Journal of Interpretation

Volume 21 | Issue 1 Article 2

2011

Peer Support and Consultation Project for Interpreters: A Model for Supporting the Well-Being of Interpreters who Practice in Mental Health Settings

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Abstract

The interpreter who works alongside mental health professionals may have equal vulnerability to occupational stress but lack adequate training in order to recognize it or take necessary steps to offset negative impacts. This paper presents a model of intervention known as Peer Support and Consultation Project for Interpreters (PSCPI) working in mental health settings. It describes a study that was designed to determine whether or not PSCPI meetings would influence participants' immediate sense of satisfaction with several qualities thought to be consistent with developing resilience to work-related stress reactions. The findings of this study indicate a strong positive relationship between attendance at a PSCPI group meeting and increased positive perception of being part of a productive and supportive professional network, as well as having a variety of strategies for self-care and self-management.

Peer Support and Consultation Project for Sign Language Interpreters: A Model for Supporting the Well-Being of Interpreters who Practice in Mental Health Settings

"It is in the speaking of our truth that we free ourselves, individually and collectively, to address our needs."

Karen Saakvitne and Laurie Anne Pearlman
Transforming the Pain: A Workbook on Vicarious Traumatization

This article is an exploration of unique areas of vulnerability to cumulative occupational stress faced by sign language interpreters and the use of formalized peer support and consultation as a model for building resilience and increasing professional well-being. It is based on a literature review and data analysis from a study of the immediate impact of attendance at a Peer Support and Consultation Project for Interpreters (PSCPI) group on several factors thought to be deterrents to vicarious trauma (VT). Having worked with individuals who have experienced trauma, interpreters, like therapists and other so-called *helping professionals*, are at risk for developing cumulative occupational stress reactions (e.g., burnout, vicarious trauma, compassion fatigue, secondary traumatization) (Harvey, 2001). Unlike therapists, however, many interpreters may not recognize their vulnerability or have strategies in place to manage it (Anderson, 2006, Harvey, 2003).

Definitions

Saakvitne and Pearlman (1996) originally defined vicarious traumatization as the "negative transformation of the therapist's or helper's inner experience as a result of empathic engagement with survivor clients and their trauma material and a sense of responsibility or commitment to help" (p. 31). Compassion fatigue, secondary traumatization, and post-secondary traumatic stress are terms that highlight distinctions between degrees and types of disruptive and painful psychological and emotional effects and negative internal transformations that may result from work with people who have experienced trauma (Chrestman, 1999). For the purposes of this article, the terms *occupational stress* and *vicarious trauma* will be used in a more global sense as representing any negative disruption in an interpreter's sense of well-being resulting from interpreting emotionally charged

interactions. Interpreting assignments may be considered as *highly charged* when the content of the communication event includes, or is likely to include, disclosure of violent, oppressive, or otherwise personally traumatic material such as one would encounter when working with individuals who have experienced trauma. The phrase *well-being* is a subjective quality which is defined as a general state of being happy as related to and influenced by one's profession (*Webster's Collegiate Dictionary*, 2009).

Literature Review

Statement of the Problem

The emotional and psychological risks associated with working with trauma survivors have been established and widely communicated to therapists and other helpers (Figley, 1995). By contrast, the interpreter who works alongside them on the front lines of mental healthcare may have equal vulnerability but lack adequate training in order to recognize it or take necessary steps to offset negative impacts (Harvey, 2001). Helping transform the experience of trauma for survivors is not insignificant work. It holds enormous personal, professional, and societal rewards for the practitioner. However, understanding and accepting the inherent risks involved is necessary for professionals to recognize when the work is shifting their own sense of self and personal safety. It is then that providers are able to establish personal and professional safeguards in order to enhance resilience and maintain perspective (Saakvitne, Gamble, Pearlman & Lev, 2000).

The effects of VT may not be readily recognizable by the people impacted. By its very nature, the slowly developing, cumulative effects of VT may be difficult to recognize (Stamm, Varra, Pearlman, & Giller, 2002). Left unaddressed, conditions such as VT and compassion fatigue diminish the quality of the affected individual's life and have the potential to erode professionalism through increased cynicism, loss of feelings of safety, disengagement, and impaired judgment (Rothschild, 2006).

McCann and Pearlman (1990) speculated that it is therapists' inability to process traumatic clinical material that will result in vicarious trauma. Interpreters, who perceive that they lack education, supervision, and the support necessary to debrief personally difficult, emotionally-charged material in an ethical and productive manner, may be inclined to process their experiences without feedback and support of their peers (Anderson, 2006; Dean & Pollard, 2009). Like therapists, interpreters who perceive that their only option for managing troubling experiences is to do so in isolation face greater risk of developing occupational-stress reactions.

Professional Peer Groups

The literature in the field of mental healthcare is replete with support for peer consultation. Benefits include maintenance of ethics, decreased isolation, increased well-being, normalization of experience, and exchange of professional and personal solutions (American Mental Health Association, (n.d.); APA Practice, 2005; Stamm, et al., 2002). Catherall (1999) stated that peer groups are helpful in ameliorating disturbing impacts of secondary trauma. Professional peer groups help, in part, by destigmatizing the disturbance and detecting and clarifying distorted perspectives that might have developed as a result of working in close proximity to clients' stories of trauma. Additionally, researchers and theorists in the field of traumatology recommend using peer consultation along with training to lessen isolation and increase feelings of efficacy (Cerney, 1995; Dane, 2000; Pearlman & Saakvitne, 1995; Talbot, 1989, as cited in Bober & Regehr, 2006).

Organizational recognition of VT and official support for the use of peer consultation groups is essential for educating practitioners, communicating and destigmatizing the feelings of vulnerability of professionals who work with trauma (Stamm, et al., 2002). The American Psychological Association (APA) Practice Organization advised members to protect themselves from the consequences of occupational stress by "seeking consultation with knowledgeable peers and experts concerning specific clinical and professional challenges. . . . [and] making and maintaining professional connections that include opportunities to discuss the specific nature and stresses of our work" (APApractice.org, 2005, p. 1).

A search of the Registry of Interpreters for the Deaf, Inc. (RID) website, which is the member organization for this nation's nearly 15,000 professional sign language interpreters, yielded no mention of vicarious trauma, secondary trauma, or compassion fatigue (September 17, 2011). While the topic

of VT is found among the offerings at interpreter conferences, no official RID-sponsored documents currently exist that define the organization's philosophy, recognized standard practices, or strategies for self-care on the topic. Clearly, this is an approach that is not being utilized in the interpreting field to the degree it is with therapists and other helping professionals.

New Energy for Peer Support and Consultation

Use of professional peer support and consultation groups is not an accepted standard of practice yet for interpreters. It is, however, gaining adherents and being promoted by leaders in the interpreting field. Dean and Pollard (2009) called for increased reflective-learning opportunities to become available "formally and widely throughout interpreters' careers" (p. 30) and recommended that "talking about one's work for the express purpose of professional development and work improvement clearly is consistent with the highest ethical standards" (p. 28).

In order to shift the professional paradigm and make peer support and consultation widely available, interpreting community leaders, teachers, practitioners, and mentors must be the agents of change. These leaders are necessary to adopt, reshape, and revise various models of peer support to form a multifaceted approach that addresses the wide-ranging needs of interpreting professionals. When the experience and research of these leaders further demonstrates the efficacy of support and consultation groups, then organizations, agencies, and institutions will ultimately lend their expertise and necessary financial support to the practice.

The Interpreter's Challenge

Since its inception, VT has been considered largely a condition of therapists, helpers, caregivers, or people who are empathically engaged with persons who have experienced trauma (Saakvitne & Pearlman, 1996). Rothschild (2006) cautioned that a sense of empathy that remains *unknown,* or *unconscious,* to the helper may result in increased vulnerability to compassion fatigue. When interested in the well-being of sign language interpreters, one must adapt the literature to fit interpreters' unique experiences and professional culture. The complicating factor of empathy that is unknown or unconscious to the individual raises the question of whether, and to what degree, interpreters self-identify as empathically engaged. Ironically, when working in close proximity to consumers who have experienced trauma, or while interacting with the content and affect of trauma-infused messages, interpreters who are not inclined to acknowledge their own empathic response may become less resilient to work-related emotional stress over time (Harvey, 2003).

Is it possible that the ethical foundation to which the interpreter subscribes may in some cases result in a subtle *dis-identification* with a sense of empathy and a stigmatized desire to be helpful? As a strategy for maintaining neutrality, interpreters may attempt to diminish or eschew their empathic response in order to assume their role as non-interfering professionals. Compassion or empathy that is unconscious to the interpreter, whether due to the professional role and mental rigors of the interpreting process, or perhaps because it has been deemed unsuitable by the interpreter him or herself, may ultimately put the individual at greater risk of occupational stress, such as compassion fatigue (Dean & Pollard, 2001; Rothschild, 2006). Professional adherence to an ethical code in which confidentiality, neutrality, and impartiality are among the core tenets may contribute a layer of complexity to interpreters' acceptance and awareness of their own vulnerability to vicarious trauma and the necessity of working to maintain well-being (Harvey, 2003). By not identifying themselves as being helpful, not acknowledging their own empathic engagement, and by perceiving that talking about one's work is unethical (all factors thought to increase VT), interpreters may inadvertently be increasing the possibility of occupational stress (Dean & Pollard, 2009).

Person of the Interpreter as Therapeutic Tool

The APA Advisory Committee on Colleague Assistance (n.d.) described, "using the person of the psychologist as a therapeutic tool" (p.15) as one reason psychologists face increased vulnerability to occupational stress. It is reasonable to argue that the person of the interpreter is utilized as a therapeutic tool, as well. The *quality of listening* in which the interpreter engages is qualitatively distinct from that of the caregiver, therapist, or helper. Interpreters report that they not only listen to, and are present for, the retellings of traumatic experiences by clients who perpetrate or have

experienced trauma, but they also interact with the trauma material on a visceral level.

Interpreters involved in peer support and consultation groups have described their experiences of interpreting for material they find personally challenging. According to these interpreters who practice in mental health contexts, the person of the interpreter is akin to a physical vehicle for the retelling of trauma. It is the interpreter who first witnesses and comprehends the survivor's retelling of his or her trauma and the perpetrator's traumatic acts of victimization. The interpreter visualizes the scene of brutality or persecution and moves the message through complex cognitions as he or she mentally accesses the syntax and vocabulary of the target language. The interpreter reads and reproduces the emotional affect and volume appropriate for the message and approximates cultural adaptations (Herndon & Joyce, 2004). The interpreter's larynx vibrates; the tongue and lips form the utterances that convey traumatic or repugnant material to the listener. The interpreter points to his or her own body to describe the types and technicalities of physical assaults and states of dress and undress. In moments of silence and pause, the mental health interpreter seeks to manage and control his or her own empathic response in order to align with and reflect the affect of the therapist, who ultimately receives the message and responds to it. Using first-person form, *I*, the interpreter is the very delivery of traumatic material (Metzger, 1999).

Peer Support for Interpreters Working in Mental Health Settings

In response to the literature and state of practitioners working in the settings described, Peer Support and Consultation Project for Interpreters (PSCPI) working in mental health settings was formed. This proposed remedy created a group structure that was led initially by co-facilitators and later by a single facilitator who supported and educated interpreters regarding VT and mental health interpreting. The process allowed for the exchange of productive approaches to managing challenging and stressful mental health environments. Consistent with professional development, group members received continuing education units (CEUs) from RID.

Group Structure

PSCPI groups met monthly for two hours. It was typical that in the first group meeting, interpreter-members designed an alliance with the facilitator and one another. Members co-designed agreements about the purpose of the group and generated desired behavioral norms to encourage the development of an environment that seeks to be personally supportive while also being professionally stimulating and challenging. The facilitator utilized the *co-active* model of coaching and group facilitation. The co-active philosophy maintains that individuals are best-served when they arrive at their own solutions (www.thecoaches.com). The facilitator elicited strategies and solutions by asking questions and by actively listening and supporting discussion amongst members and provided training in basic concepts of listening and non-judgmental support in order to generate meaningful and productive conversation.

The facilitator offered a loosely structured agenda, including a mindfulness exercise and check-in question designed to increase awareness of individual values and inner resources. Additionally, the facilitator solicited suggestions for mental health interpreting topics to be explored. Members were provided a structured case consultation format to follow when asking for consultation regarding troubling situations. The format assisted interpreters with productively processing emotional *residue* resulting from their experiences. It allowed for validation and normalization of the difficulty, while also securing respectful boundaries around confidential details of assignments. In this way, members could discuss their experiences more freely without a heightened sense of self-scrutiny. At a certain point in the consultation, members were invited to ask questions and share observations and strategies for managing the numerous professional variables present in the situation. The intention was to guide interpreters through a process by which they could be better able to accept and integrate their experience.

Method

A study was designed to evaluate if and how attendance at a PSCPI group affected the members' sense of belonging to a supportive professional network. The research question referred to whether or not PSCPI meetings would influence participants' immediate sense of satisfaction with several

qualities thought to be consistent with developing resilience to these work-related stress reactions. The null hypothesis was that there would be no significant difference between the perceptions of participants at the onset of their group involvement and their perceptions after group involvement.

Participants

Sixteen interpreters participated in this study. Each was female, nationally certified through RID, and lived and practiced in the state of Minnesota. The participants represented a broad range of experience years in the field (4 to 35). Each participant reported having experience in private practice as well as in staff positions. Participants in the research voluntarily elected to attend a PSCPI group for personal and/or professional reasons and consented to participate in this research. Each participant had occasion to provide services in highly-specialized therapeutic settings or highly-emotionally charged settings, though with varying levels of comfort, training, and experience. These participants were in a unique position to help evaluate the effectiveness of receiving collegial support and consultation as a means for increasing a sense of professional well-being and reduction of stress.

Three types of groups were studied. Group One was an established, on-going PSCPI group that had been meeting for 16 months. Questionnaire responses were collected from three of Group One's meetings. Group Two, a new PSCPI group with members of a post-secondary staff who had volunteered or been assigned to interpret in a highly-charged mental health program affiliated with the institution, was studied at its second and third meetings. Group Three, located two hours south of the Minneapolis-St. Paul area, was studied at its first meeting. It consisted of five interpreters in private practice, all of whom had previously met and worked together. Several participants traveled over an hour to attend the PSCPI meeting.

Instrument

In an effort to assess the potential impact of attendance at a PSCPI meeting immediately before and after the group, pre- and post-meeting self-assessment questionnaires were developed. Participants were asked to rank their level of agreement on 13 statements that were written to be consistent with either resilience to occupational stress or perceived proficiency in an area of mental health interpreting (see Table 1). All questions were written in affirmative voice and rated on a Likert scale ranging from 1 (representing strong disagreement) to 5 (representing strong agreement). In essence, the stronger the agreement, the more the individual participants perceived that they felt *less stressed, more content, satisfied, able, and knowledgeable* regarding the items about which they were questioned. For the purpose of this study, a score increase from pre-to post-test would indicate a positive impact and a possible increase in the individual's sense of well-being and immediate reduction in vulnerability for occupational stress.

Table 1 *(Continued to pg 6)*

Questionnaire Items	Strongly Disagree		Agree		Strongly Agree
1. I am experiencing little or no emotional or mental stress at the present moment.	1	2	3	4	5
2. I feel that I am a part of a supportive professional network.	1	2	3	4	5
3. I am comfortable seeking the support of my colleagues for stress reactions resulting from my work in mental health settings.	1	2	3	4	5
4. I am comfortable with my ability to provide support to my professional peers.	1	2	3	4	5
5. I am comfortable that I know how to discuss cases with colleagues in a confidential and ethical manner.	1	2	3	4	5

6. I feel that I am able to "debrief" emotionally difficult situations with trusted colleagues in a productive manner.	1	2	3	4	5
7. I am satisfied with my level of specialized knowledge of the mental health interpreting assignments I encounter.	1	2	3	4	5
8. I feel that I am knowledgeable about the symptoms and management of vicarious trauma.	1	2	3	4	5
9. I feel that I am able to identify subtle shifts in my own emotions as they are occurring in daily life.	1	2	3	4	5
10. I feel that I can sense my own emotional experience while in the process of interpreting.	1	2	3	4	5
11. I feel that I am able to sense nuanced emotional effect of others and attempt to include it in my interpretation.	1	2	3	4	5
12. I am comfortable that I have a range of productive strategies for managing strong emotions that may be triggered while interpreting in highly-charged settings.	1	2	3	4	5
13. I am comfortable that I am willing and able to seek my own mental health care or professional support if I sense the need.	1	2	3	4	5

Researchers designed the questions to elicit answers concerning participation in a PSCPI meeting and the meeting's impact on the participant's:

- **Perception of stress in the present moment -** The first question (1) evaluated the participant's subjective level of emotional or mental stress immediately before and following the group.
- **Perception of quality and availability of peer support -** Five questions (2, 3, 4, 5, and 6) pertained to the participant's perception of belonging to and making effective, ethical, and appropriate use of a supportive professional community.
- **Awareness of vicarious trauma -** One question (8) assessed the participant's knowledge about the symptoms and management of vicarious trauma.
- **Perception of having sufficient knowledge to work in mental health settings -** One question (7) assessed the participant's sense of being adequately prepared with specialized knowledge for the mental health interpreting assignments encountered.
- **Perception of awareness of emotion in self and others -** Three questions (9, 10, and 11) pertained to the individual's ability to sense subtle emotional states of self and others.
- **Perception of having options for emotional self-management -** Two questions (12, 13) related to one's strategies for managing strong emotions that may be triggered while interpreting in highly-charged settings, the first being self-management and the second referring to the willingness to get professional mental healthcare, if necessary.

Data Analysis

Answers to individual pre- and post-meeting questionnaires were recorded on a spreadsheet. Mean values were calculated and recorded for each group (see Table 2). Mean scores for the three groups and the difference or *percent of change* from pre- and post- were computed and recorded. In order to determine if there was significant change in pre- to post- answer values for each question, a two-sample test of hypothesis was performed. This was a two-sided test with a 0.05 level of significance, corresponding to a 95% confidence interval, assuming dependent samples. The null hypothesis asserted

that there was no difference between the perceptions before and after a session. The results of this test are included in Table 3. In explanation, if the *t* value for a given question were found to be larger than the critical value of 2.11 (95% confidence interval) then the null hypothesis was rejected, and we concluded that the perceptions were significantly different after the session. If the *t* value were less than 2.11, we accepted the null hypothesis and concluded that the observed difference between the pre- and post-perceptions reflected no real difference.

Perception of Belonging to a Supportive Professional Network

Table 3 highlights the degree of change regarding participants' perceptions. There was a significant increase in the mean score (38%) regarding participants' perception of belonging to a supportive professional network as read in Statement 2. There was a mean increase of 29% when answering, "I am comfortable seeking the support of my colleagues for stress reactions resulting from my work in mental health settings" as read in Statement 3. Also occurring was an increase of 28% in the level of agreement with the statement, "I feel that I am knowledgeable about the symptoms and management of vicarious trauma" as in Statement 8. Responses to Statement 12 yielded an average increase of 23% in perception of having "a range of productive strategies for managing strong emotions that may be triggered while interpreting in highly-charged settings".

Table 2: Mean Comparisons of Responses Across Groups and Time

Question Number	**Group 1** 10-9-09		**Group 2** 11-2-09		**Group 1** 11-12-09		**Group 3** 12-1-09		**Group 1** 12-10-09	
	M Pre	M Post	M Pre	M Post	M Pre	M Post	M Pre	M Post	M Pre	M Post
1	3.33	4.33	2.20	2.40	3.17	4.33	2.80	4.00	2.00	4.00
2	3.67	5.00	3.20	3.40	3.33	4.67	2.20	4.40	3.50	4.50
3	3.33	4.33	2.80	3.80	3.33	4.00	3.40	4.60	3.50	4.50
4	3.67	4.33	2.80	3.60	3.33	4.00	4.00	4.20	3.50	4.50
5	3.67	4.33	3.60	3.80	3.67	4.00	3.80	4.00	3.50	4.00
6	3.33	4.67	4.00	3.80	4.33	4.00	3.00	4.40	4.00	4.50
7	3.00	4.00	2.20	2.60	3.50	3.33	3.40	4.00	3.50	4.50
8	3.00	3.67	2.20	2.80	3.00	4.00	3.30	3.60	3.00	4.50
9	3.33	4.00	3.40	3.80	3.33	4.00	3.60	3.70	3.00	4.50
10	3.67	4.33	3.20	3.40	3.00	3.83	3.60	3.70	3.00	4.00
11	4.00	4.00	3.20	3.40	3.00	3.33	4.00	3.90	3.50	4.50
12	3.33	4.33	2.60	2.80	3.00	3.33	2.30	3.80	4.00	4.50
13	4.33	4.67	3.40	3.20	4.33	4.33	3.80	4.20	3.00	4.50

Table 3: Mean Comparisons of Responses across Groups and Time

(Continued to pg 8)

Total M of All Groups			**% Changed**	***t* Stat**	**Research Result**
Question Number	Pre	Post	%		
1	2.70	3.81	41.23	4.22	Improvement
2	3.18	4.39	38.16	4.65	Improvement
3	3.27	4.25	29.74	5.53	Improvement
4	3.46	4.13	19.27	3.33	Improvement
5	3.65	4.03	10.42	1.84	No Improvement
6	3.73	4.27	14.46	2.56	Improvement

7	3.12	3.69	18.16	3.43	Improvement
8	2.90	3.71	28.05	3.93	Improvement
9	3.33	4.00	20.00	2.89	Improvement
10	3.29	3.85	17.00	3.19	Improvement
11	3.54	3.83	8.10	1.59	No Improvement
12	3.05	3.75	23.19	3.62	Improvement
13	3.77	4.18	10.78	1.57	No Improvement

Note: Improvement indicates significant finding.

Questions 1-4, 6-10, and 12 indicated a significant difference between pre- and post- perceptions. This result does not indicate the amount of change, rather that there was a change. A higher t value reflects a higher degree of confidence that the difference is real. The difference between pre- and post- results for questions 5, 11, and 13 did not reach the threshold of statistical significance. Figure 1 is a comparison of pre- and post-ratings by question, and Figure 2 is a graphic illustration of the distribution by percent of change.

Figure 1: Pre- and Post- Answer Means by Question

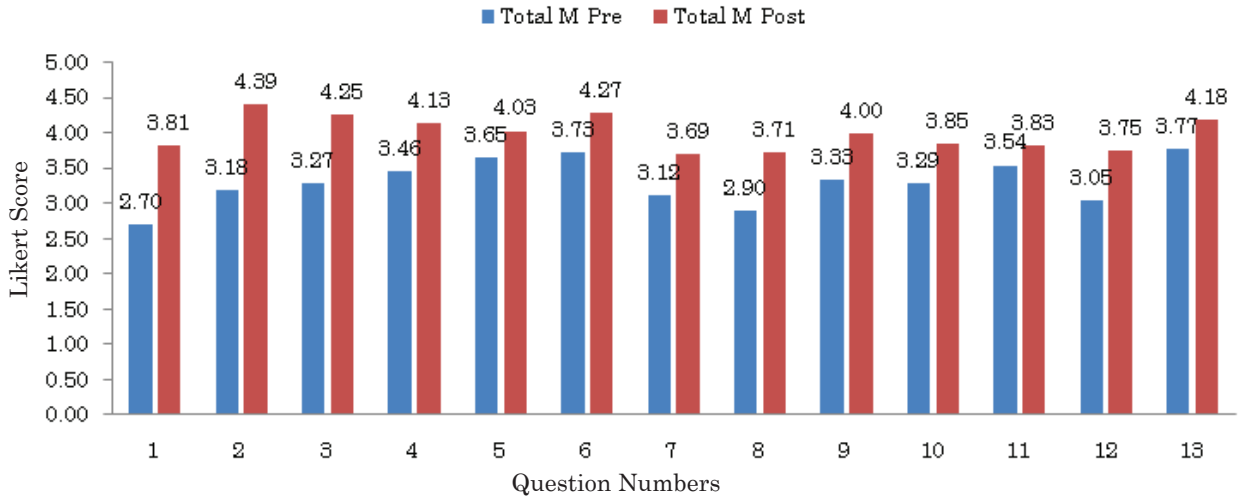
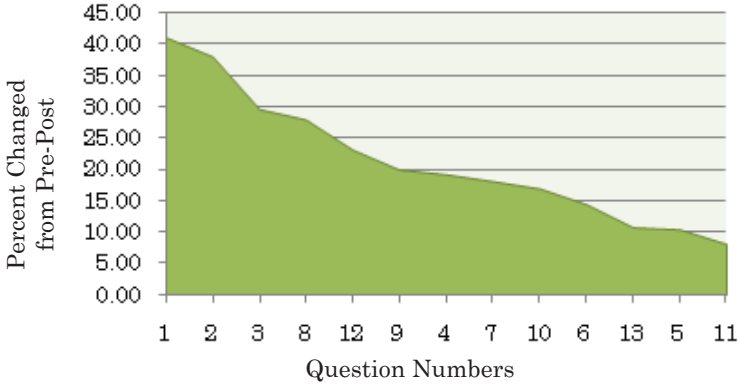


Figure 2: Percent of Change between Pre-Post Evaluations

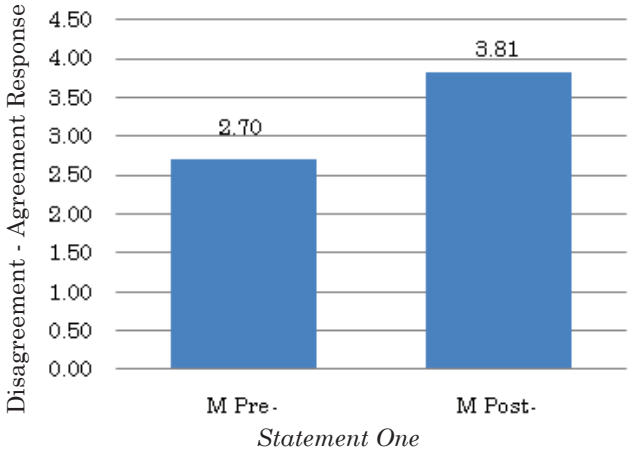


Perception of Stress in the Present Moment

Initial analysis of the data suggests that interpreters who attended a PSCPI meeting experienced a positive shift in stress levels (i.e., reduction in stress) and perception of peer support. When means of

the five groups were graphed, the most significant change noted was in reported feelings of emotional or mental stress. There was an increase of 41% in agreement to the statement, "I am experiencing little or no emotional or mental stress at the present moment" as read in Statement 1 (see Table 3). Mean scores increased from 2.70 to 3.81 on the 1-5 scale (see Figure 3).

Figure 3: Graph of Question One
"I am experiencing little or no emotional or mental stress at the present moment."



Discussion

The findings of this study indicate a strong positive relationship or correspondence between attendance at a PSCPI group meeting and increased positive perception of being part of a productive and supportive professional network, as well as having a variety of strategies for self-care and self-management. Previous studies that were conducted on the impact of occupational stress on therapists indicated that symptom levels are impacted by the availability of social support (Ortlepp & Friedman, 2002; Schauben & Frazier, 1995). This suggests that the PSCPI model of support and consultation and possibly other peer-supervision groups may be effective in increasing interpreters' resilience to occupational-stress reactions and reducing symptoms.

Limitations

Before making conclusive statements regarding the degree of perceived impact resulting from attendance at peer support and consultation group meetings, it must be noted that this study and data analysis are in preliminary stages. A limitation in the design was that participants were self-selected, as each had sought out the comfort, support, and consultation of peers. No control group was studied. Demographic data were unavailable and what was known indicated that there was limited demographic variability among participants. All participants were of the same gender and resided in the upper Midwest. The researcher had dual roles with the participants--that of group facilitator and researcher. Questionnaires were completed and collected by a neutral party without the researcher present; however, there may have been feelings of alignment with the researcher that could conceivably have influenced responses.

In spite of these limitations, the data definitely highlight the positive impact experienced by attendance at PSCPI groups. Most notable was the decrease in awareness of stress, increase in feelings of belonging to a supportive peer network, and comfort with seeking support from colleagues. Participants reported increased knowledge of vicarious trauma and its symptoms, a factor thought to be a deterrent to vicarious trauma. Also notable was the increase in participants' beliefs that they possessed strategies for accepting and internally managing strong emotions that will on occasion arise during the course of their work.

Conclusions and Future Prospects

This study raised a number of questions that point to areas of future research. How does attendance at PSCPI meetings affect participants over time? What would be revealed about the impact

of participation in a PSCPI group over a longer period of time? What is the benefit to deaf and hearing consumers who use the services of interpreters who are involved in a professional peer group? Of interest to the researcher is how and to what degree awareness of one's own emotions correlates to the ability to recognize and incorporate subtle nuances of emotion expressed by consumers (see Statements 9, 10, 11). How does self-awareness of one's biases, judgments, and sensitivities correlate to self-management while interpreting in the presence of such triggers? What approaches to self-care are most helpful for interpreters? Future studies could utilize a qualitative approach in order to assess which elements of the group are perceived as most helpful. Also of great importance to the researcher is in what manner could this group model be applied to other groups in other locations with different facilitators?

This study was designed to examine the immediate, short-term impact of attendance at a PSCPI group on participants and provide response to the key questions: "Was the group being beneficial to members, and if so, in what way?" More research is necessary to pursue empirical data on the efficacy of peer support and consultation, or supervision groups for interpreters. The data from this study hold significance for justifying the use of peer support and consultation as a means to lessen stress and isolation, and to increase interpreter strategies for self-care, self-management, and interpreting in mental health settings. Finally, this and future studies will prove instructive to interpreting businesses that arrange for interpreters to work at mental health facilities, prisons, and treatment programs for the sex-offender population, outpatient therapy, hospital emergency rooms, and countless other assignments in which they will come face-to-face with the realities of trauma, abuse, violence, and loss (including video remote and video relay providers).

In spite of working in these highly charged areas, and sometimes because of it, countless interpreters demonstrate personal resilience and remain committed to professionalism, well-being and ethical decision making in service to their consumers. They model the most enduring protective factor for vicarious trauma--*vicarious resilience* (Hernandez, Gangsei & Engstrom, 2007). With a multifaceted and community-wide embrace of self-care, including collegial support, supervision and consultation, a new paradigm can emerge. In that optimistic future, interpreters will be better able to practice in some of our profession's most demanding settings.

Acknowledgements

The author wishes to thank all past and present members of the Peer Support and Consultation Project, and especially, those "Pah-Skippies" who participated in this research. Thanks, too, to Marty Barnum, whose leadership, intelligence, and humor were instrumental in co-creating PSCPI. Special gratitude and acknowledgement go to Jan Florand, former Director of Interpreting Operations for CSD of MN, for recognizing the consequences of vicarious trauma and the significance of peer support in mitigating its impact. It was Jan's vision and support that lead to the creation of the first PSCPI group.

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