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Inviting the Perspectives of Refugee Mental Health Interpreters: A Critical Narrative Analysis

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The research literature lacks examination into several areas concerning mental health interpretation for refugee clients. This includes the management of interpreters' vicarious trauma and retraumatization, interpreter's perspectives on the appropriateness of hiring refugees as mental health interpreters, how interpreters define their trauma as well as their clients' trauma, and support that interpreters seek for their traumatic responses from their work. The literature is also missing an analysis of how oppressive power differentials are repeated in workplace institutions, specifically for refugee mental health interpreters. Thus, this study aimed to invite the perspectives of refugee mental health interpreters on several issues pertaining to their work with refugee clients.

The method of choice for this study is Critical Narrative Analysis (CNA). Critical Narrative Analysis is a method of analysis that fits within the broader category of hermeneutic phenomenology and combines hermeneutic phenomenology with critical theory (Davidsen, 2013; Langdridge, 2007; Peter & Polgar, 2020). The study utilized criterion-based sampling and there were four participants total.

From the findings, participants were able to respond to the research questions of how they define trauma, what the benefits and harms are of hiring refugees as mental health interpreters are, what power dynamics exist in their workplaces, how they manage their traumatic responses, and what supports they sought for their interpretation work. The results from this study ultimately added to themes that exist in the little literature on this topic and added novel information. For example, one participant used the concept of generational trauma to define their own experience of trauma. Another participant hypothesized about why they had experienced similar experiences as their clients, yet they had responded differently. Additionally, another participant stated how they experienced their trauma collectively, which suggests collective healing methods to respond to collective trauma. This study also aimed to present concrete suggestions of how to aid interpreters and was able to discern several, including specific trainings (e.g. mental health, population-specific, work-life boundaries), breaks between session, and factors in supervision such as positive feedback from supervisors.

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Chapter One: Introduction

Within the body of research concerning mental health interpretation for refugees, most of the research related to working with interpreters tends to focus on clinicians' perspectives (Gartley & Due, 2017; Granhagen Jungner et al., 2019; Mehus & Becher, 2015; Yakushko, 2010). This makes sense within the context of the power differential among interpreters, clinicians, and clients, where clinicians typically have more authority and power than interpreters (Becher & Wieling, 2015). Multiple researchers have pointed to the lack of knowledge about the interpretation process from the interpreter's perspective (Gartley & Due, 2017; Granhagen Jungner et al., 2019; Mehus & Becher, 2015; Yakushko, 2010). We also know very little about the interpreter's role as it is perceived by interpreters themselves, which begs to question interpreters' perceptions of and attitudes towards their role. This growing focus on the interpreter's perspective would not only benefit interpreters yet also benefit services to LEP refugee clients by informing the network of service providers on the experience of an essential member of refugee mental health services.

Refugee Experience in the United States

Three million refugees have resettled in the United States since 1975 (Igielnik & Krogstad, 2017). A refugee is defined as "a person forced to flee their home country to escape war, violence or persecution (Refugees in America)." From 2008 to 2017, the top

nine languages spoken by refugees in the U.S. were as follows, in order: Arabic, Nepali, Somali, Sgaw Karen, Spanish, Kiswahili, Chaldean, Burmese, and Armenian (Scamman, 2018). In the past two decades, increased numbers of war-related refugees have come to the United States (Searight & Armock, 2013). Up till recently, the U.S. was a leader in accepting large numbers of refugee arrivals (Krogstad, 2019). Thus, being acquainted with the significant refugee history in the U.S. leads one to infer the vast linguistic diversity that exists today.

It is important to emphasize the salience of refugee versus non-refugee experience. There is distress related to experiences of war and forced migration which refugees experience, yet immigrants do not (Miller et al., 2005). Refugees are commonly subjected to ethnic violence and genocide (Pells & Treisman, 2012). Ethnic violence is defined as mass ethnic and political violence which results in the destruction of the physical, social, psychological, and spiritual world through attempts to eradicate entire groups and their way of life (Pells & Treisman, 2012). The incalculable consequences of genocide include material devastation (e.g., losing homes, poverty, and other economic losses), human suffering (e.g., bodily injury, intense grief, trauma, chronic fear, mental health problems, and continued discrimination and structural violence), and social turmoil (e.g., dislocated populations; the loss or disappearance of family, friends, and relatives alongside the destruction of social networks) (Pells & Treisman, 2012).

Refugees demonstrate higher levels of some mental health problems than the general population with war-related refugees at particularly high risk for suicide and self-harm (Green et al., 2012; Searight & Armock, 2013). Authors from Europe, Australia,

and North America have consistently commented on the lack of preparedness on the part of receiving countries in responding to the needs of refugee families (Raval, 2005). Many newly arrived refugees point to the absence of an interpreter as a primary barrier to accessing healthcare services, including mental health services (Clark et al., 2014). Accordingly, interpreters play a vital role in helping refugees gain access to mental health services (Green et al., 2012).

Refugee Clients' Limited-English Proficiency

Limited English Proficiency (LEP) refers to the language ability of people whose primary language is not English and who have limited ability to read, write, speak, and understand English (Amouyal et al., 2020). From 1990 to 2005, there was a 61.5% increase in people in the U.S. who spoke a language other than English at home (Paone & Malott, 2008). 25 million people who are accounted for in the U.S. have limited-English proficiency (LEP) and 20% speak a language other than English at home (United States Census Bureau, 2011). In the provision of health care, language is essential to obtaining necessary information regarding symptomatology, indicating a critical need for interpreters in health care (Elkington & Talbot, 2016). Given these demographics, it is very likely that most mental health providers in Western countries will need to work with an interpreter to service clients (Searight & Armock, 2013).

Some research has indicated that Limited English Proficiency clients have a greater need for culturally competent and culturally sensitive interventions (Becher & Wieling, 2015). The increasing linguistic diversity worldwide has also increased the linguistic divide between healthcare providers and users, impacting access to basic health

care (Becher & Wieling, 2015; Elkington & Talbot, 2016). Research indicates that LEP clients use general and mental health services less than their English-speaking counterparts (Frandsen, 2016). Further, many newly arrived refugees point to the absence of an interpreter as a primary barrier to accessing healthcare services, including mental health services (Clark et al., 2014). Linguistic differences may be contributing to the gap between the need for and provision of mental health services to LEP refugee clients.

Interpreters bridge the gap between client and provider, and they help decrease the disparity of equal healthcare access (Becher & Wieling, 2015). It is widely documented that language discordance impedes access to and quality of health care and that formally trained interpreters vastly improve client satisfaction and clinical outcomes (Myler, 2017). The inclusion of interpreters not only improves clients' experience of services but has also been reported to increase their willingness to return for future services (Hillier et al., 1994, as cited in Paone & Malott, 2008). Furthermore, the use of interpreters has resulted in greater satisfaction with health care and a higher likelihood of medication and treatment adherence (Elkington & Talbot, 2016). Employment of professional interpreters in health care treatment increases access and improves delivery of services to non-English speaking communities, thereby reducing health disparities (Becher & Wieling, 2015).

The Need for Interpreters in Refugee Mental Health

In mental health care, language is the tool that clinicians use for assessment, diagnosis, and intervention (Elkington & Talbot, 2016). Psychotherapy is often referred to as "talk therapy" and relies almost primarily on language as a means of assessment and

intervention (Elkington & Talbot, 2016). Language discrepancy between the clinician and client has been shown to negatively affect treatment, including client retention, accuracy of diagnosis, and the type and depth of topics expressed by clients (Becher & Wieling, 2015; Miller et al., 2005; Paone & Malott, 2008). For example, Drennan and Swartz (2002, as cited in Searight & Armock, 2013) conducted an ethnographic study on the influence of interpreters on psychiatric diagnosis in a South African hospital. They found that when the client and clinician were language discordant, there was a greater tendency to diagnose pathology (Elkington & Talbot, 2016). Formal training in interpretation in this context would reduce the likelihood of misdiagnosis (Searight & Armock, 2013). Further, in a population of Asian Americans primarily from Cambodia, 66% indicated that language was a significant barrier to seeking mental health care (Wong et al., 2006, as cited in Searight & Armock, 2013).

Mental health programs have traditionally relied on interpreters, often refugees themselves, to facilitate communication between clinicians and clients (Miller et al., 2005). Unlike interpreting in general health care, interpreting in mental healthcare generally requires an ongoing relationship with the client and often involves deeply emotional information that may be related to trauma and other issues (Miller et al., 2005). However, qualified interpreters are often not present for many clinical encounters with LEP clients, let alone for ongoing treatment (Searight & Armock, 2013).

Executive Order No 13, 166, issued by President Clinton, required that federally funded agencies make reasonable language accommodations, including providing interpreters, for persons with limited English proficiency (LEP). The overall objective of

the Order, consistent with civil rights legislation, was to optimize access to medical and psychiatric services by eliminating discrimination based on language. Thus, securing qualified interpreter services is the responsibility of mental health professionals or their agency.

An interpreter's presence can facilitate a client's sense of belonging within the setting and increase client trust in the clinician and the treatment process (Paone & Malott, 2008). In addition, interpreters can bridge existing cultural gaps by educating counselors regarding the client's culture and culturally informed behaviors, thus acting as a cultural broker (Becher & Wieling, 2015; Gartley & Due, 2017; Paone & Malott, 2008; Ravel, 2005). Clients without interpreters were less satisfied with services and with the advice given by therapists than clients who used interpreters, despite having indicated not wanting interpreter assistance (Paone & Malott, 2008). Thus, interpreters offer the necessary skills to bridge the cultural communication gap between counselors and LEP clients (Becher & Wieling, 2015; Gartley & Due, 2017; Paone & Malott, 2008; Raval, 2005).

Interpreters are vital to the profession of counseling psychology because if we are unable to work effectively with them, and if their well-being is compromised, we cannot uphold our values of providing equal opportunities and the best possible care to all (Darroch & Dempsey, 2016). Interpreters are indispensable for the multiple roles and supports they fulfill. With clients processing emotionally intense war trauma experiences, the interpreter's presence is often beneficial both as a supportive presence for the therapist as well as a witness who validates the client's experience (Searight & Armock, 2013).

The Triad

The addition of an interpreter represents a significant shift from the traditional therapy relationship and impacts the therapeutic process (Elkington & Talbot, 2016; Miller et al., 2005). The triad of the clinician, interpreter, and client requires recognition for the complex interactions amongst members as well as the contributions of each (Elkington & Talbot, 2016; Paone & Malott, 2008). Miller et al. (2005) used the term "complex emotional reactions" to describe transference and countertransference relationships that occur in this triad.

The complex dynamics in this triad need to be thoroughly acknowledged and processed to avoid negatively influencing treatment (Elkington & Talbot, 2016). This involves the constant awareness on the part of the clinician and interpreter of each other's role and how it impacts treatment (Elkington & Talbot, 2016). In addition to relational dynamics, the cultural exchange amongst clinician, interpreter, and client is also complex. Becher and Wieling (2015) hypothesized that clinicians and interpreters would have better experiences when power dynamics allowed for a greater fluidity of cultural exchange. Ultimately, this triadic relationship requires a three-way agreement on treatment goals as well as good rapport amongst all three parties to help ensure an effective working relationship (Elkington & Talbot, 2016).

Role of Mental Health Interpreters

Multiple Roles

The role of mental health interpreters is more complex than initially realized (Gallagher, 2015). The accepted role of interpreters has slowly expanded from a "black

box," a strictly word-for-word model of interpretation, to that of a cultural broker (Becher & Wieling, 2015). Overall, interpreters are expected to be an interpreter, advocate, cultural broker, cultural consultant, mediator, community worker, co-facilitator, therapy conduit, bicultural worker, and more (Gartley & Due, 2017; Miller et al., 2005; Raval, 2005; Searight & Armock, 2013). Their role also includes creating rapport with the client for themselves and clinicians, adapting language, and holding responsibility for authoring the client's words in a second language (Gartley & Due, 2017; Granhagen Jungner et al., 2019). Gallagher (2015) pointed to how mental health interpreters also help clients access services outside of therapy when clients do not know to which services they have access; thus, interpreters' roles also extend into case management (Gallagher, 2015).

In their role as interpreter, they provide direct language interpreting, including interpreting metaphors or concepts (Raval, 2005). As an advocate, they represent the client's or community's interests (Raval, 2005). In their role as cultural broker, they help clinicians understand the client's culture by providing appropriate cultural information to assist in communication and enhance understanding between both participants (Becher & Wieling, 2015; Gartley & Due, 2017; Raval, 2005). As a cultural consultant, they provide consultation to clinicians about relevant cultural information to better understand the client's context (Raval, 2005). As a mediator, they resolve conflicts between the clinician and client, balance trust amongst all participants, and facilitate the clinician-client relationship (Myler, 2017; Raval, 2005). As a community worker, they help build the capacity of community members to resolve mental health issues within their communities (Raval, 2005). As a co-facilitator, they are co-facilitating sessions actively alongside the

clinician (Raval, 2005). As therapy conduit, they normalize psychotherapy for clients who are wary of seeking mental health treatment and affirm the value of treatment (Miller et al., 2005; Searight & Armock, 2013). As a bicultural worker, interpreters go beyond literal language interpretation and include the social-contextual meaning of the client's messages (Searight & Armock, 2013). Further, interpreters reframe Western concepts of mental health to be more relatable to the client's cultural context (Myler, 2017).

Refugee mental health interpreters occupy a poorly defined role due to the multiple expectations they are expected to fulfill, their lower professional status, and their lack of formal training or licensing (Egli, 1987). Clinicians and agencies desire interpreters who are sensitive to emotional issues, understand their role, interpret cultural content, and achieve accuracy (Freed, 1988). Interpreters must respond to numerous and sometimes contradictory expectations, which can be overwhelming (Freed, 1988).

Relational Dynamics

Interpreters experience unclear and complex relationships with other staff and clients, which they struggle to negotiate (Green et al., 2012). They have reported negotiating tensions between the expectations of being an interpreter along with cultural norms of communication and support (Green et al., 2012). Previous research has shown that negotiating multiple identities can create conflicted feelings for interpreters, being part of both a Western professional system as an interpreter and a member of and observant to their own cultural community and norms, further increasing any feelings of distress (Green et al., 2012; Myler, 2017). Thus, along with the multiple tasks to which

interpreters attend, their roles are further complicated by relational dynamics (Gallagher, 2015). For example, interpreters experience different boundaries between themselves and clients than clinicians experience (Becher & Wieling, 2015). Sharing the same language with clients influences them to view interpreters as an ally, friend, or family member (Darrock & Dempsey, 2016). Some interpreters experience a dilemma between having a positive and strong bond with clients, but this not being deemed as "professional" and thus having to enforce boundaries (Myler, 2017). Additionally, some clinicians may experience a sense of displacement from their leading role when working with an interpreter in sessions due to the linguistic and cultural and thus relational connection between interpreters and clients (refer to Repetition of Power Inequities Experienced by Interpreters: *Power Differentials*, Chapter Two) (Johnson et al., 2009). However, this can be addressed by developing mutual trust and respect between the clinician and interpreter (Gallagher, 2015).

Eliminating the Presence of the Interpreter

There is an outdated notion of requiring interpreters to be neutral conduits or direct interpreters instead of a participant in the therapy process. This view of interpreters is known as the "black box" model, which ignores emotional responses that interpreters have to their work (Green et al., 2012; Miller et al., 2005). In the black box model, interpreters are regarded as a machine whose presence is not significant unless they interfere with the therapy process (Miller et al., 2005). The interpreter is expected to try to be invisible and their presence is seen as an unfortunate necessity (Miller et al., 2005). For example, asking the interpreter to use the first person "I" instead of third person to

interpret the client's words attempts to eliminate the person or presence of the interpreter (Miller et al., 2005). The black box model transforms the interpreter into an impersonal and unobtrusive instrument whose sole goal is to facilitate communication between the therapist and client (Miller et al., 2005).

In contrast to the "black box" perspective, others understand the interpreter's role in more relational terms, where the interpreter is viewed as an integral part of a three-person alliance and an important witness to the client's experience (Miller et al., 2005). The alternative view sees interpreters as essential partners in a cross-cultural conversation and co-constructors to the interaction (Angelelli, 2003). Clinicians who work from this perspective can look to interpreters as cultural consultants who help them understand the cultural context of the client's experience and the specific cultural meanings of particular behaviors and metaphors (Miller et al., 2005). Thus, I assert that therapists who treat interpreters as equals, who look to them as consultants, who see them important and valuable contributors are more likely to be culturally competent. Further, clients regard interpreters as visible, and to regard interpreters simply as black boxes can overlook important dynamics in the triad (Miller et al., 2005).

Requirement of Neutrality

The conduit model of communication and multiple codes of ethics require interpreters to inhabit an objective and neutral role, where they are expected to be faithful to content accuracy and not add to or subtract from what the clinician and client communicate to each other (Angelelli, 2003; Bot, 2003; Freed, 1988). Professionalism in interpreter training promotes emotional detachment and neutrality to ensure accuracy and

avoid bias (Myler, 2017). Interpreters are encouraged to be emotionally separate from the content of the session and the client based upon the finding that interpreters' emotional reactions can influence the interpreted interaction (Myler, 2017).

Though it is recommended for the interpreter to turn off their feelings of compassion, they still experience emotions even when they are not expressed (Engstrom et al., 2010). If there is no support provided for their emotional response, severe distress and burnout can occur (Myler, 2017; Raval, 2005). Interpreters are empathic human beings who may be more emotionally receptive to the client's distress due to the strong rapport facilitated by cultural and experiential similarities (Green et al., 2012; Myler, 2017). Research suggests that interpreters engage with the content of what they are interpreting and subsequently experience emotional difficulties (Myler, 2017). Often, interpreters are left without consistent support and are generally expected to manage alone (Darroch & Dempsey, 2016; Myler, 2017).

There is a need to dispell the myth of neutrality, a belief similarly held by interpreters themselves (Myler, 2017). Interpreters experience internal conflict at the contradicting expectations to be a detached and invisible translation machine at the same time as being a cultural informant or co-facilitator as well as retain a good rapport with the client (Becher & Wieling, 2015; Gartley & Due, 2017; Myler, 2017). Interpreters have spoken of not being allowed to have an emotional response to the work or having to be "neutral" machines, dismissing their feelings as human beings (Green et al., 2012). Interpreters have also recognized that experiencing emotions is important and necessary in the therapeutic setting (Myler, 2017).

Being human and conveying oneself emotionally was considered key to positive therapeutic and professional rapport (Myler, 2017). Expressing emotion can be positive within the triadic relationship, and suppressing this expression can have negative connotations, such as appearing unapproachable or uncaring (Myler, 2017).

Although interpreters experienced a benefit of having shared experiences with clients, they also experienced these similarities as problematic (Green et al., 2012). Interpreter participants have acknowledged the difficulties of containing their own as well as clients' complex emotions during sessions (Myler, 2017). There was also a sense that the closer to home a story was, the harder it was to interpret (Green et al., 2012). Interpreters described moving between two contradictory stances, where they reported feeling simultaneously restricted by their role as a conduit while at the same time experiencing an element of safety when their feelings were overwhelming (Green et al., 2012). Interpreters experienced complex, demanding feelings including hopelessness and helplessness when they could not intervene due to their role, bearing an emotional weight of being unable to help clients out of their distressing situations (Myler, 2017).

Interpreters have described coping with difficult session content by attempting to detach from emotions and suppress their sympathetic reactions (Myler, 2017). Sometimes, interpreters have been so overwhelmed in sessions they felt unable to continue interpreting and had to leave, revealing how interpreters can be taken by surprise by their emotions (Green et al., 2012). Several clinicians have described situations in which the interpreter attempted to stop the clinician from asking the client to describe emotionally distressing experiences (Searight & Armock, 2013). Distressed

responses are particularly common at the beginning of their careers as interpreters (Darroch & Dempsey, 2016; Green et al., 2012; Myler, 2017; Splevins et al., 2010). Additionally, interpreters have reported having not been prepared for the impact of the work by their agencies (Green et al., 2012). Thus, interpreters not being informed of emotionally difficult content can inhibit their effectiveness. For their own as well as clients' well-being, interpreters need to be better prepared for the difficulties of mental health interpretation.

The requirement of neutrality is divorced from practice, challenging the notion that interpretation can or should be neutral (Bot, 2003). This requirement creates a mismatch between the expectations for interpreters' impartial roles and the reality of unmanageable emotional responses (Green et al., 2012). Thus, the expectation of interpreters' neutrality is unreasonable, and I assert that the myth of neutrality is false and damaging (Bot, 2003).

Internal Conflict: The Professional Versus the Personal Self

Interpreters experience internal conflict from the contradictory expectations put on them, namely maintaining professionalism versus experiencing emotional reactions (Darroch & Dempsey, 2016; Myler, 2017; Raval, 2005). The expectation to be a neutral, emotionally detached interpreter who abides by professional duties and obligations conflicts with their natural human reactions (Green et al., 2012; Myler, 2017). This inner conflict can be further described as a dichotomy between having a human urge to help those in distress, and a fear of the powerful systems that dictate who a good interpreter should be (Myler, 2017). Interpreters perceive an obligation to hold boundaries with and

detach from clients, yet this coincides with the desire to help and empower clients (Green et al., 2012; Myler, 2017). Interpreters reported prominent difficulties with remaining impartial (Darroch & Dempsey, 2016). The upholding of codes of ethics and conduct causes emotional turmoil and moral dilemmas for interpreters, further fueled by the perception that seeking support from others could be regarded as breaking confidentiality (Darroch & Dempsey, 2016; Searight & Armock, 2013).

Interpreters may believe that showing vulnerability would compromise their position in employment (Darroch & Dempsey, 2016). Despite feeling emotionally affected by their work, they are obliged to mask their reactions in order to remain professional (Darroch & Dempsey, 2016; Gallagher, 2015; Green et al., 2012; Raval, 2005). This conflict between expectation and reality regarding the requirement of neutrality creates emotional distress in interpreters. Thus, it is important to devise ethical ways in which interpreters can share their feelings without compromising their professionalism (Darroch & Dempsey, 2016; Searight & Armock, 2013).

The likelihood of conflict is greater when powerful feelings remain unacknowledged or unspoken (Raval, 2005). If these issues or feelings are not attended to, they may surface in a manner that would deter the client's treatment (Myler, 2017; Raval, 2005). Ways to address this conflict include expanding the role of interpreters beyond that of a neutral conduit and recognizing and legitimizing their work as interpreters (Becher & Wieling, 2015; Myler, 2017; Raval, 2005).

Defining Trauma

Clients' cultures may hold different views on mental health to those held in Western culture, and mental health professionals need to understand the different ways that clients communicate and understand psychological distress (Johnson et al., 2009; Myler, 2017). Beliefs around mental health problems such as trauma can vary widely based on an individual's community or cultural beliefs, and we must recognize that refugee clients' beliefs and ideas about their trauma can differ from Western beliefs and ideas about trauma (Johnson et al., 2009; Myler, 2017). The beliefs an individual holds regarding their trauma-related distress may be key in determining whether they seek and access mental health services (Myler, 2017).

We need to be careful when applying Western psychological concepts to non-Western populations, as experiences of collective traumatization are not directly considered in highly individualized Western models (Johnson et al., 2009; Myler, 2017). Trauma is individualized in Western culture, whereas trauma from ethnic persecution in the experience of refugees is experienced collectively—their understanding is a group persecution, not an individual one (Johnson et al., 2009). In previous research, refugee interpreters have taken a group position in describing their experiences of trauma, in which there was a social construction of fear or an anticipation of violence that occurred to groups based on their shared ethnic identity (Johnson et al., 2009). This depersonalization appeared to be encouraged and facilitated by social support from others who had been through similar experiences (Johnson et al., 2009). In turn, feeling that it

was society that was targeted rather than the individual served to strengthen social bonds and cultural identity (Johnson et al., 2009).

Refugee Interpreters' Trauma

Refugee mental health interpreters may experience vicarious trauma or retraumatization from their work (Elkington & Talbot, 2016). Vicarious trauma is defined as the negative response of a helper as a result of empathic engagement with survivors' traumatic material and a sense of responsibility or commitment to help (Green et al., 2012). This can happen more frequently when interpreters come from the same culture or sociopolitical background and may have similar experiences with the client (Elkington & Talbot, 2016; Miller et al., 2005; Searight & Searight, 2009). There is a strong likelihood that interpreters working with refugee clients will be involved with therapeutic processes that are emotionally intense and involve interpreting stories of trauma, separation, and loss that may echo their own experiences (Miller et al., 2005).

Two factors distinguish psychotherapy with political refugees from psychotherapy with other clients who might require an interpreter. The first factor is the prevalence among refugees of exposure to extreme violence and deprivation and the subsequent development of severe and persistent psychological trauma (Miller et al., 2005). The second factor is the experience of multiple losses—of social networks, personal possessions, valued social roles, and familiarity with their environment—occurring among people forcibly displaced from their home and community (Miller et al., 2005). Thus, I am curious about the specific experience of refugee mental health interpreters who work with refugee clients. I hope to gain a better understanding of their emotional

reactions to traumatic session content and the ways they manage these reactions, as well as the training, supervision, and other support they desire (Miller et al., 2005).

Purpose of the Study

The research literature lacks examination into several areas concerning mental health interpretation for refugee clients. This includes the management of interpreters' vicarious trauma and retraumatization, interpreter's perspectives on the appropriateness of hiring refugees as mental health interpreters, how interpreters define their trauma as well as their clients' trauma, and support that interpreters seek for their traumatic responses from their work. The literature is also missing an analysis of how oppressive power differentials are repeated in workplace institutions, specifically for refugee mental health interpreters.

The literature takes a very controversial stance on whether hiring interpreters with their own refugee backgrounds is appropriate or ethical (Miller et al, 2005). Thus, I am interested in whether refugee interpreters think it is appropriate for refugees to be hired as interpreters, considering their experiences of primary trauma, vicarious trauma, and retraumatization. I want to highlight how the literature on this topic does not come from interpreters' perspectives. For example, Miller et al. (2005) claimed that hiring refugees as interpreters was more beneficial than harmful. This judgment was made from the top-down, representing an absence of interpreters' perspectives on the issue. Thus, this study aims to incorporate the voices of interpreters in best practices for hiring those who have also been refugees as mental health interpreters for refugee clients.

I am also interested in what refugee interpreters think about their own experiences of trauma, as well as their clients' trauma. In literature and in practice, psychologists tend to define refugees' trauma for them instead of eliciting their definitions of their trauma (Johnson et al., 2009; Myler, 2017; Pells & Treisman, 2012). Thus, one goal of this study is to elicit refugee interpreters' definitions of their trauma as well as their clients' trauma. Since the literature has indicated that refugees experience trauma collectively, it would be interesting to discover whether group healing is implicated.

My study is also interested in analyzing how oppressive power differentials are repeated in refugee interpreters' work settings. These dynamics will be elaborated in the literature review in Chapter Two, yet I will briefly elaborate. Interpreters tend to experience oppressive dynamics from clinicians and hiring agencies (Amouyal et al., 2020). Though previous research has examined these power dynamics, they have not applied an analysis of how interpreters may experience a repetition of oppressive dynamics due to their marginalized status as refugees, overlapping with additional forms of oppression in their current situation. Further, a lack of rapport between interpreters and clinicians could help explain a barrier that interpreters encounter when seeking support for traumatic symptoms related to their work. Clinicians' mistreatment of and attitudes toward interpreters could translate to interpreters' perception of clinicians' helpfulness, disillusioning them from engaging in therapeutic services. In other words, interpreters' experiences of clinicians' negative attitudes could influence their desire to seek treatment for their own trauma. Thus, this study aims to investigate whether clinicians and hiring agencies are re-enacting power differentials which oppress refugee interpreters.

Lastly, this study aims to examine how refugee mental health interpreters experience and manage their traumatic reactions from their interpretation work. There is still little research on the complex emotional reactions that occur during therapy and the ways interpreters manage these reactions (Miller et al., 2005). Thus, I would like to push forward this examination and incorporate interpreters' perspective on the support they need to manage these reactions. For example, there is a dichotomy between need for and provision of debriefing for interpreters. An aim of this study is to build a bridge and elicit concrete suggestions for how to facilitate debriefing, even when time is limited. Thus, this study aims to invite the perspectives of refugee mental health interpreters on several issues pertaining to their work with refugee clients.

Research Questions

1) How do refugee mental health interpreters define their own experiences of trauma?
    a. How do they understand their clients' experiences of trauma?
2) What are the benefits and harms of hiring those who have also been refugees as mental health interpreters for refugee clients?
    a. How does having similar past experiences help their work experience?
    b. How does having similar past experiences hinder their work experience?
3) What power dynamics occur amongst clinicians, agencies, and refugee mental health interpreters?

    a. How do interpreters' experiences of coworkers' attitudes influence their desire to seek treatment for their work-related trauma?

4) How do refugee mental health interpreters manage their traumatic responses from their work with refugee clients?
    a. How do refugee mental health interpreters manage distress from retraumatization or vicarious trauma in vivo during sessions?
5) What types of support do refugee mental health interpreters need to better manage their traumatic responses?
    a. What about supervision has been or would be helpful?
    b. What about debriefing has been or would be helpful?

Chapter Two: Literature Review

Mental Health of Interpreters

Vicarious Trauma and Retraumatization

Along with clients, interpreters in mental health settings have often had traumatic experiences and are thus vulnerable to developing secondary traumatization (Kindermann et al., 2017). Results of Kindermann, et al.'s study (2017) found that a considerable group of their interpreter participants experienced primary as well as secondary traumatization. Further, Stahlbrodt (2016) found that personal history of trauma amongst interpreters was the most important predictor of higher levels of vicarious trauma when interpreting traumatic content. Mental health interpreters are emotionally affected by interpreting clients' traumatic stories, causing distress and affecting their well-being (Gallagher, 2015).

Refugee mental health interpreters are regularly exposed to emotionally distressing material, and they are consequently very vulnerable to vicarious traumatization (Darroch & Dempsey, 2016; Mehus & Becher, 2015; Myler, 2017). Risk factors for vicarious trauma include their own trauma history having overlap with a client's history, caseload size, amount of experience, role clarity, and coping style (Green et al., 2012). Interpreters have reported the negative impact of their work when clients' experiences resonated with their own past (Green et al., 2012). Yakushko (2010) and the British Psychological Society (2008) both point to the importance of attending to

vicarious victimization when working with interpreters. Of the different types of interpreting, interpreters have expressed that mental health work was the most challenging (Green et al., 2012).

Vicarious trauma is the result of exposure to demanding interpersonal work and emotionally engaging clients (Darroch & Dempsey, 2016). It is defined as the negative transformation in the self of the helper that comes about as a result of empathic engagement with survivors' traumatic material and a sense of responsibility or commitment to help (Saakvitne et al., 2000, as cited in Green et al., 2012). The theory of vicarious trauma has previously been used to understand the emotional impact of interpreting (Raval, 2006). Being reminded of one's own traumatic experiences through interpreting others' stories of trauma can lead to symptoms of Posttraumatic Stress Disorder after one's own trauma has become reactivated (Darroch & Dempsey, 2016).

Symptoms of vicarious trauma include disturbance of the individual's cognitive frame of reference or identity, as well as their psychological needs, beliefs about self, internal imagery, and interpersonal relationships (Darroch & Dempsey, 2016). Other symptoms include insomnia, irritability, preoccupation, intrusive thoughts, ruminations, nightmares, depression, physiological symptoms such as throwing up, and detaching from clients (Amouyal et al., 2020; Darroch & Dempsey, 2016). In one study of interpreters, 56% of participants reported being emotionally impacted by their work, while 67% found it difficult to stop thinking about their clients' troubles – 56% up to half an hour after sessions and 23% from several hours up to days after sessions (Darroch & Dempsey, 2016). Furthermore, 33% stated that interpreting had an impact on their

personal lives and 28% reported difficulties in taking other assignments and described feeling weary, distracted, and in emotional turmoil (Darroch & Dempsey, 2016). These symptoms sometimes increased with the number of sessions interpreters had with victims of violence (Darroch & Dempsey, 2016). In contrast, another study of interpreters working with survivors of trauma found no significant results of interpreters showing higher levels of vicarious trauma with increased exposure to traumatic events or material (Shlesinger, 2005).

However, there is increasing research support concerning how interpreting can trigger an interpreter's own trauma history (Green et al., 2012). Refugee interpreters have reported experiencing severe emotional distress and reactivation of their own traumatic memories because of their work over periods ranging from the first few months to longer term (Green et al., 2012). Additionally, existing literature presents limited information on interpreters' management of vicarious trauma, particularly from their own perspectives (Amouyal et al., 2020; Johnson et al., 2009; Miller et al., 2005). Interpreters have also stated their well-being or lack of focus can hinder their work (Amouyal et al., 2020).

Addressing Vicarious Trauma

Splevins et al. (2010) found that the amount of time that interpreters had been working in a mental health setting may influence the intensity of vicarious trauma that they experience. For example, interpreters described intense emotional reactions, including distress, in the early stages of working as a mental health interpreter (Splevins et al., 2010). Myler (2017) also noted that experience built resilience to the emotional content of sessions, and that personal experiences superseded any formal training in

handling distressing content. Interpreters have noted that familiarity and experience were protective factors against emotional distress, since experience helped them learn what to expect (Darroch & Dempsey, 2016). More experience also helped interpreters become familiar with the occupational environment, service processes, and strategies to help them handle difficult scenarios as well as their emotions (Darroch & Dempsey, 2016).

Miller et al. (2005) devised hiring criteria for refugee mental health interpreters in an effort to prevent vicarious traumatization, which are as follows: a) Interpreters must have an adequate support system, including staff support; b) Interpreters must have the same qualities as therapists, e.g. high degree of empathy, good interpersonal skills, high level of psychological-mindedness, etc.; c) Interpreters must have experienced a reasonable degree of psychological healing from their own history of trauma and loss before starting work as an interpreter. Additionally, Amouyal, Wu, and Patterson (2020) proposed several strategies to ameliorate vicarious trauma, including: a) Post-session debriefing as well as pre-session debriefing to notify interpreters if there may be high-risk content, b) Increasing the interpreter's self-awareness of their limitations and values, c) Increasing the interpreter's experience and education in mental health, d) Institutional support for interpreter mental health, e) Clinician and interpreter teamwork, and f) Increasing the clinician's knowledge on interpretation and the role of interpreters.

Post-session debriefing has been heavily recommended to address issues around secondary trauma (Paone & Malott, 2008; Searight & Searight, 2009). Pre-session briefing, where the clinician shares sufficient client information before a session, is also important to mitigate vicarious trauma to enable the interpreter's ethical acceptance or

refusal of cases (Amouyal et al., 2020). Clarification around confidentiality and the role of debriefing may also help interpreters mitigate vicarious trauma (Searight & Armock, 2013). Researchers found that interpreters were reluctant to engage in debriefing because of their confusion regarding confidentiality and what they were allowed to share in debriefing sessions with clinicians (Darrock & Dempsey, 2016; Searight & Armock, 2013).

Posttraumatic Growth

Posttraumatic growth is a conceptual view of traumatic experience that allows for an increase in well-being simultaneously with distress and growth (Calhoun & Tedeschi, 1998). The theory of posttraumatic growth holds the view that people who experience traumatic events can experience psychological growth or thriving as a result of the struggle with these stressful events (Calhoun & Tedeschi, 1998). Many psychologists have researched and written about posttraumatic growth, including Lawrence Calhoun and Richard Tedeschi (1999). Their definition of posttraumatic growth is positive change that the individual experiences as a result of the struggle with a traumatic event (Calhoun & Tedeschi, 1999). People who have experienced a differing and wide array of traumatic events have all reported being changed in positive ways by their trauma (Calhoun & Tedeschi, 1999). The authors divide posttraumatic growth into three major domains: changes in relationships with others, change in the sense of self, and change in philosophy of life (Calhoun & Tedeschi, 1999). Their views are supported by additional research described below.

In addition to the negative impact of interpreting, some interpreters have also reported experiencing positive emotions from working with clients (Myler, 2017; Splevins et al., 2010). From the results of Splevin et al.'s study (2010), interpreters reported their overall experience being positive regarding working with clients who experienced trauma. Participants from Myler's study (2017) viewed their emotional involvement as a positive link between themselves and clients, and they expressed joy at being able to witness their clients' progress. Witnessing clients recover from hardships created feelings of hope, admiration, inspiration, joy, and growth which paralleled the growth interpreters witnessed in their clients (Splevins et al., 2010). Interpreters have also perceived their work to enrich their lives and contribute to personal development (Miller et al., 2005; Myler, 2017; Splevins et al, 2010).

Interpreters frequently described how they were affected by their clients' happiness and expressed their joy, amazement and satisfaction at witnessing human resilience as their clients changed and recovered, giving them inspiration and hope in their own lives (Darroch & Dempsey, 2016; Splevins et al., 2010). Likewise, many reported a change in outlook, asking existential questions about their own life, becoming more reflective and appreciative, feeling wiser and more compassionate, and feeling as though they were better people after experiencing distress (Darroch & Dempsey, 2016; Splevins et al., 2010). The positive experience of helping can act as a buffer against the negative emotions stirred by the client's traumatic stories (Myler, 2017).

Mehus and Becher (2015) conducted a study to examine how interpreters are supported in trauma-related work. They found their interpreter participants responded

with high levels of secondary traumatic stress yet also high levels of compassion satisfaction, defined as feeling that their work is valuable (Mehus & Becher, 2015). The authors suggested that compassion satisfaction may protect against secondary traumatic stress and burnout (Mehus & Becher, 2015). This combination of high secondary traumatic stress and high compassion satisfaction may indicate post-traumatic growth (Mehus & Becher, 2015). Interpreters have reported the positive experience of compassion and empathy toward their clients, which helped them understand their clients' experiences better (Darroch & Dempsey, 2016; Miller et al., 2005).

Working with refugees in a mental health context can build courage, patience, gratitude, strength, resilience, faith, hope, and acknowledgement of humans' capacity for survival and strength (Johnson et al., 2009; Pells & Treisman, 2012). Interpreters have reported gaining a perspective which helped them appraise and reframe their own situations in a more positive light (Darroch & Dempsey, 2016; Johnson et al., 2009; Miller et al., 2005; Pells & Treisman, 2012). They have also reported gaining coping skills, knowledge, and insight from their work (Darroch & Dempsey, 2016; Johnson et al., 2009; Pells & Treisman, 2012).

Further, interpreters have reported an increased sense of meaning from their work. For example, interpreters can use their experiences to help others, bringing meaning to their own experience of trauma and deepening a sense of appreciation for their role as an interpreter (Johnson et al., 2009; Myler, 2017). Further, some interpreters felt that their traumatic experiences had taught them how to cope better with challenges, how to be grateful for opportunities in life, and to gain the perspective that other difficulties in life

were relatively small (Johnson et al., 2009). Lastly, interpreters gained access to others who had been through similar experiences, creating a mutually beneficial experience of normalization (Johnson et al., 2009). Thus, there appear to be multiple benefits that interpreters experience despite the potential for vicarious traumatization.

Hiring Refugees as Interpreters

There is a debate among mental health providers who work with refugees regarding the appropriateness of hiring refugees as interpreters (Miller et al., 2005). Since many interpreters share a cultural background with their clients, it is likely that the interpreter has also been exposed to similar traumatic events, such as war and genocide (Searight & Armock, 2013). The issue of employing interpreters who have been refugees and consideration of their work-related traumatization requires employers' consideration of their duty to care for all, including interpreters (Darroch & Dempsey, 2016). Clinicians should be aware of the potential for the interpreter to relive their trauma as a result of recounting the traumatic experiences of others (Johnson et al., 2009).

The argument against the practice of hiring refugees as interpreters is the potential risk of retraumatizing them, realizing that they may have their own history of war-related trauma and loss (Miller et al., 2005). Further, it has been suggested that psychologists should avoid having interpreters who have multiple relationships with clients (Searight & Armock, 2013). This contradicts the pragmatic limitations of when mental health agencies do not have access to anyone outside of a refugee's own community who speaks the required language and is available to interpret (Miller et al., 2005). Thus, there are conflicting messages about best guidance on hiring interpreters for refugee clients.

Multiple authors have raised concerns about interpreters' psychological reactions to clients' accounts of traumatic events (Engstrom et al., 2010; Miller et al., 2005; Searight & Searight, 2009) and the symptoms of vicarious trauma have been detailed previously in this chapter. Further, previous research investigating refugee interpreters with a shared ethnic identity with clients has suggested that distress might be associated with a personal identification with traumatic material, as well as identification with a persecuted ethnic group (Holmgren et al., 2003; Green et al., 2012). However, it was not possible to fully understand the relationship of shared identity and shared trauma to distress, but both seemed to have played a role (Green et al., 2012). This suggests that interpreters with a shared refugee history or strong identification with the persecution of their ethnic group may have added and ongoing distress at work, particularly if their trauma is unresolved (Green et al., 2012).

On the other hand, some researchers argue that there is not enough support to suggest that interpreters find work with refugees distressing, and that the merits of using refugees as interpreters far outweigh the potential problems (Miller et al., 2005). For example, Miller et al. (2005) interviewed participants who reported that they experienced an increase in short-term distress as a result of their work, yet that these reactions were relatively uncommon, usually short lived, and rarely caused disruption to their lives outside of the workplace (Miller et al., 2005). The rationale for using refugees as interpreters includes sharing a common cultural background with clients, such that interpreters who are refugees themselves can serve as a cultural liaison between the client and therapist in ways that interpreters from the host society cannot (Miller et al., 2005).

These authors claimed that with careful screening, appropriate hiring criteria, proper training for new interpreters, ongoing supervision from agency staff, and good support, many problems noted in the literature about working with interpreters can be prevented (Miller et al., 2005).

However, this judgment was made from the top-down, where the authors decided that hiring refugees as interpreters was more beneficial than harmful without input from interpreters themselves. Thus, I am left wondering about interpreters' perspectives on this dilemma. Miller et al.'s (2005) study represents a vast absence of interpreters' perspectives on their own experiences. Thus, this study aims to invite the perspective of interpreters on the issue of hiring those who have also been refugees as mental health interpreters for refugee clients.

Repetition of Power Inequities Experienced by Interpreters

Interpreter-Clinician Relationships

Interpreters' contact with clinicians outside of sessions can significantly inform their work and experiences (Bot, 2003). For example, interpreters have attributed part of their work-related emotional difficulties to dealing with clinicians (Darroch & Dempsey, 2016). Specifically, interpreters have reported difficulties due to clinicians' frustrations, impatience, biases, and blame towards interpreters, clients or other clinicians, causing fragmented healthcare teams (Amouyal et al., 2020). When problems in communication arise, the blame is put on the interpreter and they receive the brunt of frustration when a session is not going well (Becher & Wieling, 2015). Thus, clinicians demonstrate a lack

of understanding of the role of the interpreter (Becher & Wieling, 2015; Darroch & Dempsey, 2016).

Interpreters have expressed how clinicians underestimate the complex role of interpreters, treating them as interchangeable machines instead of professionals in their own right (Darroch & Dempsey, 2016; Searight & Armock, 2013). Interpreters expressed the belief that clinicians' lack of understanding of their role led to a lack of respect for the profession (Darroch & Dempsey, 2016). A lack of understanding from clinicians can also lead to a lack of support provided to interpreters (Myler, 2017). This further suggests a lack of self-to-other compassion from clinician to interpreter (Myler, 2017).

By treating interpreters as second-class employees, clinicians fail to consider the emotional impact on interpreters or to value their need for information to ensure an effective interpretation (Darroch & Dempsey, 2016; Searight & Armock, 2013). Interpreters also shared a sense of being undervalued and disrespected as professionals (Choo, 2014; Green et al., 2012). Participants described negative experiences of employers having high expectations while also devaluing the services interpreters provide (Myler, 2017). Some interpreters noted how some of the attitudes they encountered conveyed the sense that interpreters were unfamiliar, unimportant, and perceived as a financial burden (Myler, 2017). Interpreters have identified a lack of acknowledgement, respect, and recognition from clinicians to be a significant source of stress and an impediment to a successful interpretation process (Choo, 2014; Darroch & Dempsey, 2016).

Interpreters experienced their position in the system as precarious, with little status, low pay, little respect, and minimal training and support (Green et al., 2012). This is further indicated by: a) the agency model of hiring interpreters based on their availability for the appointment versus identifying a specific interpreter and working around their schedule, b) the low rate of insurance reimbursement of interpreter services, c) the practice of working with ad hoc interpreters (i.e. available bilingual laypersons), and d) the use of remote interpreting services provided by anonymous interpreters through telephone and video (Becher & Wieling, 2015). Interpreters reported feeling dehumanized, viewed as commodities rather than people; thus, there was little acknowledgement of the emotional and physical strain of their work by clinicians, with few breaks offered and their well-being rarely considered (Darroch & Dempsey, 2016).

Power Differentials

The literature exposes how interpreters experience a power differential, where clinicians have more power than interpreters (Becher & Wieling, 2015). In Green et al.'s (2012) study, interpreters reported a sense of having lower professional status than clinicians. Clinicians are typically seen as the "expert," with more education, a higher pay grade, and greater respect and authority within institutions (Becher & Wieling, 2015). Clinicians are attributed greater authority and prestige by a dominant culture that values formal education, professional hierarchy, professional ethics, and Western mental health perspectives (Becher & Wieling, 2015). In Myler (2017), an interpreter participant described of clinicians, "Obviously they're the boss (laughter) they're the qualified person." This power dynamic ultimately gives greater authority to the clinician's social

constructions of mental health (Becher & Wieling, 2015). Thus, this study aims to investigate whether clinicians are re-enacting inequitable and oppressive power differentials against refugee interpreters.

Additionally, interpreters are seen as threats who "take away" clinician power (Becher & Wieling, 2015). This perception of threat creates a power imbalance that clinicians act to compensate by dominating sessions, which interpreters experienced as a barrier to treatment progress (Becher & Wieling, 2015). Further, clinicians tend to fear judgment by the presence of a third party in therapy sessions (Paone & Malott, 2008). Clinicians' fear of being judged may be worse when the clinician has limited experience working with clients from different cultures from their own, exposing an area for cultural growth (Paone & Malott, 2008). Another error in perception is clinicians' belief that clients receiving English-only services are more satisfied with services than those working with interpreters (Paone & Malott, 2008). In Paone and Malott's study (2008), only 31% of therapists perceived the clients working with interpreters desired to return. This reveals how clinicians' discomfort in working with an interpreter may negatively influence therapists' perceptions and professional behaviors (Paone & Malott, 2008). In contrast, clients experienced interpreters' involvement positively, where interpreters provided comfort and increased client satisfaction with services (Paone & Malott, 2008).

Amelioration

A more intentional approach to the relationship between clinicians and interpreters is important and needed. An amelioration of their relationship can begin with viewing interpreters as knowledgeable professionals (Myler, 2017). Clinicians should

recognize interpreters as equals instead of subordinates because without them, therapy would not be possible (Freed, 1988).

Interpreters described clinician traits which helped them work better together, such as patience, respect, and supportive attitudes toward interpreters and clients (Amouyal et al., 2020). They also valued clinicians demonstrating concern, compassion, solidarity, affinity toward clients, and a caring personality (e.g. wanting to listen, being non-judgmental, kind, empathic, genuinely concerned, and going beyond job requirements) (Myler, 2017). Working with interpreters also requires flexibility from clinicians (Searight & Armock, 2013). Clinicians' description of a good interpreter was similar to interpreters' description of a good clinician (Yakushko, 2010). For example, characteristics such as empathy, good interpersonal skills, and psychological mindedness were described as important attributes for an effective mental health interpreter and clinician (Searight & Armock, 2013; Yakushko, 2010).

In acknowledgment of existing power dynamics, clinicians have the responsibility to lead the process of relational engagement with interpreters. Both parties would benefit from respectful conversations about the interpreter's approach to their work and what that means for the session. Potential for role confusion may be increased if the clinician and interpreter fail to establish a relationship and define their specific roles prior to starting to work with a client (Paone & Malott, 2008). Thus, it would help if the clinician attempted to develop a relationship with the interpreter, especially since they are in a position of power. Treatment works more effectively when all three participants in the triad treat each other as real people (Bot, 2003).

Training for Clinicians

Interpreters have cited clinicians' lack of knowledge and understanding about the interpreter's role and needs as sources of work strain and negative emotional reactions (Darroch & Dempsey, 2016). Clinicians' knowledge can help or hinder interpreters' work (Amouyal, 2018). Thus, it is as important for clinicians to be trained on how to work with interpreters as it is for interpreters to be trained on how to work with clinicians (Elkington & Talbot, 2016). There is a building rationale around the need for clinicians to become more developmentally mature when it comes to working with interpreters—collaborating, building knowledge of strategies, becoming more reflective, checking their biases, and more (Amouyal, 2018; Myler, 2017). Interpreters have expressed feeling hindered when clinicians lacked education on effective work with interpreters, did not adhere to protocols, or had wrong expectations (Amouyal et al., 2020). They wished clinicians knew of recommended collaborative strategies with interpreters (Amouyal et al., 2020). Ultimately, it is important for clinicians to value the perspective of interpreters because it will help improve services (Raval, 2005).

Training for clinicians may need to address the dominance of Western mental health perspectives. For example, trauma is individualized in Western culture, whereas trauma from ethnic persecution in the experience of refugees is experienced collectively (Johnson et al., 2009). Addressing the dominance of Western mental health perspectives may help address this power dynamic that ultimately gives greater authority to clinicians (Becher & Wieling, 2015).

Author's Analysis

Myler (2017) has called for changes to how refugees access mental health treatment, suggesting a preventative stance on refugees' entry to their host nations to improve their psychological well-being. This preventative stance involves educating refugees upon entry on how they may experience trauma-related distress and how they can access support (Myler, 2017). Alternately, I believe it would be more helpful to elicit the meaning that refugees make of their traumatic experiences upon resettlement, instead of telling them how they will respond to their traumatic experiences. Thus, one goal of this study is to elicit how refugee interpreters define their trauma, and to also invite their perspective on their clients' trauma.

Psychological treatment for trauma has mandated that clients feel protected from harm (Myler, 2017). A trusting, therapeutic rapport can provide individuals with the reassurance they need to recover from psychological trauma (Myler, 2017). A lack of rapport between interpreters and clinicians could help explain a barrier that interpreters encounter when seeking support for traumatic symptoms related to their work. Clinicians' mistreatment of and attitudes toward interpreters could translate to interpreters' perception of clinicians' helpfulness, disillusioning them from engaging in therapeutic services to seek treatment for their own trauma. Thus, this study aims to highlight whether refugee interpreters are experiencing inequities in how they are treated and whether that impacts their access to supporting resources.

Support for Mental Health Interpreters

Research has implicated a need for interpreters to be supported, as due to the emotional nature of their work, they are at an increased risk for experiencing vicarious trauma (Mehus & Becher, 2015; Myler, 2017). Mental health interpretation can cause emotional, psychological, and interpersonal stress (Choo, 2014). Interpreters have expressed that a lack of support from their employers left them feeling low self-worth and high amounts of stress (Darroch & Dempsey, 2016). These themes on interpreter support, gathered by Raval (2005), are enduring and still hold true today: a) a lack of training, skills, and cultural competency; b) a lack of support and professional recognition for interpreters; c) poor management of the complex communication process through interpretation; d) poor management of conflicts that arise; and e) poor management of the emotional impact of mental health interpretation work.

Many authors have stated that supervision is necessary to support interpreters in their work (Darroch & Dempsey, 2016; Green et al., 2012; Myler, 2017; Paone & Malott, 2011; Raval, 2005; Searight & Searight, 2009; Trevithick, 2005; Tribe, 1999). Supervision provides interpreters with the opportunity and space to process their emotional responses to the content they are exposed to in sessions (Green et al., 2012; Trevithick, 2005). Regular supervision is essential not only to support interpreters, but also for professional accountability (Darroch & Dempsey, 2016). Supervision is considered a confidential, supportive, and professional relationship which helps interpreters work through difficult issues raised in their work (Darroch & Dempsey, 2016).

Supervision can help create material resources such as career opportunities as well as develop internal resources through learning new skills (e.g. coping strategies), increasing self-awareness, and other personal development (Darroch & Dempsey, 2016; Green et al., 2012; Myler, 2017). Those who have not received supervision have expressed that they would value and appreciate feedback and guidance from a trusted and non-judgmental professional (Darroch & Dempsey, 2016). However, the provision and use of supervision is inconsistent (Darroch & Dempsey, 2016). There are also power inequities involved in the offering of supervision (Myler, 2017; Raval, 2005). For example, power differences place interpreters in a weaker position from which to negotiate their needs from clinicians, employers, and institutions (Raval, 2005). Clinicians may have more access to support through the occupational health benefits and supervision time that they are entitled to, while interpreters are often not offered such support (Myler, 2017).

There is plenty of evidence in the literature about interpreters' need for briefing, specifically pre-session briefing or post-session debriefing (Amouyal et al., 2020; Choo, 2014; Darroch & Dempsey, 2016; Elkington & Talbot, 2016; Green et al., 2012; Miller et al., 2005; Myler, 2017; Paone & Malott, 2011; Raval, 2005; Searight & Armock, 2013; Searight & Searight, 2009; Tribe, 1999). The purpose of post-session debriefing is to assess any negative interpreter reactions related to sessions (Paone & Malott, 2008). If the interpreter is experiencing emotional distress related to the session, the clinician can help the interpreter process their reaction (Paone & Malott, 2008). It is essential to build in adequate time for preparation, planning, reviewing, debriefing, reflection, supervision

and managerial support for sessions (Raval, 2005). Raval (2005) advised that regularly supervised work be allocated at least 15 to 30 minutes for every hour spent directly with a client.

Preparatory time is also essential to help interpreters (Raval, 2005). For example, pre-session briefing helps interpreters develop their understanding of the vocabulary used in mental health and prepare culturally meaningful interpretations (Raval, 2005). Additionally, knowing a client's age, education, communication style and preferences helps interpreters make appropriate language choices (Choo, 2014). It is also helpful when the clinician shares their goals and expectations for the therapy session (Choo, 2014; Darroch & Dempsey, 2016). Interpreters have explained that having background information helps them to understand the context and meaning of what is being said, therefore, entering a session without information hinders their work and compromises effective communication (Darroch & Dempsey, 2016). Unfortunately, interpreters are often not briefed adequately and are thus not given sufficient information, preparatory time, or support to familiarize themselves with the ways clinicians work (Raval, 2005). Interpreters perceived the lack of information or briefing provided was because clinicians did not respect, understand, or recognize the complexity of the interpreter's role (Darroch & Dempsey, 2016).

Interpreters have expressed appreciation for debriefing sessions and found them helpful for managing distressing clinical material (Miller et al., 2005; Myler, 2017); thus, post-session debriefs should be routine for every session (Paone & Malott, 2008). Interpreters were aware of their needs to be well-informed and briefed to protect their

emotional well-being and to perform efficiently (Darroch & Dempsey, 2016; Myler, 2017). Interpreters noted that when individual professionals provided support through debriefing, it was rare and precious (Myler, 2017). This contributed to interpreters feeling unworthy of support, at odds with their motivation to alleviate their distress (Myler, 2017). Though briefing and debriefing are strongly recommended to mitigate emotional and work stress, understanding of these needs and provision of these supports is inconsistent and still not commonly practiced (Darroch & Dempsey, 2016; Myler, 2017). In general, professional support was perceived by interpreters to be inconsistent, inadequate, and rarely available due to this support not being considered necessary by employers (Myler, 2017). Though interpreters are in desperate need for support to manage their emotional distress, they are left to manage on their own by using their own coping strategies (Myler, 2017). Even further, interpreters perceive that it is unacceptable to seek support and should manage this distress themselves, despite the emotional demands they experience (Myler, 2017). Requiring formal professional support is portrayed as being for those who are vulnerable, not for the ideal interpreter who should be strong and resilient (Myler, 2017). Thus, interpreters seem to be surviving, rather than thriving, in their roles (Myler, 2017).

It is helpful for interpreters to be hired as staff instead of contract workers to create collaborative relationships (Amouyal et al., 2020). The opportunity for true relationship building and collaboration is something that is only possible when interpreters and clinicians regularly work together over the course of treatment (Amouyal et al., 2020; Miller et al., 2005). Being appointed as a permanent staff member has been

found to be a positive support for interpreters, and being viewed as part of the team of staff was a strategy for improved communication in aiding their interpretation work (Granhagen Jungner et al., 2019; Yakushko, 2010). Interpreters are structurally supported by being employed as staff or regularly hired as contract interpreters (Becher & Wieling, 2015).

There are several reasons for maintaining a regular group of interpreters (Engstrom et al., 2010). First, given the relative absence of formal training in the area, it is likely that interpreters' knowledge and skills will improve over time as their experience with clinical mental health increases (Engstrom et al., 2010). Second, having the same interpreter is likely to be more comfortable and less disruptive for both the clinician and the client (Miller et al., 2005; Searight & Armock, 2013). Additionally, families find it easier to build trust when continuity and containment is provided through having the same interpreter for all of their appointments (Raval, 2005). The client-interpreter relationship is an important part of the triadic therapeutic alliance; thus, it is important to have the same interpreter for each session (Miller et al., 2005). Research support suggests that having substitutes can be deleterious to session-level, maybe even treatment-level, progress (Miller et al., 2005). Prioritizing working with the same interpreter also recognizes that interpreters are doing more than just translating language.

Several other forms of support that interpreters desired include shorter working hours, fair wages, increased compensation, observance of breaks, more interpreters on staff, and better coordination among various staff groups (Amouyal et al., 2020; Holmgren et al., 2003). Support groups were another recommendation to support

interpreters (Amouyal et al., 2020; Darroch & Dempsey, 2016; Mehus & Becher, 2015; Paone & Malott, 2011; Searight & Searight, 2009; Trevithick, 2005; Tribe, 1999). Standards or certification for mental health interpreters was also cited as an area of needed support (Amouyal et al., 2020; Gartley & Due, 2017). Another suggestion included developing appropriate referrals when interpreters presented with psychological distress (Mehus & Becher, 2015). Additionally, Gallagher (2015) discussed how interpreters needed to process the impact of being the first ones to understand emotional client information. Gallagher (2015) also pointed to the need for interpreters to process this privileged information in a meaningful way in order to interpret effectively. This sort of meaning-making brings a narrative approach to support for mental health interpreters.

Another area of need cited in the literature is interpreter training and education (Amouyal et al., 2020; Becher & Wieling, 2015; Darroch & Dempsey, 2016; Gartley & Due, 2017; Green et al., 2012; Holmgren et al., 2003; Miller et al., 2005; Myler, 2017; Raval, 2005; Searight & Armock, 2013). Topics for training and education include self-care or coping strategies (e.g., ways of recognizing and managing emotional reactions as they arise in session), mental health training (e.g. diagnoses and treatment, psychological trauma, the nature of common refugee mental health problems, theory and methods of psychotherapy, a model specific to interpreting in a psychotherapy setting), and triadic relationship issues (Amouyal et al., 2020; Gartley & Due, 2017; Green et al., 2012; Holmgren et al., 2003; Miller et al., 2005; Myler, 2017). Interpreters who have received specific training (e.g., stress management) by their institutions have appreciated the opportunity (Darroch & Dempsey, 2016).

The need for beneficial multilingual mental health services continues to grow, as does the need for interpreters to be seen by the larger mental healthcare system as essential team members (Becher & Wieling, 2015). Frustration at interpreters by other staff was related to their lack of training (Becher & Wieling, 2015). Thus, employers must invest in interpreters' training and education to help them gain greater authority and professional status, allowing for collaborative, culturally relevant approaches to treatment (Becher & Wieling, 2015).

The lack of training and education provided to interpreters is a means to disempower them. Institutional constraints further disempower interpreters through limiting training as well as limiting compensation and interpreter availability (Amouyal et al., 2020). Interpreters also highlighted the lack of mental health education as a hindering factor to their work (Amouyal et al., 2020). Shortages in money, time, or support from administration are often cited as barriers to efforts to provide comprehensive language services (Myler, 2017; Paone & Malott, 2008). Knowledge of these barriers can help us target and break them down.

Additionally, it is the clinician's prerogative to mandate and extend support for interpreters (Raval, 2005). Clinicians can support interpreters in processing emotional distress or vicarious trauma by building in shared reflective practice as a routine part of their work together (Raval, 2005). Factors such as power, knowledge, life experiences, dependency, emotional responses, and therapeutic process are important to consider when approaching work with both refugee mental health interpreters and their refugee clients (Raval, 2005).

Gaps in the Literature

Future research can explore the psychological impact of interpreting on interpreters (Mehus & Becher, 2015). For example, the interpreters' state of mind during therapy can impact the client and thus clinical outcomes (Mehus & Becher, 2015). If interpreters are experiencing psychological symptoms from their interpretation work, these should be addressed through greater institutional supports for interpreters, because interpreters are rarely included in institutional support systems such as training and supervision (Mehus & Becher, 2015). Also called for is an investigation of factors which may explain negative reactions to the work, such as stage of career, previous trauma, or stability of employment (Green et al., 2012).

Future research can also examine what information interpreters wish they knew before starting a session or treatment (Amouyal et al., 2020). It is also unknown to what extent interpreters are affected by vicarious trauma, as well as the roles that self-care, supervision, mental health training, and therapy play (Amouyal et al., 2020). Yakushko (2010) identified other themes to be explored, including the supervision process with interpreters, feeling valued as an interpreter, balancing expectations of therapists and clients, how interpreters are viewed by clients, and vicarious trauma.

Gartley and Due (2017) point to how there is a lack of research into how interpreters help develop the therapeutic relationship. Granhagen Jungner et al. (2019) assert an area for future study as interpreters' decision-making process to adapt communication. Future research can also explore what factors in cross-language and culturally competent therapy influence client outcomes, including the quality of the

triadic relationships among interpreter, clinician, and client (Becher & Wieling, 2015). Future research can examine whether the provision of supportive supervision to interpreters actually enhances the quality of their work or their perceived degree of job satisfaction (Miller et al., 2005). Additionally, there are no widely agreed upon standards for interpreter training in mental health, thus future research could help establish an interpreter training curriculum (Searight & Armock, 2013). The field of interpreting would also benefit from developing clearer and consistent codes of confidentiality to aid in supporting interpreters' well-being (Darroch & Dempsey, 2016).

It is also important to invite the perspectives of interpreters on multiple issues, including: The emotional impact of mental health interpretation work; specific guidance for their much needed and desired professional support; how to best facilitate treatment for refugee clients; how they perceive their interpreter role, as well as their attitudes towards that role; the complex emotional reactions (e.g. traumatic responses) they have during therapy and the ways they adapt and manage their reactions (Amouyal et al., 2020; Gartley & Due, 2017; Granhagen Jungner et al., 2019; Johnson et al., 2009; Mehus & Becher, 2015; Miller et al., 2005; Myler, 2017; Yakushko, 2010). The perspectives of interpreters in mental health contexts is sorely missing, particularly interpreters who work with refugee clients, let alone refugee interpreters from varying cultural backgrounds (Green et al., 2012; Miller et al., 2005). Further research is also clearly needed to establish theories of trauma and post-traumatic growth from non-Western perspectives (Johnson et al., 2009). Future research can also address compensation, regulation, and support for interpreters (Amouyal et al., 2020).

Chapter Three: Methodology

Qualitative Research

Qualitative research is defined as follows:

> "Qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns or themes. The final written report or presentation includes the voices of participants, the reflexivity of the researcher, a complex description and interpretation of the problem, and its contribution to the literature or a call for change (Creswell, 2013 in Creswell & Poth, 2018, p. 7)."

Qualitative methods take a critical stance towards knowledge by emphasizing the importance of history, culture, and context in understanding the phenomenon of interest (Davidsen, 2013; Heppner et al., 2015). Qualitative methods recognize how biased research is inevitable and how knowledge is constructed intersubjectively (Davidsen, 2013). A popular qualitative method is influenced by phenomenological philosophy (Davidsen, 2013). Phenomenological qualitative research is focused on the rich description of certain aspects of experience, described through language (Davidsen, 2013).

Phenomenology and Qualitative Research

Phenomenological research describes the common meaning for several individuals of their lived experiences of a concept or a phenomenon (Creswell & Poth,

2018). The focus of a phenomenological study is the commonality across participants' experiences (Creswell & Poth, 2018). The purpose of a phenomenological study is to create a culmination of the essence of an experience, derived from multiple individual experiences with the phenomenon of interest (Creswell & Poth, 2018). In this study, the phenomenon of interest is refugee mental health interpreters who work with refugee clients. This research aims to invite the perspectives of refugee mental health interpreters on several aspects of their experience, including the support they desire regarding their interpretation work, the meaning they ascribe to the traumatic experiences they and their clients have had, as well as their experience of vicarious trauma and retraumatization from their interpretation work and how they address these responses.

Theoretical Views on Refugee Trauma

Informing my perspective for this study is a consideration of the systematic factors which impact the experience of refugee mental health clients and interpreters. I also considered how their oppression is distantly yet inevitably implicated in my own political experience. Mass ethnic and political violence occurs globally and is a collective experience, with individuals targeted because of their identity as a member of a group or collectivity (Pells & Treisman, 2012). Genocide and ethnic violence, which often incite the mass displacement that refugees experience, are inherently political acts (Pells & Treisman, 2012). Engaging with questions of politics, justice, and agency are called for when working with refugees, necessitating that we move from a psychological perspective to a more political one (Pells & Treisman, 2012).

Researchers have found that refugees frame their problem as a collective, moral, and political issue rather than an individual issue (Pells & Treisman, 2012). Although psychological interventions can help refugees cope with traumatic experiences, they rarely address the root of injustice (Pells & Treisman, 2012). These interventions can become a way to avoid confronting the real causes of suffering, becoming a substitute for political action and adding to previous political injustices (Pells & Treisman, 2012). Additionally, we need to be reflexive of our own work in order not to sustain injustice and power inequalities when working with refugees in any capacity (Pells & Treisman, 2012).

I further considered how the experiences of individuals and communities can be taken and rewritten for purposes of psychological discourse (Pells & Treisman, 2012). Each person possesses their own voice and narrative, which can be used as a means to restore a sense of meaning to one's self and one's life (Pells & Treisman, 2012). To have this taken away through being rewritten and interpreted in an intellectual discourse further violates a person's rights and is fundamentally disempowering (Pells & Treisman, 2012). I want to avoid putting my participants in a position where they are subjected to the powerful influences of another (Pells & Treisman, 2012). As a psychological researcher, I tried to be careful to be reflexive in my work with refugee interpreters to avoid rewriting their narratives in a way that prefers my perspective over theirs. My goal is to present my analysis alongside their perspective in a way that gives credit to their voice.

Critical Narrative Analysis

The method of choice for this study is Critical Narrative Analysis (CNA). Several authors have written about the origins and tenets of CNA (Davidsen, 2013; Langdridge, 2007; Souto-Manning, 2014). Critical Narrative Analysis is a method of analysis that fits within the broader category of hermeneutic phenomenology and combines hermeneutic phenomenology with critical theory (Davidsen, 2013; Langdridge, 2007; Peter & Polgar, 2020). Hermeneutic phenomenology is focused on lived experiences and the interpretations of the researcher (Cresswell & Poth, 2018). Critical theory is a perspective from which one analyzes social action, politics, science, and other human endeavors (Budd, 2008). Research drawing from critical theory has critique as its focus, critique being defined as the assessment of the current state and the requirements to reach a desired state (Budd, 2008). This combination of hermeneutic phenomenology and critical theory into critical narrative analysis is an effort to expose hidden power imbalances and challenge the status quo (Langdridge, 2007).

CNA allows us to learn how people create their selves through social interactions on both personal and institutional levels, and how institutional discourses and personal narratives interact (Souto-Manning, 2014). Personal narratives are constructed and situated in social and institutional contexts, yet they are usually analyzed apart from issues of power (Souto-Manning, 2014). CNA proposes that when individuals make sense of their experiences through narratives, they bring together micro (personal) and macro (social or institutional) considerations, thus filling a gap in analysis that has largely ignored contextual factors (Davidsen, 2013; Langdridge, 2007; Souto-Manning, 2014).

CNA allows for the critical analysis of narratives by deconstructing social reality and challenging social norms to be changed (Souto-Manning, 2014). Souto-Manning (2014) proposed that if we are to engage in positive social change, we must start by listening to and analyzing the everyday stories people tell. Critical narrative analysis introduces an element of critique by using social theories and hermeneutics of suspicion to open up new possibilities (Davidsen, 2013).

Suitability of Critical Narrative Analysis

The selection of qualitative research as the method for this study is based on several considerations. The research literature regarding the topic of refugee mental health interpreters is in its early stages. Qualitative studies are often necessary in a new field of study to determine the relevant variables or dimensions of study (Searight & Armock, 2013). Qualitative research on topics that are scarce in literature can be used to help explain phenomena when theories are nonexistent and contribute to theory building and extension (Heppner et al., 2016).

Additional strengths of qualitative research with marginalized populations in particular include the opportunity for researchers to develop close connections to their own and participants' emotional reactions (Heppner et al., 2016). It is important to note historical distrust of research by marginalized groups (Heppner et al., 2016). Accordingly, power differentials may diminish from the combination of close connections along with fostering empathy with participants (Heppner et al., 2016). Additionally, qualitative methods may be more comfortable for participants who might

otherwise be dissuaded by surveys and other aspects of experimental research (Heppner et al., 2016).

This study is employing Critical Narrative Analysis in particular because of its suitability for topics that are directly influenced by issues of power and politics (Peter & Polgar, 2020). CNA will help check if the power structures within hiring agencies are exerting themselves on refugee interpreters who have already experienced oppressive structures (Langdridge, 2007). Langdridge, who developed a model for CNA, believes that the narratives we have access to are limited by the world we inhabit (Langdridge, 2007). This makes sense in the context of systemic oppression, where access to resources is unequal and dependent on one's social location. I am working from a perspective that acknowledges how a person's worldview is limited by the access we have in life—for example, what we are told, what we are allowed to do, to whom or what resources we have access. Our lives are dictated by systemic factors outside of our control, and these limitations are connected with systemic oppression. Thus, critical narrative analysis is a suitable method for this study due to its consideration of political issues which are relevant to the experiences of refugee mental health interpreters.

Author's Bias and Role

The question that directs this reflection is, "What drew me to this research?" In summary, I identify as a second-generation Korean American immigrant. Developing in this social, political, and cultural context in the United States has increased my awareness around forms of oppression that are relevant to this study, including race, citizenship status, nationality, acculturation, and more. Being a visibly Korean-American person

raised in mid-Michigan, I experienced being "othered" for being racially and culturally different from the majority of my peers. My response to this personal experience of discrimination has been to open myself to those whose experiences are different and also marginalized. I also recognize that I hold a position of relative privilege. Thus, I am afraid of unintentionally pitying my participants and thus enacting the same oppressive violence by adopting a stance of superiority. Despite the enormous distress they have experienced, the majority of refugees will recover from their traumatic experiences without needing intervention (Pells & Treisman, 2012); thus, I want to be open to the various possibilities of participants' responses to traumatic experiences. To create an unnecessary dichotomy of well versus unwell, where I am positioned as the one who is "well" and has not experienced trauma related to being a refugee, can recreate a power differential to which participants have already been subjected. As Pells and Treisman (2012, p. 396) warned, "Outsiders who intervene in the aftermath of genocide or political violence need to take care not to exacerbate existing inequalities."

It is important to not only address issues of power and inequality in my own work, yet also to address the political structures, processes, and conditions which enable social injustices to continue (Pells & Treisman, 2012). I hope to have the opportunity to address these political conditions in this study. In short, I have suffered from political violence, and I am determined to use my position to help refugee interpreters access resources and visibility.

Participants

Criterion-Based Sampling

A phenomenological study involves sampling participants who have experienced the phenomenon of interest (Cresswell & Poth, 2018). This study used criterion-based sampling to seek participants who met inclusion criteria of a) interpreting for mental or behavioral health services, b) working or having worked at least half-time as interpreters, c) working with refugee clients with Limited English Proficiency (LEP), d) having worked professionally for at least one year in the role of mental health interpreter, and e) have held refugee status previously.

Sample Size

Cresswell and Poth (2018) recommend that five to 25 participants be recruited for a phenomenological study. Langdridge (2007) does not recommend a specific number of participants for a CNA study, yet states that case studies as well as multiple participants can be suitable for this method. Langdridge (2007) emphasizes that CNA is "very labor-intensive" and to keep this in mind with even a "very small number" of participants. I also considered the accessibility and prominence of potential participants, as mental health interpretation for refugees is not a bountiful field of employment. Thus, with these considerations in mind, I proposed three to eight participants in total and ultimately recruited four participants.

Participant Recruitment

Participants were recruited by communicating via email with mental and behavioral health agencies that employ interpreter staff. First, I communicated with and

received permission from agency leaders and interpreters' supervisors to reach out to prospective participants (see Appendix A). Recruitment communication was primarily done over email. The initial email to recruit participants included a description of the study and contact information to reach out directly if they are interested in participating (see Appendix A). Departmental funding was granted for this study, and participants were compensated with a $20 Visa gift card for participating in the study.

Participant Characteristics

The participants are a group of four adults who are 24 years of age and older who have previously held refugee status and have worked professionally as mental health interpreters at least half-time for at least one year. Demographic characteristics were gathered from participants through a demographic questionnaire (see Appendix B), which include: Age, ethnicity/culture of origin, gender, educational status, marital/relationship status, languages spoken, job title, name of current employer, number of years/months interpreting, level of interpretation training received, and settings in which they have worked.

Data Collection

In this study, the phenomenon of interest is the experience of refugee mental health interpreters who interpret for refugee clients. This study used in-depth, semi-structured interviews, which have been described as the most appropriate form of data collection for a phenomenological, psychologically-oriented critical narrative analysis (Cresswell & Poth, 2018; Langdridge, 2007; Peter & Polgar, 2020). Interviews were typically 60 minutes long (Souto-Manning, 2014) and were conducted via phone or video

teleconferencing application (Zoom) and accordingly audio- or video-recorded. Prior to the interview, participants completed a demographic questionnaire (see Appendix B). An application to the Institutional Review Board (IRB) at University of Denver was approved after a successful dissertation proposal in September 2020 and data collection began in spring 2021 due to barriers to recruitment on the agency level.

Interview Procedures

Once a participant connected with the researcher to take part in the study, they scheduled a mutually convenient time to complete the interview protocol by phone or Zoom. Upon initiating the phone or video call, the researcher began following the interview protocol in the following steps: Introduction of the researcher and the study, informed consent, demographic questions, interview, and debrief. After giving a brief introduction of themself, the researcher began the informed consent process (see Appendix C). The informed consent form was emailed to participants with their consent prior to their interview appointment. To begin the informed consent process, the researcher provided details of the study's purpose, procedures, risks, benefits, and incentives of taking part in the study. The researcher emphasized the participant's voluntary participation in the study and how the participant could choose to discontinue their participation at any point. The researcher created space at the end of the informed consent process and invited the participant's questions or concerns before proceeding. After the participant consented to participate in the study, the researcher proceeded with the demographic questionnaire. The demographic questionnaire consisted of questions to help orient the participant to the study and to elicit information such as the participant's

amount of experience with interpreting, as well as their specific cultural position (e.g. country of origin, ethnic identity, etc.). The participant's responses were recorded by the researcher in an electronic Word document which was password-protected, saved and uploaded to an encrypted, HIPAA-compliant cloud storage space, Box. The interview audio files were also be uploaded to the same Box account to which only the researcher will have access.

Each appointment was scheduled for one-and-a-half hours with the intent of interviewing for approximately 60 minutes and with the flexibility to go over or under time, depending on the needs and response style of the interviewee. Interviews were semi-structured and followed the interview protocol (see Appendix D). The interview protocol included 14 primary interview questions with scripted follow-up prompts for several questions.

After the interview, the researcher debriefed with the participant about their response to the interview (Johnson et al., 2009). The researcher inquired into any negative feelings that the participant felt as a result of the interview. The researcher provided the participant with mental health resources for additional support, regardless of the content of the participant's disclosure, to ensure that they have access to support if they later needed it or if they felt uncomfortable sharing their response with the researcher. Participants were also asked for their email address in order to send their gift card as compensation for their participation. Prior to closing the call, participants were asked if they were interested in having the initial analysis shared with them to incorporate their input, with mixed responses from participants.

Data Analysis

I employed the six stages of CNA, as developed by Langdridge (2007). They are detailed in the following sections.

Stage 1: A critique of the illusions of the subject

During the first stage of CNA, I reflected on my background and experience and the impact that these had on the questions being asked and the data produced (Langdridge, 2007). I read through the transcripts once without making notes, as is recommended by Langdridge (2007). After gathering a sense of the meaning from the transcripts, I thought through what this topic meant to me more personally. I then wrote a short paragraph on my beliefs about the topic and the influence these might have on my understanding of the material.

I employed the imaginative hermeneutics of suspicion to gain an alternative way of viewing the data (Langdridge, 2007). This alternative view aims to recognize my personal ideology and to enable a critical move beyond the apparent (Langdridge, 2007). I aim not to create a superior interpretation of the meaning of the data, yet instead to create a *perspectival shift* in understanding the material through a critical interrogation of the social imaginary of narratives that the participants inhabit (Langdridge, 2007). I do not aim to reveal a hidden truth about the participant, but rather to offer an alternative perspective on the phenomenon grounded in broader sociocultural discourse (Langdridge, 2007).

Stage 2: Identifying narratives, narrative tone and rhetorical function

The purpose of the second stage is to identify the distinct narratives in the text, where there may be one or several narratives within one interview (Langdridge, 2007). I read through the interview transcript and delineated the narratives, searching for distinct stories (Langdridge, 2007). I also paid attention to the tone of a narrative, which provides insights into the meanings being expressed (Langdridge, 2007). The tone reveals information about the stories being told that are not apparent in the content of the text (Langdridge, 2007). I also noted changes in the narrative tone (Langdridge, 2007).

Identifying the function of a narrative was the next stage in the analysis of the text (Langdridge, 2007). This was derived by asking, "What does this particular story seem to be doing? What kind of story is being told (Langdridge, 2007)?" I also wanted to pay attention to opinions, even brief statements, understanding these as a response to some other opinion in a wider context of discourse (Langdridge, 2007). This positioning of the speaker aimed to understand them in relation to the wider world of stories that they inhabit (Langdridge, 2007).

Stage 3: Identities and identity work

The third stage of analysis looked at the particular self being brought into a narrative, recognizing that our identities are constructed narratively through the stories we tell (Langdridge, 2007). I worked through the transcript again, this time to identify the person being brought into being by the narratives (Langdridge, 2007). What kind of person did this particular narrative construct, and how does this relate to what we know of the person and the topic being discussed (Langdridge, 2007)?

Stage 4: Thematic priorities and relationships

The purpose of the fourth stage of CNA is to identify the themes and relationships between themes in the text (Langdridge, 2007). Unlike a more traditional thematic analysis, it was important not to break down the text too much in the process, and so systematic coding (first order, second order or descriptive to pattern, etc.) was not employed (Langdridge, 2007). Instead, I identified the major themes in the text without losing a sense of the narrative being presented (Langdridge, 2007). This required working through the text systematically, similar to in a hermeneutic phenomenological analysis by looking for themes through selective reading (Langdridge, 2007). The aim is to identify the key themes within the narratives directly, rather than first breaking apart the text and coding every unit of meaning (Langdridge, 2007).

During this stage, I kept in mind my own views about the topic (Langdridge, 2007). Once I worked through the text for the first time, I listed my ideas on a separate sheet of paper and tried to organize them into clusters of meaning (Langdridge, 2007). Once I had my clusters, I tried to work through the themes, deciding whether they were distinct or whether they could be collapsed into one category. I also considered whether themes should instead be categorized as subthemes (Langdridge, 2007). I returned to the transcripts multiple times in a cyclical process, refining my categories and examining the relationships between them (Langdridge, 2007).

Stage 5: Destabilizing the narrative

During the fifth stage of analysis, I directly engaged in a political critique of the text by using the imaginative hermeneutic of suspicion, interrogating the text and

incorporating sociopolitical factors into my understanding of the phenomenon (Langdridge, 2007). This stage is explicitly political and required me to engage with critical social theories (Langdridge, 2007).

Stage 6: A critical synthesis

During the sixth stage of analysis, I present the key narratives and themes contained within the text (Langdridge, 2007). Within the description of the narratives and themes, I also discuss the narrative tone, rhetorical function, and identity work (Langdridge, 2007). Lastly, I present my alternative view using the imaginative hermeneutic of suspicion (Langdridge, 2007). This is purposefully placed last to avoid overpowering the participant's perspective with my own analysis (Langdridge, 2007).

Expected Results

With phenomenologically informed narrative analyses, it is most important to let the subject speak by focusing on the structure and form of the story as it appears in the text rather than to impose any predetermined framework of meaning (Langdridge, 2007). Thus, I did not assert a formal hypothesis on the results.

Ethical Considerations

Ethical considerations for this study start in the beginning phase by considering the social dynamics between the researcher and participants. I must identify and utilize my social location throughout the research process, reflect on how my identity interacts with participants' identities to shape the study, and acknowledge how my worldview influences the research (Heppner et al., 2016). The dynamics between me and participants are influenced by my context and identities interacting with the context and

identities of participants interacting with the setting (Heppner et al., 2016). This ethical concern confronts the inevitability of bias in research, and it is addressed through my reflection and open acknowledgement of my position (Heppner et al., 2016). It is also considered ethically important for researchers to build relationships with community members who are part of the target population (Heppner et al., 2016). Otherwise, the lack of close connections could allow for a historical repetition of mistrust of researchers by participants who identify with marginalized groups (Heppner et al., 2016).

Additionally, the American Psychological Association (APA) has published the Ethical Principles of Psychologists and Code of Conduct, which provides ethical standards for psychologists within each realm of the profession (APA, 2016). This Ethics Code highlights the need for psychologists who carry out research to avoid or minimize harm to all participants involved in psychological studies (APA, 2016). Relevant ethical considerations to this study are detailed below:

4.01 Maintaining Confidentiality.

This study ensures that all research materials, such as demographic questionnaires, audio recordings, video recordings, transcriptions, and other related files will be saved as encrypted files and stored securely in a HIPAA-compliant cloud storage space (Box). I did not collect participants' names or birthdates and participants' data was de-identified in an effort to maintain participants' confidentiality.

8.02 Informed Consent to Research and 8.03 Informed Consent for Recording Voices and Images in Research.

Interviews for the study took place by phone or secure videoconferencing call. The researcher engaged in a thorough informed consent process with each participant, reading through each part of the consent form. The researcher informed the participant that they would be audio- or video-recorded for later transcription and analysis. Participants provided clear verbal consent to participate in the study before the researcher proceeded with the interview. A copy of the informed consent form was emailed to the participant prior to their interview appointment.

8.08 Debriefing.

The current study was anticipated to have minimal risks for participants. However, participants were asked to provide their experiences as mental health interpreters for refugee clients, which may have included reviewing traumatic responses to their work. Since participants were asked to explore potentially difficult memories, they may have experienced emotional stress or discomfort. In addition to informing participants that they could discontinue the interview at any time, the researcher debriefed with the participant following the interview by asking how they felt about the questions and whether any part of the interview had made them upset (Johnson et al., 2009). The researcher also provided mental health referrals for additional support.

Chapter Four: Findings

Research Question 1: How do refugee mental health interpreters define their own experiences of trauma? How do they understand their clients' experiences of trauma?

Overview of Responses

Every participant referenced living in refugee camps when describing their personal traumatic experiences, and I was surprised by how predominant this was in their trauma narratives. Other themes from individual narratives included acceptance, generational trauma, and the difficulty of identifying trauma across different cultures. An interesting idea that came up from some interviews was the idea of how age interacted with the experience of being a refugee. For example, most of the participants referenced how young they were when they lived in refugee camps, and they were even dismissive of their traumatic experience because they had been young refugees.

Narrative 1

The first participant defined "trauma" in a manner that allowed for posttraumatic growth by stating, "I think trauma is anything that affects you or changes you in either negative or positive ways." They elaborated by saying it depended on perspective. For example, "If I view trauma as something that keeps me from doing something, then it does. But part of my trauma is that it helps me be better or understand people better, see other people's view and put myself in their shoes better. It's not like positive, I would

say, but rather helpful because I went through it." Their view of their posttraumatic growth fits into Calhoun and Tedeschi's (1999) domain of *change in relationships with others,* because it helped them understand others better as well as see others' points of view.

The first participant shared the impact of living in a refugee camp, and how they had not understood how it had affected them at the time. They described how living in a refugee camp changed the way they think, interact with people, and feel. "Being in that isolated place affected me mentally." Their response emphasized how a central part of their experience of trauma was living in the refugee camps.

The first participant also described experiencing gratitude for the perspective they gained from their experience. "I grew up in a refugee camp with nothing and I think, you know, I personally feel very fortunate that I grew up that way, because if I hadn't grew up that way, then maybe I would see things differently and maybe not in so positive ways."

Narrative 2

The second participant emphasized how the limits of living in a refugee camp was part of their traumatic experience. "Living your life in a refugee camp with like limited supplies, not being able to do or eat whatever you want at the time. As a kid, I was a kid like, teenager, that's the age where everyone would like to eat different things, do different things, but we didn't have that freedom. And that was frustrating." Their story seems to speak to a loss of innocence; not only did they not have the freedom to try new experiences, yet they also did not have the freedom from worries about how to survive.

Narrative 3

When asked how they defined trauma, the third participant responded, “I think trauma, like anything like any disturbing event that happened in personal life, that would result in like hopelessness and decrease this like sense of their own self, which also includes their ability to feel a whole range of like experiences.” Therefore, this participant emphasized the depressive aspects of traumatic responses, including difficulty experiencing positive emotions.

When asked to share about their own experience with trauma, they responded that the loss of opportunity, lack of access to resources, and standard of living were all part of their traumatic experience.

> “Oh, I don't know if I should call that a traumatic experiences, but that's what I think, which I'm gonna share with you. So when I look back, I [inaudible] being a refugee was a traumatic situation for me. Although I was like little too young to fully understand the situation at that time. As I grew up in a refugee camp and started to leave a, I want to say a terrible life, it started to make more sense to me. For example like lack of infrastructure, not having enough access to health services outside of refugee camp. Also like not having a quality education, like any other normal child. Yeah, like, who are getting, like, better education like outside of camp. Having to leave it in an unhygienic atmosphere, which would lead to high like you know incidents of infectious diseases and epidemics, I would say were some of the bitter realities that would explain [inaudible] traumatic situation or what it would be like to be a refugee you know.”

These “peripheral” traumatic experiences of being a refugee create long-term consequences which seemed to create a sense of loss for the participant. Many times, people define trauma as something very violent, almost like blood or battle or death; yet, I heard them describing trauma as the deprivation of necessary circumstances such as health, education, infrastructure and opportunities. Interestingly, their original definition of trauma differed from their personal traumatic experience.

In our discussion, we delved deeper into how their personal responses to traumatic experiences differed from their clients’. They recognized that some clients had gone through different traumatic experiences from theirs, such as being separated from family members. I asked them to consider why their response to their traumatic experiences differed from those in their community who had gone through similar experiences. The participant had a perspective that they needed to move forward to overcome their traumatic past. They made a distinction of how education helped them move forward. On the other hand, they noted how some clients responded differently and wanted to go back to how things were. This calls into question how acceptance may be a factor in the ability to move forward from traumatic experiences after resettling; perhaps it even predicts one’s ability to move forward. It appears that this participant’s acceptance of their traumatic history helped them work through their difficulties and move forward to greater life satisfaction. I have included excerpts from the interview for insight:

> Interviewer: “So you say that a lot of the clients you met went through some of the same experiences you did and then some of them went through different experiences. [Mhm.] For the ones who went through more similar experiences to

you, how do you think they responded differently from you? What did you see that stood out as different?"

Participant: "I started accepting more like, you know, I went to school and I kind of learned, you know, and then I was like, in a position where I was like, Okay, if I like I was prepared like before even before moving to United States, like, I want to do something better and overcome this situation, you know, and have my own own like identity. I was able to, like, accept the reality. And I was always like looking forward to do better in my life. But, like most of the clients that have never been to school, they never had this opportunity. They had all these like language problems like culture, like barriers, so many barriers, and they were not able to accept the reality. They kind of feel like worse moving to this country. They would rather, some of them would rather prefer to go back to the refugee camps and live that life. They could at least understand the language. So I think that's the difference, like and some of them are like for me I was able to pass this citizenship, like exams and then get my own like, be a citizen of this country, but most of them, they were not able to do that. Still like they're struggling. So, this will explain, you know, some of the differences, I think."

Narrative 4

The fourth participant downplayed the trauma they experienced, saying they had not experienced trauma yet followed up with details of personal experiences that would be viewed traumatic. They also used their young age as a reason to minimize their trauma. They detailed how much of the trauma they experienced occurred in the refugee

camps, such as dealing with abusive, corrupt, and violent authority figures. Authority figures in the refugee camps inspired feelings in them of fear and persecution. When comparing their experience in refugee camps to their experience after resettling in the U.S., they seemed to observe experiencing less abuse from authority figures. Not only that, they also felt that they had more rights in the U.S. This participant also spoke from a perspective that seemed to aware that they had not experienced everything every refugee has experienced.

When describing their clients' experiences of trauma, they initially used a Western definition of trauma, deferring to the "expert" model: "When something happens, back in the day, and then they got traumatized right and then right now, they will hear the same stuff and then they will get scared." Then, they described how trauma is identified differently across cultures while continuing to use a deferent tone. They described how it is difficult to not only interpret language, yet also cultural norms and mental health diagnoses, practices, and symptoms from their culture of origin to American culture. They contemplated how to determine when someone is traumatized in one culture when the signs are different in another culture:

> "So like sometime I do not understand if they got traumatized or not because I'm not clinician too, I'm just like an interpreter, but like, for our people like our xxx people, there's like this traditional things that you do when you have like a traumatized. Like, we we will say, you know, like for example: Me, somebody really scare me a lot right like for example somebody robbed me and then I got very very scared and then I will get sick, I would get like a fever and stuff like

that and then they consider it traumatized so like they will do something in a traditional way like bring back my soul, you know, something like that, like, like they believe like my soul stay in the spot that somebody robbed me so my soul and my body is separate. So, you know, like that's when I got sick. So they would do like a, perform like a traditional things, something like that and then, like, like when you get better then that's when they feel like your trauma is gone. [Mhm.] So for me, I don't really know, like with the, like, because I'm not also--I'm also xxx but like a mixed xxx and also we don't do like a xxx traditional stuff too. So, I do not know, like, I know more obvious with the American culture, with the traumatize. So, I don't know how to answer you with this one."

Research Question 2: What are the benefits and harms of hiring those who have also been refugees as mental health interpreters for refugee clients? How does having similar past experiences help their work experience? How does having similar past experiences hinder their work experience?

Overview of Responses

The root of this research question is whether the participants thought it was more harmful for them to also have refugee backgrounds and come from the same community as their clients. Across the board, none of the participants seemed to say that it was more harmful for them to do this work. However, the participants did recognize hardships of being from the same community as their clients. Common across participants was how they spoke of the necessity of being from the same community because of the unspoken understanding that enabled them to perform their job more effectively.

Narrative 1

The first participant stated beautifully, “If we know that somebody else is suffering the way you have suffered or like something that you have seen, I think it changes your perspective in life.” In response to the benefits and drawbacks of being from the same community as clients, they said, “I'm sure it's both. I think there's a lot of harm. But there is also a lot of empathy.” For example, they noticed their family and community members express empathy towards homeless people because they had previously experienced a similar lack of food and other resources: “When they see homeless people they want to give them food or give them money and those kinds of things that are like some positives to that.” They named additional benefits of being from the same community, including increased understanding, connectedness, learning, and addressing generational trauma. They named disadvantages of being from the same community, including repeated trauma and work-life boundaries. As far as responding to the question of being from the same community, the interpreter explicitly stated, “...it’s important for me to be from the same community.”

The participant described how, because they were from the same community, they understood clients’ experience intrinsically, or with little explanation, which seemed meaningful to both the participant and clients. Another benefit of their work was an increased understanding of their parents. Interpreting helped them view their parents as more “human” instead of only as a “parental entity.” They also cited how communication with their own family had improved as a result of their interpreting experience: “They also have the same kind of feelings, they might have also suffered through things that

they don't feel comfortable talking about. … It helped me be a better [child]." This suggests the significance of age or life stage and how one's age is a factor in one's experience as a refugee. For this participant, the age at which they experienced displacement and living in a refugee camp was a significant factor in their experience. The participant also hypothesized that their young age helped bridge the gap between their clients and clients' children to foster communication among all parties.

They cited a reward of their interpretation work was fostering familiarity with clients who had similar experiences and combating isolation. They also cited how they experienced being an interpreter as a learning experience:

> "There's also the aspect of working with some great people that have so much experience in therapy and talking to them and then listening to them helps me process some of the things that I have not think of it that way before, even though I'm just interpreting. When anyone say something, I hear that and then I, I feel that and then when I see the therapist working through problems and problem-solving different ways, then I want to put that in my own life and then problem solve that way so the word uses on how they phrase things, how they view different experience or very different scenarios, really helps me see it in my own life and better myself."

They explicitly named *generational trauma* and how their work was very important in order to address and heal generational trauma.

> "I think it's very important because, so there's a lot of like generational trauma that I see in our clients, and in my family members and other people that doesn't

> ever get processed, so that trauma keeps getting pushed on and then keep going to the next and next and next generation and I think the job that I do as a[n interpreter] helps them to process their trauma from someone that who understands that. And them going through therapy helps them stop that generational trauma there, so that their younger kids or the generation after that don't have to suffer through the same kind of trauma that they have suffered through."

They shared that a disadvantage of their work was repeated trauma—having gone through their own trauma and then having to re-experience their clients' traumas while interpreting for them in session. Another difficulty they named was separating work and personal life. When they saw clients out and about at the grocery store or walking around the neighborhood, clients would ask the participant questions that were related to their work role. Therefore, work did not end with work hours, and separating work and personal life was difficult. They stated, "I don't want to mix those two together."

Particularly with the specific cultural norms shared by their community, keeping work and personal life apart was increasingly difficult. "Sometimes it becomes a little difficult to set those boundaries, especially with my culture. We are a very close, close culture where we need to help everyone and I want to help them but I also want to make sure that I didn't have two relationships with them."

Narrative 2

The second participant responded that it was beneficial for both them and their clients to be from the same community.

> "We relate to them and we know exactly what they're talking about, in comparison to working with client from a different community. For example, sometimes we have to work with clients like from [country] when [name redacted] was not there. But then I would feel that I was not able to help them as much as the other [interpreter] was able to help them."

Having similar past experiences helped the participant empathize with clients better. They said, "It's a different feeling when you actually feel it and when you empathize. ... getting to know the exact same experience makes a lot different, and you're able to understand their problems more closely and you're able to relate to them more closely."

Knowing that they were helping a population in need seemed to protect this participant to view the role positively. They mentioned multiple times throughout the interview that they were happy to help their community, and that they were in the perfect position to be helpful in the situation. They had the desire to help and experienced satisfaction from the meaning they took from the role.

Narrative 3

This participant noted more difficulties than benefits of being from the same community as clients. They noted that it took "a while" to understand the clients and the work setting due to the special demands of their role. For example, setting boundaries was difficult because of clients' expectations. Sometimes clients would feel upset that the participant was unavailable outside of work. Work could be virtually nonstop if the participant did not set boundaries with clients. The participant experienced some

retaliation when limiting their availability outside of work, receiving comments about how previous interpreters had shared their personal phone numbers with clients, saying of the participant, “How could they?” with the undertone of how dare they not be available whenever clients needed them. They also noted that learning to set boundaries with work was enjoyable, as it increased their well-being.

> “I would say working with the population from the same community and also speaking the same language as clients or, like, it is a challenge. Because I have had that same experiences as a refugee as these clients had and it was easy for me to understand the barriers that they were facing at a new place. Challenging, because sometimes clients would try to take advantage of having a[n interpreter] who would speak the same language, and would have always like high expectations.”

This participant noted that connecting with their community of origin was the most rewarding aspect of their role. “My work felt meaningful and productive. So even being in a different country, I'm still able to work with my with the people from the same community, I think that was like the most rewarding.” They shared that they experienced happiness at seeing clients outside of work.

The participant believed they were able to perform their job better by being from the same community. For example, it was easier for them to interpret clients’ experiences even if they provided minimal information. The participant attributed this ease to sharing the same experiences as clients.

Narrative 4

This participant admitted to the challenges of being from the same community as clients and their desire to be understood by their community members.

> "So like before, before I didn't have any experience, or training I, you know, whatever the reason I just help them and then I will get burn out in the end too like, with the job that I have, with the family and then with the community member, it was like a lot for me to deal with. So, and also when you don't know how to say no, it's harder, and it get a lot easier for me after I got the training, and also learn how to say no, it's okay to say no, you know, or it's okay like, 'I cannot help you with that.' And, yeah, whatever the reason. Yeah, it's easier after I learned that."

Thus, training was essential to improving their experience of being from the same community as clients. From the literature, interpreters have reported having not been prepared for the impact of the work by their agencies (Green et al., 2012). Thus, interpreters not being informed of emotionally difficult content can inhibit their effectiveness. For their own as well as clients' well-being, interpreters need to be better prepared for the difficulties of mental health interpretation. In this participant's case, they could have used more training early on about preventing burnout, learning how to establish boundaries, and saying no to client demands outside of work.

A benefit of being from the same community was unspoken understanding. Their response emphasizes the importance of context and knowing the community's history. There is definitely a quality to their experience where they and their clients are in an

unfamiliar country, and their response to seeing familiar people speaking a familiar language. The affinity is strong, and the kinship makes the participant and their community members feel more comfortable—allowing them to lean on others, because they have no other choice but codependence in that situation. This speaks to the uniqueness of the refugee experience. It was not a voluntary immigration, thus finding community members in an unfamiliar country is like finding a home away from home. This participant said that they experienced a "big happiness" when they encountered someone from the same community once they resettled in the United States.

As for the difficulties they experienced, they admitted that it felt like a burden sometimes to have community members depend on them, wishing community members understood them better, that they did not have unlimited capacity, had their own family and many other community members depending on them. They were torn because they also recognized that it was hard for community members to ask for help, and that the community members felt like they had no choice but to ask.

> "So, I feel like sometimes I like living in the same community. It's very helpful like you You want to be able to help your community member, but then the other time it's just hard like like you also wish that you kind of like wish that they understand you a bit better, you know."

This participant seems to be stating that there were simultaneously positive and negative aspects of being from the same community as clients, yet their experience improved after receiving training on boundaries and self-care. Perhaps some of their initial difficulties could have been mitigated with earlier intervention through training. In

summary, being from the same community was simultaneously positive yet difficult, and it is possible to mitigate burnout effects with early intervention via training on boundaries and self-care.

Research Question 3: What power dynamics occur amongst clinicians, agencies, and refugee mental health interpreters? How do interpreters' experiences of coworkers' attitudes influence their desire to seek treatment for their work-related trauma?

Overview of Responses

When addressing workplace inequities, participants referenced not only individual-level interactions with clinicians, yet also systemic-level barriers which hindered them. Participants' responses regarding their sense of power ranged from endorsing feeling powerless to completely denying so. Communication and personality style may be factors in participants' experience of powerlessness, because some participants described asserting their needs and communicating with coworkers when they encountered problems, while others described withdrawing and experiencing dissatisfaction at work. Notably, every participant endorsed the value of the work they did, which was a promising result.

Narrative 1

This participant had a rich response about what workplace barriers made their work more difficult. They largely cited bureaucratic barriers, such as billing to meet productivity goals and how some of the work they did was not included in their productivity goals. "Meeting the numbers, making enough money, bringing in enough like people reaching out enough people, I think that really comes in the way of trying to

help.” Additionally, “If you look at my schedule I’m busy every single hour.” Thus, “...it makes it really difficult for me to do my job.” Further:

> “Insurance is the worst honestly, because there's a--when I do my notes I have to be creative enough so that we get refunded otherwise we don't get those money reimbursed to us and, and, you know like, the policies within the state and then the government and within the institution, they all vary and it changes so much so often so it always comes in the way.”

This participant expressed often feeling powerless. “I think like the higher management or other people don’t see the value of [interpreter], and I think that makes me feel powerless at my job.” This statement seems connected to how their work is not materially valued in terms of billable hours, which echoes how interpreters are devalued by the low rate of insurance reimbursement of interpreter services (Becher & Wieling, 2015).

The participant felt powerless partly because clinicians seemed to dismiss their opinion. They remarked that some clinicians would ask them after sessions for their opinions, yet others would not. They wished that clinicians would ask for their input about client cases because they had observations that were clinically and culturally relevant. “I wish like people saw me as more than just, just [an interpreter] sometimes.” Further, “I wish this person would see the cultural norms or like cultural body language as well and not rush. … I wish my opinion mattered more.” This dynamic of dismissing the participant’s clinical and cultural observations echoes how greater authority is given to clinicians’ social constructions of mental health (Becher & Wieling, 2015).

This participant's experiences echo what has been observed in the literature. Interpreters have previously shared a sense of being undervalued and disrespected as professionals (Choo, 2014; Green et al., 2012). They have also previously identified a lack of recognition from clinicians to be a significant source of stress and impediment to a successful interpretation process (Choo, 2014; Darroch & Dempsey, 2016). The participant also echoed what is revealed in the literature in terms of clinicians having more power (Becher & Wieling, 2015): "Oh, I am the clinician, I have the experience. I know better, kind of idea and I just let it be..."

The participant stressed that education was not enough to be a good clinician—what was more important was being open to learning and receiving feedback instead of using one's educational status as an excuse to be defensive.

> "I don't think education really prepares you for all the, all the cultural nuances of other people's emotion, you know like I don't think textbook really teaches you how to be empathetic or teaches you how to see other people's emotion as much as people would like to think." ... 'I'm earning a PhD, so I don't need to listen to your feedback because you are not the same status as me.'"

As stated previously, clinicians are attributed greater authority by a culture that values formal education (Becher & Wieling, 2015). The participant felt helpless, powerless, and apathetic at work and thus less likely to speak up if she noticed something wrong. "I'm sure someone else also saw it and just let it be."

When asked about their relationship with clinicians, the participant remarked that they got along with their coworkers because they shared a common goal of helping

people. In response to the question of going to a clinician for therapy themselves, they said, “[T]here are some really good therapists at [clinic] that if I didn’t know them by working at [clinic], I would love to go see them as my own therapist.”

They also brought up the topic of upward mobility, and how this was a barrier to retaining interpreters:

> “There's not enough like resources for them to develop themselves ... there's no opportunity to move further. I think you start as [an interpreter] and you stay as [an interpreter] forever. ... You know, there isn't a lot of like opportunities for promotions, not just like monetary compensation but also the job, you know. ... I know too much about my job that it's not challenging anymore and I want to do something...so that it gives me an opportunity to learn and grow. … That's one of the reason why a lot of [interpreters] stop working at [clinic] after a while because they can't move ahead in their job and they are not challenged enough...”

From this narrative, I learned that I overlooked the wider social and political system, while focusing on individual interactions between interpreters and clinicians for repetitions of oppressive power dynamics. Thus, I overlooked the impact of a general lack of resources for their community, or the burdens of managed care in providing mental health services for refugees (e.g. low reimbursement rates for interpreter services).

Narrative 2

This interpreter had the additional perspective of working in a primary care setting in addition to mental health. They described how they were able to meet an urgent need in their community for medical education:

> "It is very important, because the population, our population are very illiterate. They don't know anything about their health conditions and how to seek help when they need it. So as a[n interpreter] we were able to at least educate them on some of the aspects, such as like taking ibuprofen when you have pain, or like Tylenol, like basic education that normal American people would know. They still don't know. And also finding healthcare options for them like healthcare access, they--due to the language barrier they struggle to go to the places and seek help when they need it. A lot of the time they would end up in the emergency department even when they have a fever. So giving basic education and helping them find places is very important for this community."

This participant was emphatically positive about their experience with clinicians, citing how they had good relationships with clinicians. They felt valued and appreciated by their coworkers and clinicians. They stated that they would "definitely" go to a clinician at the same clinic for therapy themself if given the choice, because of "the way they handle our clients. The way they make me feel...and being flexible with everything." They mentioned throughout the interview the positive impact of the work environment and how they stay in contact with past coworkers. They stated that they did not feel powerless at work.

When discussing parts of the workplace that made doing their work more difficult, they thought that more trainings would be helpful. "We were provided with minimal trainings. More trainings would be very helpful." For example, formal training

in medication management would have helped them perform their job better, since medication management was an activity that they already performed in their role.

Narrative 3

The third participant was inconsistent in their responses regarding workplace dynamics. First, they said that coworkers and clinicians were appreciative, understanding, and supportive. They also said they had good relationships with clinicians. However, when I asked, "Could you imagine going to any of the clinicians you worked with for therapy yourself? Why or why not?" they responded, "Probably not because I wouldn't feel comfortable." When I pressed further, they said that clinicians could show more appreciation, "like…employee reward and recognition, those kind of things…not just for me like for a lot of employees who always work really hard." Stepping away from the protocol, I asked, "Did you feel appreciated by the clinicians?" They responded,

> "Yes, but some of them…would be less respectful. …like when you have back-to-back sessions. …you want to do like 10 minutes break or something, they will not think about that. … how they would like overbook you. They should value your time, like respect. … they would just overbook it without even asking you…. I really have to like call them and then, like, hey, when I write something here I mean it. I have to do this."

When I asked if they ever felt powerless at work, they denied so. They responded that they tried to resolve misunderstandings by initiating communication with the other party, which prevented them from feeling powerless at work. They put the onus back on themself to resolve miscommunication.

> "I would just talk to them, communicate that'll resolve any problems. … I never let myself feel powerless, anywhere, any job, I would just talk. I would just try to understand. Sometimes it's just me, or, you know, that not being able to process or understand things. I will always ask."

Narrative 4

This participant believed that their role was important. They remarked that they had a positive experience with coworkers, including clinicians. They denied feeling powerless in their workplace and had no other comments about workplace inequities.

Research Question 4: How do refugee mental health interpreters manage their traumatic responses from their work with refugee clients? How do refugee mental health interpreters manage distress from retraumatization or vicarious trauma in vivo during sessions?

Overview of Responses

Most of the participants shared how coping with the demands of interpreting traumatic session content was more difficult when they started working as an interpreter. They gained coping strategies from experience, learning from sessions, and attending therapy themselves. A couple of the participants shared how, when they felt strong emotions during sessions, they focused on interpreting accurately, which may speak to how they fall back onto traditional interpreter training principles. As mentioned previously, the conduit model of interpretation requires interpreters to be emotionally detached and neutral to promote accuracy (Angelelli, 2003; Bot, 2003; Freed, 1988;

Myler, 2017). A different pair of participants shared how, when clients' stories were too similar to their own, it became harder to interpret because of their emotions.

Narrative 1

The first participant recounted a client story that made an impact on them was about a young client who was engaging in non-suicidal self-injury and happened to be the same age as their younger brother. It seems that because the client reminded the participant of a loved one, their story hit close to home. Their experience deepens the literature on how the closer to home a story was, the harder it was to interpret (Green et al., 2012).

The participant shared how they lacked coping strategies early in their role. "I think I was put in this role with the expectation that I should know [coping skills], without giving me proper tools how to do that and not bring back any secondhand trauma." They shared that, after time witnessing sessions as an interpreter and going to therapy themselves, they acquired coping skills such as working out, running, sweating, writing things down in a diary and reflecting on them later, and seeing a therapist. From their own therapy, they learned how to view situations with a different perspective in order to help them cope. Their experience is also congruent with the literature and how interpreters have reported gaining coping skills, knowledge, and insight from their work (Darroch & Dempsey, 2016; Johnson et al., 2009; Pells & Treisman, 2012). They called it "free therapy" when they learned skills from interpreting sessions.

Regarding coping strategies during sessions, they described focusing on keeping the integrity of the message and promoting the relationship between therapists and

clients. They seemed to push away their own feelings till later to process them. Their experience touches on themes in the literature, including how interpreters feel they are required to be passive non-participants in the therapeutic triad and are simply required to be interpretation machines (Miller et al., 2005).

> "Sometimes I feel kind of numb about the situation so then I just interpret them as they are saying, and it doesn't even hit me that, you know this is traumatic experience at that time, and I think when I'm interpreting I think I'm in that mood that I need to interpret every single word as it should be, and keep the integrity of the message and then the conversation and I want the client and the therapist to have a good relationship with each other, so I don't insert myself there and then get sad about what's happening, I just interpreted at that time. I just numb all my own personal emotions to myself and then just let that happen, I think. ... I hear so much of it that I think if I let it get to me or if I let that emotion flow through me I feel like it would tear me apart or make me sad or or make me burn out so to protect myself from burning out I think I numb my emotions at that time, and also to keep the professional boundaries."

Narrative 2

When asked, "What was it like when clients shared stories about the difficult experiences they have gone through?" the second participant responded,

> "Some of the stories are very hard. Honestly, it made me feel bad. But knowing that they're not the only one suffering. Other people are suffering too and I'm not

the only one, made me feel a little better. But talking to the clinicians afterwards about the experience was very helpful."

This calls into question the idea of collective healing in response to collective trauma. Additionally, this statement underlines how solitude made suffering worse.

When they were negatively affected by a client sharing their story, this participant said it was helpful when they talked to the clinician and/or stepped out of the session for a couple of minutes. In particular, it was difficult for the participant when they heard the story of a client who had gone through the same experience that their father had experienced. The more that a client's story related to what the interpreter had experienced themself, the harder it was for interpreter to be present and not experience trauma, e.g. dissociation, agitation, unwanted memories, avoidance, and so on. Their difficulty echoes not only the first participant's experience of how interpreting was harder the more they related to the client's story, yet also others' experiences from the literature of struggling to interpret when a story hit too close to home (Green et al., 2012). The participant listed the strategies they used to cope with hard sessions or a hard work day, including talking to their peers, going on a walk, relaxing at home, spending time with family, cooking, gardening, and watching movies.

Narrative 3

The third participant relayed how difficult it was to hear of the trials which their clients had experienced. They described becoming emotional and being reminded of their old memories. They also realized the differences in theirs and their clients' experiences.

They remarked that these differences allowed them to distance from their clients' stories and experience curiosity:

> "So, when the clients would share, like the stories about like difficult experiences, it would of course make me like, emotional in the first place, because I could very much relate to most of the stories that they have been through. Sometimes I would cry with them as I interpreted during like session and clinicians would understand that. Hearing their stories would like bring back those memories and all that past experiences of life and refugee camp, so yeah. ... I, at the same time I was also kind of hearing their stories and kind of thinking, oh, you know how they're like I said like a lot of the clients' experiences were different than mine. I would kind of, how do I say. So they had like different experiences than I did. So, I was trying to imagine like what it would happen for them, rather than like getting too emotional. [Mmm.] So like dive into their story, you know."

The third participant also made sense of their experience hearing clients' difficult stories by saying that each story helped them learn and prepare for encountering future stories.

> "Hearing their stories like it'll help me like when I interpreted like next time... I kind of know, oh okay, this client has this kind of story. So, next time like I would be prepared. Like when I see the client's name in my schedule, oh okay this client, and then [inaudible] I would read the notes and, you know, like prepare beforehand."

They described coping strategies after a hard session or a hard day at work, including talking to coworkers and taking walks outside, “So that, you know, I would be not constantly thinking about what was just discussed in this session.” They also described a preparatory coping strategy of reading session notes prior to meeting with a client. “I would kind of go over you know the summary notes from clinicians about this client, and would prepare myself. ... Yeah, if I, if I get to know their story like more about them like beforehand, it would be smooth, you know.” Thus, this may be a valuable suggestion to help interpreters prepare for traumatic session content.

Narrative 4

The fourth participant remarked on how talking with supervisors, colleagues, or really anyone was helpful to manage their vicarious trauma. They highlighted how talk therapy was another helpful way to manage their traumatic responses to work, similar to the first participant. They also voiced how they valued assertiveness as a way of getting their needs met. It seems as though they learned the value of assertiveness and a Western way of healing through talk therapy. This method of healing could also speak to how community suffering necessitates community healing.

Their coping strategies included caring for themself or self-care, and this included shopping, running, and talking to friends. They also noted that experience or maturation helped them cope with their work. They also noted that they learned coping strategies as they went along and witnessed therapy, similar again to the first participant.

When describing their difficulty coping with sessions, their response matched the literature. They described how sessions were difficult and followed them home, not only

because they had lingering thoughts or feelings, yet also because they encountered clients outside of work. “Yes. And it's not just in the office too you know because it's your community member. You go home with it, like those that you hear from the client.” They also described the requirement to stay “neutral,” similar to the first participant yet expressed in a different way: “It's hard. It's hard, sometimes you, you feel with them, you know, the emotion and, but for me I just feel like, as before like neutral. And when things is done, then I will get help, like asking for help or just get like a fresh air, you know, get out of the office sometimes helps a lot too.”

When describing how they coped with difficult emotions during sessions, they shared how they would take deep breaths and talk to themself to stay calm: “Tell my mind to be calm and telling myself it’s okay.” They also described how “You have to be able to [mentally distance], otherwise you explode.” After a hard day at work, they shared that they changed their clothes to separate work from home. Lastly, they described how their strategies changed over time, after training and after learning from interpreting therapy sessions.

Research Question 5: What types of support do refugee mental health interpreters need to better manage their traumatic responses? What about supervision has been or would be helpful? What about debriefing has been or would be helpful?

Overview of Responses

The participants had concrete suggestions for how to reduce the harm they experienced when performing this work, including mental health-specific training, population specific training, and training on boundaries with clients as well as work-life

boundaries. Prevalently, they cited having the opportunity to take breaks between sessions for a few minutes helped them manage their stressful emotions. Additionally, they cited pre-session briefing, post-session debriefing, and supervision as helpful practices. Echoing the literature, they often stated that briefing and debriefing did not happen often enough (Darroch & Dempsey, 2016; Myler, 2017; Raval, 2005).

Narrative 1

The first participant emphasized the high need at the beginning of being a new interpreter. They suggested preparing new hires by setting expectations and giving them the resources they needed to know how to do their job. “There’s so much that comes with the job that I was never prepared for in my life.” They also recognized the importance of processing their own trauma to a certain point to be appropriate for this work, and not be prohibitively retraumatized by it, which substantiates the hiring criteria for refugee mental health interpreters developed by Miller, et al. (2005), that interpreters must have experienced a reasonable degree of psychological healing from their own history of trauma and loss before starting work as an interpreter.

> “Working in nonprofit or just in general like working anywhere, I think the, the, I would say like the pressure of like making enough money or like reaching enough people gets in the way of like helping and also like it doesn't give us enough tools to work on our own trauma, because we have gone through all of that. We have not processed our own trauma, so how are we going to help the other people that we need to do, and I think that's like it comes in the way sometimes.”

The first participant named many supports they desired, including psychological first aid training to help them psychologically prepare for their work by way of learning what kind of information they were going to be exposed to while interpreting. They also desired more robust therapy benefits through their job, such as having access to additional sessions. They desired trainings about keeping boundaries and how to set apart professional life from personal life. They desired information on what kind of boundaries they were expected to keep with clients, such as clarifying what their duties were inside versus outside of work. Could they say no to client requests, and did they have to give justification for saying no? They explained that not knowing the boundaries of their role made it more difficult to be honest in their workplace about their feelings. They also desired more open communication amongst coworkers as well as desired case discussions for interpreters to discuss cases more in depth.

They cited supervision as being helpful. In particular, they described specific qualities of their supervisor that they found helpful, including being understanding, nice, personable, and caring. Some suggestions they had for improving group supervision included asking interpreters: How can we help you? What are you feeling? What is your opinion? Outside of work, the participant described deriving support from therapy and their interpersonal network. For example, they described how they appreciated going home and "venting" to their spouse without being judged.

They also cited debriefing as being helpful because they valued the opportunity to give insight into the client's functioning. However, the participant said that debriefing was only helpful if the clinician was willing to listen. "There are some other people that I

have worked with that didn't really seem like they wanted to listen to my opinion, so I didn't bother telling them what I feel either."

Additionally, they described wanting "five minutes" after every session to debrief and process their feelings. Paone and Malott (2008) have stated that post-session debriefing is helpful for assessing any negative interpreter reactions related to sessions. The participant also desired briefing prior to sessions. Their requests are supported by plenty of previously stated evidence from the literature about interpreters' need for both pre-session briefing and post-session debriefing (Amouyal et al., 2020; Choo, 2014; Darroch & Dempsey, 2016; Elkington & Talbot, 2016; Green et al., 2012; Miller et al., 2005; Myler, 2017; Paone & Malott, 2011; Raval, 2005; Searight & Armock, 2013; Searight & Searight, 2009; Tribe, 1999). They stated that briefing prior to sessions would be helpful to have the opportunity to "tell our clients to speak slower in less words."

They cited multiple barriers to post-session debriefing, including session length and a lack of time between sessions. They described how sessions "always" went longer than their allotted time.

> "When I'm done I'm always late for the next one, so I never even get time to process what I'm feeling. So it all like boils up and then I come home then I feel like shit, I'm like, oh my god this is how all of this thing happened on the same day and I have no way to talk about it, one to talk to about that so then I would either email them, or just let it be because that's how I felt. And then there was no time to process so now I don't feel like I have the resources or time to process it

afterward, on the next day or a different day because I feel like we're so busy making sure that we meet all those appointments."

Thus, this serves as a reminder of the importance of slowing down to preserve interpreters' well-being. The sense of overwhelm is apparent in the participant's response.

Other suggestions they had included trainings that were specific to the client population and more preparation to work with clients who had experienced trauma. They stated that trainings more focused on psychological concepts or trauma-informed care were more helpful than trainings that were focused on how to interpret. The support they desired most was having enough time between sessions, ideally to walk around outside, get some fresh air, and have time to think. "Or if it's really difficult, then have an opportunity to talk to the therapist about it and see why it was difficult, and how we can both process it, because I'm sure they are also feeling the same way but we just never talk about it."

Narrative 2

This participant emphasized work environment as being an immense source of support. They also cited flexibility, positive feedback in supervision, having enough time in supervision to talk about client needs, and debriefing after sessions as helpful. They specified that debriefing after sessions with clinicians helped them feel relieved and comfortable.

They also described the impact of trainings, citing that their knowledge as well as their mental health benefitted from trainings. They offered the feedback that population-

specific trainings instead of general trainings would be more helpful, as was suggested by the first participant. This interview stressed how the ability to take five minutes to leave session or between sessions was helpful, hence their emphasis on flexibility. This response also echoes the first participant's request for just "five minutes" after sessions to debrief.

Narrative 3

When meeting a client for the first time or for an intake, this participant noted that they thought pre-session briefing would be helpful. They remarked how post-session debriefing sometimes occurred, yet the absence of pre-session briefing was especially notable. Pre-session briefing, where the clinician shares client information before a session, has been noted as important to mitigate vicarious trauma for interpreters by making them more aware of details of the case (Amouyal et al., 2020).

> "Having a pre-session would be very helpful but we never had one. Yeah, we were kind of rushing like the, like, clinicians would be busy too, back-to-back clients and there was not like much time in between. And then [interpreters] were busy, so there was not enough time. I think I should have asked. But yeah, we never had the pre-session. I had a post session like discussion after the session with few with some clinicians, but never buy anything before."
>
> When asked about what was helpful about debriefing, they responded,
>
> "So, after session, clinicians would ask, especially not the more it was more from the intern who I work with were the ones like who will do post-session, talk about the client. Some clients were very difficult and not ready to accept the change, so

they would kind of ask me if I know more about this client or, you know, what would be our like, plan moving forward. You know all those, so it was, it was helpful. Yeah."

They also noted how supervision was helpful because they appreciated support and feedback from their supervisors. They also found it helpful to talk about their problems and concerns in supervision. "I think that was really helpful, like somebody there to listen to you, like your supervisor listens, ready to listen to you." They also remarked that the availability of their supervisors was important to feel supported. "If I had any questions I would just sometimes email them, or ask like there are time like I wanted to talk, and they were, they would be always available. So I think that's the biggest part." When asked whether they thought it would be helpful to meet more frequently, they responded, "I think that was good like once a week or once every two weeks, I think that's enough." They also appreciated support from coworkers as well as supervisors, and they remarked on how overall company culture was important to feeling supported.

They agreed that clinicians could ask for their input more often about how to move forward with or help clients. Therefore, their response seems to echo the first participant's desire for clinicians to seek their input on client cases. They believed that communicating about these matters would be helpful for treatment progress. They also remarked that they desired more understanding, support, and flexibility from clinicians.

One of their suggestions was to brief interpreters prior to sessions. As was stated before, this has been highly recommended in the literature (Amouyal et al., 2020; Choo,

2014; Darroch & Dempsey, 2016; Elkington & Talbot, 2016; Green et al., 2012; Miller et al., 2005; Myler, 2017; Paone & Malott, 2011; Raval, 2005; Searight & Armock, 2013; Searight & Searight, 2009; Tribe, 1999). They also recommended providing training about the necessity of setting boundaries prior to starting the job, as they thought that it would benefit them and reduce some of the difficulties they had experienced. This also echoes the first participant's request for specific training on boundaries when they began working as an interpreter. Additionally, the third participant also thought that having more trainings in general would be helpful. For example, they had completed level one of a certain training, and they wanted to complete level two, yet it was not available. "I would want like any workplace should provide employees continuous education training, you know, so that it's like more productive. Yeah, so we could serve clients better. So that was lacking a little bit."

Narrative 4

The fourth participant put a large emphasis on how this role took more introduction than they expected. "It was very, very new to me." Their emphasis seemed to imply that they were not expecting the demands of this role. This ties back to the literature and is expanded in Chapter Five, supporting how onboarding training is necessary to mitigate the initial shock of transitioning to the role of an interpreter.

They cited that training, supervision, and chances to take a break (e.g. go outside for a brief walk or breath of fresh air) were helpful supports to manage their stressful responses. This echoes what other participants in the study have requested regarding having breaks to take a walk and go outside in order to help them manage their vicarious

trauma. Regarding supervision, they specifically cited that positive feedback, understanding and care, teaching, and praise were helpful qualities of their supervisor and supervision. “She gave me terms I never heard of.”

The participant seemed to describe a process of externalization versus internalization when it came to their stress. They described how communicating “what was happening inside” to others was important, to help prevent them from “exploding” and to foster responsiveness. For example, if they communicated their feelings and needs, they said others were then enabled to understand how to treat them and what they needed. This seemed to imply that part of the onus was on the participant to ask for what they need. Thus, perhaps it would be helpful for interpreters to receive training on how to advocate for oneself.

This participant also thought that sharing struggles, achievements, and general experiences with other interpreters in order to learn from each other was helpful. They also described how problem-solving for clients in group supervision was helpful. Regarding debriefing, they stated that sharing cultural differences with clinicians was helpful. However, their tone was deferent to clinicians’ expertise on everything but culture. Their disclosure seemed to reveal how they hesitated from sharing their clinical opinion with clinicians because they thought the utility of their opinion was minimal.

When asked to share what was helpful about training, they responded that learning that they were not alone from meeting people with the same experience was helpful. They described going from feeling sad to sharing and being able to laugh with

others. They also described how being trained by a professional was helpful—learning things from someone with “education” or training.

When describing the strategies that helped them deal with difficult sessions, they cited: Support from clinicians; spending time with other interpreters either at work or socially; attending “fun,” non-work related trainings with coworkers; and generally building bonds with coworkers “to feel more supported when you're doing this work.”

They also described how a work environment that was supportive of their life outside of work was key to their well-being. They also thought that if they needed to ask for help, they had the ability to ask. For example:

> “There was time when I have a personal problems or if my baby got sick, then they are really understand[ing], like if your baby got sick, Why are you here, you know. At other place, you have to come, or we, you have to bring a doctor's note, you know, they will ask you to do that in other place, but like in [clinic] if your baby's sick, you don't have to be here, go home. They'll tell you that, so yeah. That's why I don't really know like, there's not like a time when I get really really upset and I have to ask for something and I shouldn't ask or something like that so I don't know.

Therefore, to be able to deal with stresses from work, they had to be supported with factors outside of work; if the workplace is understanding, that decreased their stress so much to be able to deal with everything else.

Unique to this interview, the fourth participant had the suggestion of emailing the clinician to let them know that they needed to debrief later because they felt upset. Their

strategy underlined an emotion regulation strategy, where they identified their thoughts and emotions to help them cope with difficult sessions:

> “If I want to talk to the clinician, I like to email them separate, like, hey, let's talk, this kind of stuff. So, I think it was different from other people but I like to email them when we can talk about like the stuff like whatever I'm upset about you know like email them something like that so that we can talk about it in person later instead of after the session because for me, I don't know, like, I don't feel as helpful after a debrief, debriefing. Yeah, yeah, because for me I like to think through like this is like what I really need to talk about, you know, or if this is what really upset me because of what he say or what she say or is it just me, you know, so I like to take some time like on my own a little bit first than talk to them like immediately after.”

Chapter Five

Introduction

Statement on the Pandemic

The COVID-19 pandemic influenced the methodology and context within which this study was conducted in unexpected ways. For example, all interviews were conducted remotely due to safety precautions in the first several months of the COVID-19 pandemic. Originally, interviews were expected to be conducted completely in-person. Additionally, the sentiments around anti-Asian hate related to the pandemic were relevant while interviews were conducted because at least some of the participants are of Asian descent. Data collection began around the time of the first lockdowns in the United States in March 2020. This time of increased stress due to the public health crises, including anti-Asian racism, undoubtedly influenced the environment in which data was collected and may have influenced what disclosures were made.

Review of Study Purpose

This study sought to better understand the professional and emotional experiences of refugee mental health interpreters who work with refugee clients. As stated previously, the research literature lacks examination into several areas concerning mental health interpretation for refugee clients. This includes the management of interpreters' vicarious trauma and retraumatization, interpreter's perspectives on the appropriateness of hiring refugees as mental health interpreters, how interpreters define their trauma as well as

their clients' trauma, and support that interpreters seek for their traumatic responses from their work. The literature is also missing an analysis of how oppressive power differentials are repeated in workplace institutions, specifically for refugee mental health interpreters. The research questions for this project are as follows:

1) How do refugee mental health interpreters define their own experiences of trauma?
    a. How do they understand their clients' experiences of trauma?
2) What are the benefits and harms of hiring those who have also been refugees as mental health interpreters for refugee clients?
    a. How does having similar past experiences help their work experience?
    b. How does having similar past experiences hinder their work experience?
3) What power dynamics occur amongst clinicians, agencies, and refugee mental health interpreters?
    a. How do interpreters' experiences of coworkers' attitudes influence their desire to seek treatment for their work-related trauma?
4) How do refugee mental health interpreters manage their traumatic responses from their work with refugee clients?
    a. How do refugee mental health interpreters manage distress from retraumatization or vicarious trauma in vivo during sessions?
5) What types of support do refugee mental health interpreters need to better manage their traumatic responses?

a. What about supervision has been or would be helpful?

b. What about debriefing has been or would be helpful?

Reflections on the Narratives

Defining Trauma

When defining trauma for themselves, all four participants responded that their experience living in refugee camps was traumatic. For example, the first participant emphasized how this was a central part of their experience of trauma. "[B]eing in that isolated place affected me mentally." The second participant emphasized how the limits of living in a refugee camp were part of their traumatic experience. The third participant referenced the loss of opportunity, lack of access to resources, and standard of living were all part of their traumatic experience.

> "As I grew up in a refugee camp and started to leave a, I want to say a terrible life, it started to make more sense to me. For example like lack of infrastructure, not having enough access to health services outside of refugee camp. Also like not having a quality education, like any other normal child. Yeah, like, who are getting, like, better education like outside of camp. Having to leave it in an unhygienic atmosphere, which would lead to high like you know incidents of infectious diseases and epidemics, I would say were some of the bitter realities that would explain [inaudible] traumatic situation or what it would be like to be a refugee you know."

The fourth participant detailed how much of the trauma they experienced occurred in the refugee camps, such as dealing with abusive, corrupt, and violent

authority figures. The experience of living in refugee camps may be an overlooked aspect of the experience of refugees who have done so; instead of an urgent danger or violence, the experience of living in a refugee camp causes more chronic problems, such as loss of opportunity, lack of nutrition, abuse of authority figures, fear, loss of freedom, and more.

The first participant specifically referenced generational trauma when describing their own definition of trauma. They recognized that they, their family, and their community members experienced generational trauma related to their experience as refugees which could be passed down to future generations. They saw their work as a means to heal the generational trauma before younger generations had to experience the same suffering.

> "I think it's very important because, so there's a lot of like generational trauma that I see in our clients, and in my family members and other people that doesn't ever get processed, so that trauma keeps getting pushed on and then keep going to the next and next and next generation and I think the job that I do as a[n interpreter] helps them to process their trauma from someone that who understands that. And them going through therapy helps them stop that generational trauma there, so that their younger kids or the generation after that don't have to suffer through the same kind of trauma that they have suffered through."

A heuristic theme about trauma that surfaced from the narratives was the idea that community suffering necessitates community healing. The literature has recognized how refugees can define their trauma collectively. While trauma is thought to be experienced

individually in Western culture, refugees can perceive their trauma collectively through their understanding of being persecuted as a group (Johnson et al., 2009). These conclusions were bolstered by the second participant's responses. For example, they shared that "knowing that they're not the only one suffering. Other people are suffering too and I'm not the only one, made me feel a little better." Thus, this calls into question the idea of collective healing in response to collective trauma. They further stated, "I don't view it as, 'Oh no, it's just me and my family who is suffering.' this, it's, it's the suffering of the group."

Further, one of the ways the fourth participant coped with the distress of working as an interpreter was by talking to others. Building community by communicating with others about their distress seemed to be one of their chosen ways of healing. Knowing that the experience of being a refugee is not only experienced as an individual yet also as a group, this also calls into question the idea of community healing to address community suffering.

From the third participant, they shared the idea that acceptance of the circumstances of being a refugee—the conceptual losses of home, community, stability, opportunity; the material losses of life, wealth, resources, location, language, navigability, status, role, and more; the violence, fear, and persecution—enabled the narrator to move through the losses and hardships to reach for a better life and opportunity in general. They compared their experience to those who seemed to have difficulty moving forward from their traumatic experience. The third participant shared how some clients wanted to go back to how things were, revealing the idea that

acceptance may be a factor, perhaps even a predictor, of one's ability to move forward from traumatic experiences after resettling.

The fourth participant emphasized how a unified definition of trauma was hard to hold onto across cultures. They described how it is difficult to not only interpret language, yet also cultural norms and mental health diagnoses, practices, and symptoms from their culture of origin to American culture. They contemplated how to determine when someone is traumatized in one culture when the behavioral signs are different in another culture. Their observations added depth to the group of responses concerning self-definition of trauma and what they had noticed about their clients' trauma.

Benefits and Harms of Being from the Same Community

One of the most important research questions that the participants responded to was whether it was more beneficial or harmful for those who were refugees to be hired as interpreters. None of the participants seemed to say that it was more harmful for them to do this work. They seemed to recognize the necessity of, and even experienced joy in, their work. The first participant even stated, "...it's important for me to be from the same community."

Common across participants was how they spoke of the necessity of being from the same community because of the unspoken understanding that deepened their connection with clients. This emphasizes the importance of context and knowing their shared history. However, the participants also recognized the hardships of being interpreters for people in their community. They had concrete suggestions for how to

reduce the harm they experienced when performing this work, which are to be explained under the section, *What Supports Are Needed?*

Many of the participants noted how their job was difficult to bear in the beginning. This connects back to the literature, how Splevins et al. (2010) found that the amount of time that interpreters had been working in a mental health setting may influence the intensity of vicarious trauma that they experience. It is important to emphasize how many of the participants seemed to be taken aback or "blown away" by the demands of being an interpreter. It almost seemed as if nothing could prepare them properly, therefore participants' responses highlight the importance of training to help them prepare for the demands of the role.

Multiple participants spoke of the burdens of being from the same community—for example, how it was difficult to maintain a work-life balance when seeing clients outside of work. Additionally, multiple participants spoke of clients' high expectations of their availability. One participant described how they eventually enjoyed drawing a clear boundary and saying "no" to clients or coworkers when they had reached their limit.

After one of the interpreters left their position, they spoke about their experience running into old clients. They spoke about how their relationships with community members strengthened.

> "They have so much respect for me and they still appreciate what I used to do. And that makes me feel that, oh yeah I was at least able to help my people, help those people who needed help. And that makes me feel happy, and like I said I still miss the work environment and culture."

Multiple participants described how being an interpreter was a learning experience. For example, both the first and fourth participants said that they learned coping strategies for themselves from the content of sessions while interpreting. The fourth participant noted that they learned as they went along and witnessed therapy. The literature supports their experiences, where other interpreters have also reported gaining coping skills, knowledge, and insight from their work (Darroch & Dempsey, 2016; Johnson et al., 2009; Pells & Treisman, 2012).

Power Differentials

The first participant emphasized the bureaucratic barriers they encountered which made doing their work more difficult. From this narrative, I learned that I had overlooked the wider social and political system when looking for dynamics that disempowered interpreters. Therefore, I focused on individual interactions between interpreters and clinicians and overlooked the impact of a general lack of resources as well as the burdens of managed care in providing mental health services for refugees (e.g. low reimbursement rates for interpreter services). Both the second participant and third participant shared similar remarks on resources. For example, the second participant explained the sense of frustration they experienced at the limited resources for clients that made their job more difficult. The third participant also mentioned frustration at the lack of resources for their community, such as language services.

The first participant's responses echo how the literature states that interpreters experienced their position in the system as precarious, with little status, low pay, little respect, and minimal training and support (Green et al., 2012). For example:

> "I think like the higher management or other people don't see the value of [interpreter], and I think that makes me feel powerless at my job. ... I wish like people saw me as more than just, just [an interpreter] sometimes. … I wish my opinion mattered more."

The first participant's response also echoes the need for interpreters to be seen by the larger mental healthcare system as essential team members (Becher & Wieling, 2015).

Everyone unanimously agreed about the value and importance of their role as an interpreter. From participants' responses, I suspect that the sense of importance they feel is not complete at a sense of self-worth yet also includes a sense of community-worth. For example, multiple participants spoke of how they saw their community was in need and they wanted to help them. This potentially speaks to a quality of their identity and/or identity development.

How Do They Manage?

Regarding managing vicarious trauma, the first participant responded:

> "In the beginning I didn't know how to cope because I didn't think I was given any kind of skills to learn how to cope with things like that. I think I was put in this role with the expectation that I should know it, without giving me proper tools how to do that and not bring back any secondhand trauma."

Thus, they developed the coping skills of working out, running, sweating, seeing a therapist, and writing things down in a diary, while later going back and reflecting on their experiences. Regarding coping strategies during sessions, they described focusing

on keeping the integrity of the message and promoting the relationship between therapists and clients. They seemed to push away their own feelings till later to process them.

The second participant said it was helpful when they talked to the clinician and/or stepped out of the session for a couple of minutes. They cited the strategies they used to cope with hard sessions or a hard workday included talking to other interpreters, going on walks, relaxing at home, spending time with family, cooking, gardening, and watching movies. The third participant responded, “I will talk to my coworker. I think I would just take a quick walk, you know, around [clinic] area ... So that, you know, I would be not constantly thinking about what was just discussed in this session.” The third participant also had the novel strategy of reviewing summary notes from prior sessions before going into a new session with a client. “I would kind of go over you know the summary notes from clinicians about this client, and would prepare myself.” They relayed that this practice helped them become familiar with the client’s story beforehand and helped the session run more smoothly.

The fourth participant responded that they coped through self-care, which included shopping, running, and talking to friends. They also noted that experience or maturation helped them cope with their work. They described how their strategies changed over time after attending trainings and learning strategies from interpreting sessions.

When describing how they coped during sessions, they shared how they would take deep breaths and talk to themself to stay calm: “tell my mind to be calm and telling myself it’s okay.” They also described how “You have to be able to [mentally distance],

otherwise you explode." Unique to this interview, this participant had a suggestion for having limited time after sessions to speak with clinicians. Their strategy spoke to how they identified their thoughts and emotions as an emotion-regulation strategy to cope with difficult sessions:

> "If I want to talk to the clinician, I like to email them separate, like, hey, let's talk, this kind of stuff. So, I think it was different from other people but I like to email them when we can talk about like the stuff like whatever I'm upset about you know like email them something like that so that we can talk about it in person later instead of after the session because for me, I don't know, like, I don't feel as helpful after a debrief, debriefing. Yeah, yeah, because for me I like to think through like this is like what I really need to talk about, you know, or if this is what really upset me because of what he say or what she say or is it just me, you know, so I like to take some time like on my own a little bit first than talk to them like immediately after."

The fourth participant remarked that talking with supervisors, colleagues, or anyone was helpful to help them manage traumatic responses to work. They also highlighted that talk therapy was helpful. Additionally, they learned assertiveness as a way of getting their needs met. One speculation from synthesizing across interviews is that it seems the people who had more positive experiences at work spoke up and asked for what they needed, or at least felt like they had the opportunity to. For example, the third participant denied feeling powerless at work.

> "I would just talk to them, communicate that'll resolve any problems. … I never let myself feel powerless, anywhere, any job, I would just talk. I would just try to understand. Sometimes it's just me, or, you know, that not being able to process or understand things. I will always ask."

What Supports Are Needed?

Many of the participants noted that having a break between sessions was immensely helpful for decompressing from session content and maintaining their well-being. Many of the participants also noted supervision as a helpful support. They noted that positive feedback and the supportive stance of their supervisor were helpful components of supervision.

All of the participants voiced the desire for more training, which echoes the literature. For example, Miller, et al. (2005) suggested that new interpreters be given proper training. The participants expanded the meaning of "proper training" to specify that training at onboarding was especially important. They identified that mental health-specific training, population specific training, and training on work-life boundaries were needed and desired, as well as training on expectations when encountering clients outside of the workplace. The need for interpreter training is well-cited in the literature (Amouyal et al., 2020; Becher & Wieling, 2015; Darroch & Dempsey, 2016; Gartley & Due, 2017; Green et al., 2012; Holmgren et al., 2003; Miller et al., 2005; Myler, 2017; Raval, 2005; Searight & Armock, 2013). Suggested topics already found in the literature matched the participants' requests, including self-care, psychological coping strategies, mental health

training, and triadic relationship issues (Amouyal et al., 2020; Gartley & Due, 2017; Green et al., 2012; Holmgren et al., 2003; Miller et al., 2005; Myler, 2017).

As stated previously, the lack of training and education provided to interpreters can be interpreted as a means to disempower them. From participants in this project and previous research, interpreters have highlighted the lack of mental health education as a hindering factor to their work (Amouyal et al., 2020). Thus, clinics must invest in interpreters' training to help them gain status and allow for more collaborative and culturally relevant approaches to treatment (Becher & Wieling, 2015).

Every participant noted that supervision was helpful to facilitate their work experience. The first participant cited specific supervisor qualities they found helpful included being understanding, nice, personable, and caring. The second participant cited positive feedback in supervision as well as having enough time in supervision to talk about client needs as being helpful. The third participant appreciated support and feedback from supervisors. They stated it was helpful to have their supervisor listen to problems or concerns they had. They also remarked that the availability of their supervisors was important in them feeling supported. The fourth participant remarked how positive feedback, understanding and care, teaching, and praise were helpful qualities of their supervisor and supervision. "She gave me terms I never heard of." Their response corroborates how the literature states that supervision can help develop internal resources through learning new skills (e.g. coping strategies), increasing self-awareness, and other personal development (Darroch & Dempsey, 2016; Green et al., 2012; Myler, 2017). Overall, the participants' responses speak to the desires others have voiced

concerning supervision—that they would value and appreciate feedback and guidance from a trusted and non-judgmental professional (Darroch & Dempsey, 2016).

Limitations

One of the limitations of this study is the potential for hindsight bias, not only for the participants but for myself. For example, some of the participants were no longer working at the relevant agency by the time of the interview. Therefore, some of these interviews may fall into hindsight bias, like a rose-colored lens, where they look back at their experiences more fondly than if they were in the trenches

Additionally, I have previously had experience as a psychologist trainee in a behavioral health clinic that employed refugee mental health interpreters and served refugee clients. My experience training in this clinic was immensely positive. I had what I perceived to be positive relationships with most of the staff, and I felt the clinic was doing work to improve the world. Possessing the politicized experience of being an intersectionally marginalized person, I am critical of oppressive power structures and skeptical of those in positions of power. Therefore, read the results knowing that these experiences influence the study.

Additionally, another limitation of the study was the limited participant numbers. As I expected to have few participate in this study, I chose a methodology that would lend to retaining the integrity of and honoring each individual's narrative. However, it would only be helpful to have more voices included in this area of research. Further, the participants were recruited from a limited geographic area. These limitations are addressed in the recommendations for research ahead.

Recommendations for Research

Future studies can use quantitative data analysis to examine the same issues. They can increase representativeness in terms of data analysis, using different approaches of methodology. It is encouraged to include more perspectives in future studies, including interpreters from different countries in order to globalize the study. Multiple participants noted that they thought this research was important and they were not surprised to hear that research from interpreters' perspectives was less common than, say, clinicians' perspectives. Thus, the more perspectives, the better.

Implications for Education and Training

Knowing the growing population of refugees in the United States, the training imperative for programs to educate students on how to work well with refugee interpreters is also growing. Recommendations for developing standards for working with interpreters in mental health have been developed by Frandsen (2016), and are summarized: 1) Ethical selection of an interpreter, 2) Orientation/coordination with the interpreter, 3) How to set-up for an interpreter facilitated encounter, 4) How to discuss roles, responsibilities, and confidentiality within the triad, 5) How to use appropriate communication within the triad, 6) How to address relationship dynamics in the triad, 7) Open debrief with the interpreter, 8) Gather additional cultural or linguistic information, and 9) Assess the interpreter's comfort, fit, and needs. Please refer to Frandsen (2016) for further details.

Implications for Clinical Practice

Multiple participants referenced clinicians' flexibility as supportive. One of the participants specifically remarked that they desired more understanding, support, and flexibility from clinicians. For them, flexibility meant the ability of the interpreter to step away either between or during sessions to manage their difficult emotional responses. Additionally, clinicians can support interpreters in processing their emotions by routinely including pre-session briefing and post-session briefing as part of their work together (Raval, 2005). This is a commonly held recommendation in the literature and yet requires repeating. This practice requires consciousness of time on the clinician's part as well as initiation, knowing the greater power they hold in the relationship. Clinicians can also consider factors such as power, knowledge, life experiences, dependency, emotional responses, and therapeutic processes when approaching their work with not only clients yet also interpreters (Raval, 2005).

Conclusion

This study hoped to lend a platform to those who have been overlooked in the research literature on refugee mental health: the interpreters. When I mentioned that interpreters' perspectives were not commonly the focus in the research literature, participants were not surprised. They also voiced how they believed this research is important. From this study, I was able to address many of the gaps in the literature regarding refugee mental health from a perspective that is often not seen. I hope this adds to your perspective and changes your practice to improve the mental health of an essential member in the provision of refugee mental health services.

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Appendix A

Recruitment Emails

Dear [insert name],

My name is Emme Paik, and I am a graduate student from the Counseling Psychology department at the University of Denver. I have also worked as a psychology extern at Asian Pacific Development Center, thus I have interest in working with mental health interpreters and the clients that are served through working with interpreters. I am writing to you to invite your staff interpreters to participate in a research study about their experiences.

The purpose of this research is to help invite the perspectives of mental health interpreters on issues such as vicarious trauma and support needed to aid in their interpretation work. I wanted to reach out to you first to see whether we had your permission to approach potential participants about interviewing them for this study. If this email is better sent to someone else, please let me know who the best contact is.

We have acquired funding to compensate participants for their time. Their participation is completely voluntary and we will keep participants' information confidential. If you have any questions, please email me at emme.paik@du.edu.

Thank you very much.

Sincerely,
Emme Paik

Dear [insert name],

My name is Emme Paik, and I am a graduate student from the Counseling Psychology department at the University of Denver. I have also worked as a psychology extern at Asian Pacific Development Center, and therefore I have interest in working with mental health interpreters and the refugee clients who are served through working with interpreters.

I am starting a research study on refugee mental health interpreters' experiences. I am writing to invite you to participate in this research study. You are eligible to be in this study because you are a professional mental health interpreter who works more than half-time and have been interpreting professionally for over a year. I obtained your contact information from [insert].

The purpose of this research is to help people understand the experiences and needs of mental health interpreters, particularly in addressing vicarious trauma and working with refugee clients. This information will be kept confidential and the results will not be connected to your identifying information in any way. For example, we will not use your name or any identifying information that you share in the results.

If you decide to participate in this study, you will complete a demographic questionnaire and a one-hour interview over phone or video, depending on your preference. We will provide you compensation of a $20 Visa gift card thanks to receiving funding from the Counseling Psychology department at University of Denver. We would like to audio- or video-record our interview for the purpose of going back and analyzing the information. We would like to share our initial analysis with you to see what you think and to incorporate your input.

Your participation is completely voluntary. You can choose to leave the study at any time. If you would like to participate or have any questions about the study, please email me at emme.paik@du.edu.

Thank you very much.

Sincerely,
Emme Paik

Appendix B

Demographic Questionnaire

Date & time:

1. What is your age?
2. What is your gender?
3. What level of education have you attained?
4. What is your marriage or relationship status?
5. What is your ethnicity (culture of origin, national identity, …)?
6. How long ago did you resettle to the U.S.?
7. What languages do you speak?
8. What is your job title?
9. Who is your current employer?
10. How long have you been interpreting?
11. What kind of interpretation training have you received?
12. In what settings have you worked?

Appendix C

Consent to Participate in Research

Study Title: Refugee Mental Health Interpreter Study
Principal Investigator: Emme Paik, MA
Faculty Sponsor: Ruth Chao, PhD
Study Site: Virtually, off-campus, and individual to each participant.

Purpose. You are being asked to participate in a research study because you work with refugee clients as a mental health interpreter, and you have held refugee status yourself in the past. The purpose of this study is to better understand the perspective of refugee mental health interpreters.

Voluntary Participation. Your participation in this research study is voluntary and you do not have to participate. This document contains important information about this study and what to expect if you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate.

The purpose of this form is to provide you information that may affect your decision as to whether or not you may want to participate in this research study. The person performing the research will describe the study to you and answer all of your questions. Please read the information below and ask any questions you might have before deciding whether or not to give your permission to take part. If you decide to be involved in this study, this form will be used to record your permission.

Procedures. If you participate in this research study, you will be invited to answer a demographic questionnaire with a handful of short-answer questions. Next, you will participate in a one-hour interview where we will ask you questions about your experience working as an interpreter. Overall, your time commitment should be approximately 1.5 hours, including going over this consent form, the demographic form, and the interview. You can refuse to answer any question on the demographic form or during the interview and it will not affect your participation or compensation.

Risks or Discomforts. Potential risks, stress and/or discomforts of participation may include stress or discomfort from thinking about your responses to the interview questions, which may bring up negative emotions. If you are having thoughts of harming yourself as a result of participating in this study, you can call Colorado Crisis Services 24/7 to talk to a trained crisis counselor at 1-844-493-8255. They also have walk-in clinics in the Denver Metro Region, including 4353 E. Colfax Avenue, Denver, CO 80220 and Anschutz Medical Campus, 2206 Victor Street, Aurora, CO 80045. Please

note the Denver/Colfax location is open 24/7 while the Aurora/Anschutz location is open 8am-11pm.

Additionally, there is the potential risk of a breach of confidentiality if the information gathered from this study is accessed by someone outside of the research team. We will do our best to keep your information confidential per federal requirements and will keep all information double-protected—that is, with two passwords or with two locks.

We will be audio- or video-recording the interviews and will delete the files after transcribing the interviews. The transcriptions will not contain any of the identifying information that you provide on your demographic form, yet will instead be given a number instead of your name to decrease the risk of someone connecting your identity to the interview. When presenting or publishing this research, we will share patterns of themes we find across all interviews instead of sharing word-for-word from individual interviews. You can ask to access the recordings, transcriptions, or results at any time.

Benefits. On a societal level, we hope to increase awareness about the experiences of refugee mental health interpreters to support their work with refugee clients. On a personal level, we cannot guarantee that you will receive any benefits from this study. Your decision whether or not to participate in this study will not affect your employment.

Source of Funding. The study team is receiving financial support from the Counseling Psychology department at the University of Denver.

Confidentiality of Information. One risk of participating in any research is a loss of privacy, which is why we are choosing not to collect your name and date of birth. Further, your interview will be given a code number instead of being linked to identifying information such as your name to further ensure your confidentiality. We will do our best to keep your information confidential by using HIPAA-compliant online storage with password protection and encryption and other confidentiality measures. No other agencies or researchers will have access to identifiable data.

Limits to Confidentiality. All of the information you provide will be confidential. There are some limits to this protection. We will voluntarily provide the information to:

- A member of the federal government who needs it in order to audit or evaluate the research;
- Individuals at the University of Denver, the funding agency, and other groups involved in the research, if they need the information to make sure the research is being done correctly;
- The federal Food and Drug Administration (FDA), if required by the FDA;
- Appropriate authorities, if we learn of child abuse, elder abuse, or the intent to harm yourself or others.
- Subpoena by a court.

Use of your information for future research. Your information collected for this project will NOT be used for future research.

Data Sharing. De-identified data from this study may be shared with the research community at large to advance science and health. We will remove or code any personal information (any of the questions you answer on the demographic form, such as age or ethnicity) that could identify you before files are shared with other researchers to ensure that, by current scientific standards and known methods, no one will be able to identify you from the information or samples we share. Despite these measures, we cannot guarantee anonymity of your personal data.

Incentives to participate. You will be compensated with a $20 Visa gift card following completion of the interview.

Consent to video / audio recording solely for purposes of this research. With your consent, I would like to audio- or videotape this interview so that I can make an accurate transcript. Once I have made the transcript, I will erase the recordings. Your name will not be in the transcript or my notes. If you do not agree to be recorded, you cannot take part in the study.

Questions. For questions, concerns, or complaints about the study you may contact:

Emme Paik, MA: emme.paik@du.edu, 989-501-3253
Ruth Chao, PhD: chu-lien.chao@du.edu, 303-871-2556

If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the University of Denver (DU) Institutional Review Board to speak to someone independent of the research team at 303-871-2121 or email at IRBAdmin@du.edu.

Consenting to the Study

I have read (or someone has read to me) this form, and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by consenting to participate in this study. I will be given a copy of this form.

Appendix D

Interview Protocol

1. When did you start working as an interpreter?
2. How did you feel about your work when you first started working as an interpreter?
    a. How did that change over time?
3. What is it like being from the same community as clients?
    a. How did having similar past experiences with clients help you do your work?
    b. How did having similar past experiences with clients not help you do your work?
4. What is your definition of trauma?
    a. Would you describe any of your own experiences as traumatic? What does that mean to you?
    b. How do you view your clients' trauma?
5. How important is the work you did as an interpreter? You vs. others
6. What was it like when clients shared stories about the difficult experiences they have gone through?
7. Tell me about a time you were affected by a client sharing their story.
8. What did you do after a hard session or a hard day at work?
    a. What did you do during sessions to help you cope?
    b. How did your strategies change over time?
    c. Did you feel the need to mentally distance yourself from what clients are saying?
        i. (If yes) How often? When did you choose to do so? When did you not?
9. How did your personal experiences affect your work as an interpreter? (If not) How did you continue to work without difficulties?
10. What was rewarding about your work with clients?
11. What parts of your workplace outside your control made doing your work more difficult?
    a. What was your relationship like with clinicians?
        i. Could you imagine going to any of the clinicians you worked with for therapy yourself? Why or why not?
    b. Did you ever feel powerless at work? What happened?
12. What kind of support did you want when you were working as an interpreter (inside or outside of work)?

a. What kind of support was helpful?
    i. What was helpful about supervision? What would you change?
    ii. What was helpful about debriefing [talking to clinicians after sessions]? What would you change?
        1. If you were limited on time after session and feeling upset, how would you want to use that precious time? What would be the most important thing to do?
b. What kind of support would help you with difficult sessions?

Appendix E

Demographic Chart

	Age	Gender	Ethnicity	Years of experience	Years in U.S.	Training received
Participant 1	24	Female	Asian	2	12	Verbal interpretation in the United States; psychological first aid
Participant 2	29	Female	Nepali	2	13	Medical interpretation training; patient navigator training (level 1 & 2); motivational interviewing training; several others
Participant 3	36	Female	Asian - Nepalese	3	10	Patient navigator training (level 1); medical interpretation training; verbal interpretation in the United States; self-care; a couple others
Participant 4	25	Female	Asian	2	12	Verbal interpretation in the United States mind-body and spirit training; taking care of clients; whole health achievement.