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## Effects of Client Trauma on Interpreters: An Exploratory Study of Vicarious Trauma

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# Effects of Client Trauma on Interpreters: An Exploratory Study of Vicarious Trauma

Submitted by Mailee Lor  
Spring 2012

## MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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## **Abstract**

This qualitative study explores the experiences of interpreters in mental health settings and examines how working with clients that have experienced torture, trauma, and war can impact their personal and professional lives. The findings from this study are not meant to be viewed as any form of incompetency that needs attention, but rather to shed light on the needs of this population within mental health settings. In working with interpreters, it is the intention of the researcher that mental health practitioners will use these findings to inform and guide their professional work with interpreters in a manner that is ethical and responsible.

A review of current literature reveals that there is not enough effective and appropriate training for interpreters; that interpreters frequently experience role conflicts while working with clients; and that interpreters are frequently emotionally impacted by the traumatic material they interpret. The literature review also reveals a gap in the research on the use of interpreters with refugee clients and populations.

Four participants were interviewed regarding their experiences as interpreters on handling traumatic client material. A content analysis of the qualitative data using inductive approach and open coding found that a majority of the participants experienced emotional, psychological, and some cognitive impact in varying degrees that they struggled to manage and cope with on a regular basis. These findings suggest that a majority of the participants have struggled or are struggling with components of vicarious trauma throughout their interpreting experiences and would benefit from more training; additional coping and self-care strategies; guidance on how to navigate changing relationships in the community; and more focus on the healing and hope that can come from their role.

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## **Introduction**

Social service agencies in the United States historically have a vital relationship with immigrant and refugee populations by being their first point of contact and helping them get connected to a wide range of resources in the community. With many immigrants, refugees, and asylum seekers coming from countries that are experiencing war and violence, it is not surprising that many need mental health services and treatment to deal with their exposure to trauma, violence, and torture.

As defined by the U.S. Department of Health & Human Services (2008), both refugees and asylees are individuals who are unable or unwilling to stay or return to their previous country of residence or country of their nationality. This is due to well-founded fears of persecution based on their race, religion, nationality, association to a particular social group, or political opinion. Whereas refugees seek protection from outside the United States, asylees travel from their home country to the United States and then apply from within United States borders for protection (U.S. Department of Health & Human Services, 2008). An immigrant, on the other hand, is a foreign-born citizen who has been approved to work and live in the United States (“Green Cards”, n.d., para. 1).

The increasing numbers of non-English-speaking immigrants, refugees, and asylees from all across the world have resulted in mental health professionals relying heavily on interpreters to bridge this linguistic gap and therefore, increase accessibility to mental health services. As outlined by the Minnesota Department of Human Services under the Minnesota Comprehensive Mental Health Acts, mental health services within the public mental health system include crisis services, outpatient mental health services,

rehabilitative mental health services, and physical mental health services (MN Department of Human Services, 2011). These mental health services are utilized to achieve a mental health level that shows positive mental functioning performance. Positive mental health functioning is evidenced through meaningful interpersonal relationships; coping and adaptability to change and hardship; and involvement in meaningful activities (Office of the Surgeon General, 1997).

With effective delivery of interventions resting heavily on the interpreters, it's startling that there is not much research on the use of interpreters in mental health and social service agencies (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). This lack of focus on an issue that has increasing need in the United States is alarming. According to the U.S. Department of Homeland Security, the number of immigrants obtaining permanent resident status in the United States has been steadily increasing in past decades. The 2009 year is no different with a total of 1,130,818 immigrants—118,836 being refugees and 58,532 being asylees (United States, 2010).

The U.S. Census Bureau found through the 2007 American Community Survey (Shin & Kominski, 2010) that over 55 million Americans do not use English as their primary language at home. From this number, over 14 million Americans self-identified that they struggled to speak and understand English (Shin & Kominski, 2010). The number of non-English-speaking clients poses a problem for those clinicians who come into contact with immigrants, refugees, and asylees and realize they need help understanding the change to the traditional dyad model between clinician and client when an interpreter enters the picture.

This paper seeks to review the available literature on the use of interpreters in mental health settings to identify trends and gaps in exploration or information. This paper will then use the findings from the literature review to further explore the use of interpreters in mental health settings and how working with clients who have experienced torture, trauma, and war can impact an interpreter who is of the same status as clients. The paper will also examine the comprehensive experience of interpreters within their organizations and within their ethnic community in relation to their role as an interpreter. By learning more about these issues, clinicians will have a better understanding of interpreter experiences within this profession and use the findings from this research to inform and improve professional practice with interpreters and clients to make it more culturally sensitive.

## **Literature Review**

### *Vicarious Traumatization in Working with Trauma Survivors*

Vicarious Traumatization (VT) is a process of change in an individual that is seen frequently in professions that not only come into close contact with trauma survivors, but who also engage in interactions that are empathic in nature (Palm, Polusny & Follette, 2004, p. 74). Through the continual exposure to explicit details of torture, abuse, and violent events, VT affects these professionals through changes in their beliefs about themselves, their world, their faith, and their psychological functioning (Palm et al., 2004; Sexton, 1999; Canfield, 2008). Also known as secondary traumatization (Birck, 2002; Sexton, 1999), VT has been linked to causing post-traumatic stress disorder-like (PTSD) symptoms or secondary traumatic symptoms that range anywhere between nightmares; withdrawal; avoidance; changes in relationships to family, friends,

community; increased alcohol use (Palm et al., 2004); burnout; switching jobs; cynicism; and intrusive thoughts (Birck, 2002; Sexton 1999; Canfield, 2008).

The effects of working empathically with trauma survivors can be debilitating and if not addressed by appropriate training, professional support/consultation, and a manageable caseload, those individuals experiencing VT will struggle in coping with the symptoms of VT (Palm et al., 2004; Sexton, 1999). As found by Canfield in his study (2008), therapists do not blame their VT on their clients. Instead, the therapists acknowledged VT as a hazard in their occupation that is inevitable. Inevitable or not, Sexton (1999), Canfield (2008), and Palm et al., (2004) all noted that individual experiences, characteristics, skills, and psychosocial makeup collectively interact to shape the magnitude and the unique way that VT affects each individual. Sexton (1999) places greater emphasis on an individual's previous experience with trauma and how it makes an individual more vulnerable to VT due to their deeper insight and greater empathy for the experiences and needs of each client they work with. In other words, interpreters are more at risk for experiencing VT and more at risk for experiencing its effects in greater severity.

#### *The Unique & Complex Experience of Interpreters Regarding Vicarious Traumatization*

A majority of the articles refer to VT in relation to therapists, physicians, nurses, social workers, emergency service personnel, lawyers, and mental healthcare providers (Palm et al., 2004; Birck, 2002; Cainfield, 2008; Sexton, 1999). Not much is mentioned about interpreters despite their role in frequently bridging the linguistic and the cultural gap to facilitate service between all the aforementioned professions and trauma survivors

who are refugees or asylees with a foreign language (Tribe & Lane, 2009; Engstrom, Roth, & Jollis, 2010; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Furthermore, Engstrom et al. (2010) pointed out that the interpreters in the mental health agencies were often refugees themselves with similar experiences of trauma to the clients they interpreted for. This similar experience and shared history and culture between the interpreter and the client do help build rapport, but puts the interpreter at greater risk for experiencing VT. This higher risk factor comes from over-identification with the clients (Splevins, Cohen, Joseph, Murray, & Bowley, 2010, p. 1706) and from interpreters revisiting their own personal and unresolved grief (Miller et al., 2005, p. 35).

Despite the higher risk for interpreters to experience VT based on their experiences, a review of the literature reveals a shortage of research on how interpreters are affected by working with refugee and asylees (Miller et al., 2005). From the available literature, there is a consensus that interpreting for refugees and asylees frequently has an emotional impact on interpreters. Furthermore, the research available discovered inadequate and ineffective training for interpreters, which leads to interpreter role conflict with the clinician and role conflict/boundary issues with the client. These issues are discussed below in more detail.

#### *Adequacy & Effectiveness of Training*

Studies (Tribe & Morrissey, 2004; Miller et al., 2005; Engstrom, Roth, & Hollis, 2010) cite the training of professional interpreters as necessary for a successful session with a client experiencing language barrier, but as noted by Tribe & Morrissey (2004), there is a disconnect in this necessary training and the desire for mental health

professionals to actually train interpreters themselves. This lack of investment and interest in training interpreters has resulted in a lack of standard guidelines for training interpreters and a lack of established protocol for training interpreters. Without training, interpreters lack communicative strategies and knowledge of best practices. Engstrom et al. (2010) found that this often led to prolonged conversations with interviewees, inappropriate questions, and inappropriate translations to both parties. Holmgren, Sondergaard, & Elklit (2003) found through a study of Kosovo-Albanian mental health interpreters that interpreters experienced crying spells, mood swings, nightmares, and detachment from family members. These emotional reactions are distressing to the interpreters and over 80% of them stressed the importance and need for supervision.

Even with formal training, Miller et al. (2005) still found that mental health interpreters were being trained on models developed for medical or legal interpreters. These models do not train interpreters in the appropriate skills and knowledge needed in an emotionally intense setting that deals with war, trauma, and violence. Tribe & Morrissey (2004) attributes this resistance and lack of investment into interpreters to the belief mental health professionals hold that interpreters will somehow know “how to do it”—but that is not the case. With mental health professionals unaware of the true need for training interpreters and with interpreters not realizing the needed training for both interpreters and mental health professionals unless they are more experienced (Tribe & Morrissey, 2004), there exists many challenges in changing this problem.

### Role Conflict

When working with clients, a strong therapeutic alliance between the client and clinician is a good sign of effectiveness (Miller et al., 2005). With the addition of the interpreter into this process, Miller et al. (2005) found that clinicians often felt excluded from the bond that develops first between the interpreter and the client. This bond of trust not only causes a role conflict between the therapist and the interpreter (Engstrom et al., 2010), but it also brings up ethical dilemmas for interpreters who are placed into a position by the clients to not only fulfill interpreting services, but also case management, transportation, and socializing services (Splevins, Cohen, Joseph, Murray, Bowley, 2010; Miller et al., 2005).

Whether or not the various mental health professionals approve of this bond between the client and interpreter depends on which model of interpreting the clinician sides with: 1) “black box” theory in which the interpreter is an impersonal translation machine; citing word for word; or 2) three-person alliance in which the interpreter is not invisible in the room, but acknowledged as being important to how the relationship and cultural awareness develops in the room between all three (Miller et al., 2005).

Inappropriate boundaries between the interpreter and the client are not the only potentially dangerous dilemmas that could impact the effectiveness of the sessions. Engstrom et al. (2010) points out that political factors and oppressive regimes in their home countries can impact a client’s response to an interpreter based on perceived or actual fear and affiliation with a certain group in the home country.

### *Emotional Impact on Interpreters*

Like many of the refugees and asylees who seek mental health services, many interpreters share the same culture, history, previous experience of trauma, and refugee status as those they interpret for (Splevins et al., 2010). Because of these shared statuses and personal experiences, many studies (Miller et al., 2005; Splevins et al., 2010; Epstrom et al., 2010) report a heightened sensitivity to the stories translated in session. This has raised concern on the ethics of using these interpreters when there is a high possibility of re-traumatizing the interpreters. This is still a debate in the mental health field. Splevins et al. (2010) found that working with clients led to both negative and positive emotions. By negative emotions, Splevins et al. (2010) meant having nightmares, experiencing distress, re-experiencing their own traumas, and intrusive thoughts about clients' traumas. By positive emotions, Splevins et al. (2010) referred to the positive growth and change that happens to a person's schema and life philosophies after encountering the traumatic material.

Miller et al. (2005) and Splevins et al. (2010) acknowledge the risks, but also point out that there are mitigating factors to lower this risk of re-traumatization. They both list factors of personality structure, coping skills, and social support as important in helping interpreters professionally and personally grow. These three factors are also important in the amount of positive growth and change an individual experiences.

### *Summary*

The literature review reveals that there is a lack of in-depth research on how refugee and immigrant interpreters are affected by their work with clients who also hold the same statuses as they do. This lack of attention is alarming given the emotional

impact, role conflicts that arise within or outside the sessions, and lack of training that interpreters have experienced as evidenced through the limited available literature on this specific population regarding this specific topic of vicarious traumatization. There is some data on how interpreters are affected professionally, but very little data on how interpreters are affected culturally or personally from their interpreting experiences with other refugee and immigrant clients. More research is needed to gain a more comprehensive understanding of how interpreters are impacted by this specific work.

### **Conceptual Framework**

This research is guided by the framework of trauma theory for understanding the impact that horrific events (i.e. physical, emotional, and sexual abuse; neglect; natural disasters; wars) can have on an individual's psychological, biological, and social systems (Williams, 2006). Each individual develops cognitive structures through their developmental years which collectively form the reality through which individuals understand and use as a framework to interpret past events, current, and future events (Jenkins & Baird, 2002). Sluzki (as cited by Hernandez, 2002) argued that individuals generally seek consistency in their understanding of themselves and consistency in their perception of the world as being orderly and safe. Therefore, when life-threatening event occurs, it drastically changes the individual's perceptions of self and world; creating confusion and identity loss (p. 17).

According to Michelle Balaev (2008), this trauma results from how an individual adapts to these horrific events and how much it alters an individual's perception of him or herself and the world. Depending on the trauma's effects, this can leave the individual

with dissociation, anxiety, depression, numbing, and an unstable internal system of arousal (Williams, 2006). These collectively experienced symptoms following personal experience to an extreme traumatic stressor such as war, torture, and violent assaults are identified as part of the criteria for Posttraumatic Stress Disorder (PTSD) in the DSM-IV-TR (American Psychiatric Association, 2000, Diagnostic and statistical manual of mental disorders).

PTSD is a reaction to trauma and is better understood through the lens of trauma theory. For an individual who is recovering from PTSD or is experiencing PTSD, events, people, and activities resembling the traumatic event or triggering memories of the traumatic event can lead to psychological distress (DSM-IV).

The trauma theory as expanded by Cathy Caruth (1996) states that trauma is found not through a specific event in the individual's past, but through the event's unassimilated nature that comes back to trouble the individual. Balaev (2008) uses the example of a film negative to parallel the traumatic experience as something that is fixed, isolated, and stored away in the brain that is hard to locate.

The constructivist-relational theory of trauma—another expansion on the trauma theory—explains this unassimilated nature of the traumatic event by pointing out that since the traumatic event is so different and out of the norm from their normal experiences, to maintain the prior cognitive schemas the individual held prior to the traumatic event, the individual will reject and not allow the traumatic event to assimilate into the prior cognitive schemas (Wrenn, 2005). In other words, the event may be treated with amnesia or as some also call it, dissociation, suppression, or repression (Hart & Nijenhuis, 1995). However, when the trauma does reappear, Caruth (1996) states that it is

in the form of repetitive flashbacks that replays the experience separate from the individual's will and desires. This being the case, Caruth (1996) states that these experiences can be contagious, cross through generations, and affect through shared narrative and shared factors such as race, ethnicity, and or gender.

This factor of having trauma history is seen as important in the constructivist-relational theory of trauma in which the therapy process is seen as an interactive and dynamic process that can impact the participating parties (Wrenn, 2005). This impact on each individual varies from individual to individual based on their developmental history and current state of their existing cognitive schemas. Therefore, the way we interpret and respond to client trauma is through the framework of our previous experiences, specifically trauma experience (Wrenn, 2005). In encountering client traumas, the individual may be reminded of their own personal and painful traumas.

With a majority of refugee and immigrant interpreters being placed in this unique situation between their own experiences and the experiences of the clients they interpret for, the trauma theory framework therefore predicts that interpreters should be impacted differently by these client stories than practitioners and professionals.

## **Methodology**

### **Research Design**

To investigate the experiences of refugee and immigrant interpreters who work with other refugee and immigrant clients, qualitative methods were used in this study. The specific qualitative method used to gather data consisted of semi-structured interviews conducted at a conference room or private room within a public library, community center, or community agency. These interviews included a combination of

rapport-building conversation, close-ended questions on demographic information, and open-ended questions on interpreter experience through working with other refugee and immigrant clients. The close-ended questions on demographic information asked about the participant's ethnicity, country of origin, language of interpretation, age, and specific year the participant arrived to the United States, experience with or exposure to trauma, and training history (Appendix A). The nine open-ended questions regarding each participant's experience with vicarious trauma through their work with other refugee and immigrant clients are also listed in Appendix A.

### **Sample & Criteria & Recruitment**

This research used nonprobability methods to select participants living in the metro area of Minneapolis/St. Paul, Minnesota. The specific samplings used were criteria sampling and expert sampling. Initial participants were found through a less invasive procedure where community agencies, Minnesota Department of Health (MDH), and interpreting programs serving the metro area were selected and contacted through phone or email. The willing agencies, programs, and/or departments then passed on the research study flyer (See Appendix B) to their contacts or interpreting staff. This method gave interpreters the opportunity to self-select and contact the researcher for further information if they were interested. A copy of the recruitment script is available in Appendix C. The criteria participants needed to meet were:

- a) Be over 18 years of age
- b) Currently or previously had professional experience as an interpreter for at least one year
- c) Have personal experience with or exposure to a traumatic event that is either related to war, violence, or torture
- d) Live in the United States for at least five years
- e) Have professional experience in settings involving mental health

This criteria used to qualify participation was set in place to not only properly address the topic of this study, but to also better protect this vulnerable population. Non-minor status and a resettlement period of over five years are both important to ensuring that participants are less vulnerable to the possible risks of participating in this study (Gonsalves, 1992). Following contact from an interpreter interested in participating in the research study, the researcher used an interpreter script (See Appendix D) to explain the research process with the potential participant.

### **Protection of Human Subjects**

The protection of these participants was taken into careful consideration throughout the entire research process from formulation to analysis to presentation of data. In recruiting possible participants, the researcher was thorough in explaining the purpose of the study, the types of questions that would be asked, and the possible risks that could happen due to participation. All participants were fully aware that their

participation was completely voluntary and that any shared information in the interview would be confidential.

In discussing the research study, the researcher walked the participant through the consent form (Appendix E) and answered any questions the participant had concerning participation in the study. In interviewing participants, the researcher made sure each participant knew that they could choose not to answer any of the questions asked and that they could stop the interview at any time. The researcher was active in looking for any visible and obvious indicators of mental distress and discomfort in facial expressions and body language throughout the interview as a sign that the interview would need to end and the specific participant's data excluded from analysis. The participants were informed that the participant's decision to end the interview would not affect their current or future relations with the University of St. Thomas and St. Catherine University.

At the end of the interview, the researcher debriefed the participants for ten minutes to address any stress or concerns that may have been brought on by the interview session. A compiled list of three agencies and the contact information for the chair of the researcher's research committee were listed in the Consent Form (Appendix E) for each participant to contact for further help.

In handling the confidential information, the researcher made sure participants were aware and gave consent for a transcriber to have limited access to the recorded interview for the sole purpose of transcribing the audio records into text. Before transcribing the records, the transcriber signed a confidentiality form stating that they would not disclose any information received through transcribing the records with anyone else besides the researcher. After the audio files were fully transcribed, the

recordings and audio files will be destroyed from both researcher and transcriber's possession no later than August 1<sup>st</sup>, 2012. The transcripts were kept in a password-protected computer that only the researcher had access to.

### **Data Collection & Analysis**

The interviews were audio recorded and later transcribed into text. Any possible identifying and sensitive information were removed or altered to prevent identification and ensure confidentiality in the transcripts and data analysis. As mentioned, all transcripts were kept in a password-protected computer with the researcher having sole access to them. The transcriber's files were also kept in a password-protected computer in their house.

To analyze the data from the interviews, the researcher completed a comprehensive content analysis on each transcript. Content analysis is a research technique that makes qualitative data more systematic, objective, and distinct. This is achieved by the researcher examining and identifying a pattern or trend of certain themes and concepts that appear throughout the transcripts. To identify themes and concepts, the data were coded first with open coding and then later restructured into categories and subsets within these categories (Stemler, 2001). These themes were then compared to the available literature and appropriate theories to explain and discuss implications of findings.

## **Findings/Results**

This research was designed to explore the experiences of interpreters within mental health settings who have past or current experience working with clients that have experienced torture, trauma, or war. For the research study, four interpreters participated in interviews during February and March of 2012. Out of the four participants, two were men and two were women; all four ranged from late 20s to early 70s years of age and had interpreting experiences ranging from three years to 30 years. All four participants had experienced or witnessed some form of trauma that ranged from having their village burned to clan conflict to dictatorship to experiencing military combat, torture, and being imprisoned. The participants identified their language(s) of interpretation to be Spanish, Karen, Vietnamese, Somali, and French. All participants stated that they had had some form of training either through interpretation courses, from supervisors, or through conferences. This demographic information is provided to not only give some context to the responses and findings of this research study, but to also emphasize the diverse and expansive experiences of each interpreter.

The following findings presented in this section is developed from the responses of these four research participants to the Interview Questions in Appendix A and are organized into three overarching themes: 1) experience within the person; 2) experience within the profession; and 3) experience within the community. Within these three themes, there are also some sub-themes that continued to come up within the interviews of a majority of the participants.

It is important to keep in mind that the terms client and patient are used interchangeably throughout the Findings section.

### **Experience Within the Person**

The first major theme is titled “Experience within the Person”. It has two sub-themes that expand on how the four participants were personally affected by the traumatic client material presented in sessions throughout their interpreting experiences.

*Emotional impact.* All four participants spoke of experiencing some form of change in their mood, behavior, and/or emotion that they couldn’t fully control. These changes varied in frequency, severity, and type of change with respect to each participant’s unique experience. At home, three of the four participants experienced crying and nightmares. At work, the same three participants experienced crying, sadness, and physical tiredness at the problems they heard. One participant talked about her struggle with this while interpreting: “When I translate—when the sick people, they talk about their problem and then when I hear that—if I cry right away, I won’t feel like I have a headache. If I don’t cry and try to keep my tears back, I feel like headaches sometimes. When you hear war you feel your body so tired.” This participant goes on to describe crying, having pain in her heart, and experiencing nightmares as three changes that she primarily encounters. These primary symptoms vary from participant to participant, but overlap in some areas.

One participant lists crying, shutting down, and feeling tired or sleepy as the three primary changes. Another participant lists nightmares, intrusive thoughts, and having

butterflies in his stomach during moments of intense client material. He remembers that “right after lunch at 1:00 PM, we had a patient. Even though I had my lunch—very filled up—the patient will talk about something very sensitive; something very touching, anxious, I will feel in my stomach like butterflies.” This uncontrollable feeling also appears to him in the form of intrusive thoughts that he will remember even though he didn’t want to because “it’ll just come and pop into your mind like something unimaginable like destructive crimes all day. Even though you don’t want to remember, it’ll come.”

Hearing some of the traumatic material seems to heavily impact the majority of these participants at work and follow them home. One participant who did not speak much of emotional impact at work was able to share his emotional struggle during interpreting moments that reminded him of his past trauma. This participant shared that although he found it to be a necessary strength that “what they went through, I went through...we were on the same boat so they have nothing to hide,” he also acknowledged that “sometimes when there’s bad stories in the camp—the life after being released from the camp; it was also like a prison too—I had some feelings that I got hurt because it reminded me of those bad events in [country].” This issue of similar experiences or relatable experiences from this particular participant’s experience is also echoed by the other three participants as well.

The majority of the participants found that hearing stories that remind them of personal experiences made them not only think of their own experiences, but also “feel more sucked in because it had some personal reference...and was close to home.” This sentiment by one participant is also shared by another:

The hardest thing is some story when they bring out is very hard to listen. I'm just like, oh my God. It's very hard to open my mouth to speak it out; it's very hard. I just feel like it's very painful. It reminds me when I was a kid; we had to run too many times in the jungle. It reminds me of my neighbor when I live in [country]. It reminds me of the story of [country] that I've been through. So that's the hard one.

Another participant talks about his struggle to forget certain incidents, but can't help but be reminded of them from other clients at work because "I can relate to them. You might have a friend, family member, or neighbor who has just seen the same thing. You don't want to remember that and yet somebody else is doing the same thing here [work]—taking you back to the incident and you have to interpret and be actively involved in the vocal part and talk. So, it's not easy."

This struggle to not only manage the impact of hearing and interpreting traumatic client material, but to also separate personal content from professional content is a very difficult one. In fact, this struggle is so difficult that three participants shared how they would question their career choice. One participant details how "in the beginning, I was sometimes thinking what should I be doing this for? Money? I was asking myself if I should stop and get something more interesting and less damaging, but later on, as a trained person, I said this is the right thing you can do. I should continue...I'm a sponge and now I'm filled."

Another participant struggled with whether or not to stay when she deals with political clients that remind her of her past:

My political views were such that—if it was coming from a country that was right-winged government, I would feel OK; we were all in the same thing. When I had to deal with people from countries or situations that came from the other side—a Leftist or Marxist—then I would be like, you know, wait a minute. Sometimes you end up dealing with people who were victims of torture but had been torturers themselves or had been part of the military themselves, I would get all of these things like...why am I doing this again?

Although this participant along with three other participants struggled at some point or another—more so in the beginning—about whether they should stay or go, the two participants who had over 30 years of interpreting experience (in various settings) found that time is a crucial factor in better managing and coping with these various struggles that were brought up. One participant said trial and error helped throughout his experience. Another one felt that “Later on, you get more experienced. Almost 90% of the things going on here are things I’ve seen. I’ve known worse know. In the beginning everything was new, you know? Yes, that was hard to digest and hard to understand and cope. Now it’s easier—getting easier as you go.”

This emphasis on time is supported by the majority of participants as something that allows for them to learn from their mistakes, get more accustomed to hearing trauma stories, get further training, and get better attuned with their own internal signals. One participant identifies the importance of trial and error in developing her internal monitoring system: “You learn from your mistakes. I think it takes a while, but there are people who don’t develop—and I’m talking about nothing to do with emotions—but just from the point of view of the internal monitoring of the interpreter. There are people who

never develop that.” This particular participant and two other participants point to time as a strong factor in not only fostering professional growth and development, but also as a factor in strengthening their motivation and feelings of responsibility to keep staying in the interpreting profession.

*Changing views.* Three participants noticed that their views had changed. One participant in particular identified that she was more protective of her kids and was hyper-vigilant. She also noticed that she had what she called ‘modified survivor’s guilt’ and would not want to complain because she knew other people were going through rougher things. Her desire to not be reminded of some of the heavy and troubling material resulted in her being selective in what she watched and what she did.

I would love to watch stupid shows where I don’t have to think about anything, and it’s like, I don’t want to go to a violent movie. My kids would always say things like, oh mommy you shouldn’t go because you’re not going to like it—it’s too violent. It’s not that I can’t take violence, I can but there’s a certain kind of violence I cannot deal with, but then there are other times when it doesn’t matter. OK, that’s what I say; I’m going through a Doris Day state. All I want to know is that we’re happy, everything is perfect, Leave It to Beaver. I would deal with things like that, that way.

On the other hand, the other half of the participants experienced a more positive change and growth of their views. Two participants felt that they had not only increased mental health knowledge, but they had also increased their ability to regulate their own feelings in session and outside of session. As one participant stated:

Before I translate about the mental health, I don't know about it, so I just feel like I'm sad. Then after I translate here, I know this hard thing, we have people to help. Because back in our country we don't have therapy. Other people would say, she's crazy, she just don't know how to control herself. She's just follow her heart, whatever she wants to do. But in here it is a sickness. I feel like I know more how this world how people is feeling. It's very helpful. I feel it's very good. It helps myself, helps my feeling, and helps my community...The most I love is help the people open their feelings and then just like I said, before I don't know that mental health word. I just know people out of their mind; crazy. When I translate them I feel like I know more about that so it's very helpful and help myself how to be better, help my family how to talk to my family. It helps when I see the other people have that, so I don't have the thinking that I think before, 'these people are, maybe they out of their mind' I don't have that so I feel like my skill inside is improved.

This change in previously held beliefs and change in knowledge is something that these participants identify as positive and helpful for themselves, their families, and their community.

### **Experience Within the Profession**

The second major theme has several sub-themes that a majority of the participants made use of or experienced within the profession.

*Importance of clear boundaries.* All the participants except one participant continually emphasized the need to maintain clear boundaries between themselves and the clients in the work setting and in session. The three aforementioned participants identified different sitting positions; constant transparency; continuous reminders to clients before, during, and after sessions; being emotionally neutral or impartial; and staying away from advocacy roles as all strategies to avoid dual relationships and set clear limits on their sphere of influence and role responsibility.

Among other strategies, two participants used their physical body to emphasize their neutral role. One listed sitting behind the client as a method to help the client maintain boundaries. In session, the participant would “just sit right behind—a little bit behind—and instruct in the beginning: ‘Look at the provider; I’m not the provider. I’m just interpreting both languages. Think about that; I’m not here—I’m a ghost. I will just repeat like a tape recorder.’” The participant went on to talk about sitting beside the client so they will not have eye contact with anyone but the provider. This particular participant lists this method as a way to not only maintain clear boundaries, but to also protect himself. In his own words, the participant states that “I don’t want to get damage to myself or ruin the session so I would sit beside the patient so the patient will not have to have any eye contact with me—so the patient will look at the psychiatrist.”

A more common strategy that was used by a majority of the participants included the verbal reminders that each of the participants gave to the clients they worked with. One participant summarized their routine conversation with clients by saying that:

I make introduction in the beginning about I'll be confidential my job is to do the language here and translation everything correctly...I'll just remind them: As the interpreter I will do everything in confidential. I have nothing to do with—I can't...and that little thing brings up...if I meet you in the community I'm not the interpreter; I'm a community member.

This typical conversation is one that a majority of the participants used frequently; especially when cultural factors within the specific community came up. One participant shared that he ran into more unique problems that were relative to his community's situation and problems. This particular participant identified that earlier on in his interpreting experiences, people would ask when they came in:

Oh, which clan do you belong to? They want to know and it's their culture—it's part of their life back home. As soon as they see you, it doesn't take a minute if you talk...they can't understand who you are...they ask you right away. We educate that to them too. Why do we need clan here? Doesn't make sense to me and they understand.

This participant doesn't want to bring in clan issues into the workplace, but readily acknowledged that issues like clan membership created a sticky situation for interpreters like him who may not have been directly involved in the conflicts within their home country, but who knew of "the injustice they [the different clans] have done to each other, you know? So I'll try to stay neutral, but again, how is this possible when I don't know the provider, but I know this person and everything?" Despite these issues and cultural factors that come up, this participant's education and emphasis on maintaining a neutral

role with firm boundaries is something that a majority of the participants agreed as necessary.

The fourth participant agreed that boundaries are important, but also strongly emphasized the essential need for interpreters to understand where the clients have been and what they've been through to get clients to open up about their problems. He shares how having this shared similar experience helps bring both clients and interpreters closer since:

“We were on the same boat...it is very interesting because the fact that you understand the patient, they are more open to speak about their health problems and their trauma with the doctor—especially the psychiatrist or psychologist. So uh, we're very comfortable—the patient feels very comfortable to see me because they know that I am one of them and they know their problem and that their problem is also my problem.”

This shared history and experience is something that this particular participant feels as central to his skills of being a good interpreter and defines his role of being an effective interpreter. The other participant, however, identified their desire to separate their personal experiences from the experiences of the clients. The maintenance of boundaries for their neutral role helps with this separation, but also ends up making them feel helpless but responsible for the clients. One client summarizes this struggle when she shares that:

I think that interpreters feel helpless in that sense...we don't have an active role in the situation [treatment and prognosis] and we are the only ones who don't...we

cannot afford to do that. I know that there is a blur in there but we cannot give our input in the situation and everyone else can...you are helpless in front of that situation...you have to force yourself to fight your desire to make the therapist do something...it's an impossible mission because there is really nothing you can do.

Although this particular participant struggles with wanting to have a more direct impact on the client, she also acknowledges that going beyond the neutral role of an interpreter is something that she can't afford. She addresses this with other interpreters who she has seen take on advocacy roles as an interpreter: "I think that the more they become an advocate, the more you're susceptible to these things." This sense of being stuck between a rock and a hard place is something that has again caused a majority of the participants to question their career choice. Another participant echoes this frustration about his struggle to maintain neutrality and be emotionless in session: "Sometimes patients will cry in front of you and you're supposed to show emotionless. But in interpreting you **can't**; you have to be neutral. And the patients will think you are a bad person who doesn't have any emotions; not human at all."

Despite their feelings of hopelessness, all three participants who felt helpless also stated that they felt responsible for the clients' well-being if they left. One participant's concern if he leaves is that "if I leave, who's coming here? Many states don't have many schools or any formal training at all. So I just say like, 'I'm good at doing this...I just have to go on with this. There's a big demand.'" Another participant echoes this concern that "If I don't translate for them, then they have to hold all of that [problems and feelings] and nobody will help them." These concerns seem to reflect the time factor

brought up earlier and are concerns that the participants list as a motivation for continuing to stay and interpret despite their struggles.

*Provider struggles & support.* All the participants felt they were able to go to their supervisors or providers when struggling with problems. One participant mentioned how hard it was to seek help in the beginning of his interpreting experience, but found it easier as time went on. Half of the participants identified that they got some form of training from their supervisors and were able to approach them if they were struggling. One participant felt that “if I can’t sleep in the night or I know it’s gonna come back to kick me, I’ll talk to the provider. And the psychologist shows us how to let go—breathe and like that.” This teaching of breathing techniques and strategies by providers and/or supervisors has been identified as one of the most useful and helpful supports that the participants received.

Not only did half the participants use it to help themselves, but they also brought it home to help with their family members and friends in the community. One participant shared that when “I learn it [strategies and techniques] from therapy on how to do that. If I go home and somebody have the pain or that sickness, I tell them to do it this way.” The participants agree that the support from providers and supervisors are very important.

Two participants mentioned that they had some struggles with providers not being fully mindful of the compromising situation they put interpreters in when they left the room to talk to staff outside; leaving interpreter alone with the client. One of those aforementioned participants also felt that debriefing was not being conducted according to what interpreters needed. She shared the frustration that “most of the time the way

things are approached in terms of debriefing is from a clinical or administrative point of view that has nothing to do with what the interpreters need...” and went on to suggest that “the agencies go to interpreters who are willing and interested to set up guidelines as to what they need.” This suggestion of guidelines is something that half of the participants felt would be very helpful to them.

*Self-care.* Given the emotional intensity and struggles all the participants experienced within the job, a majority of them employed several coping strategies to manage the emotional impact and improve self-care. A majority of the participants identified helpful strategies they found useful and helpful: doing breathing exercises; taking a small break in session by either using the bathroom, getting a drink of water, or just stepping out for a breather; talking to interpreting peers and coworkers; and having an internal check system to check if they are thirsty, have to use the restroom, are yawning or sleepy, and/or hungry. Many participants found these strategies to help recover. As one participant stated, “Sometimes, if I can’t take it and it’s too much—maybe they’re going too deep in that situation and I can barely interpret—I just say I need ten minutes to go out.” Another participant also shared that during those challenging moments, “You go out for a minute—to bathroom or something—just to break down that and come back to restart. And you are more stronger.”

Besides the helpfulness of these strategies, some strategies such as the development of the internal check system seems to help a few of the participants be more mindful and connected to their body and what it’s trying to tell them. One participant noticed that this method helped her to really identify what she was struggling with:

Checking ourselves physically is one that I think works for a lot of us. Do I need to pee and do I need to drink? There's a very fine line there. Am I hungry? The yawning—where does it come from? I'm not really tired. That's another thing that makes me realize. When I start yawning a lot, it's not that I am bored or tired, it's something. I mean I might be yawning because I had two hours of sleep last night before, but for the most part...the more anxious the guy is, the more I yawn.

This mindfulness that some of these participants utilize helps them better address and resolve their struggles in the moment during the session. Similar to the body signals some of the participants experienced, two participants noticed their linguistic struggles as an interpreter to also be a sign of something. One participant shared that “when you start feeling like it's getting to you, you have a harder time coming up with the right word or I feel that I'm lagging behind...linguistically something is happening because I am not focusing.”

Another powerful way to help with self-care is the interaction and support of interpreter coworkers. The majority of participants emphasized how valuable their interpreter coworkers were. Half talked about the helpfulness of using interpreter coworkers for professional and personal support. Not only did their peers exchange similar personal struggles or client struggles—while being respectful of client confidentiality—but they also gave encouragement and emotional support to each other. Like one participant stated, “Talking to interpreters helped a lot; people who could understand what I was talking about, which is a bit different than talking with—you

know, any of the health professionals that were there.” This particular participant further gave an example to show the unique support his interpreter peers could give:

I get mad about a session that I had with a couple ...I'll go back and talk to—tell them [interpreter coworkers] that this person etcetera etcetera etcetera. Another interpreter will say, ‘I had like that.’ Another interpreter will say, ‘Oh why don’t you tell them to calm down or have provider talk to them. Don’t feel sad, it’s OK.’ All this, you get.” This support each interpreter has for another in encouraging; keeping humor alive; and helping each other to solve problems is identified as a core support for a majority of the participants.

Another strategy that did not come up yet, but was used in varying degrees by two participants included the use of distractions and detachment. One participant shared her usage of both strategies:

If you focus on the linguistic aspect, you can detach yourself...but if I need to maintain focus, I need to bring something else that is totally unrelated, and keep a backside story so if it gets too bad, I think about things I have to do at home, especially the ones I don’t like; like laundry or things like that...I have to distract myself a little to focus; or something that is very pleasant to me or something that I am looking forward to.

This particular participant found these strategies along with her decision to do only simultaneous interpreting helped her cope emotionally while on the job because “to do anything but simultaneous is very taking on its own...but it helps because you are

focusing so much on what your task is that you are not sitting there trying to...absorb what the person is saying and getting all...you know, part of it.”

Overall, many participants shared several coping and self-care strategies that helped them to effectively address their unique struggles within the workplace.

*Hope and healing.* All participants brought attention to the rewards of interpreting. A majority of the participants spoke of the progress they saw in some of the clients as time passed and noted the positive changes in each client at the beginning compared to the end. One participant shared:

Some patients in the beginning—very emotional and crying. Later on in the end sometime, they will be calm down and be stronger...sometime it's a much longer process...you go through that with them. In the beginning, you're scared. You're worried for them. You're doing your job. You see all their layers; their pain. Today, they're not crying; it's good.

Another participant reflected on the journey each client was going through and how positive and beneficial it was:

They don't have to go back through their bad experiences and hardships they went through. Every time—they only go through a different phase now; they're internalizing now—they're different; they're stronger now. In the beginning, they're so emotional and crying, but now, they're digesting the bad stuff...they're getting support now.

The shift in focus from the trauma each client has been through to the progress each client is making gives a sense of hope that gives meaning to the emotional struggles and challenges that the majority of these participants found very satisfying. In addition to this happiness at the progress the clients are making, another participant found great reward in seeing the satisfaction in the clients' and providers' faces:

There's a lot of rewards working with the patients...I think I do a good job because I see in their face—they're very satisfied. And they say thank you. It's not that kind of thank you, but I understand that they're very happy to have me as the interpreter...it is a reward when they ask me as an interpreter and um, you see their joy in their face when you do a good translation interpretation for the patient.

In addition to seeing the growth in clients, this particular participant emphasized the satisfaction the clients had towards interpreters. Half of the participants also shared how important personal growth and healing can be in paralleling what is being taught in counseling. One participant noted the appreciation and value of what interpreting in counseling did to her own personal healing:

Deep breathe. I deep breathe a lot. I learned it from my supervisor—when she gives the counseling to the client. So she ask them to deep breathe and I learn from that. I take a deep breath; it helps. When I get home, sometimes I think about the problem; I cannot sleep and I try to do [deep breathing]. I take that and I learn...all that is therapy—the knowledge. I learn it from them [therapist]. I just do it and help myself.

This particular participant brought attention to the fact that there is not only healing and positive change for the clients within session, but that there is also healing and positive change for the participants who used the modeled skills and relationship within counseling to help herself with her own symptoms.

### **Experience Within the Community**

*Navigating relationships while maintaining a neutral role.* The way the participants negotiated their relationships in the community varied from participant to participant based on their ethnic community culture; how big the community was; and how connected they were to their own community. For one participant, he shared that “When you meet people in the street or community centers, I see them and have to look away because in our culture, they’ll say what do you think will happen?” In order to enforce or extend the neutral role at work to outside work, this particular participant shared that “Outside, it’s the same thing. We can talk, greet each other, pray together, but I would avoid actually sitting down with patients and maybe befriending them because if you have close friend with someone, you can’t be interpreter here. You may hear things you don’t want to hear outside.” Another participant echoes this sentiment of not wanting to be close “because this friendship will undervalue your professional distance and your job from here—and they’ll think you’re a close friend.”

Compared to the two aforementioned participants, the other two did not struggle as much with this issue because one was not connected to their community and the other

felt that his role as an interpreter made others feel closer, more confident, and more respectful towards him in the social and community setting.

## **Discussion**

### **Comparison of Findings to Literature Review**

This research set out to explore the comprehensive experiences of interpreters who have past or current experience in mental health settings with clients who have experienced some form of torture, trauma, or war. The qualitative interview questions were asked to better understand the participants' experiences interpreting traumatic client material and how these experiences have affected them personally, professionally, and culturally within the ethnic community. One area of interest also explored included the types of support and coping strategies available and used by the participants. This section will be used to compare the Findings to the Literature Review.

The themes that emerged from the research data regarding the participants' comprehensive interpreting experiences indicated that a majority of them struggled with issues related to physical and psychological changes; behavioral changes; and some changes in the way they looked at themselves and the world. These physical and psychological changes ranged from hyper--arousal symptoms (nightmares, trouble sleeping, trouble breathing, trouble concentrating); avoidance/sensitivity to certain types of violence; and intrusive thoughts or imagery of client material. The behavioral changes that the majority of the participants struggled with was setting boundaries and separating work from personal life. Lastly, a majority of the participants questioned their purpose and meaning as an interpreter and their sense of helplessness as an interpreter in creating

change and making an impact. Although a majority of the participants did not experience changes in their views of safety or trust, one participant did experience these changes to the point where she was more protective of her children.

This variation in individual experiences is reflected in other areas as well. While a majority of the participants struggled with intrusive client material, half of the participants stated that the client material would also lead to the triggering of their own personal traumas. This triggering is something that could lead to re-traumatization, especially if the grief is unresolved; something that Splevins et al. (2010) and Miller et al. (2005) cautioned as something that could happen. Taking this finding into consideration, one area to further explore is how primary and secondary trauma interact with each other in this particular situation and setting.

These findings support a majority of the research studies (Palm et al., 2004; Birck, 2002; Sexton, 1999; Canfield, 2008; Splevins et al., 2010) that discussed the presence of these changes as components of vicarious trauma that comes from not only from continual exposure to explicit details of torture, abuse, violent events, but also exacerbated through having shared experiences or shared status with their clients.

The unique factor of having shared experiences or shared status is also another theme that emerged from the research data. All the participants shared that having similar experiences or shared history with the clients was a mix of emotions for them. A majority of the participants found a lot of satisfaction and hope in seeing the progression of change in clients throughout time; supporting the positive emotions that Splevins et al. (2010) mentioned as part of the vicarious post-traumatic growth (VPTG) that can occur

from experiencing positive changes from working directly with trauma survivors. On the other hand, regardless of whether the participants used a simultaneous or consecutive mode of interpreting, a majority of the participants struggled to stay neutral and struggled to not only be unaffected by the experiences of the clients, but to also manage their own thoughts and emotions related to their own personal experiences that were triggered by the clients' stories.

This managing of their own thoughts and emotions in sessions seems to be countertransference from their own unresolved traumas or from having shared identities with clients and could be an indicator that a) these particular issues are not getting addressed in training and/or b) the interpreters are not getting enough appropriate training from their agency to work in mental health settings. Through further training, those interpreters who have unresolved traumas or those who have shared characteristics (history, culture, trauma, or struggles) with clients can learn how to effectively manage their own countertransference while in session with clients.

As two participants stated, they were able to learn and make personal use of coping skills and emotion regulation techniques that they learned through observation in sessions with clients. This finding indicates the need for these participants to get further training to learn the skills outside of interpretation sessions and not just from observation in the interpretation sessions. Training interpreters to recognize and manage their own countertransferences is something that should be further explored in research.

This emergence of countertransference in session is something that conflicts with their role as an interpreter to stay neutral. As stated by a majority of the participants, the

desire to help the clients or improve their situation is something that many of the participants found themselves wanting to do. Given the shared identifications with the clients, the majority of the participants felt a deeper connection with the clients in some way or another and therefore, experienced a greater struggle to separate the personal from the professional and manage their own reactions.

According to a majority of the participants, this struggle to manage their own thoughts and emotions does gradually improve with time. Many participants felt that with time, they were able to learn from their mistakes, get further training, become less sensitive to client trauma through extensive exposure, and resolve or affirm their motivation to stay within the interpreting profession. All the participants also stated that as they gained more training, more experience, and more skills as an interpreter, their obligation and feelings of responsibility to continue interpreting for their community also grew.

The impact from over-identification and shared experiences supports the Miller et al. (2005) finding of increased vulnerability and susceptibility to experiencing increased emotional impact from having shared culture, history, previous experience of trauma, and/or shared status of refugee. Due to this shared culture and shared factors, the navigation and negotiation of relationships within the ethnic community is something that emerged from the data, but was not addressed in the available literature. Doing more research and exploration into this particular setting would be beneficial for providers to know and address with interpreters who work with such high confidentiality and neutrality in the work setting. In addition, a majority of the participants shared that they did a mix of interpreting—medical, court, social services—in addition to mental health.

Since the participants have multiple interpreting roles known to the community, it would also be important to explore how interpreters are navigating between these multiple roles at work and within the community.

It is important to note that all the participants used the terms *simultaneous* and *consecutive* as the model for interpreting as compared to the “black box” or three-person alliance models that Miller et al. (2005) referred to. The participants defined *simultaneous* interpreting as oral interpreting that happens at the same time the client is speaking whereas the *consecutive* interpreting happens at a stop and go pace where the interpreter and client and provider take turns to speak. However, the “black box” model has strong resemblances to the *simultaneous* model while the three-person alliance model has strong resemblances to the *consecutive* model.

Similar to managing the emotional impact, there were other cultural and political factors that came up that threatened neutrality; the client’s willingness to use the interpreter; and possible triggering of past traumas. This finding is supported by Engstrom et al. (2010) as a potentially dangerous dilemma that could impact the effectiveness of the session.

Miller et al. (2005) and Splevins et al. (2010) emphasized personality structure, coping skills, and social support as three important factors that could help mitigate the distress and re-traumatization of interpreters who have previous experience of trauma. The findings strongly supported the use of coping strategies as an important method to help with the challenges they faced from interpreting. The strategies used by the participants had strong overlap with a few individual exceptions from participant to

participant. All participants stated that these strategies helped them manage and lower the emotional impact experienced during sessions. Despite the use of certain strategies in session and at work, all the participants did not identify other coping strategies or self-care techniques that they used outside of the job to minimize the impact or stress from doing interpreting. Half of the participants used knowledge of mental health, relaxation, and breathing techniques to help minimize the impact, but a majority of them also indicated that they just had to withstand their struggles or get out of that specific area of interpreting.

The training of the participants varied based on personal motivation for continuous learning and agency emphasis on training. The majority of participants thought they could always use more training on mental health and half mentioned the lack of standard protocol to guide them. In addition, all of the participants had worked in other settings before that did not include mental health. Their previous trainings for these other settings could have influenced their interpreting experiences. More research into what kind of trainings interpreters are bringing into mental health settings would be important to compare with their experiences. This finding of wanting more training supports the research of Tribe & Morrissey (2004) and Miller et al. (2005) that although interpreters were trained, some of them were being trained on models for medical or legal interpreters and therefore, lacked the appropriate skills and knowledge to work in an emotionally intense setting.

## **Recommendations for Future Research**

Overall, the literature review of interpreters' experiences was supported by the findings. An analysis of the findings brought up some themes that weren't present in the available literature on this specific topic. Some recommendations for further exploration and research are listed below:

1. Further exploration of coping skills and self-care strategies for interpreters. A majority of the participants identified using breathing and relaxation skills learned through observation in the therapy sessions, but did not identify other means to minimize impact outside of work besides withstanding the distress or using avoidance to cope.
2. Research more into the specific trainings of interpreters in mental health settings and examine how agencies or clinics provide supervision and provide training. In addition, hold agencies and providers more accountable for providing appropriate supervision and training to the interpreters they seek services from.
3. Explore the specific needs or supports interpreters need in place to do the job without unnecessary damage.
4. Further research into how interpreters are handling dual relationships in their community—especially if the interpreter is from a newer or smaller group

5. Explore further how observation of the progression of healing in therapy for client traumas and struggles affects interpreters who also have their own trauma experiences.
6. Explore more the positive emotions that Splevins et al. (2010) found some interpreters to experience from interpreting. The findings found these changes to be a source of healing and growth for the interpreters who noted this.
7. Explore effective ways to incorporate countertransference into training and supervision of interpreters.

### **Implications for Social Work Practice**

As social workers who provide mental health services to diverse communities, it is important to understand that the increasing numbers of immigrants, refugees, and asylees in the United States will have social workers needing to rely on and collaborate with interpreters to effectively deliver resources and treatment. Without proper investment into the knowledge, skills, and emotional well-being of interpreters, social workers are not considering their responsibility as mental health professionals to help interpreters help mental health professionals do their job effectively.

These findings show that interpreters experience a unique set of challenges that are not fully or consistently addressed by mental health providers and agencies. As mental health professionals, we can use this information and these findings to start a dialogue to set protocols and standards in place within agencies or clinics that make use of mental health interpreters. As mental health practitioners, we realize the importance of

practicing self-care; managing transference/countertransference; and resolving our own personal traumas as three factors that are all important to our own mental and emotional well-being. This standard should not change for mental health interpreters who are not only hearing the same material we are hearing, but may also share several other identifications with the clients besides sharing the same language. Ensuring competent and effective interpreting skills is very crucial, but as mental health professionals, we should not overlook the emotional or mental harm that interpreters may be experiencing despite their exceptional interpretation skills.

Given the emotional impact and shared histories, experiences, and cultures of some of these interpreters, these findings can be used to form trainings, discuss in supervision, or discuss with interpreters when social workers are the mental health providers themselves.

### **Strengths & Limitations**

The strength of this research study is that it addresses and examines a particular topic and population that is understudied and undervalued in the social work field. The data collected in this study will provide practitioners with greater insight into how refugee and immigrant interpreters are impacted by their work with clients who hold the same status and possibly the same types of experiences, struggles, and traumas. It is important to note that these findings are in no way meant to be taken as interpreter incompetency in doing the job. Instead, these findings are meant to add to the limited literature and serve as a useful guide for agencies, interpreters, and professionals to create

higher awareness for the experiences, effects, and unmet needs that arise from this unique and complex relationship. In addition, these findings will help bring attention to the effectiveness and appropriateness of current practices surrounding mental health work and the involvement of interpreters.

There are several limitations in this research study. The first limitation comes from having too many questions and therefore, having less focus on a specific area that could add more depth to the research. Having more questions helped get a comprehensive view of the participants' experiences as an interpreter, but with the limited time for the interview, there was not as much depth as the researcher would have wanted from each question.

A second limitation that is harder to account for is the different interpreting experiences all of the participants have had. Two of the participants had 30 years of interpreting that did not include just mental health, but also interpreting for social services, courts, hospitals and medical clinics, refugee camps, and translation services. The other two participants' experiences—while not as extensive as the other two participants—also varied from setting to setting. It was challenging to take that into consideration when doing the interview and analyzing the data because there may have been some other factors that were hard to account for.

A third limitation is that the majority of the participants used in this research study were more connected to their work setting by doing more in-house interpreting as compared to other interpreters who do mental health but may be on-call or come from an

interpreting agency. Therefore, the experiences of the participants could vary from those that work on-call or are independent of agencies or hospitals.

A fourth limitation is that the sample population was small and self-selected. Therefore, the findings may not be representative of the population being studied. It is important to also take into consideration that the decision to participate in the study may be reflective of some particular experience or personal characteristic that could again, make the findings unrepresentative of interpreter experiences in mental health settings.

A final limitation is the fact that this particular topic may make it harder for some individual cultures or generations to be willing to participate and share their experiences, especially if their experiences have been painful or distressing.

## **Conclusion**

Interpreters play a crucial role in helping social service agencies deliver services to immigrant and refugee communities. This study set out to explore the comprehensive experiences of interpreters in mental health settings and found that although interpreters are getting some support and training from providers and supervisors, they are still struggling to manage the emotional, psychological, and cognitive impact that comes from working with traumatic client material and from having some shared culture, history, or experience with clients. Further exploration and research is needed to help interpreters maintain their neutral role; develop healthier coping strategies in and out of the work setting; and navigate the sensitive cultural dilemmas and relationships that come up within the community setting.

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## Appendix A

### Interview Questions

#### *Demographic Questions*

1. How old are you?
2. What ethnicity do you identify with?
3. What language do you interpret for?
4. What country did you originate from prior to entering the United States?
5. Have you personally experienced or witnessed a traumatic event in your home country? If yes, please check all that apply below.  
 Military combat       Violent personal assault       Kidnapped       Taken Hostage  
 Terrorist Attack       Torture       Imprisoned/Prisoner of War  
 Other \_\_\_\_\_
6. What year did you arrive to the United States?
7. What training have you had in regards to your profession as an interpreter? What about your training in relation to working in mental health settings?

#### *Interpreter Experience Questions*

1. How long have you been an interpreter?
2. What motivated you to choose this profession?
3. How often do you work with clients that have experienced some form of trauma, torture, or violence? Out of all the clients you see, what percentage are clients who have dealt with trauma, torture, or violence?
4. Can you describe how a typical session would go with you, the client, and the therapist? Please include any pre or post sessions/interactions with the therapist and client.
5. Has working alongside trauma survivors and communicating extremely traumatic material affected you? If yes, how?
  - a. Personally? Ex: physical (headaches, stomach aches, exhaustion, sleep habits) and emotional symptoms (sadness, anxiety, prolonged grief)
  - b. Professionally? (motivation towards your job, changes in how you carry out your duties as an interpreter in and out of session)
  - c. Culturally within the ethnic community? (how you connect to the community, how active you are within the community, family, changes to lifestyle within the community)
6. In working alongside trauma survivors and communicating extremely traumatic material, do you feel your personal experiences influence your experiences as an interpreter in any way? Does this impact your ability to be an effective interpreter?

7. How have you coped with this? What supports (people, organization) are available to you? What supports have you utilized? What has been helpful? What has not been helpful?
8. How has this affected the way you view your life, yourself, and the world?
9. What do you find most challenging about this job? Most rewarding?

## Appendix B

# Research Study on the Effects of Client Trauma on Interpreters

*The purpose of this study is to better understand how refugee and immigrant interpreters are personally, professionally, and culturally impacted by their work with other refugee and immigrant clients who have experienced some form of trauma.*

### Who is Eligible?

- 18 years +
- Currently or previously have experience as an interpreter for at least 1 year
- Is an immigrant, refugee, or asylee
- Has lived in the United States for at least 5 years
- Have or have had experience in settings involving mental health. Examples include crisis services, outpatient mental health services, rehabilitative mental health services, and physical mental health services.

### What Will You Be Asked to Do?

- Participate in a one-time Face-to-Face Interview with Researcher that will last one hour
- Interview will take place in a private room within local library or community center
- Answer questions regarding your experiences as an interpreter within mental health settings Fill out a short form that asks for demographic information (age, language you interpret for, ethnicity, previous experience or exposure to military combat, violent personal assault, torture, imprisonment, etc.)

### Compensation

- You will receive a \$10 Target gift card

*If you have any questions or are interested in participating, please contact:*

**Mailee Lor**

**St. Catherine University & University of St. Thomas**

Phone: **(XXX) XXX-XXXX** • Email: **XXXXXX@email.com**

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## Appendix C

### Script for email communication & phone conversation with agencies/interpreting programs/clinics

Hello \_\_\_\_\_,

My name is Mailee Lor and I'm an MSW student at the University of St. Thomas and St. Catherine University. I'm conducting a research study on how refugee, immigrant, and/or asylee interpreters are personally, professionally, and culturally affected by their work with client trauma in mental health settings. I'm contacting your *agency/clinic/program* because your *agency/clinic/program* provides service to refugees, immigrants, or asylees.

Does your agency ever use interpreters to help deliver service to this client population? If yes, I am wondering if you would be willing to pass on my flyers to the interpreters that come to your *agency/clinic/program* regarding my research study. As a way to truly promote the voluntary nature of my research study, I do not directly contact interpreters for their participation. Instead, I am contacting *agencies/clinics/programs* such as yourself to pass on the information and give interpreters the opportunity to initiate the contact.

Do you have any questions or clarifications? I have a copy of the flyer for you to look at if you would like.

Thank you for your time and consideration.

Mailee

## Appendix D

### Interpreter Script

**Researcher:** Hello (*interpreter's name*). Thank you for your interest and inquiry. First off, let me tell you a little bit about myself. My name is Mailee Lor and I'm a social work graduate student at St. Catherine University. I am conducting a research study to better understand how interpreters are personally, professionally, and culturally impacted by their work with clients who have experienced some form of trauma.

You are eligible to participate in this study if you are over 18 years old; have either the status of immigrant, refugee, or asylee; had or have professional experience as an interpreter for at least one year; had or have professional experience in settings involving mental health; have personal experience with or witness of a traumatic event that is either related to violence or torture; and lived in the United States for at least five years. Do you meet this criteria?

**Possible Participant:** Yes. (If the answer is no, researcher will thank them for their time and end the conversation.)

**Researcher:** Great! As a participant in this study, you will be asked to participate in a one-time interview with me. This interview will last approximately one hour and consists of sixteen questions: seven regarding demographic questions and nine regarding your experience as an interpreter. If you don't feel comfortable answering any of these questions or if you simply don't want to answer any of these questions in the interview, you do not have to answer them. I have a copy of these questions here with me if you would like me to read them off to you to give you a better idea of what to expect in the interview. We will be completing the interview in a conference room of a semi-private location such as a library or community center of your choosing. To make sure that I remember our interview accurately, our interview will be audio recorded. This record will only be accessible by me and one other person who will be transcribing it from audio to text.

When we meet for the interview, we will review the consent form and have you sign it to state that you understand and consent to participate in this study. As the researcher, I will also sign the form to commit to keeping your identify and our interview confidential. Any information used from our interview will be kept safely secured in a personal computer at my home office. Any identifying information will be kept anonymous. After our interview, I will give you a list of agencies to contact in case you experience negative symptoms after our interview or do not feel like your normal self. Please know that if at any time you wish to withdraw from the study, let me know and I will destroy all data of our interview and of your contact information.

If you have any questions or concerns before or after the interview, please give me a call at (XXX) XXX-XXXX and I will be more than happy to address them. You also can contact my research advisor Dr. Pa Der Vang at (XXX) XXX-XXXX.

Do you have any questions or concerns at the moment? Did you catch all of this? I know it's a lot of information and I'd be more than happy to go through some of these parts again if you need me to. Would you still like to proceed with your participation in this study?

**Possible Participant:** Yes. (If no, thank them for their time and end the conversation.)

**Researcher:** Great! Let's set up a time and a place that will work for you.

## Appendix E

### Effects of Client Trauma on Interpreters: An Exploratory Study of Vicarious Trauma RESEARCH INFORMATION AND CONSENT FORM

#### **Introduction:**

You are invited to participate in a research study investigating the effects of client trauma on interpreters. This study is being conducted by Mailee Lor, student in the Master of Social Work Program at St. Catherine University. You were selected as a possible participant in this research because of a) your profession as an interpreter in the mental health field and b) your identification as a refugee, immigrant, or asylee. Please read this form and ask questions before you decide whether to participate in the study.

#### **Background Information:**

The purpose of this study is to better understand how interpreters are personally, professionally, and culturally impacted by their work with clients who have experienced some form of trauma. Approximately eight people are expected to participate in this research.

#### **Procedures:**

If you decide to participate, you will be asked to participate in a one-time face-to-face interview with me. This interview will last approximately one hour and consists of sixteen questions: seven regarding demographic questions which will be filled out on a form by you and nine regarding your experience as an interpreter while we will be talking about in more detail. If you don't feel comfortable answering any of these questions or if you simply don't want to answer any of these questions in the interview, you do not have to answer them. I have a copy of these questions here with me if you would like me to read them off to you to give you a better idea of what to expect in the interview. In meeting to complete the interview together, the interview will take place in a semi-private location such as a conference room in a local library or community center of your choosing. To make sure that I remember our interview accurately, our interview will be audio recorded. I take your privacy and confidentiality very seriously. This audio record will only be accessible by me and one other individual who will be helping me type the audio into written text. This individual helping me has signed a form agreeing to maintain confidentiality of your information and your file.

#### **Risks and Benefits:**

The study has several risks. First, revisiting your experiences may bring back painful memories. Second, sharing your experiences may result in discomfort and emotional distress. Third, your revisiting of your experiences in this interview may result in negative symptoms such as nightmares or sleeplessness after the interview has been completed. Please refer to the Confidentiality Section below for more information. I have listed several resources below for you to contact and get help if you experience these symptoms or are not feeling like your normal self in the time following the interview. The first two resources listed are free and do not require any fees on your part. The last two resources listed do require a fee that would be your responsibility if you choose to do service with them. Please do not hesitate to call me if you have any questions about these resources or need further clarification.

#### Resources:

1. *Interprofessional Center for Counseling & Legal Services*  
1128 Harmon Place, Suite 100  
Minneapolis, MN 55403  
Free Service
2. *Crisis Connection, (612) 379-6363 or 1-866-379-6363*  
24-hour crisis phone line  
Free service
3. *Outreach Counseling and Consulting Services, Inc., (651) 481-0664*  
4105 Lexington Ave. N. Suite 190, Arden Hills, MN 55126  
Requires a fee
4. *HealthPartners Center for International Health, Behavioral Health Services (651) 647-2100*

451 Dunlap Street, St. Paul, MN 55104  
Requires a fee

**Compensation:**

A \$10 gift card to Target will be given to participants. Receiving the gift card is not based on full completion of the interview with me. Whether you chose to stop the interview mid-way, chose to not answer all questions, or complete the interview fully, I will still be giving you a gift card. This is done to prevent any feelings of coercion on your part.

**Confidentiality:**

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. As mentioned before, the only other individual who would have temporary access to the audio file besides myself would be the transcriber. The transcriber has signed a confidentiality agreement form and will not share the audio file or written transcript to anyone. The transcriber will delete the audio and transcript after completion of transcription process.

I will keep the research results in a password protected computer and/or a locked file cabinet in my office of my house and only I and my advisor will have access to the records while I work on this project. I will then destroy all original reports and identifying information that can be linked back to you. The audio files will also be destroyed and deleted from both my computer and the transcriber's computer by no later than August 1<sup>st</sup>, 2012.

If at any point during the interview you feel uncomfortable with any question asked by me, please let me know and we will skip over those questions. If at any time you no longer wish to continue or participate in this interview, please let me know and we will stop immediately and debrief. If you experience obvious emotional or physical distress, we will stop the interview immediately, debrief, and get you connected immediately to one or more of the resources listed above in the Risk and Benefits Section. In this case, your data will be destroyed and will not be used in this research study.

**Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University or the University of St. Thomas in any way. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

**New Information:**

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

**Contacts and questions:**

If you have any questions, please feel free to contact me, Mailee Lor at (xxx) xxx-xxxx. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Pa Der Vang at (xxx) xxx-xxxx, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmitt, PhD, Chair of the St. Catherine University Institutional Review Board, at (xxx) xxx-xxxx.

You may keep a copy of this form for your records.

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study and I consent to be audio-taped.

\_\_\_\_\_  
Signature of Participant Date

\_\_\_\_\_  
Signature of Researcher Date