

Empowering healthcare interpreters: the role of training in reducing emotional strain

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Abstract

Professionals working in healthcare settings are often exposed to emotionally charged situations, which can negatively impact their well-being. However, few studies have focused on interpreters' emotional strain, particularly in the field of healthcare interpreting. This study aims to examine the type of symptoms associated with vicarious trauma in healthcare interpreters in Spain and the United States, as well as the interpersonal and organizational strategies available to them to mitigate the effects. A questionnaire was distributed amongst 74 healthcare interpreters (42 in Spain and 32 in the US), all of whom had at least one year of experience. The survey included questions about their feelings and symptoms related to the emotional impact and the training they received to manage it. Results show differences in terms of training and access to strategies such as briefing, debriefing and institutional support that appear to be more prevalent in the US. Overall, training on managing emotional impact may act as a protective factor. However, it should be provided in conjunction with adequate interpersonal and organizational strategies. Therefore, structured support resources are recommended, especially in contexts such as the Spanish one, where there is still significant progress to be made towards professionalization.

Keywords

Healthcare interpreting, emotional impact, interpreter's well-being, training, interpreter professionalization.

Interpreters working in healthcare services are exposed to situations and stories that can take a toll on their physical and mental health as well as their professional performance. Continued exposure to information concerning loss, death, pain, illness, mourning, abuse, etc., together with the requirement to communicate such information in the first person (Bontempo/Malcolm 2012; Bancroft *et al.* 2018), may bring about a series of symptoms associated with a task (interpretation in healthcare) which may be “inherently stressful and sometimes quite traumatic” (Bancroft 2015: 229). Such symptoms frequently include burnout and compassion fatigue, which refer, respectively, to the syndrome that can arise from ongoing stress due to an imbalance between the demands placed on a professional and the means at their disposal, and to the physical, psychological and emotional exhaustion resulting as a consequence of prolonged contact with the suffering of others. Ultimately, healthcare interpreters may succumb to vicarious trauma, also known as secondary trauma. This is defined as “the response of those persons who have witnessed, been subject to explicit knowledge of, or had the responsibility to intervene in a seriously distressing or tragic event” (Lerias/Byrne 2003: 130). In the context considered herein, it derives from ongoing indirect exposure to information involving a heavy emotional burden and contact with vulnerable individuals (in this case, patients) in a difficult situation. This, therefore, involves a negative transformation undergone by therapists and other healthcare professionals “resulting from empathic engagement with clients’ trauma material” (Pearlman/Saakvine 1995: 151). The symptoms associated with vicarious trauma are highly varied and may be physiological (such as migraines, trembling, dizziness, nausea, vomiting and rashes), cognitive (failing memory, lack of concentration, recurring thoughts and difficulty in taking decisions or problem solving), emotional (anxiety, sadness, feelings of guilt, irritability and mood swings), and behavioural (insomnia or difficulty in sleeping, social isolation, eating disorders or consumption of toxic substances) (Bontempo/Malcolm 2012; Lai *et al.* 2015; Darroch/Dempsey 2016; Lim *et al.* 2022).

Although there have been numerous studies concerning vicarious trauma suffered by healthcare professionals (Cavanagh *et al.* 2020; Isobel/Thomas 2022), there have as yet been few studies focusing on interpreters working in healthcare settings, especially in countries where healthcare interpreting has a lesser degree of recognition and professionalization, as is the case in Spain.

Issues such as the individual’s personality and previous experiences, training received concerning management of emotional impact and self-care, as well as the frequency with which one is called on to interpret in difficult or stressful situations, determine the probability of developing the condition (Lai/Costello 2021). Interpreters may also count on a series of strategies that help to minimize the risk of suffering the consequences of the emotional impact. Such strategies are classified as intrapersonal, interpersonal, and organizational (Lim *et al.* 2022).

Intrapersonal strategies refer to actions that the interpreter may perform on their own, such as techniques of relaxation and disassociation, physical activity, or other forms of self-care. Such strategies have been endorsed by several authors (Bontempo/Malcolm 2012; Bancroft 2015; Creeze *et al.* 2015; Korpai/Mellinger 2022), as they have proved to be extremely useful in preventing emotional impact and the development of subsequent related syndromes.

Despite evidence of the usefulness of intrapersonal techniques, they are not in themselves usually enough, and therefore, other strategies related to working conditions and relationships in the work environment need to be adopted (Bontempo/Malcolm 2012; Lim *et al.* 2022). Several authors affirm that, to protect and preserve their health, interpreters should combine their own strategies with those provided by their employers and co-workers (Splevins *et al.* 2010; Bontempo/Malcolm 2012; Ndongo-Keller 2015).

Interpersonal strategies may include support by colleagues or mentorship programs (particularly advisable for less experienced interpreters). Specifically, participation in support groups can have positive effects and reduce symptoms associated with vicarious trauma, as is shown in the results of a study carried out with interpreters working in mental health institutions in the state of Minnesota (US):

[...] the data definitely highlight the positive impact experienced by attendance at PSCPI [Peer Support and Consultation Project for Interpreters] 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. (Anderson 2011: 17).

Such interpersonal strategies may also include briefing and debriefing sessions. Briefing allows the interpreter to prepare themselves both from a cognitive standpoint, by preparing glossaries or conceptual maps related to the matter at hand, and psychologically, by foreseeing any potential issues that may arise or any emotions that may emerge during an interpretation encounter, thus anticipating, preparing for, and to some extent, protecting themselves. Despite the benefits that, according to the literature, may be derived from briefings (such as a chance to clarify any expectations of the interpreter's role or the improvement of relationships between them and any other healthcare professionals, Hancox *et al.* 2023), seldom does this come about in practice. A debriefing, preferably with a professional other than the one who participated in the previously interpreted situation (Miller *et al.* 2005; Gomez 2012), helps to pinpoint and analyze feelings. This could lessen any possible emotional impact, as well as lead to consideration of some coping strategies that could be employed in any future traumatic situations. Some interpreters believe that debriefing can come into conflict with the principle of confidentiality (Knodel 2018; Lai/Costello 2021), but that should not be the case if performed properly without revealing details that could identify the participants in the interpreted encounter. Even informal debriefings with other interpreters can have excellent outcomes, be "a good avenue for releasing stress", and contribute to "reduce or even prevent the onset of psychological distress and fatigue" (Creeze *et al.* 2015: 79).

It is equally true that training and cooperation between interpreters and the varied healthcare professionals is essential, as affirmed by authors like Costa, who maintains that:

where possible, clinicians and interpreters should be trained together so that they can understand the extent and limits of each other's roles and responsibilities. They will also, while together, have a chance to hear and understand each other's fears. (2016: 65)

Furthermore, contact and understanding between healthcare professionals and interpreters will bring about greater respect towards the latter and avoid them being seen as a mere

“shadow”, as “machines”, or as a “mouthpiece” bereft of feelings (Darroch/Dempsey 2016: 182; Lai/Costello 2021: 76-77), a point endorsed by numerous authors, who advocate “a need to address a disappointing lack of support and appreciation from service providers for the complex, nuanced role interpreters provide” (Hancox *et al.* 2023: 932).

Finally, organizational strategies refer to training and professional development programs organised by the company or institution hiring the interpreter, supervision by other professionals, or the availability of support services (by counsellors, chaplains, or similar figures). Initiatives of this type have proved to be highly beneficial, facilitating self-awareness and ongoing improvements for interpreters whilst mitigating the risk of suffering the symptoms associated with vicarious trauma (Darroch/Dempsey 2016). Organizational strategies also concern working conditions, such as rest times and the chances of interpreting in different contexts, with varying levels of emotional complexity.

After being made aware of the fact that the positive effect of intrapersonal strategies is minimal, “if an employer does not address the work environment and conditions that put workers at risk of traumatisation” (Bontempo/Malcolm 2012: 117), we decided to carry out research in this area. We formulated a study which, among other questions, analyzed the interpersonal and organizational strategies available to healthcare interpreters working in Spain and the US. The starting hypothesis was that, as healthcare interpreting enjoys greater recognition and professional development in the US (at least, during the period when the study was carried out), interpreters working there would enjoy better working conditions and receive greater institutional support, which would help to prevent or reduce symptoms associated with vicarious trauma to a greater degree than for their Spanish colleagues.

Against this background, this paper has the following objectives:

- Analyze the main feelings and symptoms associated with vicarious trauma that have been experienced by the healthcare interpreters who took part in the study.
- Learn about and classify those coping strategies intended to prevent or mitigate emotional impact available to the participating healthcare interpreters, particularly those which do not depend on the interpreters themselves, that is, the interpersonal and organizational.
- Determine any relation between the availability of interpersonal and organizational strategies and the prevention or reduction of the symptoms associated with vicarious trauma.

1. Data and methodology

The data were gathered between January and March 2023 by means of a questionnaire drawn up after a review of the literature concerning the main object of study (Bontempo/Malcolm 2012; Creeze *et al.* 2015; Lai *et al.* 2015; Ndongo-Keller 2015; Darroch/Dempsey 2016; Knodel 2018; Lai/Costello 2021; Korpál/Mellinger 2022; Lim *et al.* 2022). The questionnaire is made up of an introduction requesting socio-demographic data from the participants, followed by 18 questions, some of which are closed (yes/no and multi-option) and others open, offering the option to include comments and explana-

tions (see Annex).¹ The questionnaire was initially distributed by convenience sampling, through the researchers' personal contacts that satisfied the criteria set for the study, and later by snowball sampling, asking the informants to pass the questionnaire on to other potential participants. As regards inclusion and exclusion criteria, participants had to be adults, have worked for at least one year as healthcare interpreters in Spain or the US, and not be suffering from serious symptoms associated with vicarious trauma at the time of the study.

A total of 74 interpreters (42 from Spain and 32 from the US) participated, aged between 25 and 80.² The great majority (61) were female. Regarding their professional experience, an outstanding percentage (66%) of the participants from the US had over ten years' experience. In contrast, the percentage of participating interpreters who had worked in healthcare in Spain for more than ten years (36%) differed little from the percentage of those who had been working for only one year (26%). The number of those who had been working between one and ten years was similar in the two groups.

In relation to participants' place of work, those from the US had mostly worked in clinics (28), closely followed by those who had worked in public hospitals (26). A higher number of the interpreters from Spain (31) declared that they had worked in public hospitals, with a somewhat smaller number (20) employed in clinics. The number of those who had worked in other contexts (private hospitals or other) were, again, comparable in the two groups.³

The main differences between the two groups in terms of socio-demographic data relate to the training received. While only 3 of the 32 US interpreters were not trained in healthcare interpreting (approximately 10%), 22 of a total of 42 (over 52%) of their Spanish counterparts were untrained in this area. Furthermore, of the 20 interpreters in Spain who had received training, 3 maintained that it had been quite basic, with simple guidelines about how to handle communication, or had involved very short courses of no more than 10 hours. That corroborates the findings of previous studies regarding the exiguous training available in Spain for interpreters in public services in general, and healthcare interpreting in particular, whether it be official training provided by universities (Camacho Sánchez 2019; Nevado Llopis/Foulquié Rubio 2023) or training offered by private companies (Álvaro Aranda/Lázaro Gutiérrez 2021).

As regards the training that includes content relevant to handling emotional impact and self-care, 11 of the 29 interpreters from the US and 16 of the 20 Spanish interpreters responded negatively. Our aim when collecting these data was to understand whether training may have a positive impact on the prevention or management of vicarious trauma symptoms. In the words of the few Spanish interpreters who had received training

- 1 Bearing in mind the objectives of this paper, the focus is on the replies to questions 1-6 and 12-14.
- 2 It should be mentioned that some participants were no longer working at the time of the study or were working as voluntary interpreters, despite having retired.
- 3 Many of the interpreters had worked simultaneously or at different times in various contexts, which explains why the total number of responses for each country is greater than the number of participants.

in the area (3)⁴, the content was practical but not directly related to work as a healthcare interpreter. The interpreters from the US who affirmed to have been trained in the issue in question (18) had attended such sessions during their degree studies, or as part of in-person or online workshops of various durations. Such training dealt with techniques of self-care, stress management, and other strategies used in preventing vicarious trauma, as can be seen in the following comments:

Usually, brief segments on defining and identifying the difference between stress and vicarious trauma and some self-care tools and plans. (US1)
 Often training was through 1/2-day, full day or a series of workshops dealing with a specific topic at a time. These might have included: managing stress, recognizing trauma and the impact, vicarious trauma, self-care, mental health safety protocols, etc. (US12)
 “Dealing with Vicarious Trauma” - part of degree curriculum, “Trauma Informed Interpreting” - training provided for interpreting staff by hospital/employer. (US27)

2. Results

2.1. Feelings and symptoms associated with vicarious trauma

The first question in the questionnaire includes a series of feelings described in the relevant literature, to which the participating interpreters had to respond with a ‘yes’ or a ‘no’. As shown in Figure 1, regardless of the national context in which they were operating, the interpreters were quite frequently faced with all these emotional experiences.

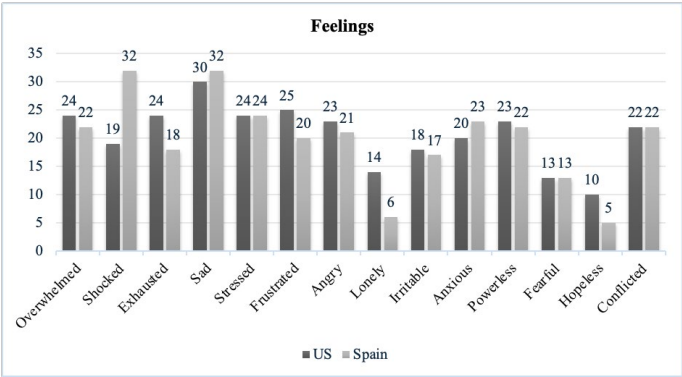


Figure 1: Feelings experienced by the participants

Sadness was the emotion manifested by the greatest number of participants, in both Spain and the US, chiefly due to their having had to interpret bad news (on occasions, for palliative patients) and empathizing with the people receiving the news.

4 One out of the 20 Spanish interpreters who affirmed that they had been trained in healthcare interpreting, left blank the question related to training to handle emotional impact.

Though there are, in general terms, no major differences regarding the number of interpreters in the two contexts who report having suffered the majority of the feelings, it is worth considering that, with reference to the total number of participants in each group, the percentage is lower among the Spaniards. The only exceptions would be feelings of shock and nervousness, with higher figures among the Spaniards, which may be due to the lack of training referred to above.

The US participants have higher figures for feelings of exhaustion, isolation, and hopelessness. This difference may be down to the particular characteristics of the professional context in each country. The type and nature of employment may influence interpreters' experiences and perceptions (Graves *et al.* 2023) and may result in a greater workload and a keener sense of loneliness. However, this study did not compile sufficient data to allow for confirmation of that hypothesis.

In order to look at this question in greater depth, the interpreters were given a chance to describe specific situations that caused them such feelings. There were several comments from professionals from both countries that serve to illustrate the contexts in which the interpreters experience one or more of these feelings. As shall be expressed in greater detail below, those situations may be linked to a specific cause or to a combination of factors.

Some interpreters explained that their emotions were related to personal experiences:

Most often I feel these emotions when what might be happening with a patient is in conflict with my own values or beliefs. (US12)

Interpreting for Pediatric Cardiac after going through a similar situation with my child. (US25)

Nonetheless, most of the difficult situations described by the participants derive from the context in which they work as healthcare interpreters, as well as the considerable emotional charge inherent in such situations:

In palliative care meetings, for example, it can be very overwhelming when end of life care decisions are made by the family. (US3)

Telling a patient who's in shock that a family member has passed away in an accident. (SP3)⁵

On other occasions, the feelings arise from the treatment patients have received from the system and from healthcare professionals, or the behavior of the patients themselves:

Much of the trauma I experience is interpreting for disenfranchised patients experiencing oppression within the healthcare system - not having their needs met, having their needs ignored and minimized [...]. (US27)

I've also been through situations where the doctor didn't let us finish speaking, neither me nor the patient, or situations where the patient (a man of Arabian origin) was rude to any woman who attended him. (SP29)

In such moments, the interpreters feel obliged to take a step further, beyond their role, to ensure proper communication and service, which brings feelings of conflict and frustration:

5 The quotes of the Spanish participants' testimonies have been translated into English for the sake of brevity and consistency.

I think conflicted is the best description for how I frequently feel while interpreting in a healthcare setting. [...] I feel like I need to break my role to make sure the consumer gets the help they need. It is difficult for me to hold back. Then, I feel frustration because other professionals in the business don't know the consumers well and/or don't follow-through. (US14)

The doctor didn't understand my role as interpreter and addressed me directly, so I had to answer questions for the patient, for the good of the patient. (SP11)

The data show that such feelings, though not usually long-lasting, have consequences in the interpreter's life, both in the professional and the personal spheres:

My feelings ended up spilling into my personal life thus affecting my mood and tolerance/patience. (US26)

When I'm upset, sad, or angry, my kids and my closest family pay the price, because they have no choice, and they understand me. (SP1)

Those feelings of sadness and frustration stay with you after you leave work, and they affect your personal relationships, how you feel about life, etc. (SP7)

However, such repercussions are greater as a proportion of the total number of participants in each group, among US interpreters, as shown in Figure 2:

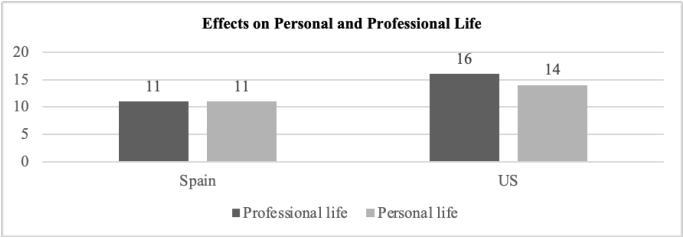


Figure 2: Effects on the participants' personal and professional lives

This finding is significant bearing in mind that, as stated above, interpreters in the US receive training specifically related to managing emotional impact and self-care far more frequently. That additional training should contribute to greater awareness of the way in which those emotional experiences impact one's professional and personal life and provide interpreters with more tools to recognize and deal with their effects. Such effects deriving from the emotional impact of their work often manifest as a series of symptoms. The questionnaire utilized in the study included a list of the symptoms most frequently identified in the specialized literature.

Symptoms of emotional turmoil, preoccupation, and irritability are the commonest among both Spanish interpreters (36%, 31%, and 26% of the total number of participants, respectively) and their colleagues in the US (with 53%, 47%, and 56%). Another of the symptoms referred to by a considerable number of the US interpreters (specifically, 18) are the ruminations related to the patients' stories. Finally, among the least frequent symptoms experienced by the two groups are nightmares and depression.

2.2. Available interpersonal and organizational strategies

The lack of support and appreciation highlighted in the literature (Darroch/Dempsey 2016; Lai/Costello 2021; Hancox *et al.* 2023), together with the vagueness of the limits of the healthcare interpreter's role, make it particularly important to look into how interpreters themselves perceive the recognition they get from healthcare professionals. That is hardly a minor question when one considers the markedly unprofessional character of the interpreting service in numerous contexts. As put by Skaaden (2023), the absence of a perception of the interpreter as a professional may have direct consequences for their employment, especially regarding the hiring of properly trained interpreters. The situation could have negative repercussions for both the quality of the interpretation service and the perception that healthcare professionals have of the added value provided by the interpreter in clinical interactions.

Given that interpreters can perform their function in multiple specialties and healthcare environments, where an institutional culture that favors collaborative work with interpreters is not necessarily present, it is fundamental to consider not only the perceptions of the medical staff, but that of the interpreters themselves as regards their function and the recognition it receives (Pöchhacker 2000; Hsieh 2008; Ortega Herráez *et al.* 2009; Hadziabdic *et al.* 2010; Bischoff *et al.* 2012; Michalec *et al.* 2014).

Responses to the questionnaire include both positive and negative perceptions by healthcare professionals, from the participating interpreters' point of view. Prominent among the negative comments were those related to the lack of professional appreciation and impersonal treatment, such as “lack of respect / understanding of your work”, “view you as a machine or a common consumable” and “underestimate you”, as reflected in Figure 3.

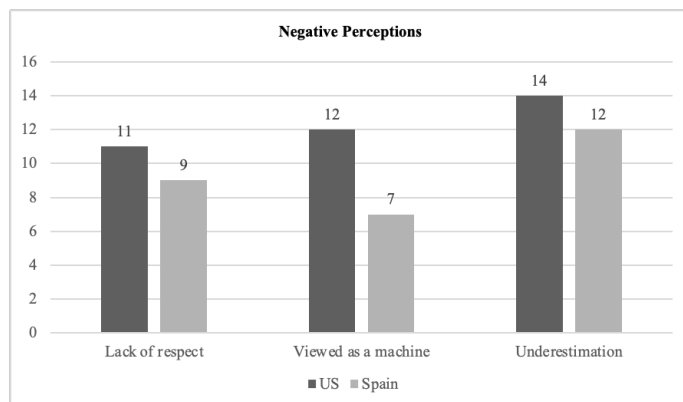


Figure 3: Main negative perceptions towards the participants

Although the number of interpreters from the two countries who have felt a lack of respect or under-appreciated does not differ substantially, as shown in Figure 3, the figures from the US are always higher, both in absolute and in relative terms. The comment “view you as a machine or as a common consumable” draws similar responses from the two groups. That invites critical reflection, especially in the cur-

rent context marked by the growing role of artificial intelligence in some spheres of doctor-patient communication. Several recent studies (Moberly 2018; Al Shamsi *et al.* 2020; Şentürk *et al.* 2021; Foulquié Rubio *et al.* 2024) find that, in certain situations, healthcare professionals turn to machine translation tools to communicate with patients speaking another language, which may lead to devaluing the interpreter’s role as a human and their equivalence with purely instrumental resources.

With reference to those perceptions considered positive, it can be seen that, for all the items analyzed, the number of affirmative responses is greater among the participants in Spain than those in the US. The most notable difference is to be found in the phrase “grant you the same rights, values and respect as to other service providers”, where 71% of the Spanish participants felt they were recognized in that way, whilst only 47% of the US interpreters felt the same.

That result is especially surprising if compared with the opinions compiled in the open responses concerning positive aspects of the profession, where only the US participants spoke of working conditions as a favorable factor:

I am generally able to keep a good home/work balance. And I am paid pretty well. (US14)
I am happy with the current wages and hours. (US23)
[...] the job I have right now offers me the opportunity to get the knowledge and training I need in this field. (US18)

The discrepancy between the quantitative and qualitative data may be due to the US interpreters having a more critical or more demanding perception of professional recognition.

The other items relative to positive perceptions show the affirmative responses by both groups to have comparable percentages, which suggests that the interpreters’ experiences in the two contexts have certain points of convergence.

The results relative to actions supporting the interpreters in the workplace reveal notable differences between the two countries. Noticeably more US participants respond positively to the items relating to briefings before interpreting sessions, to information about expectations regarding interpreters, or to training in stress management, as reflected in the data in Figure 4.

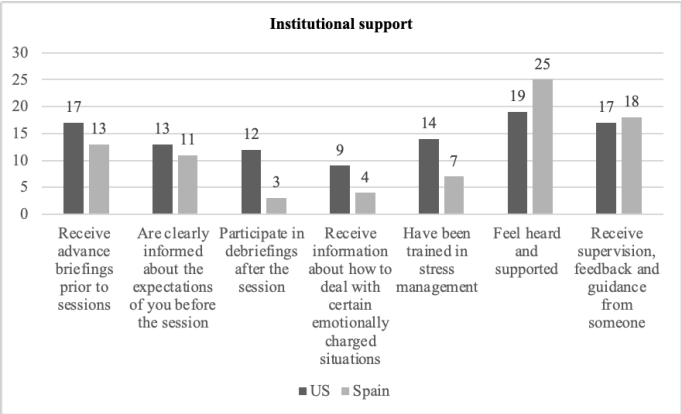


Figure 4: Institutional support received by the participants

Relevant differences between the groups are also apparent in comments about how to deal with situations with a major emotional burden, although, on this point, the affirmative responses are remarkably low from both the Spanish and US interpreters.

The single greatest difference appears regarding debriefings following a session of interpretation. While 37.5% of US participants seem to have that option, only approximately 7% of the interpreters in Spain can say the same.

Finally, the study reveals that both groups of interpreters do seem to feel themselves listened to and supported, as well as getting supervision, feedback, and orientation in similar numbers and percentages. Therefore, it is reasonable to affirm that the most outstanding differences are those in training and protocols.

3. Discussion

As reflected in § 2, one of the most evident differences between the two contexts in this study, in terms of interpersonal and organizational strategies, refers to the chance of having briefings or debriefings. The difference is fundamental for the question at hand, as debriefing can be considered a key aspect for emotional processing following complicated or emotionally intense situations (Rhodes *et al.* 2021; James/Crawford 2024).

It is also evident that training resources geared to emotional well-being are more abundant in the US, which coincides with the findings of previous studies into the degree of professionalization enjoyed by interpretation there (El-Metwally 2021; Hancox *et al.* 2023). It would ideally be the institution where the interpreter works that provides such training, fundamental as it is in reducing the effects of emotional impact (Bontempo/Malcolm 2012). Moreover, should that training involve interpreters and healthcare professionals participating together, it would foster mutual knowledge and recognition and contribute to a more positive perception of the value of interpreters (Krystallidou *et al.* 2018).

Ultimately, the inclusion of content on coping with emotional impact is of paramount importance in the training of healthcare interpreters. However, and despite the questionnaire designed for this study containing a question specific to the matter, it has only been possible to corroborate the effect of such training on the development of symptoms associated with vicarious trauma for interpreters working in the US, as the percentage of American interpreters trained in that area was outstanding (approx. 56%).⁶

Therefore, as shown in Figure 5, it seems that training in self-care, stress management, and other strategies in preventing vicarious trauma help reduce the symptoms associated with the emotional impact derived from interpreting in healthcare settings (Bontempo/Malcolm 2012; Creeze *et al.* 2015; Lai *et al.* 2015; Ndongo-Keller 2015; Darroch/Dempsey 2016; Kondel 2018; Lai/Costello 2021; Korpai/Mellinger 2022; Lim *et al.* 2022).

6 The study has not been able to confirm this for interpreters who work in Spain, as only 3 interpreters of a total of 42 said they had received training in the area and explained that the training had been only practical and not specifically related to their work as healthcare interpreters, which does not give grounds for conclusions.

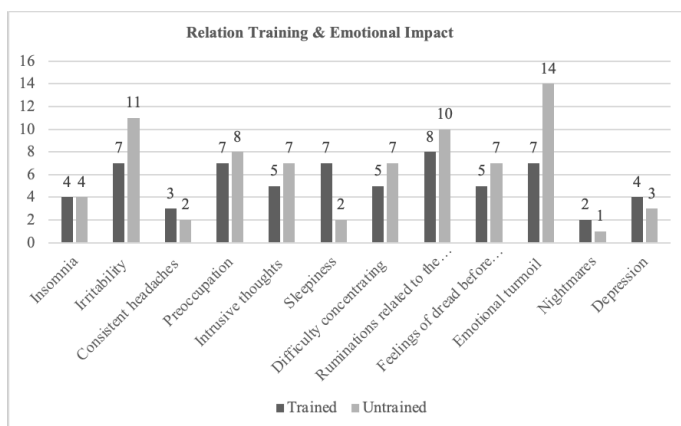


Figure 5: Symptoms experienced by trained and untrained participants from the US

Concerning the three commonest symptoms among all the participants from the US (which, as stated above, were irritability, preoccupation and emotional turmoil), the data in Figure 5 show that the number is higher in the case of untrained interpreters. The effect of training is even more evident if the percentages of interpreters with those symptoms among their same group are considered (trained or untrained interpreters), ranging from 39% of the interpreters who had been trained for the three symptoms to 79%, and 57% to 100% respectively of the interpreters without training.

Nightmares and depression are still the least frequent symptoms, and they are joined at the lower end of the scale by consistent headaches and insomnia. In relation to these symptoms, the numbers are very similar for trained and untrained interpreters, or even slightly higher for the former, but again, the lack of training led to higher percentages.

Lastly, the symptom of ruminations related to the patients' stories calls for greater attention, as the percentage of emotionally trained interpreters who complained about that remains high (44%).

In summary, the data suggest that training may act as a protecting factor, equipping interpreters with resources to face the emotional demands of their job. The prevalence of negative responses for the majority of symptoms, which can lead to workplace stress and compassion fatigue, supports the hypothesis that proper training helps to mitigate such symptoms.

On the other hand, the study has not been able to verify the initial hypothesis, namely, that the greater recognition and professional development of interpreting in the US, together with better working conditions and institutional support, would help interpreters there to prevent or reduce the symptoms associated with vicarious trauma to a greater degree than their Spanish counterparts. In fact, as shown above, US interpreters feel less appreciated (see Figure 3), and the effects of emotional impact on their personal and professional lives seem to be greater than those declared by interpreters in Spain (see Figure 2).

4. Conclusions

The Institute of Translation and Interpreting (ITI), based in the UK, recently recognized that those interpreters who carry out their work in healthcare contexts frequently find themselves facing highly emotional situations, which can affect them personally and professionally (Hancox *et al.* 2023). Faced with this reality, both healthcare institutions and other entities responsible for contracting interpreters -be they agencies or organizations- need to guarantee that those professionals can depend on the proper resources to support them and that they are properly informed at all times of the dangers inherent in their work (El-Metwally 2021).

However, this kind of institutional support would seem, in numerous cases and contexts, to be inexistent or, at best, insufficient, as:

The ambiguity about the interpreters' credentials and employment conditions is not surprising in that public service interpreting is by and large an underregulated or, in most cases [...] an unregulated profession. (Lai *et al.* 2015: 7)

Numerous studies coincide in highlighting the need for specific training for interpreters in close collaboration with healthcare personnel, especially in complicated clinical scenarios, such as when communicating bad news or accompaniment during palliative care, where interactions tend to be emotionally intense and difficult to deal with (Latif *et al.* 2022; Slusarz 2023; James/Crawford 2024; Williams *et al.* 2024). The benefits that training entails, (especially that provided by the interpreters' own institution), have been validated by the results of our study, since the most common symptoms associated with vicarious trauma were appreciably experienced more by those US interpreters who were untrained in comparison with those trained.

The importance of briefings and debriefings in preventing or reducing emotional strain has been also highlighted by the participants in our study. Therefore, focus must be placed in this context on the usefulness of briefings as a key tool in the preparation of an interpreter, not just from the linguistic and cultural viewpoint but also -and as a priority- from an emotional standpoint (Goldhirsch *et al.* 2021; Rhodes *et al.* 2021; Hancox *et al.* 2023). Furthermore, having completed the interpretive task, it is fundamental that the interpreter has access to a safe space to share and reflect on what has happened during the interpreting session. Said space should allow of the option of psychological support, if necessary (Kirby *et al.* 2017; Martin *et al.* 2022), and a review of any relevant professional aspects that may have come up during the interaction (Norris *et al.* 2005; Rhodes *et al.* 2021).

In short, the importance of interpersonal and organizational strategies is greater than that of intrapersonal ones, since:

Appropriate organisation-level strategies (specifically raising awareness among interpreters, providing opportunities for debriefing, promoting collaboration, diversification) are a major factor in preventing interpreter burnout and VT [vicarious trauma], and should therefore be prioritised over educating interpreters about personal coping strategies. (Pyke 2023: 49)

To conclude, the results of the study bring to light the need to invest in emotional management and psychological support for healthcare interpreters. It is also recommended that specific training in self-care and resilience development be included in professional training programs.

References

- Al Shamsi H. / Almutairi A. G. / Al Mashrafi S. / Al Kalbani, T. (2020) "Implications of language barriers for healthcare: a systematic review", *Oman Medical Journal* 35/2, e122.
- Álvaro Aranda C. / Lázaro Gutiérrez R. (2021) "La formación en interpretación sanitaria y su camino hacia la profesionalización: un análisis de itinerarios formativos propuestos desde distintas entidades en España", *Panace@. Revista de Medicina, Lenguaje y Traducción* XXII/53, 69-77.
- Anderson A. (2011) "Peer support and consultation project for interpreters: a model for supporting the well-being of interpreters who practice in mental health settings", *Journal of Interpretation* 21/1, 8-20.
- Bancroft M. A. (2015) "Community interpreting: a profession rooted in social justice" in H. Mikkelsen / R. Jourdenais (eds) *The Routledge Handbook of Interpreting*, London and New York, Routledge, 217-234.
- Bancroft M. A. / Allen K. / Green C.E / Feuerle L. E. (2018) "Breaking silence: interpreting for victim services", <<https://ayuda.com/wp-content/uploads/2017/06/Breaking-Silence-Training-Manual-1.pdf>>.
- Bischoff A. / Kurth E. / Henley A. (2012) "Staying in the middle: a qualitative study of health care interpreters' perceptions of their work", *Interpreting* 14/1, 1-22.
- Bontempo K. / Malcolm K. (2012) "An ounce of prevention is worth a pound of cure: educating interpreters about the risk of vicarious trauma in healthcare settings", in K. Malcolm / L. Swabey (eds) *In our Hands: Educating Healthcare Interpreters*, Washington, Gallaudet University Press, 105-130.
- Camacho Sánchez F. (2019) "Formación en traducción e interpretación en los servicios públicos en los programas oficiales de grado impartidos en España", *FITISPos International Journal* 6, 235-245.
- Cavanagh N. / Cockett G. / Heinrich C. / Doig L. / Fiest K. / Guichon J. R. / Page S. / Mitchell I. / Doig C. J. (2020) "Compassion fatigue in healthcare providers: a systematic review and meta-analysis", *Nursing Ethics* 27/3, 639-665.
- Costa B. (2016) "Training and clinical supervision of therapists and interpreters working in a gender violence context", in M. del Pozo Triviño / C. Toledano Buendía / D. Casado Neira / D. Fernandes del Pozo (eds) *Construir puentes de comunicación en el ámbito de la violencia de género/Building Communication Bridges in Gender Violence*, Granada, Comares, 61-71.
- Creeze I. / Atkinson D. / Pask R. / Au P. / Wong S. (2015) "Teaching interpreters about self-care", *International Journal of Interpreter Education* 7/1, 74-83.
- Darroch E. / Dempsey R. (2016) "Interpreters' experiences of transference dynamics, vicarious traumatization, and their need for support and supervision:

- a systematic literature review”, *The European Journal of Counselling Psychology* 4/2, 166-190.
- El-Metwally M. (2021) “Position statement on vicarious trauma in interpreters”, <<https://www.iti.org.uk/resource/position-statement-on-vicarious-trauma-in-interpreters.html>>.
- Foulquié Rubio A. I. / Niemants N. / Andreica A. (2024) “Medical Interpreting in Spain, Italy and Romania: healthcare providers’ and users’ viewpoints”, in A. Nevado Llopis / A. I. Foulquié Rubio (eds), *Medical Interpreting. Training the Professionals*, Peter Lang, 9-55.
- Goldhirsch J. / Halpenny B. / Scott N. / Ma Y. / Rodriguez M. S. / Abrahm J. L. (2021) “What’s lost in translation: a dialogue-based intervention that improves interpreter confidence in palliative care conversations”, *Journal of Pain and Symptom Management* 62/3, 609-614.
- Gomez A. (2012) *Vicarious Trauma and Posttraumatic Growth: A Study of how Interpreters Working in Psychotherapy are Impacted by their Work*, unpublished MA Thesis, Dublin Business School.
- Graves J. M. / Ross N. / Gonzalez C. / Moore M. / Denson V. / Vavilala M. S. (2023) “Compassion and trauma: occupational health experiences of certified medical interpreters in five U.S. States”, *Workplace Health & Safety* 71/9, 436-444.
- Hadziabdic E. / Albin B. / Heikkilä K. / Hjelm K. (2010) “Healthcare staffs’ perceptions of using interpreters: a qualitative study”, *Primary Health Care Research and Development* 11/3, 260-270.
- Hancox J. A. / McKiernan C. F. / Martin A. L. / Tomas J. / MacArtney J. I. (2023) “The emotional effects on professional interpreters of interpreting palliative care conversations for adult patients: A rapid review”, *Palliative Medicine* 37/7, 931-946.
- Hsieh E. (2008) “‘I am not a robot!’ Interpreters’ views of their roles in health care settings”, *Qualitative Health Research* 18/10, 1367-1383.
- Isobel S. / Thomas M. (2022) “Vicarious trauma and nursing: an integrative review”, *International Journal of Mental Health Nursing* 31/2, 247-259.
- James H. / Crawford G. B. (2024) “Healthcare interpreters and difficult conversations: a survey”, *BMJ Supportive & Palliative Care* 14 (e1), e1049.
- Kirby E. / Broom A. / Good P. / Bowden V. / Lwin Z. (2017) “Experiences of interpreters in supporting the transition from oncology to palliative care: a qualitative study”, *Asia-Pacific Journal of Clinical Oncology* 13/5, e497-e505.
- Knodel R. K. (2018) “Coping with vicarious trauma in mental health interpreting”, *Journal of Interpretation* 26/1, article two.
- Korpal P. / Mellinger C. D. (2022) “Self-care strategies of professional community interpreters. An interview-based study”, *Translation, Cognition and Behaviour* 5/2, 275-299.
- Krystallidou D. / Deveugele M. / Vand de Walle C. / Dougali E. (2018) “Training doctor-minded interpreters and interpreter-minded doctors: first insights into the benefits of collaborative practice in interpreter training”, *Interpreting. An International Journal of Research and Practice in Interpreting* 20/1, 126-144.

- Lai M. / Costello S. (2021) "Professional interpreters and vicarious trauma: an Australian perspective", *Qualitative Health Research* 31/1, 70-85.
- Lai M. / Heydon G. / Mulayin S. (2015) "Vicarious trauma among interpreters", *International Journal of Interpreter Education* 7/1, 3-22.
- Latif Z. / Kontrimas, J. / Goldhirsch, J. / Abraham, J. / Warraich, H. J. (2022) "Top ten tips palliative care clinicians should know about working with medical interpreters", *Journal of Palliative Medicine* 25/9, 1426-1430.
- Lerias D. / Byrne M. K. (2003) "Vicarious traumatization: symptoms and predictors", *Stress and Health* 19, 129-138.
- Lim P. S. / Olen A. / Carballido J. K. / LiaBraaten B. M. / Sinnen S. R. / Balistreri K. A. / Tager J. B. / Rothschild C. B. / Scanlon M. C. / Davies W. H. / Nordness K. (2022) "'We need a little help': a qualitative study on distress and coping among pediatric medical interpreters", *Journal of Hospital Management and Health Policy* 6, 36.
- Martin F. C. / Philip J. / McLachlan S. A. (2022) "Healthcare Professionals' Views of Working with Medical Interpreters in a Cancer Setting: An Exploratory Study", *Journal of Cancer Education* 37/4, 1115-1121.
- Michalec B. / Maiden K. M. / Ortiz J. / Bell A. V. / Ehrental D. B. (2014) "Providers' perceptions of medical interpreter services and Limited English Proficiency (LEP) patients: understanding the 'bigger picture'", *Journal of Applied Social Science* 9/2, 156-169.
- Miller K. E. / Martell Z. L. / Pazdirek L. / Caruth M. / Lopez D. (2005) "The role of interpreters in psychotherapy with refugees: an exploratory study", *American Journal of Orthopsychiatry* 75/1, 27-39.
- Moberly T. (2018) "Doctors choose Google Translate to communicate with patients because of easy access", *BMJ* (Clinical research ed.) 362, k3974.
- Ndongo-Keller N. (2015) "Vicarious trauma and stress management", in H. Mikkelsen / R. Jourdenais (eds), *The Routledge Handbook of Interpreting*, London and New York, Routledge, 337-351.
- Nevado Llopis A. / Foulquié Rubio A. I. (2023) "Healthcare interpreting training: present and future at Spanish universities", in R. Lázaro Gutiérrez / C. Álvaro Aranda (eds) *New Trends in Healthcare Interpreting Studies New Frontiers in Translation Studies*, Berlin, Springer, 129-156.
- Norris W. M. / Wenrich M. D. / Nielsen E. L. / Treece P. D. / Jackson J. C. / Curtis J. R. (2005) "Communication about end-of-life care between language-discordant patients and clinicians: insights from medical interpreters", *Journal of Palliative Medicine* 8/5, 1016-1024.
- Ortega Herráez J. M. / Abril Martí M. I. / Martín A. (2009) "Community interpreting in Spain: a comparative study of interpreters' self-perception of role in different settings", in S. Hale / U. Ozolins / L. Stern (eds) *The Critical Link 5: Quality in Interpreting – A Shared Responsibility*, Amsterdam, John Benjamins Publishing Company, 149-167.
- Pearlman L. A. / Saakvitne K. W. (1995) "Treating therapists with vicarious traumatization and secondary traumatic stress disorders", in C. Figley (ed.) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who Treat the Traumatized*, New York, Routledge, 150-177.

- Pöchhacker F. (2000) "The community interpreter's task: self-perception and provider views", in R. P. Roberts / S. E. Carr / D. Abraham / A. Dufour (eds) *The Critical Link 2: Interpreters in the Community. Selected Papers from the Second International Conference on Interpreting in Legal, Health and Social Service Settings*, Amsterdam, John Benjamins Publishing Company, 49-65.
- Pyke G. M. (2023) *The Psychological Implications of Interpreting for Survivors: Training as a Tool for Addressing Vicarious Trauma among Interpreters*, unpublished MA Thesis, University of Geneva.
- Rhodes M. G. / Fletcher K. E. / Blumenfeld-Kouchner F. / Jacobs E. A. (2021) "Spanish medical interpreters' management of challenges in end-of-life discussions", *Patient Education and Counseling* 104/8, 1978-1984.
- Şentürk E. / Orhan-Sungur M. / Özkan-Seyhan T. (2021) "Google Translate: Can It Be a Solution for Language Barrier in Neuraxial Anaesthesia?", *Turkish journal of anaesthesiology and reanimation* 49/2, 181-182.
- Skaaden H. (2023) "'Interpreter's mistake': Why should other professions care about the professionalization of interpreters?", in L. Gavioli / C. Wadensjö (eds) *The Routledge Handbook of Public Service Interpreting*, London, Routledge, 261-276.
- Slusarz, C. (2023) "The roles and experiences of medical interpreters in palliative care: A narrative review", *Palliative & Supportive Care* 19, 1-8.
- Splevins K. A. / Cohen K. / Joseph S. / Murray C. / Bowley J. (2010) "Vicarious post-traumatic growth among interpreters", *Qualitative health research* 20/12, 1705-1716.
- Williams K. E. / Casola A. R. / Mechler K. (2024) "Interpreting Difficult Conversations—Evaluating How to Support Medical Interpreters in the Delivery of Serious News", *Journal of Palliative Medicine* 27/9, 1210-1214.

Taking care of ourselves to be able to take care of others

INFORMED CONSENT

All personal data will be treated by the research team according to the applicable legislation, especially that relating to Data Protection, for scientific and research purposes as specified in the participant information sheet enclosed to this document. All personal data will be anonymised and identified using a code so as to protect the participants' identity, which shall not be disclosed. Any Information presented in any subsequent scientific publications will be anonymised and will not allow for the identification of the participants.

I UNDERSTAND that my participation is voluntary and that I am free to withdraw up to the point where the data is anonymised, without giving reason and without there being any negative consequences. In addition, I can decline to participate or abandon the questionnaire at any time.

☐

Yes

I GIVE PERMISSION for members of the Research Team to have access to my anonymised responses.

☐

Yes

Gender

- ☐ Male
☐ Female
☐ Other

Age

Job location - CITY

Job location - COUNTRY

How many years have you been working as a healthcare interpreter?

- ☐ Less than a year
☐ 1-3 years
☐ 4-6 years
☐ 7-10 years
☐ More than 10 years

Where have you worked as a healthcare interpreter?

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	Yes	No
Public hospital	☐	☐
Private hospital	☐	☐
Clinic	☐	☐
Other	☐	☐

Do you currently work as a healthcare interpreter

- ☐ full-time?
☐ part-time?
☐ occasionally?
☐ I do not work currently as a healthcare interpreter

Have you been trained to work as a healthcare interpreter?

- ☐ Yes
☐ No

If your answer was affirmative, what kind of training have you received and how long did it last?

In case you have been trained, did this training include any contents related to dealing with the emotional impact of interpreting and self-care?

- ☐ Yes
☐ No

If your answer was affirmative, what kind of contents were included and how were they taught?

1. While working as a healthcare interpreter, have you ever felt ...

	Yes	No
overwhelmed?	☐	☐
shocked?	☐	☐
exhausted?	☐	☐
sad?	☐	☐
stressed?	☐	☐
frustrated?	☐	☐
angry?	☐	☐
lonely?	☐	☐
irritable?	☐	☐
anxious?	☐	☐
powerless?	☐	☐
fearful?	☐	☐
hopeless?	☐	☐

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	Yes	No
conflicted?	☐	☐

2. In case you experienced any of them, could you recall and describe any specific situation which provoked those feelings?

3. In case you experienced any of those feelings, do you (Choose the one that happens most frequently)

☐ stop suffering from them after the completion of the assignment?

☐ be somewhat disturbed by them for a while?

☐ be extremely disturbed by them for a while?

☐ be extremely disturbed by them for a long time?

4. Did some of those feelings have an effect on your

	Yes	No
professional life?	☐	☐
personal life?	☐	☐

5. If your answer was affirmative, in which way did those feelings affect your professional or personal life?

6. Have you had any of these symptoms during your interpreting career in healthcare settings?

	Yes	No
insomnia	☐	☐
irritability	☐	☐
consistent headaches	☐	☐
preoccupation	☐	☐
intrusive thoughts	☐	☐
sleepiness	☐	☐
difficulty concentrating	☐	☐
ruminations related to the patients' stories	☐	☐
feelings of dread before attending work assignments	☐	☐
emotional turmoil	☐	☐
nightmares	☐	☐
depression	☐	☐

7. With respect to the patients and their stories, in general you ...

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	Yes	No
feel strong empathetic connections	☐	☐
experience shared emotions	☐	☐
find it difficult to stop thinking about them	☐	☐
feel over-identified	☐	☐
feel as though you hold and carry the emotional impact of their words	☐	☐

8. What could be, in your opinion, the consequences derived from any of the attitudes/behaviors described in the previous question?

9. Have you ever noticed that the patient sees you as an ally, a friend or a family member?

☐ Yes

☐ No

10. If your answer was affirmative, could you explain how you felt and reacted in that situation?

11. How do you feel when you have to interpret healthcare providers' words and they...

transmit an inappropriate and insulting message?

communicate bad news?

oppress or discriminate the patient?

are aloof or insensitive when exchange information with the patient?

give inadequate care to the patient?

12. Do you think that the healthcare providers who work with you ...

	Yes	No
lack respect for and understanding of your work	☐	☐
underestimate you	☐	☐
show acknowledgement and recognition of the complexity of your work	☐	☐

4

Taking care of ourselves to be able to take care of others

	Yes	No
are conscious of the stress suffered when interpreting	☐	☐
view you as a machine or a common consumable	☐	☐
pay attention to your emotional wellbeing and your physical safety	☐	☐
grant you the same rights, values and respect as to other service providers	☐	☐
take into account the emotional hardship of your work	☐	☐
are supportive and approachable	☐	☐
are aware of your needs	☐	☐

13. At your workplace, you...

	Yes	No
receive advance briefings prior to sessions	☐	☐
are clearly informed about the expectations of you before the session	☐	☐
participate in debriefings after the session	☐	☐
receive information about how to deal with certain emotionally charged situations	☐	☐
have been trained in stress management	☐	☐
feel heard and supported	☐	☐
receive supervision, feedback and guidance from someone	☐	☐

14. How important and helpful are the previous statements for you and why?

15. What coping strategies do you use to deal with the impact of your work?

	Yes	No
exercise	☐	☐
practice yoga	☐	☐
spirituality	☐	☐
ask for psychological support	☐	☐
isolate yourself from others for a while	☐	☐
positive self-talk/optimism	☐	☐
denial of your feelings and avoidance of emotional reactions while working	☐	☐
meditation	☐	☐
journal and reflect on the assignments afterwards	☐	☐

Taking care of ourselves to be able to take care of others

	Yes	No
self-medication	☐	☐
avoid accepting potentially impactful assignments	☐	☐
talk to family and friends about your experiences and feelings	☐	☐
use third person while interpreting (instead of first person)	☐	☐
socialize	☐	☐
over sleeping	☐	☐
talk to other interpreters	☐	☐
consumption of alcohol and/or drugs	☐	☐
receive emotional support from co-workers	☐	☐
take a short holiday/a regular leave	☐	☐
participate in peer-support groups	☐	☐
engage in extra learning and training	☐	☐
others	☐	☐

16. Would you like to have any of the options indicated in the previous questions but they are not provided in your workplace?

- ☐ Yes
☐ No

17. If your answer was affirmative, what option/s would you like to have?

18. Could you describe the positive aspects of your work, if any?

If you wish to receive the results of the study, please indicate your email address: