# '*You cannot pour from an empty container*': The impact of working with trauma survivors on mental health professionals

**Thesis submitted for the degree of**
**Doctorate in Clinical Psychology**
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**by**

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**Declaration**

**I confirm that this research report is my original work. It has been submitted in partial fulfillment for the degree of Doctorate in Clinical Psychology and no part of it has been submitted for any other degree or academic qualification.**

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**Sonia Kaur Dhinse**

## Thesis Abstract

**Literature Review:** In the research literature a number of different constructs have been used to describe the positive and negative impact of working with trauma survivors on professionals. These include vicarious traumatisation, secondary traumatic stress, compassion fatigue, vicarious post traumatic growth and compassion satisfaction. The systematic review aimed to explore the factors that influence the impact of working with trauma survivors on mental health professionals providing psychological therapy. 14 studies were included in the review. Despite the varying methodological limitations and relative quality of evidence, the studies suggest various therapist, support and trauma work related factors that can moderate the impact of vicarious exposure to trauma on therapists (e.g. personal trauma history, empathy, social support and vicarious exposure to trauma). The relationship between the constructs is also explored. The implications of the findings for research and clinical practice are discussed.

**Research Report:** Experiences of sexual violence are common amongst the refugee population. For therapists and interpreters involved in providing psychological therapy for women who have experienced sexual trauma the work can have a significant emotional impact. While some research has focussed on vicarious trauma in therapists little is known about the impact of working with sexual trauma survivors on interpreters in therapy. The current study aimed to explore the experience and impact on female interpreters of interpreting for female sexual trauma violence survivors. The study used an Interpretative Phenomenological Analysis. Four superordinate themes emerged. These included: The 'Invisible' Interpreter, Feeling The Trauma, Making Connections and Changed Understandings. The implications of the findings for the organisations, clinical practice and research are discussed.

**Critical Appraisal:** This section offers a reflexive account of the trainee's research journey and as such, includes the challenges faced and the impact of the process on the trainees understanding and development.

**Acknowledgments**

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My work is dedicated to my parents, especially my father. I would not be where I am today without you both.

I hope the findings of my research will be beneficial for everyone, from lay people to clients, professionals and services, as this area of research is something that we can all identify with.

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*Mandatory appendices
** Anonymised transcripts with pseudonyms are available on a USB drive.

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# Part A:

## Literature Review

# The relationship between factors that influence the psychological impact of working with trauma survivors on mental health professionals: A quantitative systematic review

Target Journal: Journal of British Clinical Psychology

(Publication guidelines can be found in Appendix A)

## Abstract

**Objectives.** To examine the factors that influence the impact of working with trauma survivors on mental health professionals.

**Methods.** Five databases were searched (PsychINFO, Scopus, Medline, PILOT & PsychExtra) using relevant keywords. These included “secondary traumatic stress”, “vicarious trauma”, “post traumatic growth”, “compassion fatigue”, “compassion satisfaction” and relevant occupational groups. Specific inclusion and exclusion criteria were applied.

**Results.** The databases yielded 710 articles (including duplicates) in total. 56 articles were deemed relevant. 14 articles were selected based on the remaining inclusion and exclusion criteria. The quality of these papers were critically evaluated using STROBE.

**Conclusions.** Despite the varying methodological limitations, the studies suggest various mental health professional, support and trauma work related factors can moderate the impact of vicarious exposure to trauma on professionals. The constructs were also interrelated. There is likely to be a complex interplay amongst these factors.

**Practitioner points**

*Clinical implications*

- Researchers’ need to work towards a consensus on the constructs and methods used to examine them in this area of research.
- A multifaceted approach is required in understanding the impact of vicarious exposure to trauma on professionals.
- Psychoeducation is essential. Clinical supervision and training can provide avenues to normalise the impact of trauma work on professionals and support professionals in reflecting on their risk and protective factors to plan appropriate support.

*Limitations of the study*

- The review omits qualitative research and studies that did not specify the occupational groups examined.
- There are likely to be differences between the occupational groups and countries explored.

# 1. Introduction

## 1.1. Concept of Trauma

Trauma is a subjective concept, as the perception and experience of trauma can vary across individuals. The definition of trauma has evolved over the years. The Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association, 2000) states that traumatic events are "an event or events that have involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" and produces an "intense fear, helpfulness, or horror" in the individual who has experienced the event (as cited in Lindsey & Powell, 2007, p. 165). The impact of traumatic experiences can exceed beyond the individual who has directly experienced a traumatic event to others through a process called vicarious exposure (Pearlman & Saakvitne, 1995).

## 1.2. The negative impact of vicarious exposure to trauma

Research has largely focused on the negative impact on those working with trauma survivors. Three constructs have been used to describe the negative effects of vicarious exposure to trauma. These include secondary traumatic stress (STS), vicarious traumatisation (VT) and compassion fatigue (CF).

Figley (1983) was the first to describe the negative effects of vicarious exposure to trauma using STS, based on his work on family and friends of trauma survivors. STS was defined as "the natural consequent behaviours and emotions resulting from helping or wanting to help a traumatised or suffering person" (Figley, 1983, p. 7). The symptoms of STS mirror symptoms of Post-Traumatic Stress Disorder (PSTD). PTSD is a psychological condition experienced by trauma survivors through their direct exposure to traumatic events. Individuals experiencing STS can experience physiological symptoms (e.g. increased arousal), cognitive symptoms (e.g. flashbacks), emotional and behavioural symptoms (e.g. withdrawal) associated with PTSD. The process of STS

is a rapid, short term process and can lead to STS disorder in therapists (Figley & Kleber, 1995).

McCann and Pearlman (1990) put forward their Constructivist Self-Development Theory (CSDT) to describe the negative internal cognitive changes that can occur in psychotherapists working with trauma survivors. They called this VT. According to the CSDT, individuals make sense of their world and themselves through cognitive schemas (e.g. beliefs) based on their experiences. Schemas help individuals to construct their own realities and can be modified overtime in light of new experiences. Therapeutic engagement with trauma survivors can negatively threaten a therapist's sense of reality and their schemas associated with five key areas; safety, trust, esteem, control and intimacy. The difficulties in making sense of the discrepancy between a therapist's existing beliefs and a client's traumatic experiences can leave the therapist feeling unsafe, fearful and powerless over situations. This can in turn lead to changes in a therapist's belief system. A therapist may view the world as an unsafe place, self as unable to cope and others as untrustworthy, contributing to further difficulties such as, problems in interpersonal relationships, emotional numbness, fatigue, depression and anxiety (Conrad & Kellar-Guenther, 2006; Pearlman and Saakvitne, 1995). The process of VT is a cumulative process, occurring overtime and can be permanently transformative compared to other constructs.

CF is a recent construct compared to VT and STS (Newell & MacNeil, 2010). Figley (2002) describes CF as emotional and physical fatigue amongst helping professions. It is viewed as a cumulative process and a product of sustained empathy with trauma survivors, work related demands and pressures.

Research has found evidence of STS, VT and CF amongst professionals across disciplines such as, interpreters, emergency service providers, nurses, social workers, police, therapists and lay people vicariously exposed to trauma (Baird & Jenkins, 2003; Bride, 2007; Meadors, Lamson, Swanson, White, & Sira, 2009; Moran & Briton, 1994; Sabin-Farrell & Turpin, 2003).

## 1.3. Moving beyond the negative impact of vicarious trauma

Recent research has challenged the common preconception that vicarious exposure to trauma can only have negative consequences on professionals. Vicarious post traumatic growth (VPTG) and compassion satisfaction (CS) have been used to describe the positive effects of working with trauma survivors. VPTG encompasses a range of positive effects such as, a sense of accomplishment, increased compassion towards trauma survivors, positive changes in a therapist's view about themselves, others and the world, a growth in spiritual beliefs and a greater personal meaning in life (Arnold, Calhoun, Tedeschi, & Cann, 2005; Tedeschi & Calhoun, 1995). Stamm (2005) describes CS as a strong sense of pleasure/fulfilment from helping others. Some suggest CS is specific to therapists and separate from VPTG, as it arises from the intense emotional engagement in therapy (Figley, 2002; Larsen & Stamm, 2008).

The positive and negative effects of working with trauma survivors can occur simultaneously. However, the exact relationship between the two has not been established. Research has found evidence of VPTG and CS amongst professionals working with trauma survivors and lay people vicariously exposed to trauma (Arnold et al., 2005; Collins & Long, 2003; Conrad & Kellar-Guenther, 2006).

## 1.4. Conceptual overlap and confusion

Originally, it was assumed that any form of secondary distress (e.g. VT, CF, STS) experienced through vicarious exposure to trauma was specific to clinicians working with trauma compared to other professional groups such as interpreters (Ellwood, Mott, Lorh & Galovski, 2010). However, later studies have found that secondary distress can be experienced by other professionals groups and lay people. Nevertheless, there is a significant overlap between all of the constructs used to describe the impact of vicarious exposure to trauma. Some researchers suggest that they are distinct constructs but related, and there is evidence to show that individuals, including non-therapists can experience them simultaneously (Ellwood et al. 2010; Figley, 1995; Newell & MacNeil, 2010). Despite STS and VT being different in nature (e.g. emotional and behavioural responses versus changes in cognitive schemata) and

process (e.g. rapid versus cumulative), they are both used interchangeably by professionals and researchers (Taylor & Furlonger, 2011). Similarly, some argue that CF consists of physical and behavioural symptoms typical of STS and burnout (Newell & MacNeil, 2010). Burnout is described as "emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who do people-work of some kind" (Maslach, 1982, p.98). It is does not require vicarious exposure to trauma to occur and is often related to organisational demands. CS and CF can be found amongst caring professions regardless of trauma (Joinson, 1992; Phelps, Lloyd, Creamer, & Forbes, 2009). A similar pattern is found amongst the measures used to examine the aforementioned constructs.

### 1.5. Aims of the current review

In the context of psychological therapy, therapists are vicariously exposed to varying levels of trauma. It is important to explore the factors that influence the vicarious impact of working with trauma survivors on mental health professionals to inform our understanding of the risk and protective factors and how the impact might occur. This is key to safeguarding mental health professionals and thereby, trauma survivors, services and organisations. Therefore, the current systematic review aims to investigate recent research (2010-2016) to explore and evaluate the quality of evidence for the factors that moderate the psychological effects of working with trauma survivors in therapy on mental health professionals. To the best of the researcher's knowledge, a systematic review in this area has not been conducted. The PRISMA Guidelines (2009) have been used to report the methods, findings and implications of the current review.

# 2. Method

## 2.1. Search strategy

An initial scoping search of grey literature (e.g. PsychExtra) and databases (Scopus, PsycINFO, PILOT and MedLine) was conducted to explore the keywords used in this field and to set the inclusion and exclusion criteria. The results suggested limited UK based research. Mental health professionals included counsellors, psychologists, clinical social workers and mental health support workers working clinically with trauma survivors (e.g. providing psychological therapy). Vicarious exposure to trauma was defined as hearing the story of and/working therapeutically with trauma survivors. This review was limited to explore the constructs of VT, STS, CS, CF and VPTG and excluded burnout unless it was in association with the constructs examined.

All searches were conducted in November 2016. PsychINFO, SCOPUS and MedLine were chosen as appropriate databases, as they enabled access to a wide range of research. Additionally, The Published International Literature on Traumatic Stress (PILOTS) database was also examined, as it contained literature relating to this topic area. PsychExtra and Google Scholar were used to explore relevant grey literature.

The search strings included the search terms “secondary trauma”, “vicarious trauma”, “vicarious stress”, “secondary traumatic stress”, “post traumatic growth”, “compassion fatigue”, “compassion satisfaction”, “empathy”, “resilience”, “mental health professional”, “therapist”, “psychologist”, “counsellor”, “counsellor” OR “mental health worker”, “nurse”, “support worker”, “healthcare assistant” and “social worker” (see Appendix B for a complete list of the search strings used). A broad range of keywords were used, as terminology varies across countries and researchers. All search strings were applied to all databases. The searches searched for the search terms in the abstract, title and/ keywords of articles. Specific inclusion criteria were applied during the searches to ensure the articles generated were peer reviewed, in English language and published between 01/01/2010 – 16/11/2016 to review recent literature. The researcher focused on research within the last 6 years because of the volume of research in this area and the range of factors being explored.

## 2.2. The shortlisting process

The searches generated 725 articles in total (including duplicates). This included an additional 15 articles from grey literature. The abstracts of articles were screened for relevance. Articles were only identified as relevant if they explored the impact of working with trauma survivors on the professional groups identified and/factors that moderate the impact. 221 relevant articles were identified (excluding duplicates) and saved to RefWorks. The articles were screened again using the aforementioned criteria and two additional exclusion criteria. Articles were selected if they provided quantitative data and the majority of the samples were mental health professionals conducting clinical work with trauma survivors. 56 articles were shortlisted for the final stage of eligibility in the current review and full texts were obtained. Three additional criteria pertaining to inclusion were applied. Articles were included if they obtained primary data and the sample were not directly exposed to trauma in their work settings (e.g. working in war zones). 14 articles met the inclusion criteria (see Figure 1 for a summary of the shortlisting process). Details about the rationale underlying the criteria are provided in Appendix C.

## 2.3. Data extraction and quality assessment

A Data Extraction Proforma (see Appendix D) was used to record key information for each study. The EQUATOR Network website was used to determine the most appropriate quality appraisal tool. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) checklist for cross sectional studies was suggested as most appropriate (see Appendix E) and is a widely used tool (Vandenbroucke et al., 2007). The STROBE consists of 22 items. To the best of the researcher's knowledge, the STROBE and other existing cross sectional quality appraisal tools do not have a scoring system. Therefore, a scoring system was created to indicate the relative strength of the studies evaluated. Each item was assigned a score of 0 (if absent) or 1 (if present). The maximum attainable score was 22.

The scores obtained on the STROBE ranged between 12-19 between studies (see Appendix F for detailed scores). The results of the STROBE were not used to exclude studies, as the review explored a range of variables and research practices and publication guidelines can vary across countries.

### 2.4. Data analysis

A meta-analysis of the selected studies was not possible given the research question, limited of studies conducted on each factor, varying sample sizes and the different analyses performed. As such, the results are synthesised according to the factors explored and the quality of evidence.

## 3. Results

14 studies were selected for the current review. One study was conducted in South Africa, five in the USA, two in UK, one in Poland, one in Europe, one in Israel and three in Australia. Two studies explored STS and VT, two explored VT, two explored STS and CS, one explored CF and CS, two explored STS and VPTG, three explored STS, one explored VPTG and STS and one explored VPTG alone. All studies were cross sectional and sample sizes ranged from 38-320 across the studies. Further methodological details about the individual studies can be found in Table 1.

For the purposes of clarity, the factors moderating the impact of vicarious exposure to trauma on mental health professionals have been grouped into mental health professional related factors, trauma work related factors and support related factors, followed by evidence of the interrelationships between the constructs. Only relevant findings are discussed. These include those relating to the variables of interest in the study which were STS, VT, CF, CS and VPTG.

### 3.1. Mental health professional related factors

These included personal factors relating to the mental health professional such as, personal trauma history, temperament, resilience, personal meaning in life, age, gender, therapeutic experience, training, education, subjective perceptions, sense of coherence, empathy, coping strategies, personal therapy, positive reframing and emotionality.

#### 3.1.1. Personal Trauma History

MacRitchie and Leibowitz (2010) found that personal trauma history correlated with higher levels of VT. Moderated multiple regression analyses revealed that empathy consistently moderated this relationship. Similarly, Williams, Helm, and Clemens (2012) conducted a path analysis and found that a childhood history trauma was directly related to greater levels of VT, and personal wellness mediated this relationship. Counsellors with a personal history of childhood trauma and who

engaged in personal wellness activities (e.g. physical activity) reported lower levels of VT.

Furthermore, Ekundayo, Sodeke-Gregson, Holttum, and Billings (2013) and MacRitchie and Leibowitz (2010) found positive correlations between personal trauma history and STS. Similarly, Cosden, Sanford, Koch, and Lepore (2016) found personal trauma history was predictive of higher levels of STS in their regression analyses. Those in recovery reported higher levels of STS and higher personal trauma history than those who were not in recovery. Ivicic and Motta (2016) found that professionals with personal trauma history showed delayed response times in identifying the colour of trauma related words than control and neutral words based on their hierarchical regression analyses. However, McKim and Smith-Adcock (2014) found no relationships between STS and a personal trauma history.

McKim and Smith-Adcock (2014) found that a personal trauma history was predictive of higher levels of CS. However, Ekundayo et al., (2013) found no significant relationships between the two variables. Brockhouse, Msetfi, Cohen, and Joseph (2011) found no significant relationships between a personal trauma history and higher levels of VPTG. However, those who had a personal trauma history reported significantly less engagement in new possibilities (e.g. new interests in life). Cosden et al., (2016) found personal trauma history to predict higher levels of VPTG. Those in recovery reported higher levels of VPTG and higher personal trauma history than those who were not in recovery.

### 3.1.2. Temperament

Rzeszutek, Partyka, and Golab (2015) found that high levels of emotional reactivity correlated with high levels of STS whilst lower levels of sensory sensitivity were associated with high levels of STS. Regression analyses also found that emotional reactivity and sensory sensitivity were predictive of STS.

### 3.1.3. Resilience and personal meaning in life

Zeleskov-Doric, Herich, and Doric (2012) found a greater personal meaning in life and resilience correlated with lower levels of VT. Regression analyses revealed that personal meaning of relationships with others (e.g. perceiving self as altruistic, trusted by others and helpful to others) was predictive of lower levels of VT and mediated the relationship between resilience and VT. Resilience was not a significant predictor of VT.

### 3.1.4. Age and gender

Robinson-Keiling (2014) found that female therapists were more likely to report greater levels of STS than male therapists. Similarly, Ivicic and Motta (2016) found that female therapists were more likely to exhibit STS than male therapists even though they did not differ on personal trauma history. However, Rzeszutek et al., (2015) did not find this association. Similarly, Zeleskov-Doric et al., (2012) found no relationships between age and VT.

Ekundayo et al., (2013) found that older therapists reported higher levels of CS. Similarly, Brockhouse et al., (2011) found that older therapists reported significantly more total VPTG and appreciation of life and personal strength. However, there were no relationships between gender and VPTG.

### 3.1.5. Therapeutic experience, training and education

Robinson-Keiling (2014) found that experienced therapists reported lower levels of STS compared to least experienced therapists. However, other studies found no relationships between STS and professional experience (Cosden et al., 2016; Ekundayo et al., 2013, Ivicic & Motta, 2016 & Rzeszutek et al., 2015). Similarly, Zeleskov-Doric et al., (2012) found no relationships between therapeutic experience, education and VT.

Gil (2015) found a significant positive correlation between VPTG and years of professional experience. Other studies found no relationships between years of education, training, professional experience and VPTG (Brockhouse et al., 2011;

Cosden et al., 2016). However, McKim & Smith-Adcock (2014) found that being an experienced therapist correlated with higher levels of CS but was not predictive of it.

### 3.1.6. Subjective perceptions

Gil (2015) asked therapists to rate the negative experiences (e.g. pain, horror) and positive experiences (e.g. intimacy, sexual stimulation) related to the client's trauma in therapy. Higher levels of VPTG correlated with perceiving the client's trauma as a physical threat, positive and negative experiences related to client's trauma. The therapist's perception of the client's trauma as a personal threat and the perceived positive and negative experiences related to the client's trauma was also predictive of VPTG.

### 3.1.7. Sense of coherence

Brockhouse et al., (2011) found that a lower sense of coherence (e.g. viewing the world as less meaningful, understandable and manageable) was associated with higher levels of VPTG, personal strength and relating to others. Sense of coherence was also predictive of VPTG.

### 3.1.8. Empathy and/over involvement with trauma survivors

MacRitchie and Leibowitz (2010) found that high levels of empathy were associated with higher levels of VT and STS. Empathy also moderated the relationship between personal trauma history and STS and personal trauma history and VT. Empathy accounted for 45% of variance in STS and 20% of variance in VT together with personal exposure to violent crimes. Empathy was further categorised into low, medium and high. Empathy was then found to moderate the relationship between personal history of trauma and STS but not VT. McKim and Smith-Adcock (2014) found that greater over involvement (e.g. perceived responsibility of clients' welfare) was predictive of increased CF.

Brockhouse et al., (2011) found that high levels of empathy were related to higher levels of VPTG, personal strength, appreciation for life, engaging in new possibilities and relating to others but not spiritual growth. Empathy also directly predicted VPTG and moderated the relationship between cumulative vicarious exposure to trauma and relating to others. Higher levels of empathy reduced the negative impact of cumulative vicarious exposure to trauma on relating to others. Empathy and cumulative vicarious exposure to trauma scores were categorised into low, average and high based on the mean VPTG scores required for each category. The negative relationship between cumulative vicarious exposure to trauma and relating to others was most significant amongst therapists with low empathy, weak in therapists with average levels of empathy and absent in therapists with the highest levels of empathy.

### 3.1.9. Coping Strategies, personal therapy, positive reframing and emotionality

Ekundayo et al., (2013) found greater time spent on self-care activities was predictive of higher levels of STS. However, Williams et al., (2012) found that engaging in personal wellness activities was associated with lower levels of VT and might reduce the negative impact of personal trauma history on VT.

Furlonger and Taylor (2013) found no relationships between coping styles and VT. However, an increased trauma caseload correlated with the use of an increased negative coping style (e.g. avoidance).

Brockhouse et al., (2011) found that therapists who undertook personal therapy reported higher VPTG. However, Cosden et al., (2016) did not find this association.

Samios, Rodzik, and Abel (2012) found that higher levels of VPTG was associated with higher levels of positive emotions. Similarly, Samios, Abel, and Rodzik (2013) found that higher levels of CS was associated with higher levels of positive reframing and positive emotionality. Additionally, positive reframing was found to partially mediate the relationship between high emotionality and high CS.

### 3.2. Trauma work related factors

These included vicarious exposure to trauma, perceived sense of control over work activities, therapeutic model and type of practice.

#### 3.2.1. Vicarious exposure: Trauma caseload and/ time spent working with trauma survivors

Two studies found a positive correlation between caseload and STS (Furlonger & Taylor, 2013; Robinson-Keiling, 2014). McKim and Smith-Adcock (2014) also found that greater vicarious exposure to trauma was predictive of higher levels of CF. However, other studies found no relationships between the above variables (Ekundayo et al., 2013, Ivicic & Motta, 2016; MacRitchie & Leibowitz, 2010; McKim & Smith-Adcock, 2014; Rzeszutek et al., 2015; Williams et al., 2012).

Brockhouse et al., (2011) found that higher levels of cumulative vicarious exposure (years of career) directly predicted higher overall levels of VPTG. Recent measures of vicarious exposure did not predict VPTG.

Ekundayo et al., (2013) found no relationships between caseload and CS. However, spending more time on non-therapeutic work (e.g. development activities) was predictive of high levels of CS. Similarly, McKim and Smith-Adcock (2014) also found no relationships between negative clientele and CS.

#### 3.2.2. Perceived sense of control over work activities and therapeutic model

McKim and Smith-Adcock (2014) found that perceived less control over work activities was predictive of increased CF and low levels of CS.

Ekundayo et al., (2013) found no relationships between predominant therapeutic model and STS.

### 3.2.3. Private vs Public practice

Brockhouse et al., (2011) found that public work rather than private practice was associated with higher levels of spiritual change.

## 3.3. Support related factors

These included supervision, perceived organisational support, job satisfaction and social support.

### 3.3.1. Supervision

Two studies found no relationships between supervision and STS (Ivicic & Motta, 2016; Rzeszutek et al., 2015). Furlonger and Taylor (2013) found that a good supervisory relationship and regular supervision was associated with lower levels of VT but this relationship was insignificant. Similarly, Williams et al., (2012) also found no relationships between a good supervisory relationship and VT. McKim and Smith-Adcock (2014) also found no relationships between perceived levels of support from supervisors and co-workers and CF.

Brockhouse et al., (2011) found that higher levels of supervision correlated with higher levels of spiritual change. However, Cosden et al., (2016) found that having supervision was not related to higher levels of VPTG. Ekundayo et al., (2013) found that high perceived levels of support from supervision was predictive of high levels of CS. However, McKim and Smith-Adcock (2014) found no relationships between the aformentioned two variables. In relation to STS, Ekundayo et al., (2013) found that greater time spent in individual supervision was associated with higher levels of STS.

### 3.3.2. Perceived organisational support and job satisfaction

Ivicic and Motta (2016) found no relationships between job satisfaction and STS. Similarly, Williams et al., (2012) found mixed findings about the relationship

between job satisfaction and VT. Low job satisfaction was related to greater levels of VT in correlational analyses but not the path analysis in the presence of other factors.

Brockhouse et al., (2011) found that perceived level of management support did not predict VPTG. However, Ekundayo et al., (2013) found that a high perceived level of support from management was predictive of high levels of CS.

### 3.3.3. Social support

Rzeszutek et al., (2015) found that higher levels of perceived social support correlated with lower levels of STS. Perceived social support was also predictive of STS following therapists' emotional reactivity and sensory sensitivity. Similarly, MacRitchie and Leibowitz (2010) found that greater perceived social support was associated with lower levels of STS. MacRitchie and Leibowitz (2010) also found a moderate negative relationship between perceived social support and VT. However, perceived social support did not moderate the relationship between personal trauma history, STS and VT as hypothesised.

## 3.4. Interrelationships between constructs

The interrelationships between constructs included CS and STS, VPTG and STS, STS and burnout and VT and STS.

### 3.4.1. CS and STS

Ekundayo et al., (2013) found a negative correlation between STS and CS. However, Samios et al., (2013) found that CS and STS were not significantly related to each other. Instead, higher levels of anxiety and depression were related to STS and STS significantly predicted depression and anxiety. Anxiety increased as STS increased in those with low levels of CS. CS moderated the relationship between anxiety and STS in therapists.

### 3.4.2. VPTG and STS

Samios, Rodzik, and Abel (2012) found that higher levels of VPTG was associated with higher levels of positive emotions. In the presence of STS, VPTG positively predicted life satisfaction, personal meaning and positive emotions but not depression or anxiety. In therapists with low VPTG, depression and anxiety increased as STS increased. Similarly, satisfaction and personal meaning in life decreased as STS increased. These variables did not differ significantly to varying levels of STS amongst therapists with high VPTG. This suggests VPTG might moderate the negative impact of STS on adjustment.

Higher levels of STS significantly correlated with higher levels of VPTG, depression, anxiety and lower levels of positive emotions, satisfaction and meaning in life. STS was not significantly related to life satisfaction. However, STS was predictive of all adjustment variables. Those who experienced high levels of STS experienced high levels of depression and anxiety and low levels of positive emotions, low satisfaction and meaning in life.

Similarly, Gil (2015) found a positive correlation between VPTG and STS and that STS was predictive of VPTG. Cosden et al., (2016) also found a positive correlation between VPTG and STS.

### 3.4.3. STS and Burnout

Ekundayo et al., (2013) found a positive correlation between burnout and STS.

### 3.4.4. VT and STS

Furlonger and Taylor (2013) found that a positive correlation between STS and VT.

### 3.5 Critical Appraisal

One study was found to be the strongest (Ekundayo et al., 2013) and four studies (Furlonger & Taylor, 2013; Gil, 2015; MacRitchie & Leibowitz, 2010; Zeleskov-Đoric et al., 2012) were found to be the weakest based on the scores obtained on STROBE.

#### 3.5.1. Study design

All studies were cross sectional. This is a limitation, as direct cause and effect relationships cannot be drawn from correlational, regression and moderation analyses. For example, moderation analyses assume the temporal precedence of the moderators. The studies are also prone to retrospective bias, as therapists were expected to recall past information. The majority of the studies asked therapists to complete online or postal questionnaires. This is advantageous, as it can reduce any direct researcher influences. However, it is prone to self-report bias. Therapists may have withheld information given the sensitive nature of the area or responded in ways to portray themselves in a positive light (e.g. a good therapist). Self-report bias and/demand characteristics may have been more prevalent in Gil's (2015) and Ivicic and Motta's (2016) studies, as they involved direct face to face contact with participants. Response rates also varied within and across studies which could lead to selection bias. Therapists who perceived themselves as being less distressed might have been more likely to participate in these studies.

#### 3.5.2. Sample size and characteristics

All of the studies excluding two (Ekundayo et al., 2013 & Robinson-Keilig, 2014) did not conduct a power analysis. This is a limitation, as the inconsistency in the results could be a consequence of not having enough power to detect significant relationships between variables. For example, Williams et al., (2012) had a smaller sample size than the recommended 200 for path analysis (Kline, 2005). This could have contributed to the mixed findings between their path and correlational analyses. Similarly, Furlonger

and Taylor (2013) were unable to conduct regression analyses due to a small sample size compared to the predictors examined. Conversely, the power analysis conducted by Ekundayo et al., (2013) and Robinson-Keilig (2014) is a strength of their studies, as this decreases the chances of making a Type II error.

The majority of the sample in all of the studies were female and age range, ethnicity and years of professional experience varied within and across studies. Collectively, these sample characteristics limit the generalisability of the results. The studies were conducted in different countries and included therapists working in private and public practice. Different countries may have varying training and practice regulations. Additionally, a minority of the sample in 5 studies were not therapists, as defined in the current review (Gil, 2015; Ivicic & Motta, 2013; McKim & Smith-Adcock, 2014; Williams et al., 2012). The sample in three studies also consisted of voluntary and paid therapists (Furlonger & Taylor, 2013; Samios et al., 2012; Samios et al., 2013). This can create difficulties in generalising the findings, as these factors can act as confounding variables.

### 3.5.3. Measures

There are varying levels of missing information across studies. For example, it is unclear how the regularity of supervision was measured by Furlonger and Taylor (2011) and how perceptions of organisational support and supervision were measured by Ekundayo et al., (2013). Similarly, MacRitchie and Leibowitz (2010) do not specify how they measured previous non-work related trauma. This creates difficulties in assessing the quality of some of the measures used and thereby, affects the strength of findings.

The majority of the studies used standardised measures to assess VT, STS, CF, VPTG and CS with good psychometric properties and reported good reliability coefficients (e.g. Cronbach's Alpha) for the measures used in their samples. However, three studies did not report reliability coefficients for the measures used in their samples (Ivicic & Motta, 2016; Furlonger & Taylor, 2013; MacRitchie & Leibowitz, 2010). This creates difficulties in ascertaining the internal consistency of the measures used.

All of the studies use measures based on individuals who have been directly exposed to trauma rather than vicarious exposure to trauma. This is a limitation as vicarious trauma is likely to be different to direct trauma in presentation. Additionally, Ivicic and Motta (2016) used an objective measure of STS in form of a Stoop test to overcome the limitations of subjective measures. This is problematic, as performance on this task could be accounted for by factors other than vicarious exposure to trauma.

Three studies also used a measure of STS that conceptualises STS as part of CF rather than a separate phenomenon (Ekundayo et al., 2013; Samios et al., 2012; Samios et al., 2013). Similarly, MacRitchie and Leibowitz (2010) used a test for CF to measure STS. This creates difficulties in generalising the results. However, Robinson-Keiling, (2014) used a measure specific to secondary exposure in examining STS, which is a strength of the study.

McKim and Smith-Adcock (2014) used The Psychologist's Burnout Inventory to measure work related factors. This is a limitation as no studies report the psychometric properties of this measure and the internal reliability coefficients were below .7 for the workplace support, control and over involvement with clients' subscales in the sample. Similarly, Ivicic and Motta (2016) also created a supervision scale based on an adaptation of a supervisor scale for social workers and did not report the validity or reliability of the scale. MacRitchie and Leibowitz (2010) also used the Interpersonal Reactivity Index to measure empathy and the scale had not been used by other studies. Gil (2015) developed two questionnaires to measure subjective experience and subjective perception of exposure to vicarious childhood sexual abuse and did not ascertain the reliability or validity of the measures. The sensory sensitivity subscale of the temperament measure used by Rzeszutek *et al.* (2015) has shown to low theoretical validity. Collectively, these create issues in the validity and reliability of the measures used.

### 3.5.4. Additional confounding variables

Samios et al., (2012; 2013) focused on sexual violence and Gil (2015) focused on childhood sexual abuse. However, other studies did not control for or measure the nature of a client's trauma which could have impacted the results.

Furlonger and Taylor (2011) conducted their study on telephone and online counsellors. This limits the generalisability of their findings to face to face trauma therapists, as the mode of therapy delivery could act as a confounding variable. Zeleskov-Doric et al., (2012) also focused on humanistic and psychodynamic psychotherapists. This creates difficulties in generalising the results to therapists from other therapeutic orientations, as therapeutic orientation might also be factor.

Cosden et al., (2016) conducted their study on substance abuse counsellors. This is a limitation as the impact of working with a client population with substance misuse might act as a confounding variable. Furthermore, the nature of clients' trauma was not identified and some of the counsellors were not in recovery themselves. Collectively, this limits the generalisability of the results.

Although MacRitchie and Leibowitz's (2010) study was not conducted in a war zone area, it was confounded by contextual factors (e.g. high levels of violent crime in South Africa) and 50% of the sample experienced violent crime. This creates difficulties in disentangling the effects of personal trauma and living in a consistently dangerous environment and vicarious exposure to trauma through therapy.

# 4. Discussion

The review aimed to explore the factors that might moderate the impact of working with trauma survivors on mental health professionals. The majority of studies explored mental health professional related factors. Given the varying levels of relative strength, the methodological limitations of the studies and the limited number of studies that explore individual factors, firm conclusions cannot be drawn. However, the reviewed literature offers indications of a number of factors that may have an impact on the psychological wellbeing of professionals providing psychological therapy to trauma survivors.

## 4.1. Summary of findings

### 4.1.1. Factors that moderate the impact

Therapists who were emotionally reactive and had a reduced sensory sensitivity experienced higher levels of STS. However, it was unclear as to whether this was a product of STS or a risk factor. Those with higher levels of empathy and a personal trauma history experienced more STS. Empathy was also found to weaken the negative relationship between cumulative vicarious exposure to trauma and relating to others. This suggests that empathy might function as a risk and protective factor and is consistent with past findings (Hojat, 2007). There were mixed findings regarding the relationships between various demographic variables and STS. These included being female, having greater professional experience, training and education, greater vicarious exposure (e.g. increased caseload) and high levels of STS. This inconsistency is consistent with the past literature and is likely to reflect the analysis approach that is taken to examine the influence of demographic variables rather than examining them from the outset (Newell & MacNeil, 2010; Rzeszutek et al., 2015).

Higher levels of perceived social support was associated with lower levels of STS which is consistent with previous findings (Hunter & Schofield, 2006; Rothschild, 2006). One study found no relationships between therapeutic model and STS.

However, therapeutic model was not directly manipulated. Similarly, there were no relationships between job satisfaction and STS. Interestingly, greater time spent on self-care activities was associated with higher levels of STS. This is inconsistent with past findings and might reflect the nature of self-care activities and/ how it was measured in the study.

Higher levels of empathy, resilience and having a personal meaning in life were associated with lower levels of VT. There was no evidence to suggest that therapists who were younger, female, with less experience, lower levels of training and/ education experienced greater levels of VT. Therapists who engaged in personal wellness activities experienced lower levels of VT, particularly those who had a personal trauma history. However, one study did not find this relationship. Instead, an increased trauma caseload was associated with an increased negative coping style. Personal trauma history was associated with higher levels of VT. There was some evidence to suggest empathy and engaging in personal wellness activities might moderate the relationship between personal trauma history and VT. Furthermore, therapists who perceived themselves as having high levels of social support and job satisfaction were found to experience lower levels of VT, which is consistent with past research (Hunter & Schofield, 2006). Also, there was no evidence to suggest that supervision reduced VT.

In relation to CF, over involvement with clients which can be seen as resembling empathy, greater vicarious exposure to trauma and low perceived sense of control over work related activities was associated with higher levels CF. This suggests that CF might be related to work related factors.

In relation to CS, therapists who experienced high levels of positive emotions and engaged in positive reframing (e.g. positive thinking) also experienced high levels of CS. Positive reframing appeared to mediate the relationship between positive emotions and CS. Therapists who were older, more experienced and perceived themselves as having low sense of control over work also appeared to experience greater levels of CS. There were inconsistent findings regarding the relationship between personal trauma history and increased CS. High perceived levels of social

support, management support and supervision were also associated with higher levels of CS.

Therapists with a lower sense of coherence, high levels of empathy and positive emotions experienced greater levels of VPTG. Therapists who perceived the client's trauma as a personal threat and experienced greater positive and negative experiences related to the client's trauma also reported greater VPTG. This suggests that VPTG can occur in the presence of the negative effects of working with trauma. However, the exact nature of the relationship is unclear. Furthermore, therapists who were female and older also appeared to experience greater VPTG. Mixed findings were present regarding the relationship between personal trauma history, greater professional experience, experience of personal therapy, increased vicarious exposure to trauma and increased levels of VPTG. Certain aspects of VPTG appeared related to various factors. For example, working in clinics/public services, perceived high levels of support and supervision was associated with greater spiritual change.

#### 4.1.2. Interrelationships between constructs

The constructs examined appeared related to each other. The stronger studies based on the critical appraisal found that low levels of CS were associated with higher levels of STS and moderated the relationship between anxiety and STS in therapists with low CS (Ekundayo et al., 2013; Samios et al., 2012; 2013). High levels of VPTG was associated with higher levels of STS. High levels of STS also correlated with higher levels of VT and burnout. Interestingly, Samios et al., (2012) found that VPTG moderated the negative impact of STS on adjustment. This is consistent with research that suggests the positive and negative impact of vicarious exposure to trauma can occur simultaneously and that CS and VPTG might act as protective factors buffering the negative effects of vicarious exposure to trauma (Linley & Joseph, 2007). The results could also reflect the considerable overlap between the constructs.

The minimal role of supervision and mixed findings relating to the role of vicarious exposure to trauma is inconsistent with past research (Baird & Kracen, 2006; Hunter & Schofield, 2006; Pearlman & Saakvitne, 1995). This could reflect the role of

those variables for the samples examined and/ be a by-product of the measures used, as different aspects of supervision and vicarious exposure to trauma were assessed across the studies. Overall, the mixed findings are likely to reflect the methodological limitations of the studies, the conceptual overlap between the constructs and the complex interplay between the factors in producing the impact of vicarious exposure to trauma on mental health professionals.

### 4.2. Strengths of the review

- The review is one of the first to amalgamate research in this area.
- A systematic/rigorous approach guided the review.

### 4.3. Limitations of the review

- The contribution from qualitative studies in understanding what and how the factors moderate the impact is absent from the current review.
- The review did not use an independent assessor to appraise the quality of the studies included. As such, the inter-rater reliability of the critical appraisal was not assessed to establish the consistency and accuracy of the appraisal. This means that the quality appraisal of the review should be interpreted with caution.
- The current review adopted a shorter timeframe to select studies rather than selecting studies over a longer timeframe and focusing on more circumscribed professional groups. In hindsight, professional groups could also act a confounding variable, as training and clinical practice are likely to vary across professional groups working therapeutically with trauma survivors. Similarly, the shorter timeframe prevents other relevant studies from being included in the review.

### 4.4. Implications for theory

McCann and Pearlman (1990) CSDT theory suggested that there is a complex interplay between factors relating to the therapist, trauma work and support to produce VT. The results of the systematic review suggest that this theory may also be applicable to understanding the short term and long term impact of working with trauma survivors on professionals. This framework can be adapted to understand the affective, cognitive, relational and behavioural effects of working with trauma survivors.

### 4.5. Clinical implications

- A multifaceted approach in understanding the impact of vicarious exposure to trauma on mental health professionals should be adopted.
- Clinical supervision, reflective practice groups and training can provide avenues to encourage professionals to understand and reflect on their experiences of working with trauma survivors. This should include discussions on factors that might increase their vulnerability to the negative effects of working with trauma and protective factors. The impact should be normalised to promote awareness and encourage reflection.
- Appropriate support should be in place for professionals to promote resilience and manage the impact associated with working with trauma.

### 4.6. Research implications

- Researchers should work towards a consensus on the nature and relationships between constructs used to describe the impact of vicarious exposure to trauma.
- Measures specific to vicarious exposure to trauma should be explored to improve the quality of the evidence base in this area.
- Power analyses should be conducted to ensure quantitative studies have appropriate statistical power to detect significant relationships.

- Researchers should devise and/follow existing guidelines on reporting their studies, as many studies excluded vital information to assess the quality of their evidence.
- There is a need to develop quality appraisal tools for cross sectional studies with scoring systems in the area of psychological research, as many are based on medical research.
- Future research should continue to explore the complex relationships between the constructs and factors that were associated with mixed findings and/ not found in the review (e.g. environmental factors, spirituality) to obtain a more comprehensive understanding.

**Conclusion**

Mental health professionals are affected by their work with trauma survivors. The effects can be positive and negative and occur simultaneously. As such, professionals and organisations should facilitate reflection on the risk and protective factors specific to individuals to manage the impact of working with trauma survivors. This will be beneficial to all stakeholders involved.

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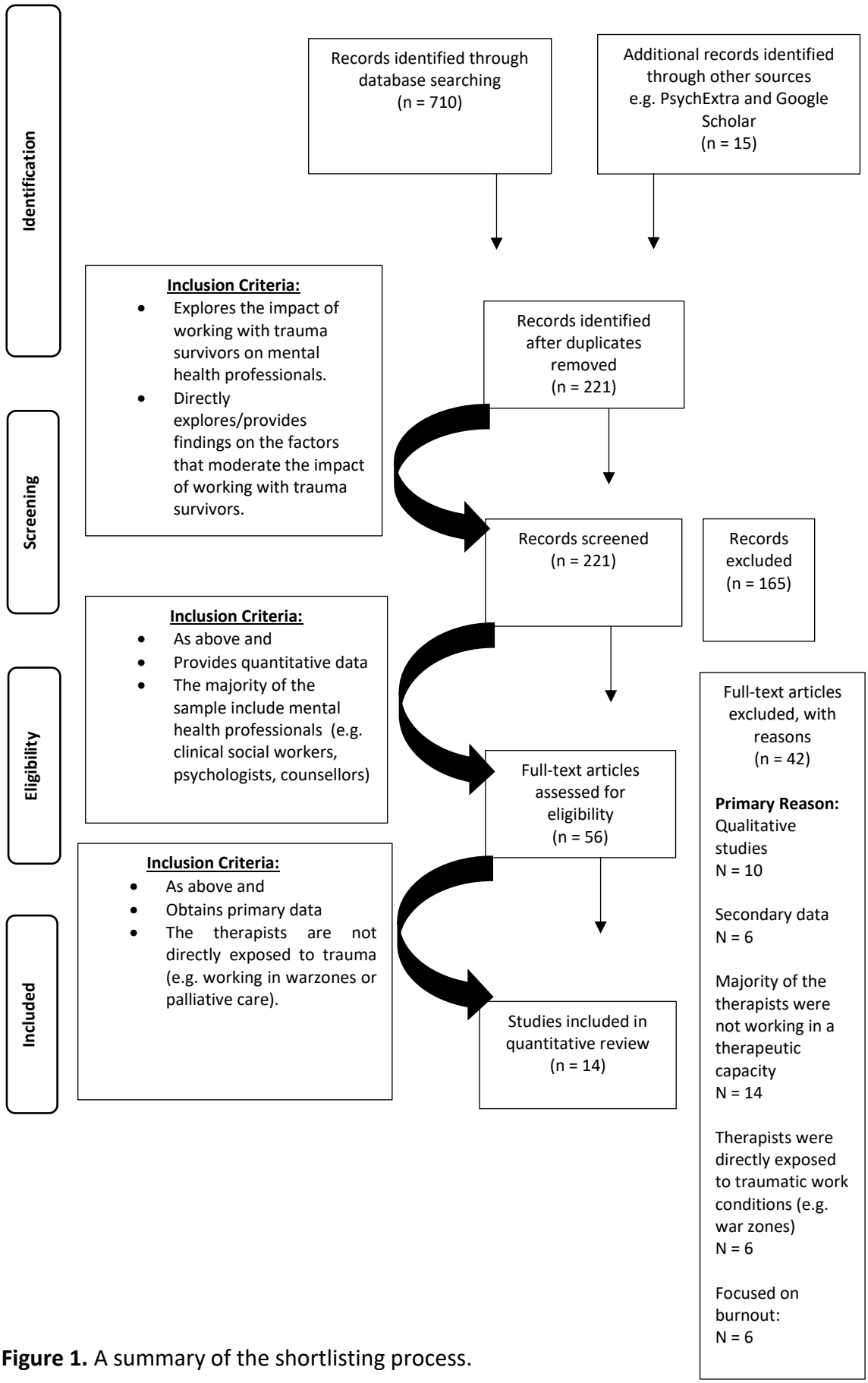


**Figure 1.** A summary of the shortlisting process.

**Table 1.** Methodological details of the reviewed studies

| Article & Country | Method | Participants & Relevant Demographics | Relevant Variables & Measures | | Relevant Significant Findings Reported |
|---|---|---|---|---|---|
| | | | Independent Variable (s) | Dependent Variable (s) | |
| Brockhouse et al., (2011).<br><br>UK | Online Questionnaires | 118 registered therapists (Males: 38, Females: 80)<br>Age: 27-73 years<br>Length of career = 1-50 years<br>Work settings: Private practice (27%), public practice (32%) and both (41%) | **Therapists sense of coherence**: The short form of the Sense of Coherence scale (Antonovsky, 1987)<br>Empathy: Jefferson Physician empathy scale (Hojat et al., 2001)<br>**Perceived organisational support**: The Perceived Organisational Support Scale (Eisenberger, Stinglhamber, Vandenberghe, Sucharski, & Rhoades, 2002)<br>**Demographic data**: Age, gender, years of education, personal therapy (yes/no response), personal history of trauma (yes/no response) and work settings.<br>Cumulative vicarious exposure: Calculated based on a therapist's years of practice and exposure to trauma.<br>**Recent measures of vicarious exposure**: Percentage of week spent in therapy with trauma survivors<br>Supervision (frequency and orientation) | **VPTG**: The Post Traumatic Growth Inventory (Tedeschi & Calhoun, 1996) | **Correlational analyses**<br>Positive correlations between age and VPTG ($p < .05$), age and personal strength ($p < .05$), age and appreciation of life ($p < .01$), working in a clinic and spiritual change ($p < .05$), more supervision and spiritual change ($p < .05$), sense of coherence and VPTG ($p < .01$), sense of coherence and relating to others ($p < .01$) and sense of coherence and personal strength ($p < .01$).<br>**Regression analyses**<br>Positive predictors of VPTG: Empathy ($p < .001$).<br>Negative predictors of VPTG: Strong sense of coherence ($p = .001$).<br>Empathy moderated the relationship between vicarious exposure to trauma and relating to others ($p = .018$). |
| Cosden et al., (2016).<br><br>USA | Online questionnaires | 51 substance misuse counsellors (Males: 29%, Females: 71%) | **Personal trauma history**: The Trauma History Screen (Carlson et al. 2011)<br>**Demographic data**: Length of career, personal therapy (yes/no response), supervision (yes/no response) and personal history of substance use and abstinence. | **STS**: The Impact of Event Scale-Revised (Weiss & Marmar, 1997)<br>**VPTG**: The Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996) | **Correlational analyses**<br>Positive correlation between STS and VPTG ($p<.01$).<br>**Regression analyses**<br>Positive predictor of STS: Personal trauma history ($p<.001$).<br>Positive predictor of VPTG: Personal trauma history ($p<.001$). |
| Ekundayo et al., (2013).<br><br>UK | Online questionnaires | 253 Registered therapists (Males: 71, Females: 182)<br>Age: 64.5% between 30-49 years<br>Work settings: secondary care (62.5%), specialist trauma services (22.5%), Other (15%).<br>Occupational groups:: clinical/counselling psychologists (69.6%)<br>Length of career: 56.2% worked less than 10 years | **Personal trauma history**: yes/no response on an item.<br>**Coping Strategies**: The two part Coping Strategies Inventory (Bober, Regehr, & Zhou, 2006)<br>**Demographic data**: Age, years of professional experience, predominant therapeutic model, caseload, supervision and perceptions of organisational support. | **STS, CS and Burnout**: The Professional Quality of Life Scale, Version 5 (Stamm, 2009) | **Correlational analyses**<br>Positive correlation between STS and burnout ($p<.001$).<br>Negative correlations between CS and Burnout ($p<.001$) and CS and STS ($p<.003$).<br>**Regression analyses**<br>Positive predictors of CS: Age ($p=.02$), time spent on R&D activities ($p=.03$), perceived management support ($p=.03$) and supervision ($p=.02$).<br>Positive predictors of STS: Time spent in supervision ($p=.04$), time spent in self-care activities ($p=.04$) and personal trauma history ($p=.04$) |

**Table 1.** Methodological details of the reviewed studies

| Article & Country | Method | Participants & Relevant Demographics | Relevant Variables & Measures | | Relevant Significant Findings Reported |
|---|---|---|---|---|---|
| | | | Independent Variable (s) | Dependent Variable (s) | |
| Furlonger & Taylor (2013).<br><br>Australia | Postal questionnaires | 38 online and/telephone counsellors (Males: 25%, Females: 75%)<br>Age: 23.8-60.8 years<br>Average length of experience: 4.2 years (telephone counsellors) | **Coping styles**: The Coping Strategy Indication (Amirkhan, 1990)<br>**Workload**: Trauma caseload and weekly contact with trauma survivors.<br>**Regularity of Supervision**<br>**Quality of supervision**: The Supervisory Form from the Supervisory Working Alliance Inventory, (Efstation, Patton, & Kardash, 1990) | **STS:** The Impact of Events Scale – Revised (Weiss & Parmar, 1997)<br>**VT**: The TABS (Pearlman, 2003) | **Correlational analyses**<br>Positive correlations between STS and VT (p<.05), trauma caseload and negative coping style (p<.05) and caseload and STS (p<.05). |
| Gil, S. (2015).<br><br>Israel | Face to face questionnaires | 102 therapists (Males: 61, females: 87)<br>Age: Mean: 47.8 SD:2.9<br>Length of career: Mean 10.9 years<br>Work settings: 67% worked in private and public practice. | **Years of professional experience**<br>**Subjective perceptions**: Researchers developed two questionnaires. They measured subjective experience and subjective perception of exposure to vicarious childhood sexual abuse. The latter included rating negative experiences (e.g. pain, horror) and positive experiences (e.g. intimacy, sexual stimulation) related to the client's abuse in therapy. | **VPTG**: The Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996)<br>**STS**: PTSD Symptoms Scale-Self Report (Foa, Riggs, Dancu, & Rothbaum 1993) | **Correlational analyses**<br>Positive correlations between STS and VPTG (p<.01), perceiving client's abuse as a personal threat and VPTG (p<.01), professional experience and VPTG (p<.01), positive experiences and VPTG (p<.01), negative experiences and VPTG (p<.01).<br>**Regression analyses**<br>Positive predictors of VPTG: STS (p<.001), Positive experiences (p<001), negative experiences (p<.001) and perceiving client's abuse as a personal threat (p<.001). |
| Ivicic, & Motta. (2016).<br><br>USA | Mixed design: questionnaires and experimental | 88 qualified mental health professionals (Males 20.5%. Females: 79.5%)<br>Age: 24-82 years<br>Length of career: 1-20+ years | **Personal trauma history**: The Life Events Checklist (Blake et al., 1995)<br>**Job satisfaction**: The Job Satisfaction Survey (Spector, 1985)<br>**Quality of supervision**: Authors created a questionnaire to assess the quantity and perceived quality of supervision. Items were adapted items from the Administrative Support subscale of the Professional Organisational Culture (Ellet & Miller, 2004)<br>**Demographic data**: Age, length of career, gender and exposure to trauma clients (no of hours). | **STS**: A modified Stroop test to assess cognitive intrusions associated with STS. | **Regression analyses**<br>Positive predictors of STS: Female (p=.009) and personal trauma history (p=.036). |

**Table 1.** Methodological details of the reviewed studies

| Article & Country | Method | Participants & Relevant Demographics | Relevant Variables & Measures | | Relevant Significant Findings Reported |
|---|---|---|---|---|---|
| | | | Independent Variable (s) | Dependent Variable (s) | |
| MacRitchie& Leibowitz. (2010).<br><br>South Africa | Postal questionnaires | 64 trauma workers<br>Mostly, white female.<br>Length of career: 1-15 years | **Exposure to trauma**: Authors devised a Level of Exposure Checklist to obtain the number of violent crimes therapists had dealt with and personal non work related trauma.<br>**Empathy**: The Interpersonal Reactivity Index (Davis, 1980)<br>**Social Support**: The Crisis Support Questionnaire (Joseph, Andrews, Williams, & Yule, 1992) | **STS**: The Compassion Fatigue Self-Test (Stamm & Figley, 1996)<br>**VT**: The Trauma and Attachment Belief Scale (Pearlman, 1996) | **Correlational analyses**<br>Positive correlations between personal trauma history and VT (p<.05), personal trauma history and STS (p<.05)<br>Negative correlations between perceived social support and STS (p<.05) and perceived social support and VT (p<.05).<br>**Regression analyses**<br>Moderator between vicarious exposure and STS: Empathy (p<.05). |
| McKim & Smith-Adcock. (2014).<br><br>USA | Online questionnaires | 98 trauma counsellors (Males: 25, Females: 73)<br>Occupational groups: Psychologists (n=49), clinical social workers (n=26) and professional counsellors (n=23) | **Personal trauma history**: The Stressful Life Experiences-Short Form (Stamm, 1997).<br>**Demographic data**: Length of career and vicarious exposure to trauma (weekly hours spent with trauma clients). | **CF and CS**: The Professional Quality of Life Scale, Version 5 (Stamm, 2005)<br>**Burnout**: The Psychologist's Burnout Inventory (Ackerley, Burnell, Holder, & Kurdek, 1988). | **Correlational analyses**<br>Positive correlation between:<br>Years of experience and CS (p<.05).<br>**Regression analyses**<br>Positive predictors of CS: Personal trauma history (p=.001).<br>Negative predictors of CS:<br>Perceived less control over workplace activities (p=.001).<br>Positive predictors of CF:<br>Over involvement (p<.011), vicarious exposure to trauma (p<.001) and perceived less control over workplace activities (p<.010). |
| Robinson-Keilig, (2014).<br><br>USA | Online Questionnaires | 320 qualified mental health professionals (Males: 67, Females: 249, Transgender: 1, no gender information supplied: 3)<br>Age: 25-89 years<br>Length of career: 1-55 years | **Demographic data**: Gender, age, length of career and exposure to trauma clients. | **STS**: The Secondary Traumatic Scale (Bride, Robinson, Yegidis, & Figley, 2003) | **Correlational analyses**<br>Positive correlations between:<br>Gender and STS (p <.05).<br>Percentage of trauma clients and STS (p <.01).<br>Negative correlation between:<br>Years in practice and STS (p <.05). |

**Table 1.** Methodological details of the reviewed studies

| Article & Country | Method | Participants & Relevant Demographics | Relevant Variables & Measures | | Relevant Significant Findings Reported |
|---|---|---|---|---|---|
| | | | Independent Variable (s) | Dependent Variable (s) | |
| Rzeszutek et al., (2015).<br><br>Poland | Postal Questionnaires | 80 therapists (Males: 21, Females: 59)<br>Age: 27-65 years<br>Length of career: 1-38 years<br>Work settings: crisis, private and/ public. | Temperament traits: The Formal Characteristics of Behaviour-Temperament Inventory (Strelau & Zawadzki, 1995)<br>Social support: The Berlin Social Support Scales adapted to polish (Łuszczy´nska, Kowalska, Mazurkiewicz, & Schwarzer, 2006)<br>Demographic data: Gender, years of professional experience, caseload (average number of trauma clients over the past year), sought supervision (yes/no response) via questionnaires. | ST: The PTSD Questionnaire: Factorial Version (Strelau, Zawadzki, Oniszczenko, & Sobolewski, 2002) | **Correlational analyses**<br>Positive correlation between emotional reactivity and STS (p<.01).<br>Negative correlations between sensory sensitivity and STS (p<.01), perceived social support and STS (p<.01).<br>**Regression analyses**<br>Positive predictor of STS: Emotional reactivity (p<.001).<br>Negative predictor of STS: Sensory sensitivity (p<.001) and perceived social support (p<.001). |
| Samios et al., (2012)<br><br>Australia | Postal questionnaires | 61 therapists (Males: 51, Females: 10)<br>Age: 23-66 years<br>Occupational groups: Psychologists (n=53), Counsellors (n=5) and social workers (n=3) | **STS**: STS subscale of the Professional Quality of Life (Stamm, 2003)<br>**VPTG**: The Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996) | **Positive indicators of adjustment**<br>Personal meaning in life: The meaningfulness subscale of the Sense of Coherence Scale (Antonovsky, 1987)<br>Life satisfaction: The Life Scale (Diener, Emmons, Larsen, & Griffin, 1985)<br>Positive emotions: The Bradburn Affect Balance Scale (Bradburn, 1969)<br>**Negative indicators of adjustment**<br>The depression and anxiety subscales of the Depression, Anxiety and Stress Scales (Lovibond & Lovibond, 1995) | **Correlational analyses**<br>Positive correlations between VPTG and positive emotions (p<.05), STS and VPTG (p<.001), STS and depression (p<.01) and STS and anxiety (p<.05).<br>Negative correlations between STS and positive emotions (p<.05) and STS and meaning in life (p<.001).<br>**Regression analyses**<br>STS positively predicted depressions (p<.01) and anxiety (p<.05).<br>STS negatively predicted positive emotions (p<.01), life satisfaction (p<.05) and meaning in life (p<.01).<br>VPTG positively predicted life satisfaction (p<.05), meaning in life (p<.001) and positive emotions (p<.05) in those with high STS. |

**Table 1.** Methodological details of the reviewed studies

| Article & Country | Method | Participants & Relevant Demographics | Relevant Variables & Measures | | Relevant Significant Findings Reported |
|---|---|---|---|---|---|
| | | | Independent Variable (s) | Dependent Variable (s) | |
| Samios et al., (2013)<br><br>Australia | Postal questionnaires | 61 therapists (Males: 51, Females: 10)<br>Age: 23-66 years<br>Occupational groups: Psychologists (n=53), Counsellors (n=5) and social workers (n=3) | **Positive emotionality**: The Bradburn Affect Balance Scale (Bradburn, 1969)<br>**Positive reframing**: The Brief Cope (Carver, 1997)<br>CS: The Professional Quality of Life Scale (Stamm, 2003) | **STS & CS**: The Professional Quality of Life Scale (Stamm, 2003)<br>**Negative indicators of adjustment**<br>Depression & Anxiety: Depression, Anxiety and Stress Scales (Lovibond & Lovibond, 1995). | **Correlational analyses**<br>Positive correlations between positive emotionality and CS ($p<.001$) and positive reframing and CS ($p<.01$).<br>**Regression analyses**<br>Positive predictor of CS: High emotionality ($p<.001$) partially mediated by positive reframing ($p=.016$). |
| Williams et al. (2012).<br><br>USA | Online questionnaires | 134 mental health counsellors from community mental health organisations (Males: 48, Females: 83)<br>Age: 25-71 years<br>Length of career: 2-33 years<br>Occupational groups: Clinical social workers (n = 50), marriage and family therapists (n=11), professional counsellors (n = 40), psychologists (n=7) and unlicensed professionals (n=17). | **Childhood Trauma**: The Childhood Trauma Questionnaire (Bernstein & Fink, 1998)<br>**Personal Wellness**: The Five Factor Wellness Inventory (Myers & Sweeney, 2005)<br>**Organisational Culture**: The Job Satisfaction Survey (Spector, 1985)<br>**Workload**: The Quantitative Workload Inventory (Spector & Jex, 1997)<br>**Supervisory Working Alliance**: The Supervisory Working Alliance Inventory – Supervisee Form (Efstation, Patton, & Kardash, 1990) | **VT**: The Trauma And Attachment Belief Scale (Pearlman, 2003) | **Correlational analyses**<br>Negative correlations between childhood trauma and VT ($p<.001$), personal wellness activities and VT ($p<.001$) and job satisfaction and VT ($p<.001$).<br>**Path analyses**<br>Overall model accounted for 45% of the variance found in VT ($p<.05$).<br>Other significance values were not reported. |
| Želeskov-Đoric et al., (2012).<br><br>Europe | Online questionnaires | 68 therapists (Males:20, Females: 48)<br>Length of career: average of 13 years<br>Country of work: Serbia (n = 46), Germany, Austria, UK and France (n= 22) | **Personal meaning to life**: The Personal Meaning Profile (Wong, 1998)<br>**Resilience**: The Adversity Response Profile (Stoltz, 2000)<br>**Demographic data**: Age, gender, length of therapeutic career and education. | **VT**: The Trauma and Attachment Belief Scale (Pearlman, 2003) | **Correlational analyses**<br>Negative correlations between personal meaning in life and VT ($p<.05$) and resilience and VT ($p<.05$).<br>**Regression analyses**<br>Negative predictor of VT: Personal meaning of relationships with others ($p<.001$). The variable also mediated the relationship between resilience on VT ($p=.009$). |

**Part B:**

**Research Report**

# The impact on female interpreters of working with female clients receiving trauma therapy for sexual violence: An Interpretative Phenomenological Study

**Abstract**

**Introduction:** One in five women from the refugee population have experienced some form of sexual violence. Working with sexual trauma can have a significant emotional impact on professionals. Little is known about the impact of vicarious exposure to sexual trauma on interpreters working in therapy. Therefore, the current study aimed to explore the experiences of female interpreters of interpreting for female sexual violence survivors in therapy using Interpretative Phenomenological Analysis.

**Methods:** Six female interpreters agreed to participate. Participants were interviewed twice. Eleven semi structured interviews were conducted in total, as one participant was unable to complete the second interview.

**Results:** Four superordinate themes emerged. These included: The 'Invisible' Interpreter, Feeling The Trauma, Making Connections and Changed Understandings.

**Conclusions:** Interpreters are affected by their work with trauma survivors. Emotions play a key role in this process. The effects can be both positive and negative and can co-occur. The implications of the findings for clinical practice and research are discussed.

# 1. Introduction

## 1.1. Setting the context

Within the context of psychological therapy, it is essential to understand an individual's experience and having a common language between the therapist and the client facilitates this process (Clauss, 1998). The client's choice of words can provide important information on how they understand their experiences and difficulties (Risager, 2007). Language does not operate as a separate entity. It is influenced by an individual's cultural context (Vygotsky *et al.* 2012). Language can often be a barrier for clients in accessing mental health services. Interpreters play a crucial role in enabling organisations (e.g. National Health Service) to provide equal access to services to meet the healthcare needs of clients (Karliner *et al.*2007).

Research suggests that interpreters use four main modes of interpreting: the linguistic, the psychotherapeutic, the advocate and the cultural broker (Tribe & Morrissey, 2004). The modes vary across clients and contexts and require different training and support options for interpreters to fulfil their role. The linguistic mode involves a verbatim interpretation or factual account without emotional involvement (Tribe, 1999). The psychotherapeutic mode involves communicating the meaning of words and associated emotions (Raval, 2003). The advocate mode involves taking the stance of a client's advocate to communicate health needs or a client's view in individual or community contexts whereas, the cultural broker mode involves communicating the cultural context alongside a verbatim interpretation of a client's account (Drennan & Swartz, 1999).

Interpreters are likely to adopt a psychotherapeutic mode in the context of psychological therapy (Tribe, 1999). Often, interpreters share the same cultural background as clients and can feel highly responsible in enabling the client to be heard and supported. This can contribute to increased trust and empathy between the interpreter and client, placing interpreters at an increased risk of being affected by the client's traumatic experiences.

### 1.2. Theory and impact

Therapists and interpreters are vicariously exposed to varying levels of trauma experienced by trauma survivors. This can include chronic exposure to traumatogenic events and more acute traumas. Various concepts, with conceptual overlap, have been used to describe the impact of vicarious exposure. Secondary traumatic stress (STS) is used to capture the rapid physical, emotional and behavioural effects of vicarious exposure such as, withdrawal from others, increased heart rate and anxiety. These symptoms can parallel posttraumatic stress disorder, often experienced by trauma survivors (Figley, 1983). Another concept, compassion fatigue, has been used to describe the possible emotional and physical fatigue that can experienced over time (Figley, 2002). Furthermore, vicarious traumatisation (VT) is a concept used to describe the cognitive changes that occur through cumulative exposure to vicarious trauma over an unspecified period of time. These include an individual's beliefs about themselves, others and the world and include safety, trust, esteem, control and intimacy (McCann & Pearlman, 1990). Conversely, vicarious post traumatic growth (VPTG) is used to amalgamate the positive effects of vicarious exposure to trauma (Tedeschi & Calhoun, 1995). These include an increased sense of accomplishment, spirituality, compassion and positive changes in views and relationships with others. Similarly, compassion satisfaction captures the strong sense of pleasure obtained from helping others (Stamm, 2005). The positive and negative effects of working with trauma survivors can occur simultaneously amongst professionals and there is evidence to suggest that they can occur in non-professionals (Joinson, 1992; Phelps *et al.* 2009). Some researchers suggest these concepts (e.g. VT and STS, VPTG and CS) are distinct but related whilst others suggest that they are the same phenomena (Newell & MacNeil, 2010).

### 1.3. Research and impact on interpreters

Research has largely focused on the negative impact of working with trauma survivors on therapists. There has been less focus on the impact on interpreters, particularly in the UK. Mehus and Becher (2015) conducted a quantitative study and found high levels of secondary traumatic stress amongst their sample of interpreters in the USA. Miller *et al*. (2005) conducted a qualitative study using semi structured interviews in the USA. Interpreters who were refugees themselves reported re-experiencing their trauma and experiencing high levels of anxiety in response to hearing their clients' trauma experiences. However, this was a short lived effect. Similarly, Butler (2008) found that all of the interpreters reported feeling overwhelmed and distressed by their clients' experiences. They also suggested that this was because they had over identified with the experiences of their clients. The study was conducted in the UK on the experiences of women interpreters working with trauma survivors who had been raped in a war.

A few studies have found evidence for vicarious post traumatic growth amongst interpreters interpreting in trauma therapy. Miller *et al*. (2005) found that the process of interpreting helped interpreters deal with their own traumatic experiences and increased compassion towards their clients. Similarly, Mehus and Becher (2015) also found high levels of CS (e.g. viewing work as worthwhile) amongst interpreters. Splevins *et al*. (2010) found greater evidence for VPTG rather than VT amongst interpreters in the UK. All interpreters discussed experiencing initial high levels of emotional distress at the start of their employment. They reported feeling a strong sense of empathy and identification with their clients. The majority of the interpreters reported managing the emotional impact by consciously adopting strategies to help them cope (e.g. meditation). All interpreters (excluding one) reported experiencing positive changes in their views relating to themselves and others as a result of their experience of interpreting. One interpreter stated that her experience of interpreting for her client lead to the view that "people were evil and the world is unsafe" (Splevins *et al*. p.1713). The authors suggested that this was related to the interpreter's personal traumatic history and inadequate coping strategies. It is important to acknowledge that the

interpreters' experiences of interpreting in a therapeutic setting ranged between 3-8 years, which may have confounded the findings.

In summary, the studies suggest that interpreters can also be affected by working with trauma survivors in trauma therapy. The impact of interpreting can be both positive and negative and might be influenced by an interpreter's personal traumatic history and experience of interpreting.

### 1.4. The present study: Rationale and aims

All but two of the studies were conducted in the UK (Butler, 2008; Splevins *et al*. 2010). Further research in this area is warranted given the important role interpreters play in delivering trauma therapy to clients and the limited research in this area. All of the studies excluding Butler (2008) did not specify the nature of the client's trauma. This is important as the impact of interpreting might differ depending on the type of traumatic event experienced by the client. Furthermore, Butler (2008) used a small sample size of 3 participants and participants were working in sexual health services rather than therapy. Therefore, the current study explored the experiences and impact of interpreting in trauma therapy for female interpreters working with clients who have experienced sexual violence (e.g. rape, sexual assault or female genital mutilation). The study focussed on the experience of female interpreters working with female clients, as research suggests women are more likely to experience VT, STS and sexual violence and are also more likely to seek support for psychological distress than men (Galdas *et al*. 2005; Pratchett *et al.* 2010).

The research aims to understand the experience of interpreting for female sexual violence trauma survivors, how interpreters make sense of their experiences, the impact of their experiences and how they manage the impact. The population that the interpreters in the study work with are refugee and asylum seekers. Quite often, interpreters for this population have themselves been refugees and/had personal experiences of political conflict (Tribe, 2011). Sexual trauma is also common amongst the refugee population and can be used as a weapon by perpetrators. Some studies predict that one in five women have experienced some form of sexual trauma (Vu *et al.* 2014). Often sexual violence is associated with high levels of posttraumatic disorder for

survivors and studies have found higher levels of secondary distress amongst those working with sexual violence survivors compared to other types of trauma (Ellwood *et al.* 2010; Kessler *et al.* 1995). This can place both the interpreter and therapist at risk of being affected and therefore, makes this an important area to investigate (Kassam-Adams, 1999).

# 2. Method

## 2.1. Design

A qualitative interview study based on the Interpretative Phenomenological Analysis (IPA; Smith *et al.* 2003) approach was considered the most appropriate to achieve the aims of the study. IPA enabled an in-depth exploration of individual interpreter's experiences and meaning making rather than a descriptive account of experiences using other descriptive qualitative approaches (Biggerstaff, 2012).

## 2.2. Epistemological position

A contextual constructivist stance was taken by the researcher. According to this stance, the personal, social, cultural and situational context in which experiences occur are important in meaning making (Willig, 2013). A more detailed description can be found in Appendix G.

## 2.3. Ethical considerations

The research proposal for the study was peer reviewed by staff members from the Clinical Psychology Department at the University of Leicester and by members of the service user reference group. Ethical approval was obtained from the ethics committee at the University of Leicester. Relevant correspondence can be found in Appendix H.

In line with guidance provided by the ethics committee, the researcher took steps to ensure ethical practice. Informed consent was obtained from all participants. The researcher held initial telephone conversations to inform participants of their rights to confidentiality, withdrawal and the advantages and possible risks of participating in the research. Participants were asked if they had personal experiences of sexual violence to ascertain whether they would feel affected by the interview. The researcher explained that if they were distressed at any point during the interviews then they could stop the interview. The researcher also gave participants information about the support they could receive should they require this. The researcher removed any identifying information and used pseudonyms to preserve anonymity. All electronic material was

also stored securely on an encrypted, password protected memory stick and will be kept securely for five years, following which it will be destroyed.

### 2.4. Participants

All interpreters were recruited from a national charity organisation working specifically with survivors of torture who were seeking asylum. Out of a pool of twenty seven interpreters working directly for the organisation, six female interpreters agreed to participate. Six participants is considered sufficient for a doctoral IPA study (Smith *et al.* 2009). Purposive sampling was used as advised for IPA using the following inclusion and exclusion criteria:

**Inclusion criteria**

Participants were included if they:

- Were female interpreters.
- Were able to provide informed consent.
- Had a minimum of six months of experience of interpreting for trauma survivors in a therapeutic setting.
- Have/are interpreting for sexual violence trauma survivors.

**Exclusion criteria**

Potential participants were excluded if they:

- Did not meet the inclusion criteria.
- Participation would cause significant psychological distress to the participant.

The above criteria enabled the researcher to recruit a homogenous sample, important in IPA to identify patterns across individuals with a shared experience (Smith *et al.* 2009).

Table 2 summarises relevant demographic details of the study participants. Other details are not reported to preserve anonymity.

**Table 2.** Summary of relevant participant demographics.

| Relevant Demographics | |
|---|---|
| Age range | 38-60 years |
| Experience of interpreting for the organisation | 2-5 years |
| Experience of interpreting | 6-20 years |
| Personal history of sexual violence | 3 participants in total |
| • Childhood sexual violence | 1 participant |
| • Adulthood sexual violence | 1 participant |
| • Vicarious exposure through a loved one | |
| Personal history of psychological therapy | 1 participant |

## 2.5 Materials

All material were developed collaboratively between the researcher and research supervisor. This included a participant information sheet, consent form and topic guide. Material can be found in Appendices J - L. The topic guide was influenced by IPA. As such, questions around how interpreters made sense of their experiences and the impact of their experiences were included. Additional topics included how they managed the impact of interpreting, available support options and suggestions for further support. The questions were also revised following the initial interviews to aid the exploration of participants' experiences and minimise researcher bias (e.g. leading questions).

## 2.6 Procedure

### 2.6.1. Recruitment

All interpreters were approached by emails with an attached information sheet in September 2016.

### 2.6.2. Interviews

Participants were given the choice of conducting the interviews at their workplace, an alternative location or through Skype. Five participants chose face to face interviews and one participant chose Skype. Two interviews were conducted per participant (excluding one participant to prevent further psychological distress). Double interviews were considered useful given the qualitative approach of IPA, the possible positive impact of this on building rapport, to encourage disclosure when discussing sensitive topics and obtain the opportunity to reflect on the interview. (Smith *et al.* 2010). A total of eleven interviews were conducted over the period of November 2016 – March 2017.

All the interviews were audio recorded and each lasted between 45-60 minutes. On arrival, each participant was verbally briefed about the study, the process and their rights as participants, provided with a participant information sheet and the opportunity to ask any questions. Verbal and written informed consent was obtained. Participants were paid for their participation at their hourly rate of pay for interpreting.

The researcher employed a semi structured approach in the interviews to discuss predetermined topics and additional topics that arose in the process of the interviews. On completion of the interviews, participants were debriefed, thanked for their participation and provided with the researchers contact details, should they have any further questions or feedback. A reflexive account of each interview was kept. This enabled the researcher to explore their influences on the analysis (Larkin and Thompson, 2011).

The interviews were transcribed by a professional transcriber who signed a confidentiality statement. The transcripts were anonymised and checked for accuracy by the researcher.

### 2.7. Data analysis

IPA uses a double hermeneutic in that the researcher is interpreting the interpretation given by the participants of their experiences (Smith *et al.* 2003). There is no uniform process for analysis in IPA. As such, the analysis followed the suggestions made by Larkin and Thompson (2011). Table 3 illustrates the process adopted by the researcher. Examples of the analysis process can be found in Appendix L.

**Table 3.** Seven steps taken to analyse the data obtained

| Steps taken | Process involved |
|---|---|
| 1. Familiarisation with data | The researcher listened to the audiotapes. |
| 2. Initial reading of each transcript and free coding | The researcher noted their initial emotional reactions, preconceptions and exploratory ideas. This helped in being aware of some of the researcher's personal assumptions and beliefs. |
| 3. Second reading of the each transcript and line by line coding | The researcher noted the objects of concern to each participant (e.g. what matters to participants) and experiential claims (e.g. what it meant to the participants). This included non-verbal utterances (e.g. repetition, laughter, pauses), linguistic devices used by the participants (e.g. metaphors) and the researcher's questions and thoughts. |
| 4. Creating a list of emerging themes | The researcher used the results of the previous steps to create a list of emerging themes. This was followed by the researcher's interpretation of how participants made sense of their experiences. Irrelevant data to the research questions was discarded.<br>Steps 1-4 were repeated with the second transcript. |
| 5. Making connections between the themes | The researcher searched for patterns of meaning amongst the emerging subthemes and used abstraction, subsumption, polarisation, contextualisation and numeration wherever appropriate to organise themes.<br>This was followed by a written summary of the key features for each participant to ensure the intricacies were not lost during the final stages of analysing the data as a group. |
| 6. Repeating the process | Steps 1-5 were repeated with the remaining transcripts and for each participant. |
| 7. Searching for patterns across transcripts/participants | Relationships between the themes, contradictions, commonalities and differences across participants were explored. This led to an overall structure to incorporate the relationships within and between superordinate and subthemes. |

### 2.7.1. Quality issues

Qualitative research is about meaning making and the researcher's interpretation is part of the IPA analysis. As such, the analysis is susceptible to a researcher's personal views and experiences (Willig, 2013). This makes it important for the researcher to be self-reflective throughout the process. Yardley (2000) suggests four criteria to evaluate qualitative research. Table 4 highlights the steps taken by the researcher to meet the criteria. A chronology of the research process is provided Appendix M.

**Table 4.** Steps taken by the researcher to address quality issues.

| Criteria | Step(s) taken by the researcher |
|---|---|
| 1) Sensitivity to context<br>2) Commitment and rigour<br>3) Transparency and coherence<br>4) Impact and importance | • Kept a reflective log of the research process to aid self-reflection and bracket/encourage awareness of possible preconceptions.<br>• Used IPA to guide the methodological and analytical process.<br>• Used research supervision to discuss the themes and connections embedded within data extracts/the context and to be clear about the researcher's influences on interpretation by discussing dilemmas and reflexive issues. This included keeping supervision logs to track changes.<br>• Used peer supervision to review the themes.<br>• Used the results of the research to formulate recommendations at a local organisational and national level and suggested implications for future clinical practice and research. |

## 3. Results

The analysis generated four superordinate themes and associated subthemes. These were 1) The 'Invisible' Interpreter, 2) Feeling The Trauma, 3) Making Connections and 4) Changed Understandings. The four superordinate themes are outlined below with and without supporting quotes. A diagrammatic representation of the themes is also included in Appendix O. The organisation expects all interpreters to interpret in first person.

### 3.1. The 'Invisible' Interpreter

The first superordinate theme captured the 'invisible' stance that interpreters appeared to take in therapy sessions, as shown by Figure 2.

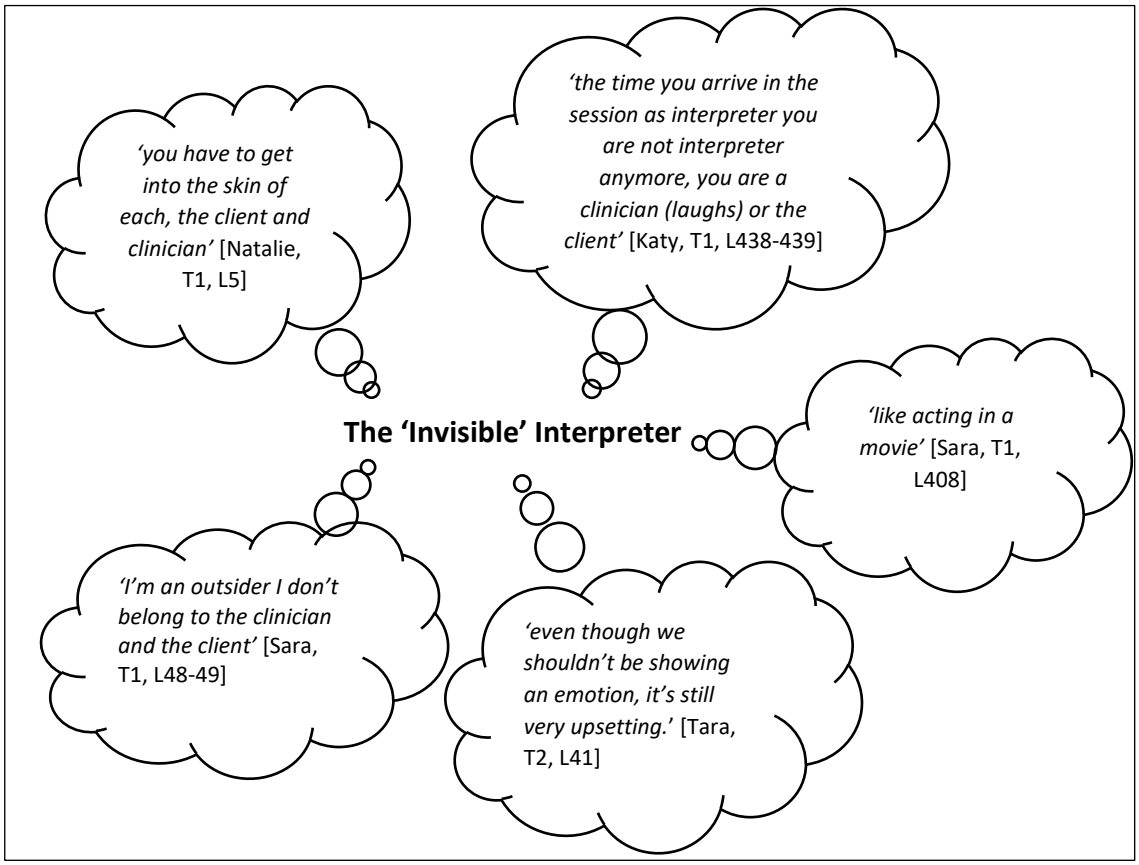


**Figure 2.** Quotes highlighting the first superordinate theme.

The interpreter's sense of the self was made '*invisible*' in the process of interpreting. One interpreter, Tara, described herself as being the voice, providing '*the words for them as well as for the therapist*' [Tara, T1, L264-265]. Another, Natalie, spoke of acting as '*a bridge between the client and the therapist.*' [Natalie, T1, L3]. The '*bridge*' appeared to be a metaphor that resonated across participants and had various functions. These included to '*transfer accurately everything that's been said*' [Wendy, T1, L33], '*facilitating conversation*' [Eve, T1, L4] and '*a helping person, bonding them both together*' [Sara, T1, L28]. Eve also described her role as letting clients release their emotions.

Interpreters also appeared to extend the position of invisibility towards the emotional impact of hearing the clients' stories of sexual violence. There was a sense that they should not be affected by their clients' trauma, as this might have a negative effect on their ability to interpret. This was evident through their common preconceptions. Being negatively emotionally affected by their work was seen as a sign of weakness and something to be avoided, as demonstrated below:

> '*If you are really affected by the sessions, you won't be able to work in this place*.'[Wendy, T1, L626-627]
> '*[…] need to be strong to hear it, not show any of your emotion and not adding or cutting […] Passing the pains*.' [Katy, T2, L391-393]

However, some interpreters recognised exceptions to maintaining this position of invisibility. Obvious exceptions included when providing a cultural understanding of the client behaviours to the clinician and when invited in by the client through a personal question. Others described difficulties in maintaining this emotionally unaffected stance within sessions when emotions were evoked. These can also be seen as exceptions to the stance. One interpreter, Eve, described having '*to swallow everything*' [Eve, T1, L532] and stated that '*I try my best to stay calm and not to show my feelings*' [Eve, T1, Line 149]. Others described taking sips of water and avoiding eye contact with the client and clinician to compose themselves. Interestingly, one interpreter, Tara, described her experience of automatically switching to third person when interpreting:

> '*When we started going into these kind of sexual things, automatically without even noticing later I find out that I just start saying she's been raped by four people. Um, then later I realise myself thinking how did I say that?*' [Tara, T1, L382-385]

Tara also went onto to state that following her experience she switches to interpreting in the third person, as a conscious strategy '*to separate myself from the torture victim*' [Tara, L1, L70].

All interpreters shared the experience of finding it difficult to interpret in the first person but also found it rude and insensitive to interpret in the third person, as *'it would really diminish*' the clients experience [Natalie, T2, L489]. The interpreters also experienced a great sense of responsibility in conveying the clients' affective and factual experience accurately.

### 3.2. Feeling The Trauma

The second superordinate theme captured the immediate and ongoing emotional impact of interpreting, despite the interpreters attempts to be 'invisible' to the impact. The researcher observed an initial hesitance to explore the negative impact amongst interpreters. Figure 3 summarises some of the key quotes.

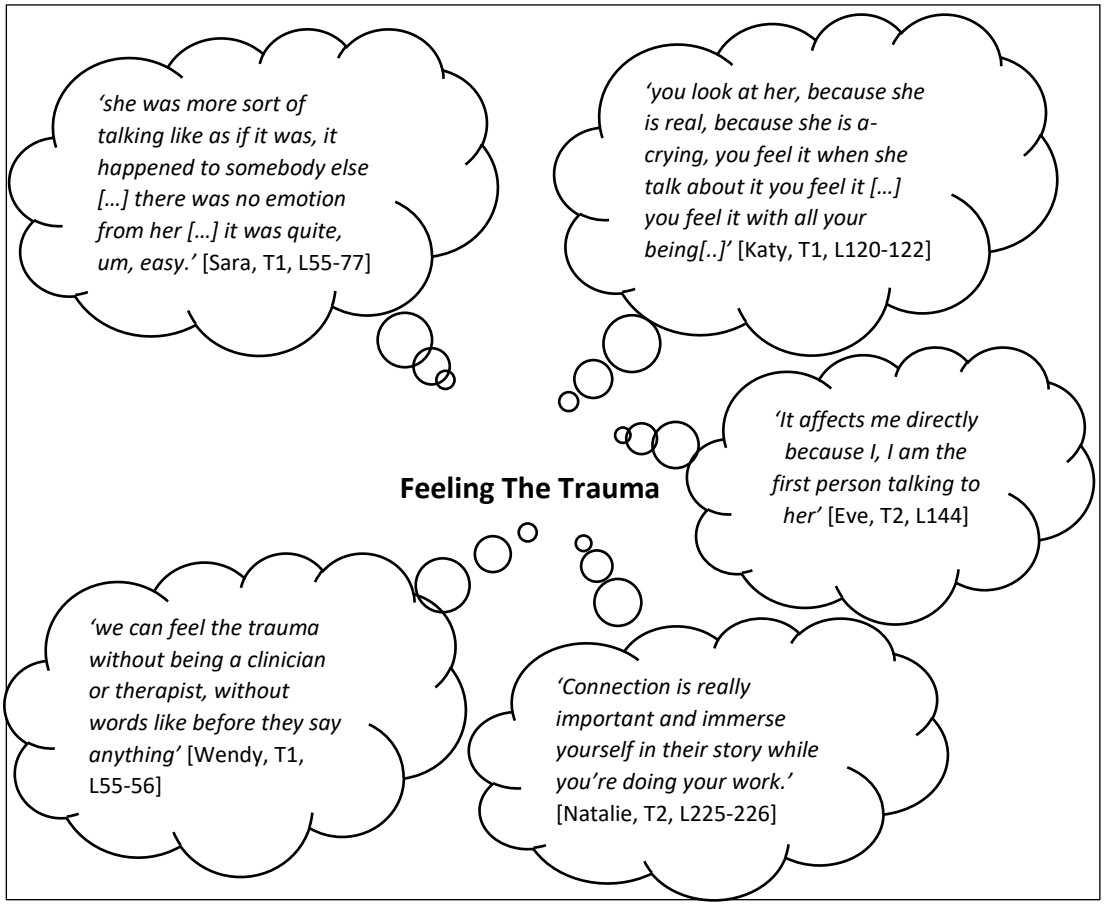


**Figure 3.** Quotes highlighting the second superordinate theme.

There were differences in how a client's distress and trauma were felt. The majority of the interpreters described feeling the client's story with her. However, Natalie and Wendy described also *'becoming the client'* to communicate the client's distress, as shown below:

> *'you repeat her words and at that moment you are her, because you have to really render this honest distress to the other person who's listening. So you,*

*you feel it with her, you are her […] in that particular moment, that's where you live the story with her.'* [Natalie, T1, L81-85]

Similarly, retelling the client's experiences during sessions was experienced as *'like reliving same experience.'* [Natalie, T1, L157]. However, Sara stated that she did not become the client and said that she has:

*'mental filters through, uh, you know, my head […] I know what's me and what's client in sessions.'* [Sara, T1, L313-314]

There were mixed reactions to hearing the client's trauma within and across interpreters. Wendy described the first time she heard a client's sexual trauma as:

*'it was like a shock, oh my god! People they do things like that'* [Wendy, T1, L582-583]

Tara also shared the feeling of shock and particularly with one case, on hearing that the perpetrator was female, as she was unfamiliar with this. Other interpreters were not shocked by their client stories, as they also shared a sense of familiarity with the political context of the abuse through indirect and/direct personal experiences. Sara went onto to state that *'I think I'd be shocked if it didn't happen'* [Sara T1, L120-121]. Instead, interpreters shared feeling the brutality of the abuse as being unrelatable, as shown below:

*'the brutality at that level and caused by institutions and things that's something you don't, no I can't relate to […] not this type of intrusion and brutality and abuse.'* [Natalie, T1, L112-116]

The brutality of the abuse was experienced as shocking, *'frightening'*, *'a bit sick'*, *'uncomfortable'*. Katy described it as being something *'really heavier than what I knew before'* [T1, L323-324]. The brutality also raised a sense of wanting to understand why the perpetrators were so brutal amongst all interpreters.

All the interpreters described experiencing a range of emotions, some of which were experienced as unbearable, based on what they saw and heard within sessions. All interpreters found the clients story hard to hear. The experiences were described as *'excruciatingly painful'*, *'traumatic'* [Natalie, T1, L74, L153] and something that *'break your heart hardly'* [Katy, T1, L117]. Tara described her experience as frightening, *'very, very intrusive'* as *'you have to go through each and every simple things'* [T1, L173-174]. For Tara, this appeared related to being brought up in a culture where sex was not openly spoken about.

All interpreters shared a sense of being affected by what they saw, as shown below:

> *'the first time I met this client was shocking in itself because she, uh, just the way she arrived into our place. That kind of distress you just, you know, that already has a huge impact.'* [Natalie, T1, L150-152]

For Katy it was hard to see her client struggling to talk whilst for Sara, it was difficult to interpret the emotions, as she stated that was *'you can interpret the words but sometimes you can't interpret the feelings'* [T1, L284-285].

Wendy, Natalie and Eve also spoke about the physical impact of hearing their clients' sexual trauma, examples of which from Natalie are provided below:

> *'I had pain having to say it but I would, literally a physical pain.* [T1, L264-265]

> *'the brutality is such of the story that you see the images. And when she talks about what she's been through, you just see it.'* [T1, L101-102]
> *'I can feel great fatigue and feeling drained […] Some sessions will do that to me.'* [T2, L166-167]

As indicative from the above quotes, Natalie experienced a range of physical effects both during and at the end of the session. She also later spoke about the images coming back to her after the sessions, suggesting that the impact can extend beyond the sessions. Similarly, Eve spoke about experiencing an urge to leave the

session on hearing her client's difficult trauma experiences, whilst Wendy reported leaving the session the first time she heard her client's story as:

> *'the first time it was like I couldn't breathe […] It was building up […] I just came out of the door [...] I was just sitting there for like five minutes trying to compose myself […] and breathing really and then I just came back.*' [Wendy, T1, L392-399]

For Wendy, the impact was associated with being reminded of her personal sexual trauma history which will be discussed later.

Many interpreters shared feeling a sense of urgency to help the client, helplessness and frustration for not being able to do more to support their clients. Sara said she felt helpless as *'you can't make that pain go away'* and *'don't have a magic wand to make them feel better'* [T2, L109-L112]. For others helplessness was related to wanting to do more to support the client (e.g. offering financial support). Tara described this experience as '*you feel like both your hands are tied up'* (T2, L509) because of professional boundaries and having to wait for a clinician's response to comfort a client rather than initiating it themselves within sessions.

Other emotions included feeling sad, depressed, sorry and disappointed at what had happened to the client and anxious about their recovery. However, Eve spoke about feeling anxious within sessions as *'we don't know what, what sort of reaction we will get […] from the client.'* [T1, L146-147]. In comparison to the negative affect, Natalie also discussed feeling satisfied by being able to convey her clients' stories despite experiencing the negative affect.

Interpreters also shared emotions of anger towards the perpetrators of the abuse. For Tara, anger transformed into hatred, as demonstrated below:

> *'If I could, had a gun I'd shoot them or chop their main part off. I felt so angry towards them.'* [T1, L220-221]
>
> *'the hatred has gone a bit higher I could say. When it was like fifty percent, I would probably raise it up to eighty percent, or ninety percent.'* [T2, L191-193]

Interestingly, Sara spoke about her experience of emotional disconnection from a client. Her client spoke as if she was telling a story. Sara described hearing the content of what her client said as *'difficult to digest'* [T1, L58] but the experience as easy, as the client did not show her emotions. Natalie also spoke about finding sessions involving conversations about the practical/health needs of the client easier rather than the sexual trauma.

The emotional impact of events was not limited to the sessions. Many interpreters described the residual emotional impact of the sessions despite their attempts to separate their professional and personal lives, as demonstrated below:

> *'[…] when I heard it's rape, I can still remember when I closed that door and went out. Normally I say, I try to leave it but I can remember, uh, feeling very angry and all these feelings […] the anger came outside, yeah I was walking. Not inside session. You know, like I said I tried to keep everything, um, within this building but that day I carried it with me […]*' [Sara, T2, L142-144]

Similarly, Tara spoke about ruminating about client experiences outside of sessions in trying to make sense of the brutality of the abuse. She also spoke about feeling down following sessions and finding it hard to forget some of intimate details of the abuse at home and being reminded of them, as shown below:

> *'they make sometimes, you know, drink the urine […] even when I drink water sometimes I used to feel my god, how will I, how will that person could have done this, you know? […] it's very hard to get rid of from your mind.'* [T1, L513-522]

Others also spoke about thinking about their clients outside of sessions. For some, this included both happy and sad moments, looking forward to the sessions and thinking how the client is doing after clients have completed therapy.

All interpreters spoke about experiencing a reduction in the emotional impact of their work following experience and time, an example of which is provided:

*'I think it goes away with time, so it becomes normal, you hear it and I think it becomes part of you maybe.'* [Katy, T2, L74-75]

Similarly, Natalie spoke about the client's story *'not being as a raw as it was [...] into the second year'* and the focus changing to other issues (e.g. health) which she described as a *'more acceptable distress'* [T1, L489-493]. Others spoke about developing skills in being able to manage the impact of the client's story over experience and feeling more prepared for subsequent cases. For example, Eve stated that *'more or less I know what they are going to say'* [T2, L90]. Tara also spoke about experiencing initial '*teething problems'* when interpreting in the first person and stated that over time '*I've switched to say, okay, this doesn't happen to me, I'm an interpreter, not client'* [T2, L104-105]. This suggests difficulties in separating the self from the client when interpreting in the first person. There was also a sense of coming to terms with the limitations of the interpreting role and focusing on how clients can be supported over time. However, there were some contradictions. Some interpreters also stated that the impact of hearing the client's trauma stories was the same over time, raising questions as to how and whether experience makes things easier.

### 3.3. Making Connections

The third superordinate theme captured the relationship between the experience of interpreting and the connections interpreters made with themselves and others, as demonstrated by Figure 4. Interpreters connected with trauma survivors, with their sense of self, with personal relationships and with the wider community and the organisation they interpreted for.

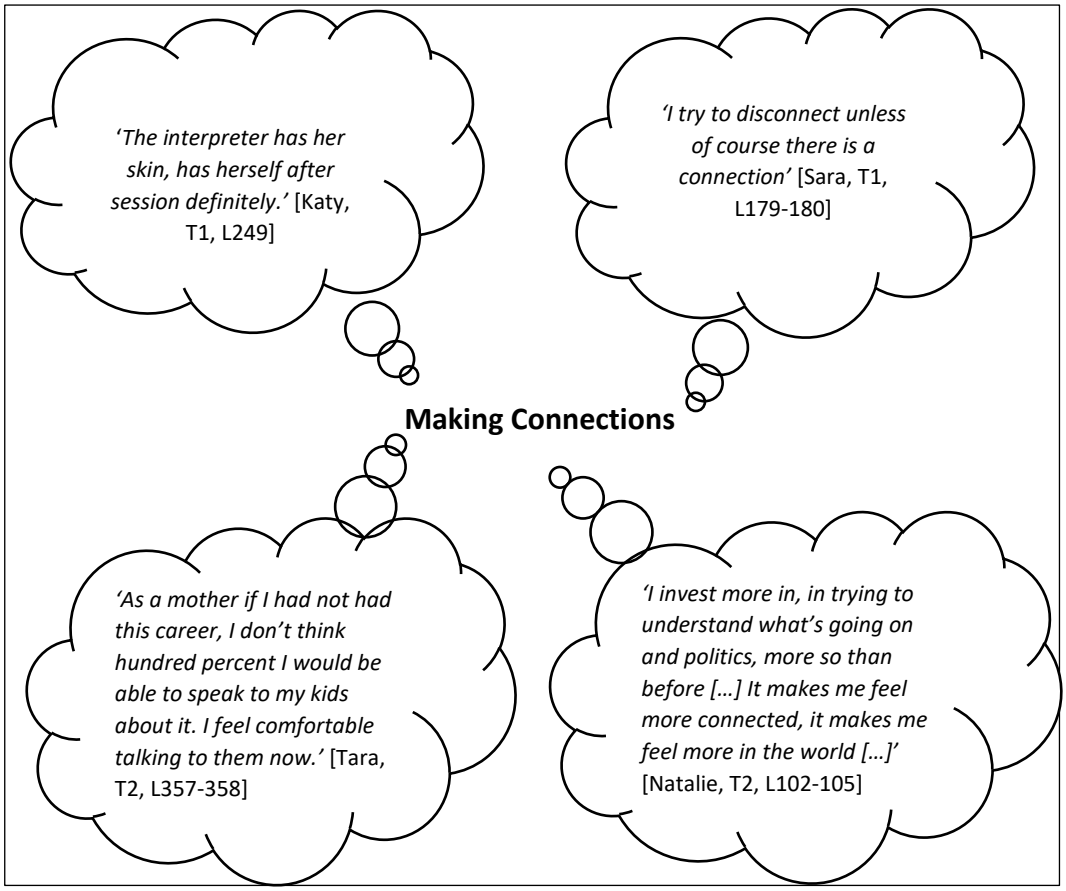


**Figure 4.** Quotes highlighting the third superordinate theme.

#### 3.3.1. Connecting to the trauma survivors

> *'because you work so much with those people you can start to identify […] Identify that that this is similar to me.'* [Wendy, T1, L58-60]

All interpreters spoke about particular clients during their interviews and the associated impact of working with those clients. On closer inspection, it appeared that

some aspect of each client connected with something personal to the interpreter, which varied across them. One interpreter reported sharing a similar trauma to the client:

> *'people they have like a minor torture I can explain, I can say that, so I can say that and some people they are very deep…And the deep one, the deepest one that is like you can relate it to that […]'* [Wendy, T1, L22-27]

Natalie also described her client's story as a story that *'resonates so much with you personally'* [T1, L593]. She compared the impact of two experiences and wondered if sharing the same language and cultural identity led to a greater impact with one of the clients. As shown below:

> *'Maybe because this was [culture] interpreting so we spoke the same language. We shared the same cultural identity […] Instead with the lady from [place] first of all, […] I didn't speak her language, she didn't speak mine […] But it was a bit different […]'* [Natalie, T1, L127-136]

Similarly, other interpreters identified personal connection with their clients. Katy identified herself as *'I'm one of those'* [T1, L45], as she herself was a refugee when she first arrived to the UK. Tara identified sharing gender with her clients and stated that 'that's makes us connect more', as she perceived females as being '*very emotional and very sensitive'* [T1, L327-328]. Katy and Sara described being impacted by particular clients, as they resembled their personal relationships with younger females within their lives. Sara reported finding herself *'unable to block it off'* [T2, L212] outside of sessions when she spoke about the impact of working with a young female client. Similarly, she also reported being affected by her client losing her son, as it reminded her of her son who was of a similar age to the client's son rather than being affected by the client's sexual trauma.

Conversely, Eve reported a connection with her client through their common interest in poetry, as shown below:

> *'I love poetry and she was also describing her feelings using poetry because it was hard for her to just say it […] It's like we shared our passion for poetry*.' [T1, L393-395]

Tara also spoke about finding it hard to understand silence and that this had also contributed to the impact of the client she spoke about.

### 3.3.2. Connecting with self

> *'we never show emotional things in the session but outside the sessions I will.'* [Tara, T1, L456]

All interpreters recognised debrief as an important opportunity to connect with themselves as interpreters following the session and make sense of a client's emotional reactions. Sara stated that debrief '*gives a sort of an end to it*' [T1, L35] when talking about the sessions. All interpreters described their experience of not having a debrief as difficult and not being able to let go of the impact of the session. Eve described it as *'you are swallowing things and you are not able to, uh, take it out'* [T2, L392-393]. Interestingly, Tara described debrief as *'the therapist does like a therapy on you'* as '*they let us bring out how you feel at the end of the session'* [T2, L555-557]. Katy and Natalie spoke about experiencing a sense of togetherness with the clinician and normalising emotions through mutual sharing in debrief, as shown below:

> *'Sometimes it's enough when the clinician tells me my goodness this was a really heavy session wasn't it? […] you've shared that. You know that's therapeutic in itself. You don't feel like you are the only one feeling it, affected by it […] Makes you feel more together with the clinician.'* [Natalie, T1, L708-711]

Four interpreters reported that their experience of interpreting evoked past memories with varying levels of emotions. Wendy shared her difficult experience of listening to a client's sexual trauma for the first time, as shown below:

> *'The physical impact, it was like I could feel, I could feel, I was like sweating, I feel like, I feel like something bubbling, you know, this if I see that man, so that man did it to, so basically another person did that to someone and then it start coming back and it's like oh that man he did a bad thing to me, bad thing to me, it was wrong, it was wrong just like with the client it was wrong, it wasn't right. I thought it was normal but it wasn't So you see? It was wrong and I had to come out of that session, I couldn't stay in'* [T1, L401-406]

As indicative from the quote above, the client's sexual trauma evoked a strong emotional reaction in Wendy, as it resonated with her sexual trauma history. Similarly, Natalie reported that *'the feelings were there but it really brought it up'* [T1, L403], as she spoke about pre-existing conflict around her identity and relationships prior to interpreting and that this had contributed to arguments with particular family members and led her to reject her identity, as she did not want to be associated with that culture and country. Conversely, Katy reported that her client's story had brought *'a flash back of memory'* and that *'it reminded me of my difficulties when I converted'*. She described this experience as helping her to understand the client and validate the client's experiences by telling the clinician that *'she's right, it's happened to me.*' [T2, L18-321]. For Tara, her client's experiences reminded her of her sister's personal history of sexual violence and she found herself ruminating about what may have happened to her sister. In summary, interpreters made varying connections between the clients' trauma and their own difficult personal experiences.

Furthermore, Wendy and Tara shared the experience of *'healing'* with the client and making sense of their personal traumas. For Wendy, this included realising what happened to her was not normal and was not her fault, as shown below:

> *'I know now from doing this work, it isn't, I don't feel ashamed anymore, it wasn't my fault.'* [T1, L418-419]

Wendy also described this experience as '*healing'* and connecting with the client, as a survivor at the end of therapy, as shown below:

> *'I can see that she's a survivor, so I'm a survivor too. You see? And then when they blossom I can say wow, so I did it! And then it's like myself because I knew that I came out of it.'* [T1, L572-574]

Similarly, Tara spoke about the therapy sessions as indirect therapy for herself when facing marital arguments similar to her clients and stated that she understood her sister more following her experiences of working with trauma survivors and realised *'how hard it is to come out it'* [T2, L569].

All interpreters shared a sense of personal growth through their work which was often tied to seeing the client's progress and included experiencing a positive energy, a sense of achievement and pride, a greater appreciation for life, maturity and increased resilience, as demonstrated below:

> *'it makes you more humble. So difficulties that are thrown at you, you stop and say wait a second, this is not important. Or you can cope with this one.'* [Natalie, T1, L529-530]

Interpreters also appeared to connect with various strategies to manage the ongoing impact of interpreting on them. These varied within and across participants. Wendy and Tara connected with faith to manage the emotional impact of their work but in different ways:

> *'God give me guidance so when we talk he give me a path that is going to help, I mean he says your work it's not going to be like just talking in vain.'* [Wendy, T1, L529-534]

As evident from the above, Wendy appeared to draw her strength from God to both view her work as worthwhile and hopeful. Similarly, Tara spoke about reading religious books as *it 'helps to take the mind off of the other bit'* [T1, L550-551] outside

of sessions. Other strategies used included yoga, breathing exercises, housework, listening to music, having coffee, watching TV, long walks, holidays, talking to themselves and thinking about ways in which they could make their clients happy. There was a sense that these strategies were helping them to distract themselves, as the function was described as 'to protect ourselves not to get all these feelings' [Eve, T1, L520]. Interestingly, Natalie acknowledged that these strategies may not always be a way of dealing with the impact, as shown below:

> *'I don't think I'm dealing with it actually. I'm pushing it aside, I'm ignoring it.'* [T1, L336]

Rationalisation, optimism and the hope that things will become better and that they are trying their best within the remits of the interpreter role was found amongst some interpreters. Interestingly, for Sara hope for her client was linked to her being a survivor of childhood abuse and as such, she felt she is not greatly affected by her work, as shown below:

> '*with proper help I think you can come out of it and you can lead a normal life. I strongly feel that. Uh, I don't know whether that's because, I feel because I was, uh, sexually sort of, not raped but assaulted as a child and I'm okay now […] I think that's why I don't feel, um, too traumatised by these*' [T1, L219-224]

### 3.3.3. Connecting to personal relationships

The interpreters experiences also influenced how they connected with their personal relationships. As discussed previously, for Natalie the re-evoking of past memories and emotions through interpreting contributed to her arguments with significant others. Additionally, Tara, Katy and Eve shared the experience of not wanting to talk to others following their sessions, especially, if they had been feeling upset:

*'it will take me normally an hour to get back from the interpreting session to my house […] I won't speak to anyone in the car […] I'll be like I don't want to talk to anyone […]when I come home, I'll just do my work and go to bed. I won't talk to anyone, it's just managing it.'* [Tara, T1, L467-472]

Tara also reported feeling irritable with others following some of her sessions. She shared an incident where she saw a broken bottle in the house following an emotive session and said:

*'So, when I came in, I saw this, you know, I just started jumping on them […] these kind of things does affect you. Sometimes get angry with others or at things quickly.'* [T2, L308-312]

Conversely, Sara, Eve and Tara spoke about connecting with others to manage the impact of interpreting. Sara described her mother as her 'coping strategy' and stated that:

*'sometimes she says things I mean, whatever the counsellor would be saying like don't worry about it's understandable, you will feel this way, whatever, whatever. Say I know how you feel and that's the phrase, it must be hard for you.'* [T2, L229-231]

The acknowledgement and normalisation of how Sara might be feeling was found helpful. A similar pattern was found for Tara and Eve.

Interpreters also reported the positive effects of their work on their relationships. These included becoming more compassionate and understanding towards others, as shown by an example below:

*'[…] working with people's problems you realise, you know, how these problems affect them. So you have a clear understanding of other people. So you're more caring and considerate and sympathetic towards other people.'* [Sara, T2, L279-281]

For Tara, this extended to feeling more compassionate towards her sister with personal sexual trauma history. Two interpreters also discussed the safety measures that they had implemented for their family members following their awareness of safety. Tara stated that she worries about the safety of her kids and their future and as such:

> *'I tell my sisters as well, they have daughters, I tell them you need to send them to karate lessons, because they need to get that confidence, cos like women are very soft […] I take my sister's daughters as well […] because I tell them, women need more support than men because they are weak'* [T2, L237-245]

She also spoke about now being able to openly talk about sexual relationships and abuse with her children, as the sessions offered a template as to how she might discuss these topics.

Tara and Natalie spoke about the impact of interpreting on male relationships. Tara spoke about her initial difficulties in maintaining a sexual relationship with her husband, as shown below:

> *'whenever I go to interpreting and come back when I had this kind of therapy I think I wasn't talking much, and even with my husband knows, okay. I have been to interpreting today, [Interpreter] mood is different so he won't even come near me and you know in your marriage relationship I won't attempt to do anything for a couple of days at least (laughs). Cos it's just, you feel a bit of, it was hard that's all I could say.'* [T1, L248-252]

The above illustrates that alongside a withdrawal from others, others also withdrew from Tara and she noticed difficulties in initiating sexual contact. Similarly, Natalie stated that *'I've got no romantic view of them'* and that *'I tend to keep men away'* [T2, L53, 80-81]. However, she acknowledged that interpreting contributed to the pre-existing difficulties that she had encountered with male relationships and that she had a few childhood male friends. Natalie also spoke about the impact of her experiences on her relationships with her son:

*'I love him dearly but every now and then something in his character I'm, I have feelings of dislike towards him when I see some aggression creeping up in him. Sometimes, there's a little voice in me saying, there you go, this is a male again, you know? And it's not a nice feeling to have that.'* [T1, L337-340]

As a consequence she reported that she is *'striving very hard to help for him to improve'* [T2, L79].

### 3.3.4. Connecting with the community and organisation

Interpreters also spoke about connecting with the community and the organisation they were interpreting for as a result of their experiences of interpreting. Natalie and Tara reported being more conscious about what is going on in the world. For Tara, this extended to doing good deeds to help others in her community. All interpreters also spoke about their experiences of connecting with other interpreters in the organisation through monthly interpreter meetings. Interpreters described the group and sharing experiences as useful in learning from others, validating their experiences and supporting each other, as demonstrated by an example below:

*'it's very helpful because we hear what other people think and how they perhaps would approach a certain situation. Or you hear that other people have felt the same so you know that you're not, you know, it's not just you or we've had some of our colleagues come in and sometimes they could cry for example, by being overwhelmed by stuff and we're there to, you know, help and give our input.* [Natalie, T1, L577-581]

However, not everyone found themselves being able to openly discuss personally relevant issues but for different reasons. Tara stated that she preferred taking a listening role as:

*'if I start talking about it, then it will trigger, and I start thinking about it.'* [T2, L476-477]

The above suggests that Tara avoided talking about the impact of interpreting on her to prevent things from getting worse (e.g. rumination). Sara spoke about not feeling *'very safe'* in the group, as she does not know *'who is taking things out of the group'* [T2, L476-477]. Interestingly, Wendy stated that no one had ever spoken about having personal experiences of sexual violence in the group. She perceived this as *'something that is more private'* and felt that *'no one wants to talk about their business'* [T1, L610-612].

### 3.4. Changed Understandings

The fourth superordinate theme captured the different ways in which interpreters said their work had impacted their existing beliefs about others, the world, concepts such as, rape and organisational needs. There was a sense of knowing more about the '*reality of the life*' [Katy, T1, L314] amongst all interpreters, as also indicative from Figure 5.

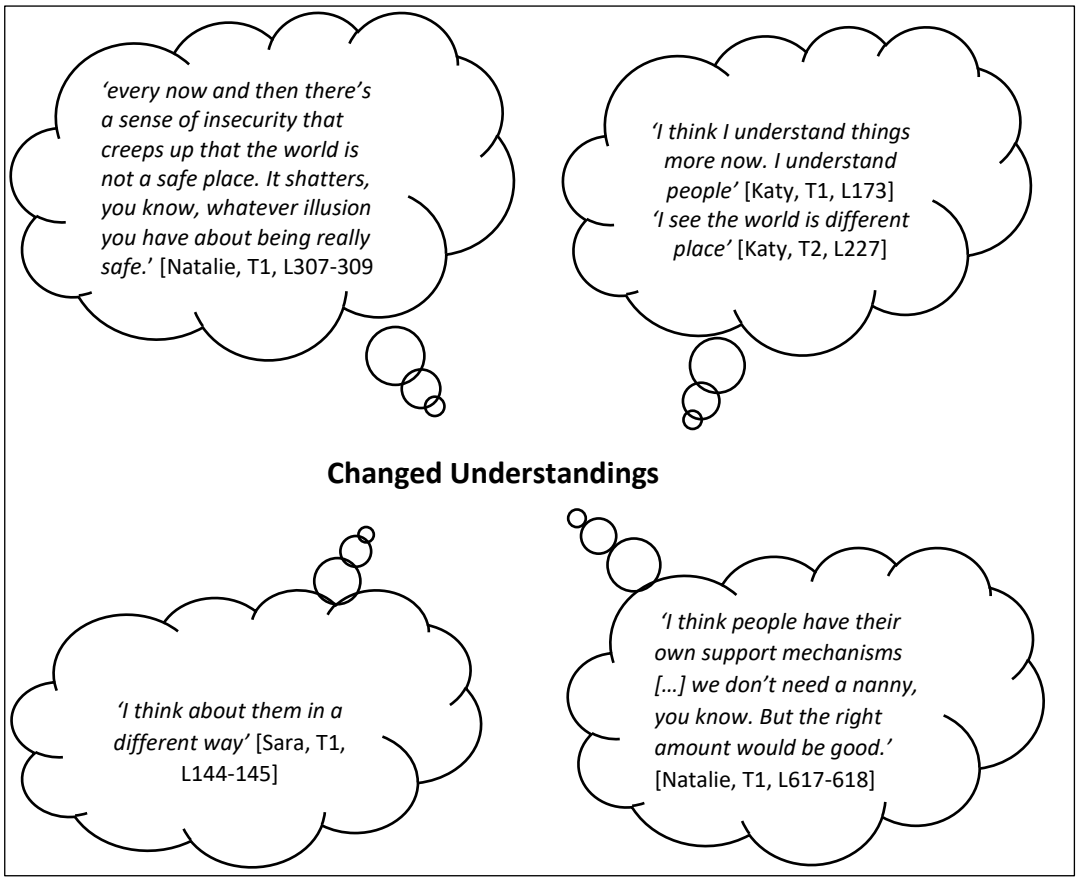


**Figure 5.** Quotes highlighting the fourth superordinate theme.

Natalie, Sara and Wendy reported feeling more aware of safety issues following their work. Sara stated that following her work, she came to the realisation that refugees have a *'valid reason'* to flee their country *'because of their safety'* [T1, L154] rather than financial gains as she previously thought. Consequently, she reported feeling *'more sympathetic towards them'* [T1, L168]. Similarly, other interpreters stated that *'the view of the people was like everyone is good'* [Tara, T2, L266], '*the world is nicer'*, there is *'fairness, more freedom'* in the world [Katy, T1, L335; T2, L230] and that these had now changed. Katy experienced the impact of this as:

> *'I'm really happy, glad I'm between people I can feel their feelings, I understand them more'* [T1, L339-340]

The above suggests that facing reality, despite it being negative, can be beneficial. Many interpreters also spoke about their experiences confirming their understanding of the political context of the country. Eve also viewed this as having a *'positive impact'* [T2, L315]. Awareness of the political context of the abuse was seen as important by all interpreters in understanding reality. Many interpreters stated that they actively researched the political context to contextualise the abuse. Natalie described this experience as it '*helps a lot in terms of, never justifying it, but rationalising it, understanding it*' and later went onto to say that this is better *'than focusing strictly on the brutality because that's when it affects you in an unhealthy way'* [T1, L167-168; T2, L503-504]. The context was also considered important in conveying the client's story and making '*you feel more aware'* and *'less shocked when clients tell you'* [Katy, T2, L65]. Similarly, Eve and Natalie stated that new interpreters should have an understanding of the political context beforehand, to prepare themselves. Interestingly, Tara said that she no longer avoided material on sexual abuse in the media following her work. However, she was unsure if this was to increase her knowledge or something else.

The impact of an increased awareness of the political context appeared more pronounced for Natalie:

> *'[…] the more and more I work with people like this, I realise the brutality of that country […] It's a cruel place […] it's completely erased any, um, romantic view I may have had in my childhood growing up in a [anonymised culture] household with very gentle people, cultured people who did not portray [country] in that way at all, it was exactly the opposite what they, the portrait they gave me.'* [T2, L25-30]

This appeared to evoke strong emotions in Natalie towards those who she felt *'force fed me this identity'* [T1, L412]. She reported feeling '*an aversion to anything [anonymised culture]'*, not wanting *'nothing to do with that culture or country'* and *'embarrassed'* by having a shared identity with the perpetrators of the abuse [T1, L381-382; T2, L32-33]. It is important to note, that there was pre-existing conflict between Natalie and a parental figure. Natalie felt this had influenced the impact of the interpreting.

Interpreters also reported various changes to their views about men, women and understanding of rape. Tara reported feeling *'women need more support than men because they are weak'* and '*some kind of power'* [T2, L243, 249]. In comparison, Natalie reported having '*great affection'*, *'time'* and '*a mothering type of feeling'* towards them and felt that *'women are the stronger gender'* [T2, L86-87, L89].

Varied perceptions of men were also found. Wendy reported hearing the stories of sexual trauma as making her '*hate men even more'* and there being *'no compassion about men*' [T1, L365, L381]. Similarly, Natalie stated that *'I maybe like men a little less'*, '*I'm wary of them […] something in the male that scares me'* [T1, L315-316, L318]. It is important to note that both Wendy and Natalie had negative personal experiences with men prior to interpreting, which could have also contributed to their views. Similarly, Tara reported that she had *'started hating men'* [T, T1, L222] as she was unaware of men being capable of abusing women. However, this was described an initial effect. She reported *'making a lot of assumptions'* about men based on how men around her were look at her and others and judging them as

*'not good men'* if she felt they were looking *'in a wrong way'* [T1, L232-234]. Conversely, Katy reported no effects of her experiences of interpreting on her perception of men.

> *'in movie you base your judgement on the movie so it was never really, it wasn't real until I worked here.'* [Katy, T1, L378-379]

As indicative from the above quote, interpreters' experiences also brought reality to understandings of rape but in different ways. Wendy had multiple personal experiences of sexual violence and spoke about coming from a culture where rape was seen as *'normal*', an expression of love and stated that people could '*get married in right way or by rape'* [T1, L188-190]. Following her work, she realised that *'rape is not normal'* and as such, stated that *'I'm a group-up, I won't tolerate, I won't accept it'* [T1, L385-386]. Wendy's experiences of interpreting appeared to help her realise that what had happened to her was also wrong.

Similarly, Katy reported thinking that rape is *'not the woman's fault and that 'the rapist is sick'* [T1, L369-370] compared to her prior thinking of marital rape not being rape and that women must have done something to provoke rape. Tara spoke about realising that females could also commit rape. As previously discussed, many interpreters found some of the brutality of rape stories difficult to comprehend. As such, some tried to make sense of the brutality through thinking perpetrators abuse for *'power and money and just selfishness'* [Katy, T2, L226-227].

Initially, Tara found silence in therapy 'a bit hard' to understand and '*a waste of time'* [T1, L297, L229]. Following her experiences, she stated that '*I just come to understand, silence speaks a lot'* [T1, L147] and understood the difficulty for clients in talking about their abuse.

All of the interpreters identified organisational needs to support their work, based on their experiences of interpreting and the impact of it on them. These included further training, one to one counselling support and greater appreciation as interpreters.

### 3.4.1. Further training

The majority of interpreters suggested further training. This included training on therapeutic procedures, terminology, legislation, translating words, working on accent/voice, current political contexts particularly, for new interpreters, trauma and abuse, the emotional impact of interpreting and how to manage the impact. Natalie suggested involving interpreters in delivering training and sessions on '*how to work well in sessions'* [T2, Line 413] for interpreters and clinicians, particularly younger or newly qualified clinical. Training was considered important in having the knowledge and *'tools'* to '*produce a better job'* [Katy, T2, L443, 447], to be able to translate concepts better (e.g. flashbacks) and for interpreters to '*feel confident'* in their roles [Eve, T2, L556]. Barriers to training were also identified. These included finding the time to attend training and the financial implications, if interpreters were expected to pay for training.

### 3.4.2. One to one counselling support

The majority of interpreters suggested the option of individual supervision or counselling sessions. This was considered an important space to make sense of their experiences especially when there is a personal connection with clients, as demonstrated below:

> *'I think I would use that space by, you know, especially for example when you have a story like this one that resonates so much with you personally also. Um, to be able to see someone about it and just talk about it.'* [Natalie, T1, L592-594]

Similarly, Sara reflected on her experience of making sense of the impact of interpreting on her during the interviews and likened her experience to that expected from individual supervision:

*'Like us, as we have been speaking about it, it's making me understand the reason I was feeling angry and it came out of the building with me, because she was of my son's age and her abuse was childhood trauma so like my childhood trauma, not the same but in childhood. That helps to understand my reaction.'* [T2, L360-363]

Other interpreters stated that they would use the space if they did not get along with the clinician and to find a way to solve clinical problems. Sara suggested offering anonymous sessions, as there was a fear of what the organisation would think. She stated that interpreters might interpret 'going for counselling' as being '*seen as a weaker person'* and that as a consequence '*they may not be given enough jobs*' [T2, L637-638].

### 3.4.3. Greater appreciation

*'the interpreter's as important, as important as the clinician, in a different way.'* [Natalie, T2¸ L346]

Some interpreters spoke about their experiences of feeling unappreciated. This included situations when clinicians had dismissed and restricted their input, as shown below:

*'They will kind of immediately shut you up and, and they can be quite abrupt too. And make you feel that this is not your place, you're just here to interpret or give you a look'* [Natalie, T2, L275-276]

Some interpreters stated that they felt frustrated, '*a bit undervalued*' [Eve, T2, L624] and like '*a tool'* [Natalie, T2, L259] under these circumstances. Consequently, they did not share their feelings about the session and restricted their input within sessions. Others stated that *'the relationship broke down completely between all of us'* [Natalie, T2, L338] and it did not feel like a team. It was suggested that clinicians should treat interpreters *'Like an equal, equally important partner in this job'* [Natalie, T2, L255-256] and show interest professionally and personally.

For Natalie, interpreting was seen as a '*not respected enough or a recognised profession'* across organisations and services [T2, L523]. She felt the organisation valued interpreters but they were still '*totally disposable and replaceable'*, as they were *'agency'* [T2, L532-533]. As such, she suggested the inclusion of interpreters in general conferences held by the organisation for staff and *'annual staff award ceremonies'* to '*feel a bit more appreciated'* [T2, L574-575]. Similarly, Katy suggested a stable job. She recognised this as being more financially viable for the organisation, as external recruitment is *'expensive and costly'* [T1, L563] and stated that it would make the interpreters *'more happy because we'll feel part of this organisation'* [T1, L566-567].

## 4. Discussion

The purpose of the current study was to explore the experience and impact of interpreting for female survivors of sexual trauma in therapy on female interpreters. The study had three foci; the interpreter's experience of interpreting, the impact of interpreting on the interpreters and how they managed this impact.

### 4.1. What is the interpreter's experience of interpreting?

Figure 6 provides the researcher's interpretation on the relationships between the four superordinate themes found to capture the process and impact of interpreting.

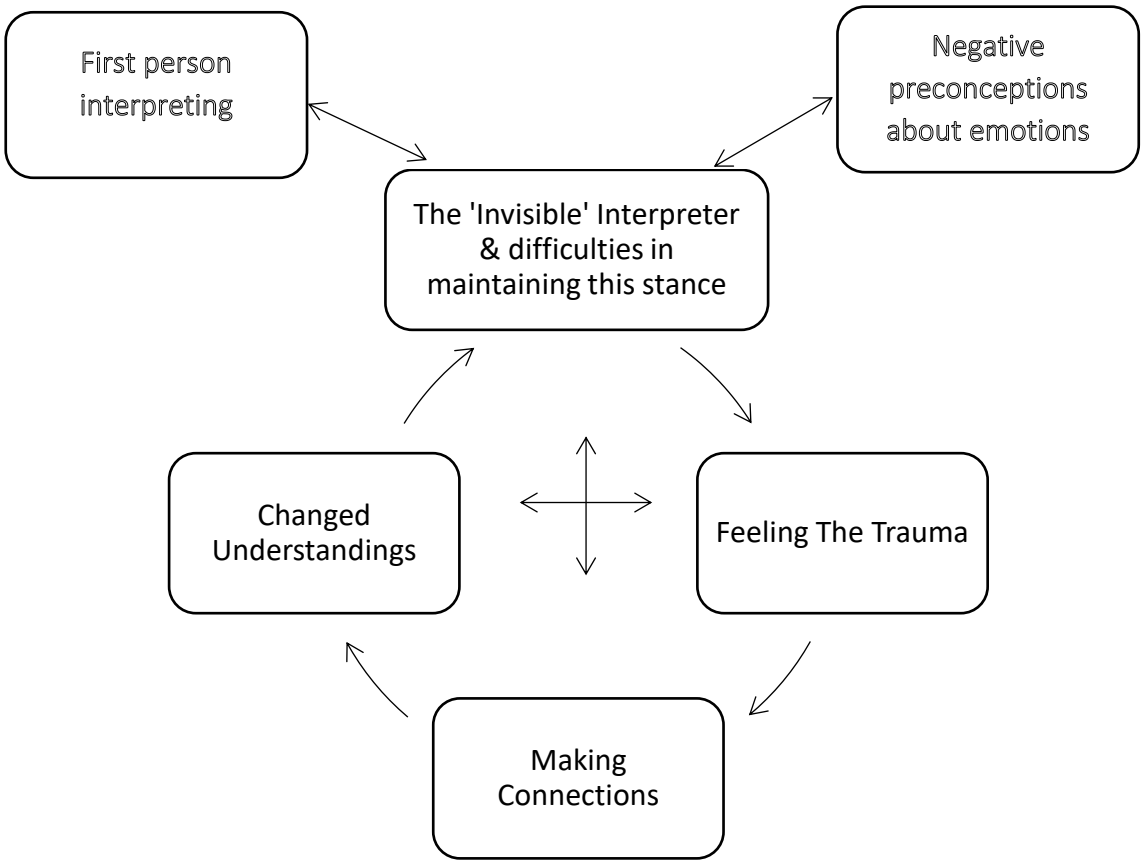


**Figure 6.** An interpretation of the process of interpreting in the current study.

First person interpreting and pre-existing negative preconceptions about emotions (e.g. viewing negative emotional reactions as a weakness, a hindrance in the interpreting process) is likely to have influenced the 'invisible' stance adopted by all interpreters within therapeutic sessions. The 'invisible' stance was coupled with a sense of great responsibility towards conveying the client's story (details and emotions). The focus for interpreters was to role play the client and the clinician and bridge the distance caused by language barriers. Interpreters recognised exceptions to invisibility. These included when invited by the clinician or the client to answer a question or to provide cultural understanding. This stance is similar to the 'linguistic' and 'culture broker' modes of interpreting, where interpreters employ a distant position with limited emotional involvement with clients (Tribe & Morrissey, 2004). The negative preconceptions about emotions were reflective of societal and cultural discourses about emotions and for one interpreter was a message given during her training (Lim, 2016).

This 'invisible' stance was difficult to maintain when emotions were evoked within sessions, bringing visibility to the interpreter's sense of self. This is likely to have been a product of first person interpreting, making connections (e.g. with trauma survivors and self) and normal emotional reactions to '*bringing reality to rape*' through their clients experiences and the '*shocking*' brutality involved.

First person interpreting appeared to have a perplexing role. All interpreters found interpreting in the first person difficult, including one interpreter who reported automatically switching to third person, when a client began to explore intimate details relating to the sexual abuse. While some interpreters viewed the first person interpreting as demonstrating warmth, respect and sensitivity to clients and as an important way to convey the client's story, other interpreters spoke about 'becoming the client' in the process of conveying the client's stories. This suggests that first person interpreting might increase an interpreter's vulnerability to the impact of working with sexual violence trauma in therapy.

All interpreters spoke about forming an emotional connection with their clients through identification. The nature of the identification varied across interpreters and included, shared interests, similar personal trauma histories, clients resembling

significant others, shared gender, language and cultural identity. This suggests that the process of identification is a complex one and does not always involve shared trauma. Research suggests that an emotional connection is an important prerequisite to empathy and empathy is a paradox, as it is required for a good therapeutic alliance and can function as a protective and risk factor (Figley & Kleber, 1995; Hojat, 2007). As such, it is likely that identifying with the client increased empathy amongst the interpreters, as some stated that they had become more sympathetic towards their clients. This is likely to have left them vulnerable to the impact of interpreting.

### 4.2. What is the impact of interpreting?

Despite the attempts to remain 'invisible', all interpreters spoke about the emotional impact of interpreting. This varied within and across all interpreters and included the impact of verbal (e.g. what the client said) and non-verbal information (e.g. the client's physical appearance). Some interpreters stated that they were not affected by their work but through exploration, the effects were found. It is likely that the initial hesitance in exploring the emotional impact during the interviews was associated with their preconceptions about emotions and was reflective of the 'invisible' stance. Emotions played a key role in producing the impact, as interpreting was considered easy in the context of emotional disconnection with a client.

The emotional experience of interpreters included a range of emotions: shock at the brutality of the abuse; anger towards the perpetrators; sadness; depression; empathy; an urgency to help; helplessness; and frustration at not being able to do more to support the client. The physical arousal associated with these emotions was also present during the sessions (e.g. breathlessness, physical pain and an urge to escape). The emotional impact of interpreting continued outside of the sessions, as some reported thinking about their clients, environmental cues reminding them of the client's abuse and continuing to experience some of the intense emotions (e.g. anger). One interpreter also reported initial sexual difficulties in initiating and responding to sexual contact. This is consistent with past literature on interpreters and research

reporting sexual difficulties and STS amongst professionals working with trauma survivors (Butler, 2008; Mehus & Beecher, 2015; Newell & MacNeil, 2010; Sexton, 1999).

Those who reported 'becoming the client' appeared to experience a more intense emotional reaction within sessions. One interpreter spoke about seeing images of the abuse and described the experience of retelling the client's story, as reliving the client's story. This suggests that some interpreters experienced symptoms similar to their client's experiences and post-traumatic stress disorder. However, it is important to note that not all interpreters reported this effect. This suggests that the impact of first person interpreting and working with trauma is likely to vary across interpreters.

The client's stories also evoked personal memories and additional emotions amongst some interpreters. This appeared more intense for interpreters who identified with the client's trauma through direct or vicarious experience of sexual violence and those who reported themselves as 'becoming the client'. This is consistent with the past literature that suggests a personal trauma history is associated with greater levels of VT and STS and that interpreters can re-experience their own traumas whilst interpreting (Cosden *et al*. 2016; Ekundayo *et al.* 2013; Miller *et al*. 2005). However, the nature of the personal memories evoked varied, as one interpreter reported being reminded of their experience of converting. This suggests that the experience of interpreting for sexual trauma survivors has the potential to evoke emotionally salient memories which may not be specific to the nature of the client's abuse.

Interestingly, identifying with the clients sexual trauma was experienced as a positive effect. One interpreter reported being able to make sense of her sister's emotional reactions and consequently, being more compassionate towards her. She also described the sessions as indirect therapy for issues she experienced in her personal life. Another interpreter reported making sense of her personal trauma history and coming to the realisation that the abuse was not her fault and consequently feeling no longer ashamed by the abuse. She described this as '*healing'* with the client. The above examples are consistent with past research and is reflective of the concept of the wounded healer, which is often applied to therapists (Miller *et al.*

2005; Sedgwick, 2017). This is the notion that a therapist's personal difficult experiences can facilitate an empathic connection with clients. Clients and therapists can heal/recover through the processes of transference and countertransference (Gelso & Hayes, 2007). However, this requires acknowledgment and reflection on part of the therapist, as a lack of self-awareness can have a potentially unhealthy effect on the client, therapy and therapist. This suggests that the wounded healer can also be applied to interpreters.

Conversely, one interpreter spoke about rejecting her cultural identity and increased arguments between her and significant others. However, she noted that this was not a direct consequence of interpreting. Collectively this suggests that the relationship between interpreting experiences and personal trauma/conflict is complex and is thereby, consistent with literature (Newell & MacNeil, 2010).

All interpreters reported a range of positive effects from interpreting for survivors of sexual trauma in therapy. These included a sense of achievement, greater appreciation of life, happiness, maturity, increased resilience, compassion towards others, greater involvement with the community, improved relationships (e.g. openness to talk about sex with children) and increased safety measures to protect significant others. This is consistent with the emerging literature on post traumatic growth and research that suggests the positive and negative effects of vicarious exposure to trauma can occur simultaneously (Brockhouse *et al.* 2011; Cosden *et al*. 2016).

Clients trauma stories challenged many existing ideas about safety, the world, others and concepts such as, rape and silence in therapy amongst interpreters. This was perceived as a positive change and as bringing '*reality to life'*. This is consistent with literature on VT amongst professionals exposed to vicarious trauma (Newell & MacNeil, 2010).

There were inconsistencies regarding the role of experience in the impact of interpreting on interpreters. It was unclear whether experience was a reflection of becoming desensitised to client stories, developing coping strategies and/changing the

nature of the work (e.g. the focus moving from sexual trauma to meeting the clients practical needs).

All interpreters described their caseloads as including 80-95% of clients who have experienced sexual violence mainly, rape and had between 2-5 years of interpreting experience for the organisation and 6-20 years of interpreting experience as a whole. Research suggests that the impact of chronic exposure to traumatogenic material versus exposure to acute trauma is likely to vary (Elwood *et al.* 2011). As such, the noticeable impact of vicarious exposure in the study might be a reflection of the acute trauma experienced by clients and nature of the abuse.

### 4.3. How do interpreters manage the impact of interpreting?

During sessions, interpreters reported many attempts to restore the 'invisible' stance by not showing their emotions, swallowing everything and/ detaching themselves from the client through interpreting in the third person. Interpreters made sense of their client's experiences by putting the abuse into a political context. As such, many reported not feeling shocked by the occurrence of the abuse, whilst others reported researching the political context. This was considered helpful in managing the unrelatable '*shocking*' brutality involved in their client's sexual abuse.

Outside of sessions interpreters appeared to use many avoidance based coping strategies (e.g. yoga), cognitive strategies (e.g. rationalisation) and the hope that things will get better for the client. This is consistent with past literature (Newell & MacNeil, 2010; Splevins *et al*. 2010). Some interpreters found it helpful to have their emotions labelled and validated by significant others. Two interpreters spoke about the role of spirituality and faith in helping them to distract themselves from the impact of interpreting and provide a source of strength/reassurance that things will become better. This is consistent with research that suggests spirituality can reduce the negative impact of working with trauma on professionals (Newmeyer *et al.* 2016).

Organisational support was also considered helpful in managing the impact of interpreting. Debrief appeared to be the interpreters space to connect with themselves, reflect on their experience, makes sense of their reactions and their clients reactions and normalise and validate their emotional experiences. Similarly, the interpreters group was considered helpful in learning ways to manage difficulties during sessions, normalise and validate the impact of interpreting and offload. However, some reported finding it unsafe to contribute in the group because of the unfamiliarity with group members, worries about confidentiality and personal trauma history not being discussed in the group.

Relational contexts are key in influencing the dynamics of any interaction within and outside of clinical contexts. As aforementioned, making connections with trauma survivors and hearing their trauma stories evoked a range of emotional responses amongst interpreters and as such, influenced the relationship between the interpreter and the client and the impact of it on the interpreters in the study. Additionally, the interpreters shared their positive and negative experiences of working with clinicians, another important part of the triadic relationship. The interpreters reported experiences of feeling unheard and unappreciated by clinicians and felt that this had a negative impact on the relational dynamics in the room and in one situation, contributed to the client's disengagement in therapy. Given the importance of debrief for interpreters and the interpreters group, it is likely that clinicians function as an important 'coping strategy' for interpreters in understanding and managing the emotional impact of their work (Raval & Tribe, 2002). Therefore, establishing a good working relationship where '*both are treated as equals*' was viewed as key in producing a '*harmonious*' triadic relationship.

### 4.4. What additional support might be required?

Interpreters identified a number of additional support options. These can be found under clinical and policy implications, as they have formed the basis for the recommendations to the organisation.

## 4.5. Study strengths

- Double interviews is a strength, as the researcher noticed that some participants were more open to discussing the negative impact of interpreting during their second interviews and two interviews enabled the researcher to corroborate themes and further discuss relevant topics.
- The results add to a limited pool of literature in this area.
- All interpreters were from the same organisation and had similar training/support options.

## 4.6. Study limitations

- The study was qualitative study and as such, cannot be generalised to all interpreters. Similarly, sexual trauma can be perceived as an acute trauma compared to more chronic exposure to traumatogenic material. Studies have found higher levels of secondary distress amongst those working with sexual trauma survivors compared to other types of trauma. Thus, the significant impact of vicarious exposure to sexual trauma found in this study could in part reflect the nature of the abuse.
- The sample is atypical. The interpreters were part of an internal pool. Interpreters are typically recruited from external agencies and as such, the impact of interpreting may vary. The study is prone to self-selection bias and the audiotaping of interviews may have restricted/influenced disclosure in fear of the possible negative effects of this on their employment.
- Double interviews can also function as a limitation. It may have increased the chances of demands characteristics and anxieties amongst interpreters particularly, as the same topic was discussed.

## 4.7. Clinical and policy implications

Clinicians and organisations should explore the possible impact of interpreting in therapy on interpreters given their significant role. This is important in safeguarding interpreters and will influence the relational dynamics and outcomes of therapy. Freelance interpreters employed on an ad hoc basis are at greater risk, as typically they do not have access to a protected space to reflect or consistent support options. Training and policies for interpreters should ensure that they normalise the possible impact of interpreting on interpreters and as such, challenge existing unhelpful narratives around emotions. This should include careful thought into the use and implications of first person interpreting.

A number of recommendations are proposed to the organisation based on the findings of the study. These can be found in Table 5, along with the rationale underlying the recommendations.

**Table 5.** Recommendations to the service.

| Recommendation (s) | Rationale (Why?) |
|---|---|
| 1) Interpreters should be offered the option of regular one to one supervision and/counselling sessions with an appropriate professional. If possible, this should be kept anonymous unless there are risk concerns. | • Given the impact of interpreting on interpreters in the current study.<br>• To enable interpreters the opportunity to reflect on and make sense of their emotional reactions particularly, when they have identified with their clients.<br>• A safe place is important to facilitate disclosure.<br>• To offer the opportunity to explore the processes of transference and countertransference in therapy. This will assist in safeguarding interpreters, clients and clinicians and may also be beneficial for the outcomes of therapy for clients.<br>• This might be helpful if interpreters do not get along with clinicians or feel unable to share their feelings and thoughts. This will offer them to space to reflect and to problem solve any difficulties they may be having with clinicians. |
| 2) All interpreters should be debriefed following sessions. Clinicians should take the time to get to know interpreters personally and professionally and both should equally value each other's contributions. | • Given the impact of interpreting and the 'invisible' stance taken by interpreters during the session.<br>• Debrief was identified as an important space for the interpreter to connect with themselves, their emotions, their thoughts, the impact of interpreting on them and to obtain closure.<br>• To normalise and validate their experiences.<br>• To facilitate a positive relationship between interpreters and clinicians, as this will be conducive to them and to therapy. |
| 3) Information relating to an interpreters personal trauma history should be obtained in an appropriate manner (e.g. during individual sessions and at the start of employment). The interpreters group could also encourage disclosure of personal trauma history. | • Given the varying impact of personal trauma history.<br>• To safeguard interpreters and ensure appropriate support is in place.<br>• To normalise the possible impact of having a personal trauma history on their experiences and impact of interpreting. |
| 4) The organisation should foster a healthier alternative narrative about emotions to counter any existing negative beliefs about emotions. They should normalise the emotional impact of interpreting on interpreters and reassure interpreters that they will not lose their jobs if they are affected by their work. Training, supervision, written resources and informal conversations may provide possible avenues for this. | • To validate the range of emotional experiences possible through interpreting for trauma survivors.<br>• To enable interpreters to reflect on their emotion regulation strategies, as this will influence how they manage the impact of interpreting and can provide important information about the processes of transference and countertransference in therapy.<br>• To reduce anxieties about losing employment. |

**Table 5.** Recommendations to the service.

| Recommendation (s) | Rationale (Why?) |
|---|---|
| 5) Interpreters should be offered regular training on a number of topics. These can include training on therapeutic procedures, terminology, legislation, translating words, working on an accent/voice, current political contexts particularly, for new interpreters, trauma and abuse, the emotional impact of interpreting and how to manage the impact. Wherever possible training should be free and flexible (e.g. options for workshops during the day and evening). | • Training was identified as a need to be met.<br>• To offer an opportunity for further development, enable interpreters to fulfil and feel confident within their roles.<br>• To promote self-awareness around various important topics (e.g. possible emotional impact of their work) which will help interpreters to develop a reflective stance. This will be important in managing the impact of their work.<br>• Interpreters stated that the cost of training and time slots may act as barriers to training and development. |
| 6) Interpreters should be involved in offering training and their perspectives on working with interpreters in therapy (e.g. how to produce effective working relationships within therapy). Training can be conducted in conjunction with clinicians. | • To offer an opportunity for further development.<br>• To further promote a collaborative team culture.<br>• To increase interpreters sense of feeling valued and appreciated. |
| 7) Interpreters should be involved in annual meetings for all staff. | • To promote a collaborative team culture.<br>• This will provide an opportunity to value and appreciate interpreters. |
| 8) The organisation should consider annual ceremonies to celebrate and reflect on the work of all staff. | • To further value and appreciate the contribution of all team members. |
| 9) The organisation should consider offering stable or more permanent posts. | • Stability in employment is associated with a happier and resilient workforce.<br>• This might be cost effective for the organisation in the long run.<br>• This offers another opportunity to help interpreters feel valued within their roles.<br>• Feeling stable and safe can also encourage reflection and disclosure. |
| 10) The feasibility of interpreting in first person should be reconsidered. | • Given the impact of first person interpreting, particularly for those who reported becoming the client and those with personal trauma histories.<br>• To ensure appropriate support is in place (e.g. training on the possible impact of first person interpreting, availability of support options/opportunities to reflect on the impact and possible risk and protective factors), if the decision to continue with first person interpreting is made. |

### 4.8. Research implications

Further research is required given the limited pool of research on the impact of interpreting in therapy on interpreters. This can include investigating the role of factors that were not explored in the current study, such as, culture and the impact of interpreting for male sexual trauma survivors, as some interpreters reported greater distress on working with male sexual violence survivors. The impact of chronic exposure to traumatogenic material compared to acute trauma also requires further investigation, as the impact of chronic exposure might be harder to detect but equally as detrimental (Elwood *et al.* 2011).

Research can also explore if a similar process of interpreting can be found amongst other interpreter groups, other types of trauma, clinicians, researchers and non-professionals working with trauma survivors. This is key in improving our understanding of the process and impact of working with trauma survivors and to have appropriate support in place.

## Conclusion

Interpreters are affected by their work with trauma survivors. The effects can be positive and negative and can co-occur. The impact of interpreting is likely to vary across interpreters depending on a range of factors (e.g. personal trauma history, personal beliefs and values, coping strategies and empathy). Emotions play a huge role in this process. Therefore, it is vital to have appropriate support, training and opportunities to reflect in place for them.

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**Part C:**

# Critical Appraisal: The researcher's journey

## 1. Critical Appraisal: The researcher's journey

The information provided in this section is based on a number of sources. This includes my research supervision and reflective logs to capture my experiences.

### 1.1. Why this area of research?

*'I never think about the impact, I just come in, interpret and leave, that's my job'*

My interest in this area of research stems from my personal experiences of caring for others with physical and/mental health issues. In relation to interpreters, I vividly remember my experience of talking to an interpreter about their experiences of interpreting prior to starting my Doctoral training. An interpreter and I were waiting for the arrival of a client, who we realised much later into our conversation was unlikely to attend the session. I was aware of the range of resources (e.g. clinical supervision, reflective practice groups and psychological thinking) available to clinicians, to manage the impact of their work and was interested in the training offered and support options available to interpreters interpreting in therapy. I was shocked by the interpreters account. The interpreter described going from one session to another and being vicariously exposed to varying levels of trauma in almost a robotic manner. The interpreter also spoke about having no knowledge of what clients were going to speak about prior to sessions, a lack of briefing and using debriefing to sign forms to confirm attendance rather than an opportunity to reflect on the session and its possible impact. I asked the interpreter whether they had ever been affected by their client stories. The interpreter appeared baffled by my question and stated that they had never thought about the impact and tended to '*just get on with things*'. However, they reported feeling '*a bit upset sometimes*' and was quick to shrug this off. I felt annoyed by the lack of support offered to interpreters despite good practice guidelines on working with interpreters. I was intrigued why clinicians had not taken the time to debrief interpreters despite the vast psychological knowledge and understanding available to us (e.g. about processes of transference and countertransference and our personal experiences of working with clients).

From talking to clinicians and being a clinician myself, I later realised the pressures we face from the system (e.g. increased caseloads, huge waiting lists and limited resources), which can make it harder for us to have some reflective space for ourselves and others (e.g. interpreters). I am a strong believer in the saying that '*you cannot pour from an empty container*' and as such, self-care and reflection is essential in working with clients. My personal experiences, experiences of talking to interpreters and clinicians along with my beliefs led to my interest in this research area.

My interest in the area of sexual violence trauma was influenced by my personal experiences of being vicariously exposed to a loved one who experienced sexual violence and hearing incidents of sexual violence within the media.

### 1.2.Preparing the research proposal

I was hoping that I would find more research on the impact of interpreting on interpreters in therapy. However, I was not surprised by the lack of research in this area. This further fuelled my interest, as I felt this is an area that I could contribute to and make a difference. I was interested in conducting an IPA study as my research experience has largely involved quantitative research and I enjoy listening to peoples experiences and how they make sense of their experiences. The process of an internal review of my research proposal by the course team was anxiety provoking, as I was familiar with research proposals but not the review process by a panel. This experience highlighted the need for me to think about my decisions, be transparent with my decision making process and provide justification for choices, as a researcher. Additional feedback from the internal peer review also made me realise that IPA is an approach that needs to be applied to the whole research process (e.g. recruitment and methods) rather than just the analysis. As such, it influenced my recruitment decisions. I was grateful to receive the feedback from the service user reference group, as it further fuelled my motivation.

### 1.3. The literature review process

Originally, I was planning to conduct a literature review on the impact of interpreting for trauma survivors on interpreters. However, given the lack of research in this area I choose option B. This was the factors that moderate the impact of working with trauma survivors on mental health professionals. I felt overwhelmed by the research and complexity of the findings in this area. I also wanted to enhance my understanding of risk and protective factors rather than focusing on a particular factor, as I felt this would be more beneficial for clinicians, services and researchers. As such, I decided to conduct a systematic review of recent literature. Initially, I was surprised that a systematic review had not been conducted in this area. The results of my scoping search provided possible explanations for this. The complexity, confusion and conceptual overlap involved in the concepts used to examine the impact of working with trauma survivors and varying methodologies used within and across countries might have contributed to this.

I experienced a challenging dilemma when deciding on an appropriate critical appraisal tool to assess the quality of the evidence provided by the studies. Based on discussions during research supervision and research into critical appraisal tools for cross sectional studies, I realised that none of tools had a scoring system. Typically, the scoring system as part of a critical appraisal tool enables researchers to exclude studies in a systematic review on the basis of providing poor quality of evidence (e.g. not meeting the cut off for quality). On one hand, I understood the purpose of a quality appraisal tool. On the other hand, I was also aware that my studies were all cross-sectional compared to intervention studies with a range of quality appraisal tools to choose from. I did not have sufficient time, the knowledge and experience to devise an appraisal tool with a scoring for cross sectional studies. As such, my research supervisor and I discussed the option of creating an appropriate scoring system to an existing, validated tool for cross sectional studies known as the STOBE. Then I was faced with another dilemma. This was the choice of excluding studies on the basis of the score obtained. Given the nature of the systematic review (e.g. exploring a range of factors), the inclusion and exclusion criteria adopted, the likely differences in publication and research guidance across countries and the absence of inter-rater reliability, I decided to use the scores to indicate the relative

quality of the studies included, rather than excluding studies on the basis of the score attained.

The results of the findings improved my understanding of a systematic review, quality appraisal tools and what constitutes good quality research, as a researcher. As a clinician, it highlighted the importance of reflective practice and being aware of my own risk and protective factors when working with clients. This is something which I was guilty of not doing before. This also had a positive effect on my relationships with colleagues and psychological thinking when working with client and staff groups.

### 1.4. The recruitment process

I was delighted when the organisation I approached was also enthusiastic about my research project, as it facilitated the recruitment process. For example, the interpreting manager emailed interpreters to encourage participation. I was pleasantly surprised by the organisation's research committee that were responsible in assessing and approving my research with the organisation and their queries on how I was planning to safeguard interpreters in the process of their participation. This led to additional measures such as, initial telephone conversations asking participants about their personal trauma history and summarising the nature of my research. I was aware that this is atypical of interpreting services. Similarly, initial conversations with service managers revealed that the organisation have a number of support options in place to support interpreters (e.g. monthly group meetings, brief and debrief policies). I was also aware that I was recruiting from an internal pool of interpreters, which can also be atypical of services. Often services rely on recruiting interpreters from external agencies. This was both a strength and limitation. This was a strength, at it enabled me to recruit a homogenous sample in line with IPA. However, the nature of sample restricts the generalisability of the findings.

Initially, I was disappointed at the lack of responses to my emails. However, through persistence six interpreters agreed to participate.

### 1.5. Data collection: The interview process

Interestingly, all but one interpreter due to other work commitments chose to be interviewed at the organisation. I disliked the time it took to travel to the organisation, as it was at a significant distance. However, the car journeys enabled me to debrief with myself following the interviews.

I noticed that it was helpful and unhelpful to be a clinician and researcher within this context. I took the time to get to know interpreters to help them feel comfortable. My interviews began with exploring the interpreting role, likes and dislikes and challenges faced before moving onto specific topics of interest. This decision was influenced by my clinical experiences and understanding of working with emotions. I was also aware of my personal experiences and experiences of working with interpreters. I used research supervision, peer supervision and reflective logs to reflect on my interview style and topic guide, to be aware of some of my personal assumptions that might influence my question choices. For example, following an initial interview I noticed that I had the tendency to ask questions that resembled the questions a clinician would ask to formulate (e.g. leading questions). As such, I made the conscious decision to take a step back and remind myself that I am researcher curious about the experience of interpreting and that my interpretation would follow on from the analysis stage.

I found it incredibly helpful to interview participants twice, as I noticed a significant difference in the openness to talk about the impact of interpreting amongst two interpreters and felt more of a relationship with all interpreters during our second interviews. Similarly, the second interviews enabled me to clarify particular topics that arose during the first interview. I wondered if this was a product of relationship building, focusing on the experience and impact and/normalising the positive and negative effects of interpreting.

Interestingly, I noticed initial resistances to explore the negative impact of interpreting. This could be a consequence of the 'invisible' stance, preconceptions about emotions and the context of the interview. The context of the interview involved looking

back at experiences rather than capturing the impact at the time. When I asked interpreters what they would say about the impact of interpreting to new interpreters, the majority of interpreters openly discussed the likely negative emotional impact. This was in contrast to their personal experiences. This could be a product of the interviews (e.g. experience of talking about the impact) and/or reflective of it being easier to talk about emotions by distancing from the self, an experience familiar to us all.

I was particularly drawn to one interpreter during the interviews. This was the interpreter who was only able to participate in one interview, as it was mutually agreed that another interview was likely to be emotionally overwhelming for her. I remember finishing the interview with the reaction '*oh my god, is this how it is like for you every session*'. The interpreter spoke about her personal trauma history and became very emotional as we began talking about her reactions to hearing the client's trauma. During debrief, it appeared that this was the first time that she had openly spoken about her experiences and she was aware of the impact of her personal experiences. At the time, I remembered thinking '*how helpful is it for us to continue with the interview for her?*' and explained the ethical dilemma that I was experiencing to the interpreter. However, the interpreter insisted that she wanted to continue and went onto talk about the positives of her experiences of interpreting. She described healing with the client and sharing a sense of being survivors. This experience highlighted the possible impact of interpreting with personal trauma history and offered an insight in a way that could not be captured by quantitative means.

Despite my attempts to facilitate disclosure and ensure anonymity, I am aware that participants could have restricted their input in fear of the implications of this on their employment, particularly as all interviews were audiotaped.

### 1.6. Engaging in IPA

IPA enabled me to maintain an awareness of my experiences of working with interpreters prior to my Doctoral training, during the interviews and the dual role of a clinician and a researcher throughout the research project. This is because

intersubjectivity and the role of the researcher is seen as important to reflect upon in the process of making sense of how a participant is making sense of their experiences, referred to as '*double hermeneutics*' in the research world. I was aware that my initial assumptions were that the interpreters might find it easier to discuss the emotional impact of their experiences of interpreting because of the support options available to them. I was aware of my personal experiences prior to the interviews and research knowledge based on my systematic review. Research supervision, peer supervision, reflective logs and free coding during the analysis stage supported me in trying to bracket/be aware of some of these influences in order to remain grounded within my data.

As a person, I am quite organised and like structure. This together with the pressures of Doctoral training, no experience of conducting IPA and there being '*no specific right or wrong*' way of analysing the data, made IPA a challenging process. Initially, I felt overwhelmed by the enormous amount of rich data I had and wanting to put across the interpreters experiences in an accurate and representative manner. This process almost mirrored the experience of interpreting for interpreters. The reflective log and research supervision enabled my analysis to stay grounded within interpreters' accounts of their experiences. I was also wary of giving a voice to all interpreters particularly, as I noticed that I was drawn to a couple of interpreters who appeared to experience greater negative effects of interpreting. I used research supervision and peer supervision to examine any possible unintentional biases in my analysis and write up of the research project. Nonetheless, the end result was most certainly intriguing and satisfying. This included the 'invisible' stance taken by interpreters, the difficulties in maintaining this stance, how trauma was felt and dealt with, processes of identification, the wider impact and healing with the client. The concept of the wounded healer resonated with some of my past experiences and once again highlighted the importance of self-care and reflection in the work that we do with clients. I was also able to apply the model generated based on my interpretation of the data and process involved to my experiences as a researcher within this context. For example, I noticed that I felt a stronger emotional connection to the interpreters when I saw their emotions within the

room and the research has most certainly changed my understandings about a few concepts in my mind.

I was intrigued by the use of first person interpreting especially, in the context of working with trauma survivors and the significance of this for interpreters. On one hand, I understood the importance of this for the interpreters in conveying the client's story and showing the client respect, sensitivity and warmth. However, I was mindful of how vulnerable this could leave interpreters to the emotional impact of their work particularly, when client stories resonated with them and given what is known of transference and countertransference processes in therapy and working with trauma survivors. I found myself leaning more towards this being unhelpful rather than helpful for interpreters, clinicians, clients and therapy, following my reflections on the whole process. I also wondered where this guidance came from and the evidence base/thinking underlying this decision. Overall, I was amazed at the parallels that can be drawn between the experiences of clinicians and interpreters when working with trauma survivors.

### 1.7. Final thoughts

In summary, my research journey was both a challenging and enriching experience, as a researcher and a clinician. It is a journey which will never be forgotten. This includes a metaphor that was used by one of the interpreters. She referred to the impact of interpreting as '*two sides of a coin*'. I feel this is a good metaphor to describe the '*positive*' and '*negative*' effects of working with trauma survivors that are part of the reality of our work and can co-exist.

# Appendices

## Appendix A: Guidelines for journal targeted for literature review

Name of target journal: British Journal of Clinical Psychology

Author guidelines were retrieved in May 2017 from:

http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)2044-8260/homepage/ForAuthors.html

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

All papers published in The British Journal of Clinical Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

The following types of paper are invited:

• Papers reporting original empirical investigations

• Theoretical papers, provided that these are sufficiently related to the empirical data

• Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications

• Brief reports and comments

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to BJCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, figures, or tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length. In such a case, the authors should contact the Editors before submission of the paper.

3. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use the Submission Checklist to help you prepare your paper.

4. Manuscript requirements

• Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

• Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediTwebsite for a list of roles.

• The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

• Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

• Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

• All papers must include a structured abstract of up to 250 words under the headings: Objectives, Methods, Results, Conclusions. Articles which report original scientific research should also include a heading 'Design' before 'Methods'. The 'Methods' section for systematic reviews and theoretical papers should include, as a minimum, a description of the methods the author(s) used to access the literature they drew upon. That is, the abstract should summarize the databases that were consulted and the search terms that were used.

• All Articles must include Practitioner Points – these are 2–4 bullet points to detail the positive clinical implications of the work, with a further 2–4 bullet points outlining cautions or limitations of the study. They should be placed below the abstract, with the heading 'Practitioner Points'.

• For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

• SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

• In normal circumstances, effect size should be incorporated.

• Authors are requested to avoid the use of sexist language.

• Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright. For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.
If you need more information about submitting your manuscript for publication, please email Melanie Seddon, Managing Editor (bjc@wiley.com) or phone +44 (0) 1243 770 108.

5. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author name and address are not included in the word limit.

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Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a Colour Work Agreement form upon acceptance of the paper. A copy of the Colour Work Agreement form can be downloaded **here**.

9. Pre-submission English-language editing

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11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following web site:http://www.adobe.com/products/acrobat/readstep2.html.
This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred. Further instructions will be sent with the proof. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

12. Early View

British Journal of Clinical Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.

## Appendix B: Search strings used for the literature review

**Table 6.** Search strings used and the limits applied to databases.

| Database | Limits Applied | Search strings used across all Databases |
|---|---|---|
| PsycInfo<br>Scopus<br>PILOT<br>Medline<br>PsyEXTRA | 01/01/2010 – 16/11/2016<br>Peer Reviewed Journal Articles<br>English | "secondary trauma*" OR "vicarious trauma*" OR "vicarious stress" OR "secondary traumatic stress" OR "burnout" OR "post traumatic growth" OR "compassion fatigue" OR "compassion satisfaction" OR "empathy" OR "resilience"<br>AND<br>"mental health professional*" OR "therapist*" OR "psychologist*" OR "counselor*" OR "counsellor*" OR "mental health worker*" OR "nurse*" OR "support worker*" OR "healthcare assistant*" OR "social worker* |
| Google Scholar | None | "impact of working with trauma survivors on professionals"<br>"vicarious exposure to trauma" |

## Appendix C: Rationale for inclusion and exclusion criteria

**Table 7.** Rationale for inclusion and exclusion criteria

| Stage Applied | Inclusion Criteria | Exclusion Criteria | Rationale |
|---|---|---|---|
| Search and selection stage | Studies that explore VT, STS, CF, CS and VPTG and/factors that moderate the impact of working with trauma survivors. This includes burnout providing it is explored in relation to the aforementioned constructs. | Studies that explore other constructs or solely focus on burnout. | This is the topic of the review. |
| | Peer reviewed journal articles. | Articles that have not been peer reviewed. | For quality purposes as peer reviewed journal articles are reviewed for acceptable quality by experts in the field before being accepted for publication. |
| | Articles published between 01/01/2005 – 16/11/2016 | Articles published prior to 01/01/2005. | To explore recent research conducted in this area and to obtain a sufficient number of articles to select from. |
| | Studies conducted worldwide and published in English. | Studies in other languages. | To obtain a sufficient number of articles to select from and the researcher cannot comprehend articles in other languages. |
| Additional criteria at eligibility stage | Quantitative and mixed studies. | Qualitative studies | This review focuses on quantitative findings in this area. |
| | Studies that involve mental health therapists (e.g. psychologists, counsellors and clinical social workers) that have or are conducting some form of psychological therapy with trauma clients as the majority of the sample. | Studies that are solely based on other professionals (e.g. medics, social workers, domestic staff) that come into contact with trauma clients. | The review focuses on the vicarious impact of working with trauma survivors on mental health therapists during therapeutic encounters. The vicarious impact might vary between therapeutic and non-therapeutic/clinical encounter (e.g. a medic in comparison to a psychologist). |

## Appendix D: Data extraction proforma

| | | |
|---|---|---|
| Title: | | |
| Author (1st only): | | |
| Publication Date: | Place of Publication: | |
| Journal: | | |
| Volume: | Number: | Pages: |
| Keywords/Definitions: | | |
| Aims: | | |
| Sampling/Participants: *(total number of participants? Age range, who was studied, how was the sample recruited? Response rate? Other demographics?)* | | |
| Study Type/ Design: *(Is a control group used? Self report? Cross sectional?)* | | |
| Measures and Outcomes: *(What outcomes are being measured? What measurements are used? Are measures validated? At what time points are measures completed? Self report or clinician rated?)* | | |
| Analysis*: (What statistical methods were used? Was power calculated? Intention-to-treat?)* | | |
| Findings: | | |
| Controls/Validity/Reliability: | | |
| Conclusions*: (What do the findings mean? Generalisability? Implications & Recommendations?)* | | |
| Additional Comments: | | |

## Appendix E: STROBE checklist

STROBE Statement—Checklist of items that should be included in reports of ***cross-sectional studies***

| | Item No | Recommendation |
|---|---|---|
| **Title and abstract** | 1 | (*a*) Indicate the study's design with a commonly used term in the title or the abstract |
| | | (*b*) Provide in the abstract an informative and balanced summary of what was done and what was found |
| **Introduction** | | |
| Background/rationale | 2 | Explain the scientific background and rationale for the investigation being reported |
| Objectives | 3 | State specific objectives, including any prespecified hypotheses |
| **Methods** | | |
| Study design | 4 | Present key elements of study design early in the paper |
| Setting | 5 | Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection |
| Participants | 6 | (*a*) Give the eligibility criteria, and the sources and methods of selection of participants |
| Variables | 7 | Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable |
| Data sources/ measurement | 8* | For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group |
| Bias | 9 | Describe any efforts to address potential sources of bias |
| Study size | 10 | Explain how the study size was arrived at |
| Quantitative variables | 11 | Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen and why |
| Statistical methods | 12 | (*a*) Describe all statistical methods, including those used to control for confounding |
| | | (*b*) Describe any methods used to examine subgroups and interactions |
| | | (*c*) Explain how missing data were addressed |
| | | (*d*) If applicable, describe analytical methods taking account of sampling strategy |
| | | (*e*) Describe any sensitivity analyses |
| **Results** | | |
| Participants | 13* | (a) Report numbers of individuals at each stage of study—eg numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analysed |
| | | (b) Give reasons for non-participation at each stage |
| | | (c) Consider use of a flow diagram |

| | | |
|---|---|---|
| Descriptive data | 14* | (a) Give characteristics of study participants (eg demographic, clinical, social) and information on exposures and potential confounders |
| | | (b) Indicate number of participants with missing data for each variable of interest |
| Outcome data | 15* | Report numbers of outcome events or summary measures |
| Main results | 16 | (*a*) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (eg, 95% confidence interval). Make clear which confounders were adjusted for and why they were included |
| | | (*b*) Report category boundaries when continuous variables were categorized |
| | | (*c*) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period |
| Other analyses | 17 | Report other analyses done—eg analyses of subgroups and interactions, and sensitivity analyses |
| **Discussion** | | |
| Key results | 18 | Summarise key results with reference to study objectives |
| Limitations | 19 | Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias |
| Interpretation | 20 | Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence |
| Generalisability | 21 | Discuss the generalisability (external validity) of the study results |
| **Other information** | | |
| Funding | 22 | Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based |

*Give information separately for exposed and unexposed groups.

**Note:** An Explanation and Elaboration article discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available on the Web sites of PLoS Medicine at http://www.plosmedicine.org/, Annals of Internal Medicine at http://www.annals.org/, and Epidemiology at http://www.epidem.com/). Information on the STROBE Initiative is available at www.strobe-statement.org

## Appendix F: Detailed STROBE scoring for articles included in the systematic review

**Table 8.** Detailed STROBE scoring for individual studies

| Article | Item Number[1] | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | Total (/22) |
| **Brockhouse *et al*. (2011).** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | **17** |
| **Cosden *et al*. (2016).** | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | **13** |
| **Ekundayo *et al*. (2013).** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | **19** |
| **Furlonger & Taylor, (2013).** | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | **12** |
| **Gil, (2015).** | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | **12** |
| **Ivicic & Motta, (2016).** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | **14** |
| **MacRitchie & Leibowitz (2010).** | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 0 | **12** |
| **McKim & Smith-Adcock, (2014).** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | **17** |
| **Robinson-Keilig, (2014).** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | **18** |
| **Rzeszutek *et al*. (2015).** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | **14** |
| **Samios *et al*. (2012).** | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | **17** |
| **Samios *et al*. (2013).** | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | **18** |
| **Williams *et al*. (2012).** | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | **17** |
| **Zeleskov-Đoric et al., (2012).** | 1 | 1 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | **12** |

**Scoring guide:**
1 = if at least one of the recommendations were present/reported, 0 = all recommendation (s) were absent/ not reported

## Appendix G: Trainees statement of epistemological position

Epistemology is the theory of knowledge (Willig, 2013). It is concerned with what constitutes knowledge (e.g. beliefs versus facts) and constructs knowledge (e.g. how do people come to know what they know). Quantitative and qualitative research is about knowledge and as such, is often underpinned by particular epistemological positions which influence methods of inquiry and analysis. Researchers often find themselves grappling between realism and social constructionism, two polar opposite paradigms (Lyons & Coles, 2007). Realism suggests that there are universal truths (e.g. objective realities) and these are independent of our sensory experiences and constructions. This often leads to scientific, cause and effect based inquiries to reveal relationships. In comparison, social constructionism suggests that universals truths/objective realities do not exist. Instead, our realities and knowledge is socially constructed rather than discovered through our social interactions with the world (e.g. others) through language. As such, we can have different versions of events.

As the researcher was interested in the individual experiences of female interpreters of interpreting in therapy for survivors of sexual violence rather than cause and effect relationships, a realist epistemological position was rejected. A social constructionist approach was considered as the researcher agrees with the notion of individuals actively constructing their realities. This would have lent itself to narrative or discourse analysis to explore the role of language in how the experiences were socially constructed. However, the researcher was not interested in the role of language in constructing realities or societal discourses. As such, a radical social constructionist view was also rejected. An alternative constructivist stance was preferred. Contextual constructionism takes into account the personal, social, cultural and situational contexts in which experiences occur. The context is seen as important in meaning making.

Within the context of the present study, the meaning making of interpreting experiences can vary within and across the accounts of interpreters (Willig, 2013). Similarly, the researchers meaning making of the participants' experiences can also be influenced by the researcher in context. IPA appeared to best fit the researcher's epistemological position. The assumptions underlying IPA overlap with the context constructivist stance. IPA aims to understand how an individual (e.g. an interpreter) in a particular context (e.g. interpreting in psychological therapy, as part of an internal pool of interpreters with existing support options) makes sense of a particular phenomenon (e.g. client's story of sexual violence). In doing so, reflexivity is important as access to the interpreters experiences and meaning making will depend upon the researchers own conceptions, a process known as double hermeneutics. As such, the researcher was aware of her personal experiences, prior experiences of working with interpreters, the findings of her systematic review and the limited experience and knowledge of working with asylum seekers and refugees. The researcher engaged in continuous self-reflection throughout the research process through research supervision, peer supervision and reflective logs.

## Appendix H: Letter of ethical approval from the ethics committee

University Ethics Sub-Committee for Psychology

01/02/2016

**Ethics Reference:** [redacted]

TO:

Name of Researcher Applicant: Sonia Dhinse

Department: [redacted]

Research Project Title: Impact on female interpreters of working with clients receiving trauma therapy for sexual violence

Dear Sonia Dhinse,

**RE: Ethics review of Research Study application**

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

I approve this application

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Sub-Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the University Ethics Online System. With your permission, the Sub-Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

Best wishes for the success of this research project.

Yours sincerely,

[redacted]

Chair

**Appendix I: Feedback from the service user reference group**

SERVICE USER REFERENCE GROUP (SURG)

EVALUATION OF TRAINEE RESEARCH

TRAINEE NAME: Sonia Kaur Dhinse

TITLE OF STUDY: Impact on female interpreters of working with clients receiving trauma therapy for sexual violence.

1. Is this a topic that has relevance to service users?

   YES – I felt very strongly about this piece of research as soon as I read it. It's almost so obviously significant – a very relevant topic.

2. Is the research problem stated clearly?

   YES – yes thank you. The language you have used is clear and concise and gives a clear indication of your research proposal in language that is easy to understand and it is well balanced.

   If no, please state what you feel is difficult to understand.

3. Is the background to the research clearly stated?

   YES – the background as to how this is a topic area that has been missed is set out and the rationale for undertaking this powerful piece of work. Again it surprises me that there hasn't been more work done on the impact of culturally matching interpreters in such a traumatic area for the victim.

   If no, please state what you feel is missing

   Is the proposal logically organised and clearly written?

   YES – again thank you, it has been set out in a well ordered and easy to follow way.

   If you wish to make any additional comments about the research, please give these below:

What a fantastic proposal. This looks like an area that could have far- reaching use for service users in making their experience of having to work through a third party to discuss such trauma. Thank you for letting me have sight of it.

## Appendix J: Participant information sheet

**Who are the researchers involved?**

The researcher (Sonia Dhinse) conducting the interviews is a trainee clinical psychologist in her second year of the Doctoral training at the University of Leicester. The Doctorate in Clinical Psychology requires trainees to conduct a research project as part of their training. The purpose of the research project is to conduct clinically significant research in an area of interest. Sonia is supervised by Dr Stephen Melluish (Head of Clinical Practice) of the department of Clinical Psychology at the University of Leicester.

**What is the purpose of the study?**

Sonia has worked closely with interpreters in clinical practice and is interested in the experiences of interpreting in psychological therapy from an interpreter's perspective. More specifically, Sonia is interested in the impact on female interpreters of working with clients receiving trauma therapy for sexual violence (e.g. rape and female genital mutilation).

**Why have I been invited?**

As an interpreter you play an essential role in overcoming language barriers for clients to benefit from psychological therapy. You are responsible for communicating emotions, difficult experiences and therapeutic techniques between the therapist and the client. A lot of your work can be emotionally distressing particularly, when working with sexual violence trauma survivors. Therefore, your experiences and views are important in helping others to understand the impact of working with clients receiving trauma therapy for sexual violence on interpreters and how to further support interpreters.

**Do I have to take part?**

No, taking part is entirely voluntary. If you agree to participate then you will be invited to attend two interviews at your workplace or an alternative suitable location (e.g. your home). After consenting to participate you are free to withdraw (leave the study) at any time without giving a reason. You will not be penalised if you decide to withdraw.

**Can I withdraw from the study after participating?**

Yes. You are free to withdraw yourself and the information that you provide after participating but before the end of **January 2017**.

**What will happen next if I agree to take part?**

If you agree to participate, then Sonia will arrange a pre-screening telephone conversation with you to discuss the study, protocol and answer any questions you may have. During the telephone conversation, two interview appointments at your workplace or an alternative suitable location (e.g. your home) will be arranged. The interviews will be audiotaped to make sure any valuable information is not missed. The time taken to complete the interview will depend upon your input and should last no longer than one hour per interview.

**What kind of questions might be asked in the interviews?**

The questions asked during the interview will provide an opportunity for you to discuss a number of relevant topics. This includes your role, your experiences of working with clients receiving trauma therapy for sexual violence, the impact of your experiences on you, how you managed the impact of your experiences, the support and training offered and any other support or training that you would find helpful.

Your input is of great importance. There are no right or wrong answers and you are free to not answer a question or provide details if do not wish to.

**Why will I be interviewed twice?**

Given the nature of the study, it can be useful to arrange two interviews to ensure that Sonia is able to explore your experiences in depth. It also offers both yourself and Sonia the opportunity to discuss things that you may have not discussed during your first interview.

**What will happen to the data that I provide?**

The information audiotaped from the interviews will be transcribed and analysed. Your input along with the input of other interpreters will be collated and presented as a presentation to interested parties (e.g. the course team, mental health and interpreting services) and a journal article. The findings will be used to improve others understanding of the experiences and impact on interpreters of working with clients receiving trauma therapy for sexual violence. The findings will also be used to suggest recommendations to further support interpreters.

**Who will know that I have taken part?**

You will be provided with the option of being interviewed at your workplace or another suitable location. The information you provide will be kept confidential and anonymous in that your identity will not be revealed. If the work is published, quotes may be used to give examples of what was discussed but they will be presented anonymously. If you do not want your quotes to be published for other professionals to see then please let us know, by contacting Sonia using the contact information available at the end of the sheet before the end of **January 2017**.

Guidelines of the Data Protection Act (1998) will be followed and you will not be penalised in any way for not wanting to publish your quotes.

Confidentiality will only be breached if you disclose something that suggests a risk to yourself or someone else. Should this happen, the researcher will discuss this with you first.

**What are the possible disadvantages and risks of taking part?**

The researcher does not anticipate any harm or disadvantages to you by participating in this study. However, given the nature of the study you could experience psychological distress when discussing your experiences of interpreting in psychological therapy for sexual violence trauma survivors. Should this happen, please inform the researcher (Sonia)

during or after the interviews using the contact details given at the end of the sheet. Sonia will discuss this with you and signpost you to appropriate support if needed.

**What are the possible benefits of taking part?**

Your participation will provide you the opportunity to share your experiences, voice your opinions and to be listened to. Your experiences and views are integral to inform and improve others understanding of the impact of interpreting on interpreters in psychological therapy and the support offered to interpreters. This can contribute to better communication amongst interpreters and therapists and could also improve clinical outcomes for clients.

**Will I be paid for my time?**

Yes. You will be reimbursed for your time at your hourly rate of pay for interpreting.

**Contact for further information**

If you have any questions or concerns about participating in the study before and/ after participation then please feel free to contact the researcher Sonia or Dr Stephen Melluish if you feel you cannot contact Sonia, using the details below.

**Miss Sonia Kaur Dhinse (Trainee Clinical Psychologist)**

**[Trainee's Picture]**

Email: [redacted]

**Dr Stephen Melluish (Head of Clinical Practice & Research Supervisor)**

Tel: [redacted] Email: [redacted]

UNIVERSITY OF LEICESTER

## Appendix K: Consent Form

Please tick the boxes that apply below.

1. I confirm that I have read and understood the information sheet given for the study. ☐
2. I agree to participate in this study, consisting of a two stage interview process. ☐
3. I understand that my participation is entirely voluntary, the information I provide will be kept confidential and if published will be in an anonymised format. ☐
4. I understand that I have the right to withdraw both myself and the information I have given at any time, without any reason and without being penalised in any way, but before the end of **January 2017**. ☐
5. I understand that the information I provide will be used to improve others understanding of the impact of interpreting in psychological therapy on interpreters and suggest any recommendations to further support interpreters. ☐
6. I understand that the information that I provide will also be shared anonymously along with the information provided by other participants with interested parties. For example, in the form of a presentation, article, summaries and recommendations. ☐
7. I agree to be quoted anonymously. ☐
8. I have had an opportunity to ask questions and am content with the answers given. ☐
9. I agree to participate in the interview and for this to be audiotaped. ☐
10. I agree to participate in a skype interview and for this to be audio and/ videotaped (if chosen as an option). ☐

Name of Participant: Date:

Signature:

Researcher: Date:

Signature:

## Appendix L: Topic guide

Age: Cultural Background: No of years interpreting: Personal history:

FT/PT: Any other occupations: Personal therapy:

**Interpreter role**

How would you describe your role? What does it involve?

What drew your interest in your role? What do you like about your role?

What kind of training/qualifications have you had to undertake for your role?

Is there a model of interpretation being used?

Are any professional guidelines being applied? How are these? How do you find them?

**Experience of interpreting**

What mode of therapy is was provided?

How would you describe your experiences of interpreting?

How was the experience of interpreting in terms of your relationship with the client and the therapist? Were there any difficulties? If yes, what happened? How was it managed?

**Impact of interpreting**

How would you describe the impact of interpreting for survivors of sexual violence in therapy on you?

How did you make sense of a client's trauma?

Has it ever affected how you thought about yourself? If yes, how and in what ways?

Has it ever affected how you thought about others? If yes, how and in what ways?

Has it ever affected how you thought about the world around you? If yes, how and in what ways?

Has it ever affected how you felt emotionally? If yes, how and in what ways?

Has the impact of interpreting on you, ever affected the relationships between you and the client? If yes, in what ways?

Has the impact of interpreting on you, ever affected the relationships between you and the therapist? If yes, in what ways?

Has the impact of interpreting on you, ever affected the relationship between the therapist and the client? If yes, in what ways?

How did you manage the impact of interpreting for survivors of sexual violence in therapy on you? What was helpful and unhelpful in managing the impact?

Has the impact changed since you first started interpreting? If yes, how? In what ways?

**Support and training**

What support and training have you received? What was your experience of this support and training?

Is there any other support and training that you would find useful?

Is there anything else that you find difficult about your role or that could be improved? If yes, how?

What would you say to or advise others wanting to interpret for survivors of sexual violence in therapy?

## Appendix M: Chronology of the research process

**Table 9.** Chronology of the research process.

| Stage in research | Timescale |
|---|---|
| Research proposal submission | May 2015 |
| Internal panel and peer review | 9th June 2015 |
| Preparation and ethics application submission to the University of Leicester Psychology Ethics Committee | October 2015 |
| Obtained feedback from the service user reference group | November 2015 |
| Obtained ethical approval | Feb 2016 |
| Submitted a research application to the organisation for participant recruitment | March 2016 |
| Obtained approval from the organisation | August 2016 |
| Literature Review | October 2016 - January 2017 |
| Participant recruitment and data collection | November 2016 – March 2017 |
| Data transcription and analysis | November 2016 - April 2017 |
| Write up of the thesis | November 2016 – May 2017 |
| Thesis submission | 26th May 2017 |
| Research viva | 17th July 2017 |
| Preparation for publication | August 2017 |
| Poster preparation for the Trainee Research Conference | August 2017 |
| Oral and poster presentation at the Trainee Research Conference | 19th September 2017 |

## Appendix N: Examples of the analysis process

| Initial coding | Example extract from Natalie, Interview 1, Transcript 1 | Emerging theme (s) |
|---|---|---|
| **Object of concern:** Interpreting role<br><br>**Meaning assigned to the object:**<br><br>Many roles<br><br>Like a bridge (metaphor)<br><br>Purpose of bridge? To facilitate communication<br><br>Holding them together?<br><br>Switching between client and therapist ? What about the interpreter?<br><br>I'm the voice – appears quite definite ? A sense of responsibility?<br><br>'It's not acting' contradicts you have to get into the skin of each<br><br>Is it almost like you have to become the client and the clinician? | ***Interviewer***<br>1 Okay, so I guess one of the first things that I wanted to ask [redacted] is how would you describe<br>2 your role of an interpreter?<br><br>***Respondent***<br>3 Well like a bridge between the client and the therapist. Un and I switch constantly, one<br>4 moment I'm the voice of the therapist, at the other moment I'm the voice of the client. It's<br>5 like almost, it's not acting but you have to get into the skin of each, uh, alternatively and<br>6 then help them and obviously facilitate the communication. | The Bridge<br><br>The Voice<br><br>Get into the skin of each<br><br>(The 'Invisible' Interpreter) |

**Figure 7. First** example of the analysis process.

| Initial coding | Example extract from Sara, Interview 1, Transcript 1 | Emerging theme (s) |
|---|---|---|
| **Object of concern:** Experience of listening to a client talking about her experiences in third person<br><br>**Meaning assigned to the object:**<br><br>Coming like a story (simile)<br><br>'It was easy'<br><br>? No emotions shown/'disconnected' client, no emotional connection therefore easy/'disconnected' interpreter?<br><br>Session still stays on her mind after the session<br><br>Having a son of a similar age affected her rather than the rape | ***Interviewer***<br>63 Okay, okay. And when you say she kind of spoke in a third person, did she use like third<br>64 person words like she rather than I or was it just that, or was it that you felt like it was, it<br>65 was third person?<br><br>***Respondent***<br>66 Yeah, yeah, no, she didn't use it, you know, use the third person but the way she said, um,<br>67 the way she was sort of describing it, um, I felt like, you know, she was disconnected with,<br>68 um, the incident. Because I've met other clients and, um, you know there's so much<br>69 emotion, you know, they are crying, sometimes they can't talk. Um, um, so you know, and<br>70 then you really feel for them. But this person, particularly person was just, you know, talking<br>71 about it as if it was just a story.<br><br>***Interviewer***<br>72 Okay, okay. And how did you find that for you, when she was, that kind of disconnection,<br>73 how was that like for you?<br><br>***Respondent***<br>74 I think it was, uh, because it was like a story it was coming as if it was a story, I was listening<br>75 to it as if, as if I was listening to someone telling me a story. It didn't happen to that<br>76 particular person, although I know it did but because she didn't have that much emotion,<br>77 um, it was quite, um, easy. But after the session, uh, finished I had a lot of, um, sort of, you<br>78 know, I was going through what was going on but then what happened was there was<br>79 something else in that session which she brought up which affected me more than the rape.<br>80 Um, so I think my thoughts were with that, her losing her son, that was, that affected me a<br>81 lot. Um, more than the rape in that particular case. | Emotional disconnection: 'It was coming as if it was a story'<br><br>(Feeling The Trauma)<br><br>Stays on my mind<br><br>(Feeling The Trauma)<br><br>Connecting through personal relationships<br><br>(Connecting to the trauma survivor) |

**Figure 8.** Second example of the analysis process.

## Appendix O: Diagrammatic representation of the themes

**The Experience and Impact of Interpreting**

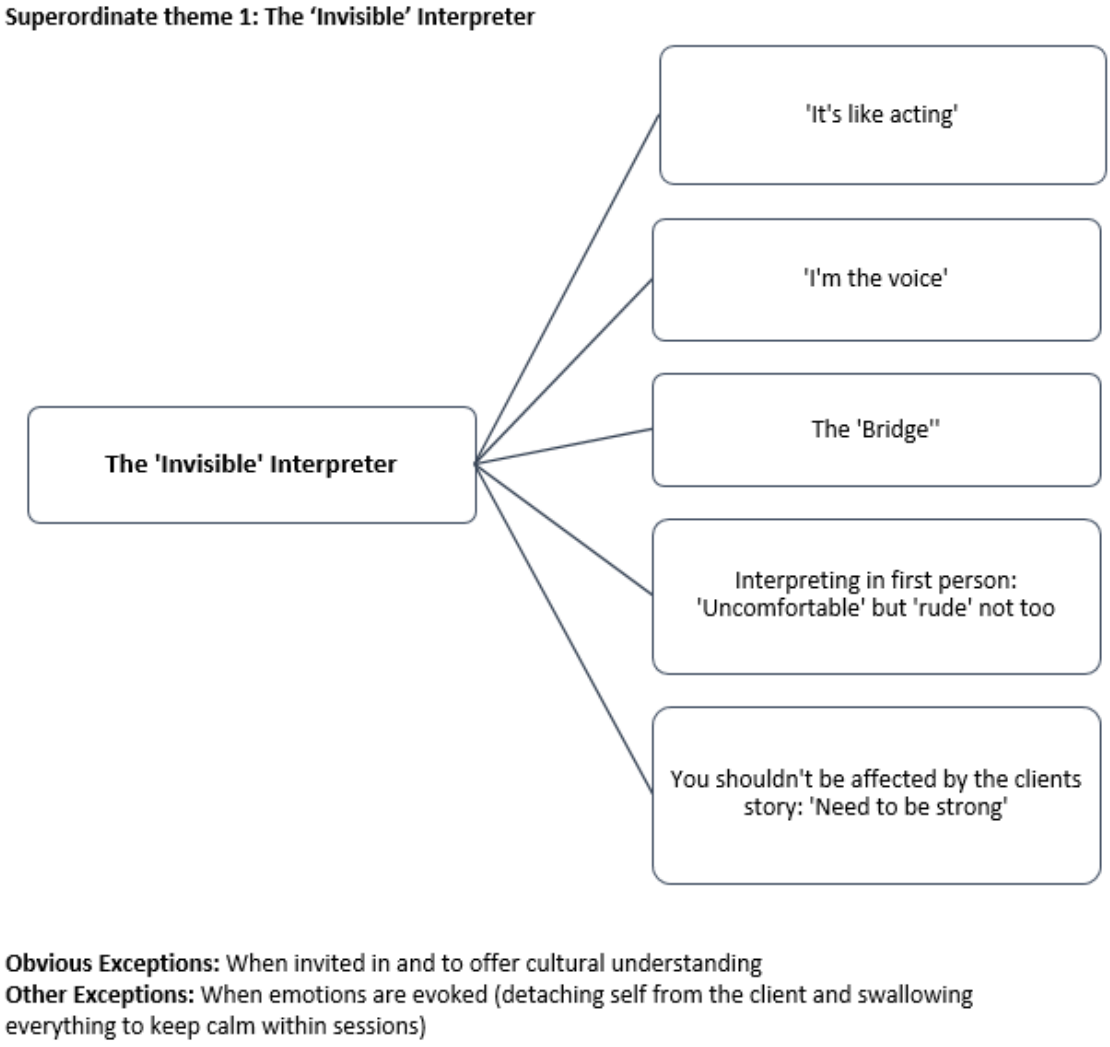


**Figure 9.** First superordinate theme.

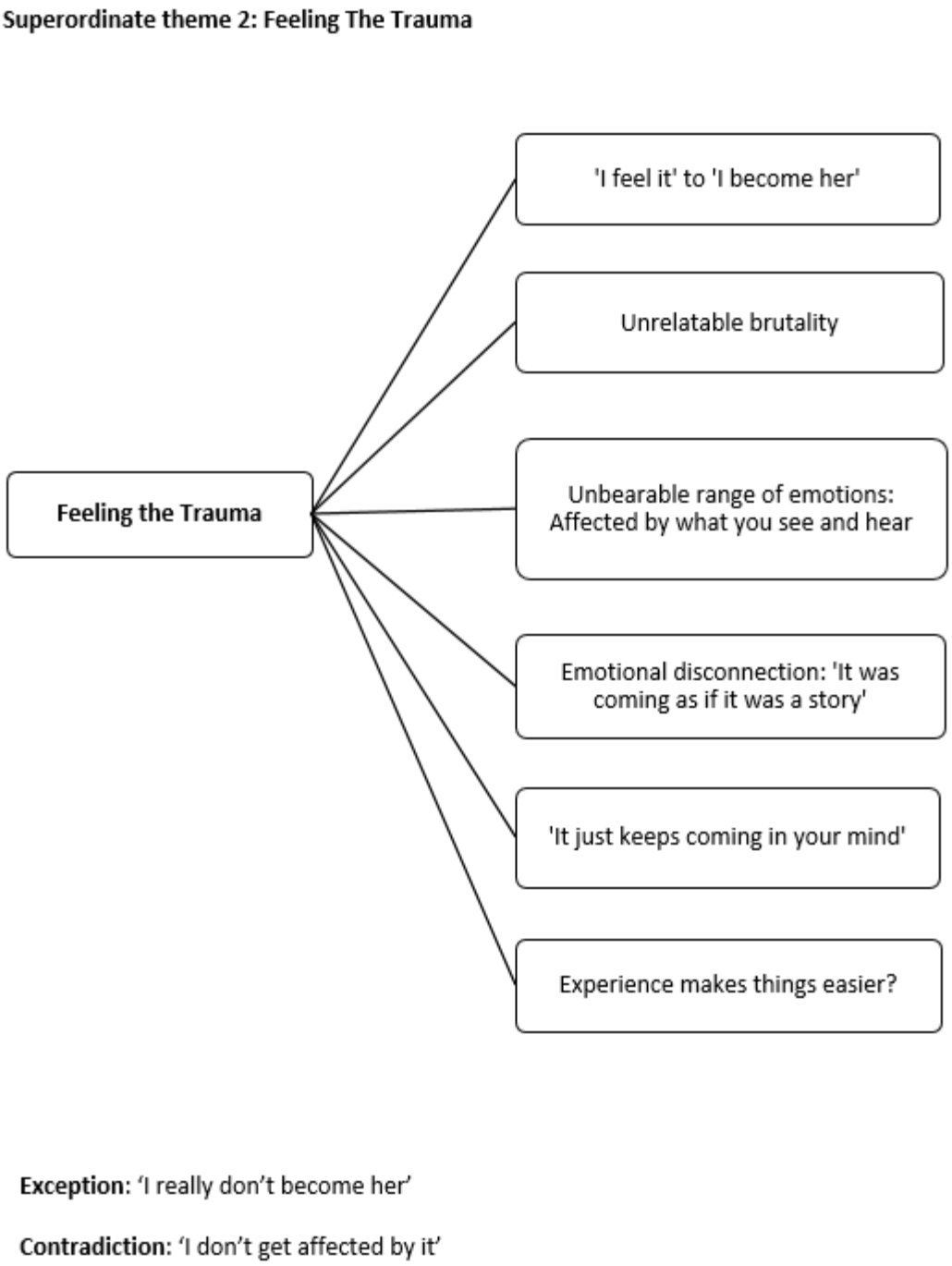


**Figure 10.** Second superordinate theme.

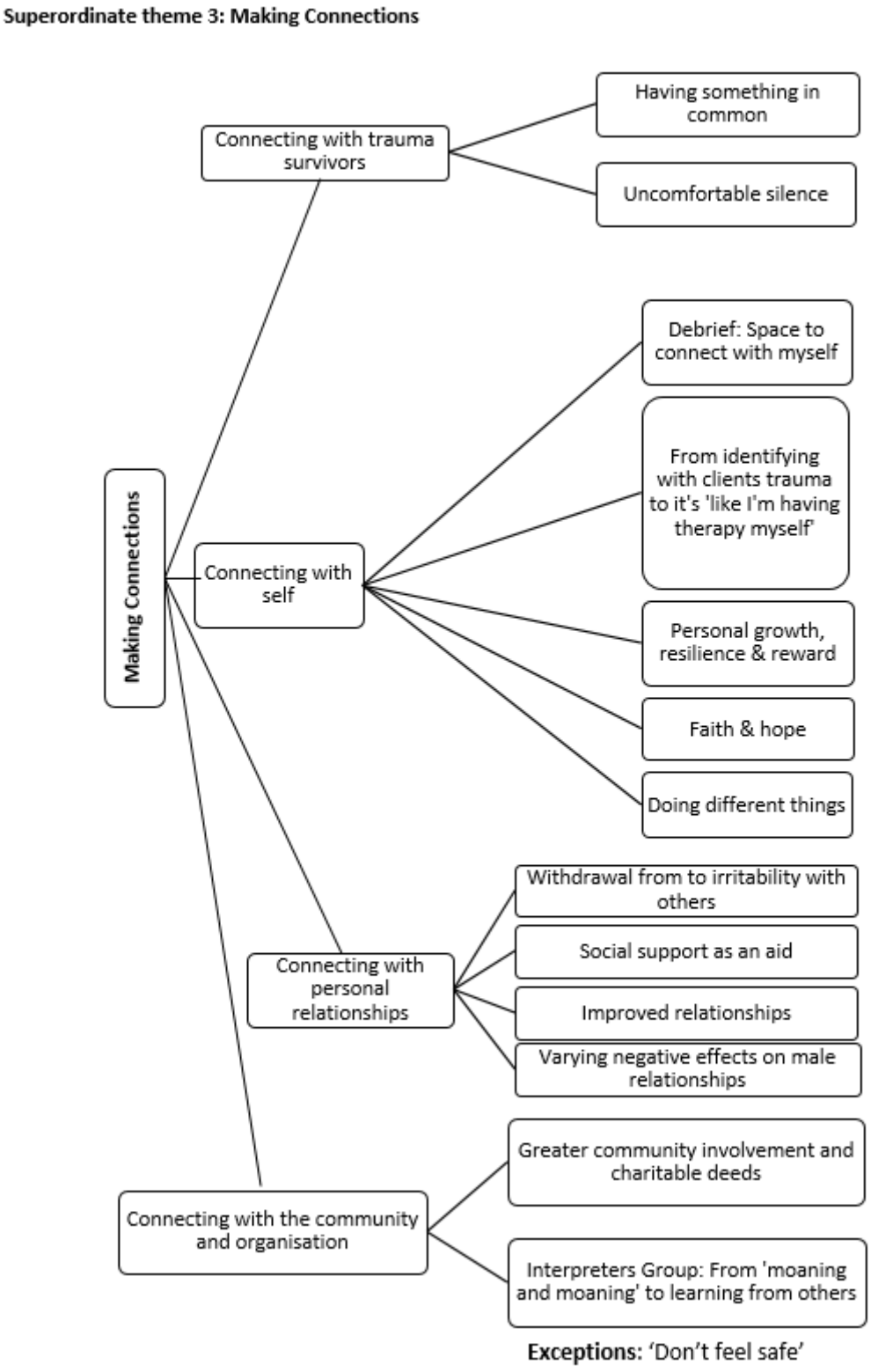


**Figure 11.** Third superordinate theme.

**Superordinate theme 4: Changed Understandings**

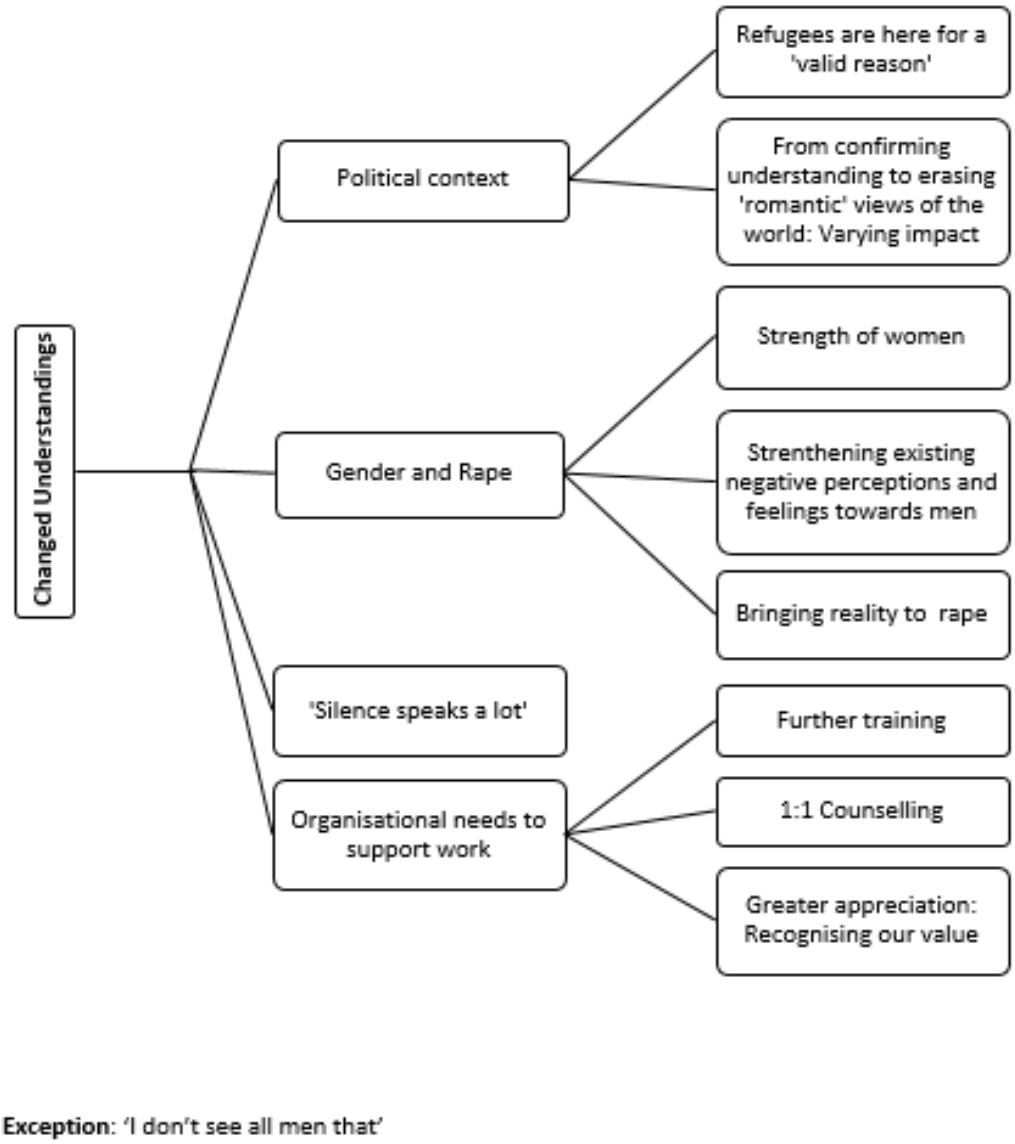


**Figure 12.** Fourth superordinate theme.