological needs are considered schemas. According to the theory, VT is a result of an alteration in these five specific schemas. This alteration occurs when

engaging with people who have experienced trauma. More specifically, when visual language interpreters are exposed to the traumatic events experienced by Deaf consumers, the interpreters' schemas are more vulnerable to alteration. The effect of working with trauma can impact each of the five schemas differently. For example, a threat to the trust schema may cause the interpreter to become more cynical or distrustful whereas a threat to the intimacy schema may cause the interpreter to isolate themselves from their family and friends (McCann & Pearlman, 1990). Similarly, VT may temporarily or permanently distort the interpreter's memory system by internalizing the accounts of Deaf consumers. These internalizations may appear as dreams, flashbacks or intrusive thoughts (Horowitz, 1976). Alterations in memory most often occur in two instances, the first is when the traumatic material is most relevant to the interpreter; for example, when the material relates closely to their psychological needs. The second occurs when there is no opportunity for the interpreter to debrief after being exposed to the traumatic material.

The theory most relevant to vicarious trauma as related to visual language interpreters is based off of the framework of Demand-Control Theory created by Karasek in 1979 that analyzes occupational stress and burnout. The two fundamental aspects of Demand-Control Theory are the demand and control portions of a job; "demand" is the job requirements and "control" is the degree to which the person is able to make decisions regarding the demands of the job. Dean and Pollard (2001) applied this theory to visual language interpreters and refer to it as the Demand-Control schema. There are four types of demands with regards to interpreting including: linguistic, environmental, interpersonal, and intrapersonal. Linguistic demands include the communication aspects of interpreting (e.g., the interpreter's receptive and expressive skills or the use of technical vocabulary). Environmental demands are factors relating to the setting of the interpreting assignment (e.g., room temperature and lighting quality). Interpersonal demands are

elements relating to the interaction between participating individuals (e.g., clinician/client's understanding of the interpreter's role and power/authority dynamics). Lastly, intrapersonal demands are the factors relating directly to the interpreter (e.g., vicarious reactions and availability of support) (Dean & Pollard, 2001). Dean and Pollard believe that interpreting involves heavy restrictions in decision making for interpreters who are most often in high demand positions; thus putting them at risk for high stress and the potential development of VT. For example, in a clinical setting, there is high linguistic demand on the interpreter to understand psychological terms in order to help make an accurate diagnosis and treatment plan for the Deaf client; however, the interpreter has no control over what is discussed between clinician and client creating a stressful environment for the interpreter. The Demand-Control schema creates the theoretical framework for the present study as it demonstrates the risk for visual language interpreters working in high demand, low control environments.

Previous literature has focused on the lack of training and preparedness of interpreters working in mental health settings as an explanation for why they experience symptoms of VT. A study by Sande (1998) looked at spoken language refugee interpreters. The findings of this study demonstrated that the interpreters felt unprepared for the emotional consequences of interpreting for this disadvantaged population. Additionally, they were overwhelmed by the amount of trauma experienced by the refugees. The implications of this study suggest there is a need for more focused training on how to handle highly traumatic situations and how to engage in self-care in order to protect oneself from experiencing symptoms of VT (Doherty et al., 2010; Vernon & Miller, 2001; Walker & Shaw, 2011). Furthermore, being unfamiliar with the therapeutic process or lacking experience when working with trauma can result in high stress for interpreters (Walker & Shaw, 2011). Dean and Pollard (2001) found that when it comes to interpreting in

mental health settings, most of the knowledge the interpreters gained occurred after their training. The study showed that 64% of participants' knowledge about working in mental health environments was learned after training while only 36% was learned in training. Likewise, 78% learned how to engage in self-care after training while only 22% learned self-care in training. The high discrepancy between what was learned in training versus in the field shows a lack of proper training for visual language interpreters. This inexperience puts interpreters at risk for developing symptoms of VT and demands the necessity of incorporating more focused preparation on what to expect when working in mental health settings and how to deal with the material more effectively (Doherty et al., 2010; Walker & Shaw, 2011). For example, to better prepare interpreters, training programs could focus on teaching the specialized language used in mental health settings. Additionally, courses on self-care could be offered to help interpreters effectively work through the material.

In addition to not receiving the proper training, interpreters working with Deaf clients in mental health settings are often faced with various challenges regarding the interpreter-client relationship, interpreter-clinician relationship, and the emotional demand of the job (Doherty et al., 2010). Looking specifically at the relationship between the interpreter and the Deaf client, challenges arise when establishing rapport with the client, or when clients are inattentive as it may take away from the ability of the interpreter to convey the client's message properly. Furthermore, the code of ethics has policies in place that prevent interpreters from interjecting in the therapeutic dialogue. Therefore, it is especially difficult when the interpreter knows that the client is being evasive toward the clinician but, due to these policies, is unable to inform the clinician.

In some therapeutic settings challenges can arise between the clinician and the interpreter. A few of the most commonly noted challenges include the professional misunderstanding of the interpreter role and when the clinician attributes poor client communication to inadequate interpreting (Doherty et al., 2010). On occasion, a clinician might make assumptions about what the interpreter's role is; for example, they may assume that because the interpreter is able to understand the Deaf client, they should be able to provide insight into the client's issues. While it is important to view the interpreter as part of the clinician's team, working toward a specific therapeutic goal, it is also necessary to be aware of the interpreter's lack of expertise in the field of psychology (Hamerdinger & Karlin, 2003). Additionally, clinicians may attribute their client's lack of communication as the inability of the interpreter to relay the message effectively. However, it may actually be that the client is having difficulty expressing their thoughts and feelings or that they lack the necessary linguistic skills. In any case, these challenges between the clinician and interpreter can create unnecessary stress for the interpreter.

Lastly, with regards to emotional challenges for interpreters, one of the most difficult is often that due to strict policies in the code of ethics, there is no outlet for the interpreter's emotional distress resulting in the accumulation of traumatic material over time (Doherty et al., 2010). As previously discussed, interpreter training programs often do not provide the necessary self-care information; therefore, when faced with traumatic material, interpreters have few resources they can refer to in order to help them work through their stress.

Apart from relational and emotional challenges, the interpreter is faced with linguistic challenges. ASL is very different from English and often there are words in the English language that are not directly comparable in ASL – this involves “expansion” (explaining a word in depth

to the Deaf consumer) (Vernon & Miller, 2001). In mental health settings this would require the interpreter to have background knowledge of psychological terms, a requirement that is often not included in interpreter training programs (Walker & Shaw, 2011).

One last, but important challenge faced by visual language interpreters is their lack of formal training on proper self-care. Self-care is necessary when working in high stress situations, and more specifically, when working in mental health settings. Engaging in self-care whether it is exercising, eating properly, or meditating can reduce the experience of symptoms related to VT (Figley, 2002; Harrison & Westwood, 2009). Clinicians receive the proper care and tools to minimize the risk of VT but interpreters often do not or because of confidentiality policies in their code of ethics, they tend not to seek out help (Doherty et al., 2010; Harrison & Westwood, 2009; MacIntyre, & Wyne, 2010; Macdonald, 2012). When interpreters continue working while experiencing symptoms of VT, it not only makes their symptoms worse, but it is also a disservice to their consumers (Harrison & Westwood, 2009).

Finally, referring to Dean and Pollard's (2001) Demand-Control schema, it is clear that the restraint on interpreters' code of ethics creates a high demand and low control work environment, thus increasing the stress on interpreters. There are two code of ethics used across North America: AVLIC and NAD-RID. Within both code of ethics, there are several overlapping policies which may cause unrealistic restraints on the interpreters. The first is that interpreters must maintain confidentiality unless they have been ordered by the court or the consumers have given them permission to disclose any information. At times, this restraint on disclosing information prevents interpreters from debriefing with other colleagues and can also cause some interpreters to refrain from seeking help for fear of jeopardizing their career by breaching confidentiality (Macdonald, 2012). Not seeking help will lead to a no-win situation in which the

risk for developing VT increases. One possible outcome is that the interpreter may continue working while experiencing symptoms of VT resulting in both a disservice to themselves and their consumers. A second possible outcome is that the interpreter may abandon their assignment, resulting in a tremendous loss of resources and opportunity for Deaf clients to receive proper care (Harrison & Westwood, 2009).

The second policy stated by AVLIC and NAD-RID is regarding the necessity of possessing professional competence required for each specific interpreting situation which includes, faithfully conveying the message of the consumer. Faithfully conveying the message requires the interpreter to express the tone, content, and essence of the client's message. A necessary step in order to better understand the tone, content, and essence, is for the interpreter to internalize the message of the consumer. In a clinical setting, the interpreter must reiterate the message of the client – which at times can be traumatic – and do so in a way that captures the client's true emotions. This is critical to the therapeutic process as it aids in the diagnosis and treatment of the client. The interpreter needs to be able to read the facial expressions and body language, as well as include the unspoken interactions into the therapeutic setting (Dean & Pollard, 2001; Sheppard, 2011).

Thirdly, it is expected that interpreters possess the appropriate knowledge and skills required of working in a particular setting. However, a study designed by Walker and Shaw (2011) looked at interpreter preparedness for specialized settings and found that the majority of participants accepted their first assignment in a mental health setting within a year of starting their interpreting career. This resulted in lack of understanding and skills. In this same study, 30% of participants purposely avoided working in mental health settings because they felt unprepared. This can result in a shortage of interpreters in mental health settings causing further

oppression and distress for Deaf consumers. Additionally, the AVLIC code of ethics addresses the importance of the interpreter remaining neutral throughout the assignment. In a clinical setting, this could mean that despite a client sharing a traumatic story, the interpreter must remain calm. Overtime, this inability to show emotion may emerge in settings outside of the therapy session resulting in isolation from friends and family (American Counselling Association, 2011). The low control issued by the code of ethics to interpreters working in mental health settings is unrealistic and is related to a slow increasing risk of developing burnout and VT (Dean & Pollard, 2010; Heller, Stansfield, Stark, & Langholtz, 1986). Policies need to be re-evaluated to ensure that interpreters are receiving more control over their assignments which in turn will relieve some of the stress placed on them in their high demand positions.

An extensive literature review has revealed that there is an insufficient amount of research on VT as experienced specifically by visual language interpreters. Much of the research focuses on VT experienced by mental health specialists, such as clinicians or social workers, rather than visual language interpreters. However, the few studies that have focused on VT in interpreters have found support for high rates of VT (Dean & Pollard, 2001; Doherty et al., 2010; Vernon & Miller, 2001). Despite these general findings, there is no research looking specifically at the relationship between VT and life satisfaction in visual language interpreters. Life satisfaction is considered one of the three major influences of well-being and measures an individual's feelings and attitudes toward their life (Diener, 1984). Ideas such as perceived control, self-esteem and interpersonal relationships contribute to the satisfaction of one's life (Lybomirsky, King, & Diener, 2005). The primary purpose of the current study is to examine the relationship between VT and life satisfaction in interpreters. Being exposed to traumatic material on a day to day basis can result in experiencing symptoms of VT. In turn, if left untreated VT has

the potential to characterize every aspect of a person's life including personal relationships, values and beliefs and mental and physical well-being (American Counselling Association, 2011; McCann & Pearlman, 1990). Therefore, the current study will offer a new area of research with regards to VT in visual language interpreters. Using a correlational study, the researcher hypothesizes a negative relationship between VT and life satisfaction suggesting that participating visual language interpreters experiencing higher rates of VT will experience lower feelings of satisfaction towards their life. In addition, the researcher hypothesizes that formal training in mental health interpreting will moderate this relationship such that those who indicate that they had not received any formal training will experience higher levels of VT compared to those who indicate that they have received formal training. The participants will be given three questionnaires including a demographic questionnaire, the Secondary Traumatic Stress Scale, and the Satisfaction with Life Scale.

Method

Participants

The study consisted of 85 visual language interpreters (females =74, males = 11) across Canada. The age range of participants was 18 to 65+ years with majority of interpreters between the ages 35 to 44 (n=29). See Table 1 for demographic characteristics. The following inclusion criteria was required for participation in this study: the participant must be a certified visual language interpreter. Interpreters were recruited through the Leading Education Advancements in Deafness conference at Kings University College hosted through the Centre of Deaf Education and Accessibility Forum (CDEAF) as well as through relevant websites (e.g., the Canadian Association of the Deaf and the Association of Sign Language Interpreters). No compensation was provided, but they were thanked for contributing to the research of the interpreting profession and told the results would be posted on the CDEAF website.

Table 1

Demographic Information of Visual Language Interpreters

Variables	Interpreters (n=85)	%
Gender		
Male	11	12.9
Female	74	87.1
Age		
18-24	0	0
25-34	20	23.5
35-44	29	34.1
45-54	22	25.9
55-64	12	14.1
65+	2	2.4
Interpreting Settings		
Medical	71	83.5
Educational	68	80.0
Community	83	97.7
Mental health	65	76.5
Legal	47	55.3
Emergency	63	74.1
Conferences	60	70.6
Theater	25	29.4
Designated Staff	30	35.3
Media	20	23.5
Years of Interpreting Experience		
Under 5	11	12.9
6-10	16	18.8
11-15	20	24.4
16-20	10	11.8
21-30	19	22.4
31-50	9	10.6
Graduate from Interpreter Training Program		
Yes	75	88.2
No	10	11.8

Materials

Participants completed three questionnaires to evaluate the relationship between vicarious trauma, life satisfaction and mental health interpreter training. Questionnaires assessed vicarious trauma, overall life satisfaction and basic demographics about participants and their interpreting background. See Appendix A for demographic questionnaire.

The Secondary Traumatic Stress Scale (STSS). The STSS (Bride, 1999) measures the intrusion, avoidance, and arousal symptoms resulting from the accumulation of empathetic engagement with another person's traumatic experiences. The scale is intended for individuals working in high stress environments (e.g., mental health settings). The scale is devised of 17 items divided into three subscales: intrusion, avoidance, and arousal. Participants rate themselves on a 5-point Likert scale where 1=*never* and 5=*very often*. Example question statements include: "I had disturbing dreams about my work with clients" (indicating intrusive symptoms), "I avoided people, places, or things that reminded me of my work with clients" (indicating avoidance symptoms), and "I have been irritable" (indicating symptoms of arousal). Each subscale receives a separate score that is then included to provide one overall score. Higher scores suggest a more severe experience of vicarious trauma with Bride recommending that individuals with a score of 38 or higher be considered to have PTSD due to VT. The STSS has demonstrated high overall internal reliability ($\alpha = .93$) and moderately high reliability for the intrusion subscales ($\alpha = .80$), the avoidance subscale ($\alpha = .87$) and the arousal subscale ($\alpha = .83$) (Bride, Robinson, Yegidis, & Figley, 2004).

The Satisfaction with Life Scale (SWLS) (1985). The SWLS (Diener, Emmons, Larsen, & Griffin, 1985) measures global cognitive judgments of an individual's overall life satisfaction and is appropriate for various diverse populations (e.g., prisoners, students, those working in

mental health settings). The scale is devised of 5 items to which participants indicate on a 7-point Likert scale how much they agree or disagree with each statement where 1=*strongly disagree* and 7=*strongly agree*. Example statements include: “So far I have gotten the important things I want in life” and “In most ways my life is close to my ideal”. Responses are averaged to provide an overall life satisfaction score. A score of 20 is the neutral point in the scale, higher than 20 indicates more satisfaction while lower than 20 indicates less satisfaction with life. The SWLS has demonstrated high internal reliability ($\alpha = .87$) (Diener et al., 1985). To some degree, factors such as current mood and situational factors are likely to affect the individual’s responses. Support for convergent and discriminant validity as a measure of life satisfaction have been reported (Lykken & Tellegen, 1996).

Procedure

This study is part of a larger study regarding vicarious trauma and visual language interpreters. Upon receiving ethical approval from the King’s University College Research Ethics Review Committee, seven questionnaires were loaded onto Western’s version of Qualtrics, three of which were relevant to this particular study. Qualtrics is a private research company that enables researchers to collect and analyze their own data. Furthermore, data collected through Qualtrics is kept highly confidential. In June 2015, the researcher attended the Leading Educational Advancements in Deafness conference where recruitment papers discussing the study were handed out to all visual language interpreters in attendance ($N=80$). In addition, information was posted nationally on various relevant websites including: the Association of Visual Language Interpreters of Canada, the Canadian Association of the Deaf, the Ontario Association of the Deaf, the Western Association of Visual Language Interpreters, the Association of Sign Language Interpreters, and Ontario Interpreting Services. If interested in

participating in the study the interpreters went to the website provided where they filled out an informed consent form before being allowed access to the surveys on Qualtrics. The informed consent explained that they can discontinue participation in the study at any time and that their identity would remain anonymous through the use of identification numbers assigned to each participant. Once completed, they were thanked for their contribution to the interpreting profession and were told that results would be posted on the CDEAF website. No remuneration or thank you gift was provided.

Results

A study analyzing the relationship between vicarious trauma (VT) and life satisfaction in visual language interpreters was conducted. For the purpose of this study, VT was measured using the Secondary Traumatic Stress Scale (STSS).

First, a reliability analysis was conducted on the 5-item Satisfaction with Life Scale (SWLS). Cronbach's alpha was $\alpha=.90$ and a summed SWLS score was obtained by summing the raw scores across the five items ($M=26.92$, $SD=6.22$). Of the 85 participants, only 9% ($n=8$) scored below 20 indicating that they were dissatisfied with their life.

Second, a reliability analysis was run on the 17-item STSS. Cronbach's alpha was $\alpha=.90$ and a summed STSS score was obtained by summing the raw scores across the 17 items ($M=33.06$, $SD=14.14$). Of the 85 participants, 31% ($n=26$) scored above the cut-off score of 38 indicating that they were experiencing VT. Lastly, a reliability analysis was run on the three subscales of the STSS. To view the reliability and the means and standard deviations of all of the measures see Table 2.

Table 2

Reliability Analysis, Means and Standard Deviations of Scales

Construct	No. of Items	Cronbach's Alpha	Mean (SD)
STSS	17	.90	33.06 (14.14)
Avoidance Subscale	7	.74	13.84 (6.06)
Intrusion Subscale	5	.77	8.61 (4.17)
Arousal Subscale	5	.76	10.61 (5.10)
SWLS	5	.90	26.92 (6.22)

A correlational analysis between VT and life satisfaction was conducted (see Figure 1). A significant moderate negative correlation between VT and life satisfaction was found, $r(83) = -.40$, $p < .001$ indicating that participants who rated high on vicarious trauma frequently rated low on life satisfaction. Additional correlational analyses were conducted between VT and each of the demographic variables including gender, age, years of experience, different interpreter settings and graduating from an interpreter training program to see if any of the variables related to VT. No significant results were found.

A multiple regression analysis was conducted with life satisfaction as the criterion variable and VT, gender, age, years of experience, and graduating from an interpreter training program as the predictor variables to see if the relationship between VT and life satisfaction remained significant independent of these other variables (see Table 3). It was found that VT, gender, age, years of experience, and graduating from an interpreter training program explained a significant amount of the variance in life satisfaction, $F(5, 79) = 3.98$, $p = .003$, $R^2 = .201$. The analysis shows that VT was the only variable that significantly predicted life satisfaction, $\beta = -.42$, $t(79) = -4.01$, $p < .001$.

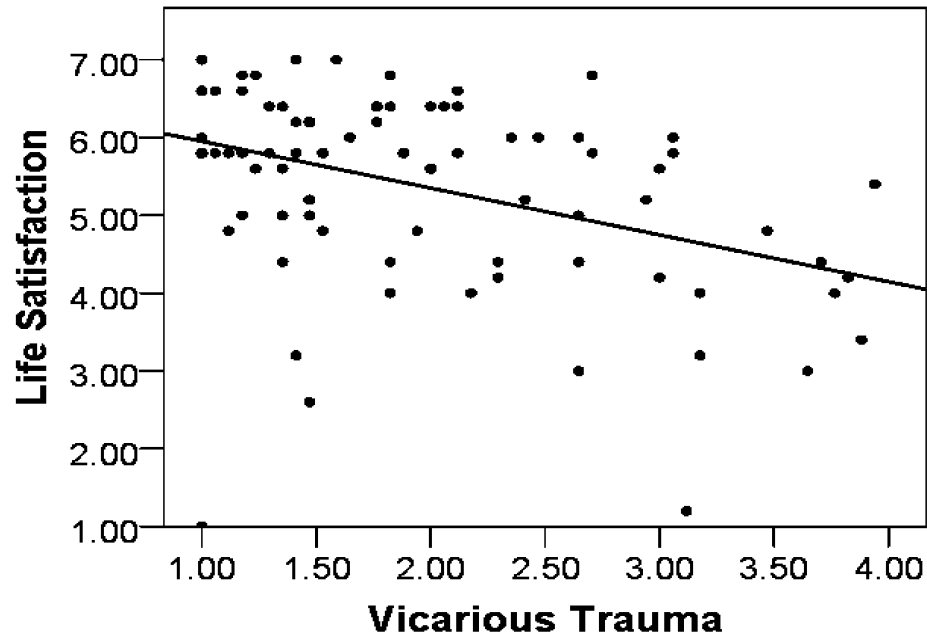


Figure 1. Relation between VT scores and life satisfaction scores. A significant moderate negative correlation was found $r(83) = -.40, p < .001$.

Table 3

Predictors of Life Satisfaction

Variable	Life Satisfaction	
	Model 1 B	β
STS	-.62**	-.42**
Gender	-.43	-.12
Age	.32	.27
Years of experience interpreting	-.06	-.07
Graduate from interpreter training program	-.34	-.09
R^2		.20
F		3.98**

Note. $N = 85$. ** $p < .01$

Additionally, the researcher wanted to test for moderation to investigate if formal mental health training moderates the relationship between VT and life satisfaction. However, due to only eight responses to this question in comparison with the 85 participants the researcher was unable to investigate this.

Discussion

Vicarious trauma (VT) is a highly detrimental condition affecting approximately 40-85% of individuals working in a “helping profession” (Mathieu, 2012). The impact of VT can be demonstrated through not only the negative consequences on individuals’ careers, but also through their values and beliefs, interpersonal relationships, and mental and physical well-being (American Counselling Association, 2011). To date, very little research has focused on how VT affects visual language interpreters; therefore, the current study was among the first to examine how VT affects the life satisfaction of interpreters working with Deaf consumers.

In accordance with the hypothesis that visual language interpreters who have been experiencing effects of VT will experience lower satisfaction with life, there was some support suggesting that VT negatively impacts how satisfied interpreters are with their life. These findings are consistent with previous research that indicates interpreters working with Deaf consumers in mental health settings experience emotional and physical consequences that in turn negatively impact their life (Doherty et al., 2010; Sande, 1998). Furthermore, in relation to Dean and Pollard’s (2001) Demand-Control schema, it is possible that when interpreters are working with Deaf consumers in high demand settings (e.g., mental health settings) with low control over the demands of their job (e.g., due to restrictions in the code of ethics), they are more at risk for experiencing symptoms of VT.

One explanation for why the relationship between life satisfaction and VT did not have a stronger significant result is the idea that individuals who experience VT also experience something called Posttraumatic Growth (PTG) (Abel, Walker, Samios, & Morozow, 2014). PTG is the idea that experiencing trauma can bring about personal growth which is described as the positive changes that can occur within the individual after experiencing a traumatic event. Experiencing PTG can increase strength and resilience, and positively change both self-perception and perception of worldview (Janoff-Bulman, 2006; Janoff-Bulman & Yopyk, 2004). In a study by Abel, Walker, Samios, and Morozow (2014) the researchers found that the more positively individuals viewed their world, the more satisfied they were with their lives. With this in mind, the positive changes in worldview experienced as a result of PTG may be related to a greater appreciation of life and relationships, thus higher satisfaction toward their life. In relation to the current study, it is possible that interpreters who have experienced a change in worldview as a result of PTG have a greater appreciation of life; therefore, protecting them from the negative consequences of VT.

An alternative explanation to PTG is the idea that visual language interpreters truly are conduits of information and are not emotionally invested in what the Deaf consumer is saying as they are more focused on the language and not the material. This is different from other occupations, for example, clinicians. It is the job of the clinician to be invested in the material and to notice the symptoms, defenses and raw emotions of the client, putting them more at risk of developing symptoms of VT (Terr, 1989). In contrast, the sole purpose of the interpreter is to act as a passive third link, facilitating communication between clinician and client (Raval, 1996). Relative to the current study, it could be that the interpreters have set appropriate boundaries for

themselves allowing them to focus on the language aspect of interpreting and less on the traumatic material experienced by the Deaf consumer.

Unfortunately, the researcher was unable to investigate if formal mental health training affected the relationship between VT and life satisfaction because only eight out of the 85 participants responded to the question on the demographic form. There is no known explanation for why this happened, it could be that those who did not answer the question had not received any formal training but that is speculative at best.

Although on average, visual language interpreters did not score in the clinical range of experiencing VT, approximately one third of participants scored above the cut-off score for the STSS indicating that they were experiencing VT. From a clinical perspective, this a significant portion of interpreters experiencing the negative consequences of working with Deaf consumers in mental health settings.

The finding that high rates of VT relate to low levels of life satisfaction has important implications for interpreter training programs when looking at including self-care components or additional resources to provide debriefing for interpreters from the traumatic interactions with Deaf consumers. Research has shown that advanced briefing before the session begins, talking to the clinician at the end of the session, and balancing time spent interpreting in mental health settings versus other settings may help in managing the demands of interpreting (Doherty et al., 2010). Furthermore, the finding that one third of participating interpreters scored above the cutoff on the STSS have important clinical implications, which posit that when working with Deaf consumers, a marginalized and oppressed population, it is important to be aware of the negative impact these interactions can have on the mental health of the interpreter.

Although the present study contributes to the literature on VT and visual language interpreters in important ways, a number of limitations should be considered. First, this study was part of a larger study that included six questionnaires, this large amount of questionnaires may have resulted in exhaustion which could explain why several participants dropped out before completing all questionnaires. In addition, because this study was addressing VT, it is possible that participants who were experiencing symptoms of VT (e.g., low motivation, loss of interest, exhaustion) lost motivation or interest to complete the surveys. Another possibility is that interpreters who were experiencing symptoms of VT avoided participating in the study altogether. A second limitation refers to the lack of incentive to participate, although participants were told the results will be made available to the public, there was no remuneration for completing the study. Thirdly, although secondary traumatic stress and VT are used interchangeably in the literature, using the STSS to measure VT rather than using a scale specifically designed to measure VT could have impacted the degree to which participants felt they were experiencing VT.

Future research should focus on the idea of PTG in visual language interpreters to further investigate the impact that working with traumatic material experienced by Deaf consumers has on these individuals. Additionally, future research should investigate different personality characteristics (e.g., neuroticism, or openness) that might be affecting the relationship between VT and life satisfaction in interpreters. Of interest might also be the impact that working in different settings has on the mental health of the interpreter; for example, comparing the effects of interpreting in a clinical setting versus an education setting.

This study offers a new area of research for VT and visual language interpreters and provides support for previous literature discussing the negative consequences of interpreters

working with Deaf consumers in mental health settings (Doherty et al., 2010; Harvey, 2001; Vernon & Miller, 2001). Specifically, the results of this study demonstrate that when visual language interpreters experience symptoms of VT, they tend to experience lower satisfaction toward their lives.

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Appendix A

***Centre for Deaf Educational Advancements Forum***Demographic Questionnaire

Thanks for completing this form.

Your responses will only be coded as a number to preserve confidentiality.

1. What is your age? _____
2. Gender _____
3. How many years have you been interpreting? _____
4. Please check all settings in which you interpret.
 Medical ___ Educational ___ Mental Health ___ Legal ___ Designated/Staff ___
 Community ___ Emergency ___ Conference ___ Theatre ___ Media ___
5. What is the highest degree or level of school you have completed?
 Some high school, no diploma ___ High school graduate, diploma or the equivalent ___
 Some college credit, no degree ___ Trade/technical/vocational training ___
 Bachelor's degree ___ Master's degree ___
 Doctorate degree ___ Other _____
6. What is your relationship status?
 Single, never married Married or domestic partnership
 Widowed Divorced Separated
7. Do you have children? Yes ___ No ___
 If yes, how many? _____
8. Are you currently:

Employed for wages ___ Self-employed ___ A student ___
Military ___ Retired ___ Unable to work ___

9. How long have you been in this current employment status? _____

10. Did you graduate from an Interpreter Training Program? Yes No

if yes, what year? _____

11. Did you receive any formal training in mental health interpreting during your Interpreter Training Program? Yes ___ No ___

If yes, was this enough training to work effectively in a mental health setting? Yes ___
No ___

12. Are you a member of AVLIC? Yes No

If yes, for how many years have you been a member of AVLIC? _____

13. Are you a member of a provincial interpreter association and if so, which one?

Yes ___ Name: _____

No ___