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The Impact of Compassion Fatigue on Mental Health Sign Language Interpreters Working with Children: A Thematic Analysis

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ABSTRACT

The impact of compassion fatigue (CF) on frontline professionals has been widely researched. However, interpreters often work alongside frontline professionals and are exposed to similar traumatic experiences. Despite this, there is a dearth of research exploring the impact of CF on interpreters. Mental health sign language interpreters (SLIs) are believed to be at a higher risk of developing CF compared to other professionals due to high engagement with therapeutic content, demands of their role, and low perception of control over those demands. Research demonstrates that working with children increases one's risk of developing CF further. Nevertheless, there has been no known research investigating the impact of CF on mental health SLIs working with children. This qualitative study aimed to explore this impact and the factors that may prevent CF from developing. In-depth semi-structured interviews were conducted with seven mental health SLIs working with children in mental health services in England between March and May 2018. An inductive thematic analysis highlighted five themes: 1) emotional challenges of the job, 2) ruminating on patient's emotions and experiences, 3) consequences of interpreting dilemmas, 4) becoming used to interpreting emotional sessions, and 5) benefits of obtaining support. Findings urge organizations involved in the development of interpreting guidelines, interpreter training, and those that require interpreting services, to consider the implications of CF and measures that can be taken to prevent it.

INTRODUCTION

Compassion fatigue (CF) is commonly recognized as the "cost of caring" (Figley, 2002a, p. 1433). It is the result of frequent exposure and empathic engagement with traumatic experiences faced by other individuals (Hall, 2016), and is believed to impact between 40% to 85% of healthcare professionals (Mathieu, 2012). Although some research distinguishes CF from vicarious trauma and secondary traumatic stress, it is more widely recognized as the same phenomenon and is commonly used interchangeably (Figley, 2002a; Hall, 2016). Therefore, for the purposes of this paper, the term CF will also encompass vicarious trauma and secondary traumatic stress.

CF can be associated with various symptoms such as reduced life satisfaction, distress, insensitivity and reduced interest towards clients, work disputes, burnout, hopelessness,

withdrawal, flashbacks, difficulty concentrating, and apathy (Figley, 2002a). According to Figley (2002b), mental health professionals are at a higher risk of developing CF as their work demands high levels of empathizing abilities combined with the motivation to support individuals in need. Direct exposure to patients requires an empathic response from the therapist, which could involve envisioning one's self in the patient's position to better understand their thoughts, feelings and behavior. This projection of one's self onto the patient's traumatic experience may then result in the mental health professional feeling the emotions associated with the trauma (Figley, 2002b).

Although there is substantial research investigating the impact of CF on frontline professionals such as nurses and clinicians, there has been minimal research on other professionals working in the health care setting. Language interpreters, for example, often work alongside frontline mental health professionals and due to their direct contact with patients, may also be exposed to the same traumatic disclosures and experiences (Anderson, 2011). Unlike clinicians, interpreters are often not provided with the appropriate training and support (MacDonald, 2015). A qualitative study by Doherty et al. (2010) on mental health interpreters working with refugees found that more than half of their participants reported emotional impact from work and difficulty forgetting clients' experiences, one third reported that their work impacted their personal life, and approximately a quarter struggled to proceed with their subsequent job as a result of distress.

Anderson (2011) argues that interpreters may in fact be at a higher risk of developing CF compared to other mental health professionals, as they interact intuitively with patient's experiences. To retell an experience with the patient's intended meaning, interpreters are required to visualize the experience, cognitively engage with the content to translate it, reproduce the emotions of the patient, and use a first-person form when delivering the message (Herndon & Joyce, 2004; Metzger, 1999). Although all mental health professionals may project themselves onto the patient's experiences (Figley, 2002b), the high engagement with the patient's experience suggest that interpreters are required to produce a greater empathic response. Additionally, although interpreters are trained and expected to be merely a communication conduit, it is impossible for them not to have emotions linked to the interpreting session, and they often shift between different roles such as being viewed as a confidant by the patient (Hsieh, 2006; Kaufert & Koolage, 1984). Hence, the impact of CF on interpreters may differ from frontline professionals, prompting further research in this domain.

Using the Demand-Control Theory (Karasek, 1979), Dean and Pollard (2001) add that interpreting is a highly demanding role with low perceived control. More specifically, they evaluated sign language interpreting, and argue that Sign Language Interpreters (SLIs) face greater demands in their role compared to spoken language interpreters. This may be because SLIs are responsible for bridging the communication gap between the deaf population and the hearing world (Champagne, 2017). It is also argued that SLIs may have a higher empathic response as most of them have a deaf family member or a deaf close friend who have experienced communication breakdown and depreciation, amplifying the perceived demand to facilitate communication (Harvey, 2002). SLIs are also assumed to have a low perception of control over the demands faced in their role. This is because interpreting guidelines and traditions expect them to suppress their personal opinions and feelings, and merely translate what is being said or signed (Dean & Pollard, 2001). This lack of control, combined with the high demands of the job results in large amounts of strain, which could build up and consequently lead to CF (Dean & Pollard, 2001). This is supported by a systematic review by Darroch and Dempsey (2016) analyzing eleven studies

investigating interpreters. Their review revealed that SLIs may experience CF due to factors such as empathic engagement with patients, countertransference of patient's trauma, avoidance of own emotions, relationship with patients, lack of protocol within organizations, and identity conflict. However, only two of the studies in the review addressed SLIs directly, whilst the rest were based on spoken language interpreters, questioning the generalizability of the review to SLIs. Hence, further research directly investigating SLIs is required to effectively recognize the impact of CF on SLIs.

Additionally, working with children may impact the development of CF. A longitudinal study investigating Finnish social workers found that child protection social workers reported higher levels of CF compared to social workers without child protection duties (Baldschun et al., 2019). This is supported by Conrad and Kellar-Guenther (2006) who found that over 150 child protection staff in Colorado experienced high to very high levels of CF, and by Maytum et al. (2004), who found that CF was a common occurrence amongst nurses working with children with chronic conditions. These studies suggest that working with children who experience trauma or difficulty further increases one's risk of developing CF. As clinicians often rely on mental health interpreters when assessing a child's language skills and delays during mental health assessments (Rousseau et al., 2011), interpreters play an important role in children's mental health services.

The aim of this study is to explore mental health SLIs' experience of CF when working with children, and to explore the factors that may prevent mental health SLIs from experiencing CF. As this study explores a novel relationship, a qualitative approach is adopted as it is useful for theory generation and can act as a foundation for further qualitative and quantitative research (Braun & Clarke, 2013).

METHOD

DESIGN

An inductive qualitative approach from a critical realist perspective was employed. This assumes participant knowledge to be a true reflection of their motivations, perspectives and experiences, and thus can improve our understanding of society (Bonnington & Rose, 2014). To collect detailed data regarding experiences of SLIs, semi-structured interviews were conducted (Galletta, 2013). This study received ethical approval from the University of Bath Department of Psychology Ethics Committee (code: 18-025).

PARTICIPANTS

Seven SLIs working with deaf children in mental health services in England were recruited via opportunity sampling (4 females, 3 males; age range 30-56, $M = 43.14$, $SD = 9.72$). Three participants identified as White British, three as Black British, and one as White Other. All participants had a family member or close friend who is deaf. Although the sample may seem small, this may be justified by considering the challenges in recruiting freelance individuals as research subjects, the in-depth data provided, and its ability to appropriately consider the research questions.

All participants were fully qualified SLIs registered with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD). To become a mental health SLI, participants would have been required to have at least three years of interpreting experience as a fully qualified registered SLI prior to working in mental health. Additionally, although not mandatory, most participants would have also attended a two-day workshop on mental health and deafness.

MATERIALS

An interview schedule was created to flexibly guide the researcher during interviews (see Appendix). Open-ended questions allowed respondents to share and explore their own thoughts and experiences, whilst providing room for follow-up questions (Powell et al., 2014). Core questions aimed to explore participant views of working with children with mental health difficulties, followed by questions exploring interpreting experiences that may have been difficult, and the potential impact of witnessing negative therapeutic outcomes. The interview moved to focus on participants' understanding of CF, the symptoms, and whether they perceive it to relate to their life. Participants were given the opportunity to add additional comments at the close of the interview.

PROCEDURE

Interviews were conducted by the first author in a private and quiet room, ensuring participants felt safe to talk about their experiences whilst minimizing distractions. Participants were presented with the participation information sheet and consent form, reminded of their right to withdraw and given time to read the information and ask questions. Once consent was obtained, interviews were carried out using the interview schedule as a guide. Interviews ranged in length from 24:44 to 55:26 minutes ($M = 37:03$, $SD = 10:58$). Participants were then given the debrief sheet, provided with additional detail about the study, and made aware that a clinical psychologist was available for additional support if required. Interview recordings were transcribed verbatim according to transcription guidelines adapted from McLellan et al. (2003).

DATA ANALYSIS

An inductive approach was chosen to help identify patterns in the data, since this approach is not theory bound, and can thus fully represent perceptions and experiences of participants (Braun & Clarke, 2013). Initial codes were first identified by analyzing the whole dataset and highlighting quotes of interest and relevance to the research questions. These were then categorized into initial themes and subthemes. The data was checked to ensure codes and themes were consistent and represented the dataset. Themes were redefined accordingly.

ANALYSIS

Following analysis, five themes were derived: 1) emotional challenges of the job, 2) ruminating on patient's emotions and experiences, 3) consequences of interpreting dilemmas, 4) becoming used to interpreting emotional sessions, and 5) benefits of obtaining support. These will now be considered individually in detail.

EMOTIONAL CHALLENGES OF THE JOB

A recurrent theme throughout all interviews was the emotional challenges of interpreting for children in mental health services. Feelings of “distress,” “upset,” and “frustrated,” words commonly used to describe CF, were frequently used by all participants when describing their experiences of mental health interpreting in children’s services. Hence, all participants may be impacted by a degree of CF. This may be because the very nature of children experiencing trauma at a young age is emotionally challenging, as outlined by Participant 5 (P5):

working with the children is obviously their sort of, their, their life, their, their backstories, it’s quite upsetting because some of them are young, all of them are young and, you know that, I guess you carry that around, with you because, you know, it’s different from say, interpreting someone’s IT training. to come here and, working with children that’ve had. quite upsetting starts to life or going through upsetting things.

P5 stresses that learning about children’s traumatic backgrounds can be upsetting and SLIs may “carry that around” with them, implying the impact may persist post-session. P5 also highlights the difference between other interpreting roles and interpreting in a children’s mental health service, emphasizing the greater emotional challenges faced.

Participant 4 (P4) adds that mental health interpreting for children is more emotionally challenging compared to interpreting for adults as all humans naturally want children to “enjoy themselves,” “thrive,” and “not be ill.” Hence, interpreting children’s traumatic experiences can be “very difficult.” This suggests that interpreting for children in a mental health setting is more emotionally challenging than other domains, implying that mental health interpreters working with children may be more susceptible to developing CF compared to other interpreters. The upsetting nature of working with deaf children who have experienced trauma and difficulties is emphasized by Participant 6 (P6):

the deaf children that come here ... whatever that’s going on out there, they will have experienced it, but even to a, more extreme degree. so, you know, deaf children who’d been sexually abused and, not been able to talk about that sexual abuse because, a, they don’t think that they’d be believed or, b, they simply can’t, find the, tools to communicate that, to make people understand that.

P6 highlights the struggles faced by deaf children in society and emphasizes that deaf children may experience trauma and difficulties to a greater extent due to communication barriers. Consequently, deaf children may stay in their traumatic situation or environment for a longer period and may be diagnosed much later compared to hearing children. This suggests that mental health SLIs may be faced with one of the most emotionally challenging interpreting roles and may be exposed to more severe traumatic experiences compared to other interpreters, placing them at greater risk for developing CF. Additionally, Participant 7 (P7) draws attention to the communication barrier between deaf children and their hearing parents, and the sense of frustration surrounding this issue:

you can start to see the root causes, of umm, of someone’s illness, and a lot of the time with deaf children, especially to hearing parents, it’s because of a lack of communication ... make you feel angry or, upset, ... just completely

puzzled as to how a parent, won't or can't learn sign language to communicate with their child, and then wonder why they're having, problems.

P7 highlights that interpreting home visit sessions enables interpreters to witness the communication barriers faced by children first-hand and the different attitudes towards deafness, proposing these factors to be the root cause of deaf children's mental health difficulties. This demonstrates that mental health SLIs potentially witness deaf children being discriminated and undervalued by their own family members, consequently resulting in anger towards parents, confusion, or feeling upset.

RUMINATING ON PATIENT'S EMOTIONS AND EXPERIENCES

Mental health interpreting may not only be challenging during an interpreting session but may also impact one's life post-session. This is illustrated here via two sub-themes.

Thinking About Previous Sessions

Participants also shared experiences of ruminating on past interpreting sessions by thinking about specific patients or related events, as demonstrated by Participant 1 (P1):

I have this memory in my head of this really really sad story he told me, it, it it, has stuck, it has stuck in my head ... so some kids stand out in my mind and if things, bad things happen to them I guess, you know, it upsets me a little.

A child's traumatic experience or story may result in mental health SLIs thinking about the child and their circumstances post-session, consequently provoking feelings such as worry and sadness. This is concerning as mental health SLIs will often interpret "sad stories" and trauma experiences, implying a high number of interpreting sessions are ruminated upon post-session. This is supported by P4 who answered "forget about it, I don't think you can forget about it" when asked about post-session experiences. P6 adds that emotional sessions may lead to more than just post-session thoughts:

when I say it would stay with me, it would be, I might be sitting on a bus, and then suddenly have a flashback, to two days ago therapy session and think, oh gosh, that poor child ... it would be momentary flashbacks. where. the emotions would well up in me again.

Thus, interpreting events may result in momentary flashbacks during post-session everyday activities. These flashbacks may also trigger the re-arousal of the emotions experienced during sessions, implying that these symptoms of CF may extend to one's daily life. This is supported by P5 who said, "I kept thinking about it, a lot afterwards, I found it quite distressing." As flashbacks and rumination are also common symptoms of CF, this further suggests that the participants may be impacted by CF.

Feeling Responsible for Emotions and Outcomes

Participants, like P5, also reported that they may be the only person in the therapeutic session who understands both languages, creating a sense of power and responsibility over the information being interpreted:

you have quite a lot of power in, the interpretation that you give ... it's not an exact translation, so it's always our decision about what we're, what we're giving over to each client. and whether we're making the right decisions ... most interpreters worry about that all the time so, I probably always worry that I'm not doing a good enough job ... always have, that, underlying, feeling, oh I could've done that, I should've signed it like this, I should've voiced that over. I think quite a lot of us are, you know, beat ourselves up a lot.

The linguistic complexities of sign language interpreting may result in mental health SLIs ruminating on how they could have interpreted better, resulting in the constant worry of “not doing a good enough job.” Additionally, as interpreters act as an intermediary between the patient and clinician, the patient often looks at the interpreter during communication, especially due to the visual nature of sign language. Participant 2 (P2) illustrates that the eye-contact between the interpreter and the patient may result in mental health SLIs perceiving they are responsible for mediating the patient's emotions:

Well because the deaf person is always looking at the interpreter ... countertransference doesn't, doesn't always happen with the hearing psychologists ... the interpreter who kind of. gets all the range of emotions from the deaf person. because. you're always responding to how, you know, if they, if they tear up and they start crying then, then they very rarely look at the psychologist ... they'll always look at the interpreter to get that, empathy ... so they're, they're always judging themselves through the interpreter rather than the psychologists, it all kind of happens with the, not all, but the interpreter, is the, the one who has to, kind of. deal with it to a certain degree.

P2 highlights that mental health SLIs “get all the range of emotions from the deaf person” and perceive that they “take on much more” responsibility for the patient's emotion than the clinician. This suggests that mental health SLIs do not merely translate information since they also engage emotionally with the interpreting content, demonstrating the high demands of the job. Moreover, P2 perceives that clients look to the SLI for support instead of the clinician, highlighting the expectations others impose on them, adding to feelings of responsibility. The perceived responsibility over containing and accurately portraying patients' emotions may further amplify the pressure to produce perfect interpretations, increasing the likelihood of rumination post-session. However, P7 demonstrates that although mental health SLIs may ruminate on the quality of their interpretation, they may not ultimately feel responsible for any negative outcomes:

you would think. was it because I said anything, or, was it because I translated it like that, yeah, I think you would do a quick check ... but I don't think I would ultimately feel responsible, or to blame.

Even though rumination may result in CF symptoms, mental health SLIs may be aware they are not to blame for any negative outcome. However, although P7 states they do not “ultimately feel responsible or to blame,” when asked about a specific interpreting experience, they reveal it took “a few years to sort of like remove” the idea they held responsibility for the negative outcome. P7 was able to stop ruminating on the experience only after meeting a family member of the patient who thanked them for their work, providing “closure.” However, this form of closure is not available for every experience or interpreter, indicating a potential long-term impact of CF on mental health SLIs.

CONSEQUENCES OF INTERPRETING DILEMMAS

The emotional challenges of interpreting may also be heightened when mental health SLIs are faced with interpreting dilemmas, resulting in a sense of hopelessness in regard to one’s role, another symptom of CF. This is outlined by P7:

it could be, that, uhh, an interpreter’s been in a family therapy ... and then he comes off to the inpatient service, and some of the information, is different ... so you’re holding on to this, so you’ve got this information as well, and it’s a bit of a dilemma there, what you do as an interpreter, can you offer that information up, or shouldn’t you ... there’s always like an inner battle going on.

P7 highlights the “inner battle” faced by mental health SLIs. Interpreters are expected to adhere to the interpreting guidelines which discourages interpreters from sharing any information from previous jobs (Dean & Pollard, 2001). However, mental health SLIs may hold vital information that could prevent a misdiagnosis, or aid in the formulation of an intervention, resulting in a dilemma. They are therefore forced to either diverge from the interpreting guidelines, or risk vital information being missed or misreported. The former choice may result in guilt, whilst the latter may induce anxiety over the possibility of a negative outcome, suggesting a negative impact either way, and potentially inducing a sense of hopelessness. Since participants were freelance interpreters working across the various children’s services, this may be a common dilemma faced.

P7 adds that a sense of hopelessness may also emerge as mental health SLIs are faced with the dilemma of whether to interpret what is being said exactly as it was said, or to adjust their interpretation to lessen the impact of the information in certain situations:

if somebody wanted to, umm, take their own life. so that’s difficult. and that was difficult saying that in front of parents ... you automatically feel you want to adjust the language so it doesn’t have such an impact on the parents. choosing the words carefully but at the same time. you can’t really do that because that’s what’s being said.

P7 highlights the dilemma faced by mental health SLIs when interpreting trauma-related content in the presence of parents. This dilemma is also caused by the dissonance between the interpreting guidelines which requires an exact interpretation, and the interpreter’s emotions and perspectives. Consequently, mental health SLIs are forced to choose between two options that may lead one to either feel guilty about acting against the guidelines or feel responsible for upsetting parents. As children’s mental health difficulties are often approached systemically (family

included in interventions), this may also be a common dilemma faced by mental health SLIs working with children.

Furthermore, Participant 3 (P3) stresses that mental health SLIs may occasionally feel like speaking out and correcting parents' perceptions about deafness, but are unable to since interpreters have "certain boundaries":

when the deaf children's parents, think, that their deaf child can't do something because they're deaf, I also kinda wanna say, but there are loads of case studies, like there's a lot of deaf people out here who can do stuff ... I think as an interpreter because you, there are certain boundaries you can't really, cross ... that could be frustrating, I think.

According to P3, witnessing the derogation, oppression, and/or mistreatment of deaf children could add to the list of possible dilemmas faced by mental health SLIs. As interpreting guidelines prohibit them from voicing their opinions, mental health SLIs are forced to either break this rule or witness the perceived mistreatment of deaf children in silence. This may add to the feelings of hopelessness related to one's role, and P3 highlights that these dilemmas also lead to frustration.

Although these dilemmas may not be exclusive to mental health SLIs working with children, participants' perception of their experiences suggests that they may have a greater risk of encountering these dilemmas, making them highly susceptible to symptoms of CF such as feelings of hopelessness and frustration in their role.

BECOMING USED TO INTERPRETING EMOTIONAL SESSIONS

Participants expressed that their experience of interpreting emotional sessions may help them become used to and normalize emotional sessions, consequently preventing the development of CF as they progress along their career, as demonstrated by P2:

you're helping the parents and children communicate for the first time properly in, probably ever ... the first time you do that, you kind of like, it's quite overwhelming, there's a lot of emotion in the room ... having done that several times now. umm, with different families. you know, you can kind of go, okay this is probably going to happen now, and you feel it coming and you do it.

Interpreting an emotional session for the first time may be significantly "overwhelming" as mental health SLIs are not prepared to face the responsibilities associated with bridging the communication gap for the first time or come into contact and engage with the various emotions in the room. However, after multiple experiences of interpreting emotional sessions, they are able to predict the emotions that arise, giving them enough time to prepare themselves to engage with the emotional content of the information. This idea is shared by P1 who states, "I work here enough to know when stuff is coming," implying that newly qualified mental health SLIs working with children may be at a higher risk of developing CF, whilst experienced SLIs are impacted to a lesser degree.

Besides being able to predict and prepare for emotional interpreting sessions, P4 adds that mental health SLIs' experience may also normalize trauma and difficult experiences faced by children:

I think maybe at the beginning, yes, but not so much anymore, I. you know when you, you start to see things more, it it, not that you become desensitized, but you just, it then becomes, normal, to a certain, normal in inverted commas.

Additionally, P4 stresses that normalizing traumatic and difficult experiences faced by children is separate from being "desensitized," implying that experienced mental health SLIs may not experience this symptom of CF. However, the process of normalizing traumatic and difficult experiences could progress to desensitization, as illustrated by P3:

none of it is new, it's the extreme, but none of it is new ..., I sound apathetic now I guess, but it's like, you know, it's that's what happens, like, that's what happens.

P3 has interpreted for mental health services for many years, and thus has been exposed to a lot of trauma and difficulty. They emphasize that "none of it is new," implying an extent of normalizing traumatic and difficult experiences faced by children. However, P3 also demonstrates a degree of apathy and pessimistic outlook in life by saying "that's what happens," suggesting that mental health SLIs may demonstrate desensitization, a symptom of CF. Thus, although a vast amount of mental health interpreting experience may reduce CF symptoms such as distress and flashbacks, it may instead increase the risk of symptoms such as apathy, hopelessness, and life dissatisfaction. Furthermore, it seems as though mental health SLIs may be more aware of the first set of symptoms, whilst not realizing the features and impact of desensitization. For example, P2 highlights the difficulty in recognizing symptoms such as desensitization and apathy, and appears uncertain on whether they have developed these symptoms:

I think I am, I don't think I am apathetic, I don't think I, don't, I don't think I. have numbed myself or ... don't care, anymore, I don't, you know, I don't think that's happened, I mean, it's how do you know, often it's hard to kind of recognize those things but, you know, I cert, I don't think that that's happened.

Therefore, even though increasing one's experience in mental health interpreting with children and normalizing children's traumatic experiences may progressively reduce the risk of developing certain symptoms of CF, it could also lead to other symptoms of CF such as becoming desensitized or apathetic.

BENEFITS OF OBTAINING SUPPORT

The support that the participants received from other interpreters and professionals was perceived to be a preventative factor for CF. All participants spoke about receiving peer support from other interpreters, and some also received additional support via formal supervision. The ability to "offload" (P5) and "vent" (P3) to others was perceived to be a reason behind why more experienced SLIs feel less impacted by CF, as outlined by the following exchange between P6 and the interviewer:

P6: Umm ... yeah, I think in the early days, I, I did, I think I definitely, came away grieving for the situation ... I don't have that anymore.

Int: Do you know why?

P6: I think supervision, I think having regular supervision, and a group of interpreters in the, uhh where we share, and look out, and unpick, you know, whatever issues we bring to the group, that really, kind of helps to put it into perspective.

P6 highlights that the process of sharing interpreting experiences with others allows them to put things “into perspective.” P6 adds that they were more impacted by symptoms of CF previously as they did not have supervision or peer support. This idea that newer mental health SLIs may not access supervision or peer support is also demonstrated by P7 who stated, “I’m in a better position now because I have a supervisor,” supporting the argument that mental health SLIs with less experience may be more at risk of developing CF.

The effectiveness of seeking support from others in reducing symptoms of CF was attributed to the benefits of reflective practice. P2 states that supervisors and other interpreters will encourage SLIs to reflect on their experiences by “asking questions about it” and “get you to think about it.” P3 adds that this reflective process may help mental health SLIs rationalize and accept the decisions they have made whilst interpreting:

because I remember thinking like, oh I hope I did the right thing, or what should I've done, or like, could I've done it differently, or, but I think yeah, so you'd have to like talk to people. and then afterwards I was like, okay, I feel okay about it now.

As previously discussed, participants expressed that they often worry about their interpreting choices and are frequently faced with dilemmas, leading to feelings of hopelessness and frustration. Hence, reflecting on their interpreting choices and decisions in a “structured” (P2) and “supportive” (P1) group may support mental health SLIs to justify their actions to themselves and consequently reduce CF symptoms. Therefore, although the exposure to children’s traumatic experiences may have an impact on mental health SLIs, the impact could be reduced by getting support from other professionals.

DISCUSSION

This study aimed to investigate the impact of CF on mental health SLIs working with children and the factors that may prevent CF from developing. The analysis demonstrated that all participants experienced elements of CF to some degree and were unaware of the existence of some symptoms and/or the association between their symptoms and CF. Themes related to emotional challenges of the job, ruminating on patient’s experiences, interpreting dilemmas, becoming used to interpreting emotional sessions, and benefits of obtaining support.

EXPERIENCE OF CF

The analysis suggested that the mental health SLIs working with children experienced various symptoms of CF including feeling distressed and upset, a sense of frustration regarding their role, hopelessness, flashbacks, re-arousal of emotions post-interpreting session, feeling responsible for negative outcomes, guilt, and feeling apathetic towards future children and their trauma-related stories. This array of CF symptoms is in line with previous literature investigating front-line mental health professionals (Beck & Gable, 2012; Benoit et al., 2007; Kumar, 2016; Markwell & Wainer, 2009; Melvin, 2015; Perry et al., 2011) and language interpreters (Darroch & Dempsey, 2016). As suggested by previous research, mental health SLIs working with children may be at a greater risk of developing CF compared to other professionals and interpreting roles. This may be because they engage greatly with the emotions of the clients during therapeutic sessions and feel a great sense of responsibility to contain patients' emotions and accurately enact it in sign language.

Mental health SLIs may also be affected by CF due to the significant impact their interpretations can have on others' lives. The analysis suggests that deaf children may stay in their trauma or difficulty for a longer period as they do not have the right tools to communicate their experiences and feelings to others. This is supported by Hindley (2005) who highlighted that 95% of deaf children are born to hearing parents, and these parents often experience difficulties in exploring emotions with their deaf child. As a result, deaf children may not know how to communicate their emotions effectively, may not be surrounded by individuals who understand them, or may feel apprehensive about disclosing their experiences (Hindley, 2005). Therefore, as highlighted in the analysis, the SLI may be bridging the communication gap between the deaf child and their hearing parents or hearing professionals for the first time, unveiling a vast array of concealed emotions and incidents. SLIs may thus feel a sense of responsibility over triggering the emotions and the outcomes that may arise from the session, and thus feel guilty for causing such an event. Interpreters are also often responsible for making clinicians aware if a form of assessment is not culturally appropriate for the child (Rousseau et al., 2011). For example, as standard mental health tests are created to assess hearing children and are often not generalizable or valid for deaf children (Fellinger et al., 2012), mental health SLIs may need to voice concerns or suggest adaptations. Hence, mental health SLIs may be perceived as the holder of Deaf culture in a hearing-dominated world, increasing the pressure to execute the perfect interpretation and represent the deaf community, as their interpreting decisions may influence the clinician's decision and treatment pathway offered. Further support for this idea comes from a qualitative study on genetic counsellors' experience of CF by Benoit et al. (2007). They found that genetic counsellors perceived themselves to be embedded into patients' negative memories due to the impact of their role and this perception was consequently a strong predictor of CF.

Conversely, helping a child communicate with the world for the first time and ending their trauma could instead increase compassion satisfaction (CS) - the pleasure resulting from providing help, alleviating others' suffering, and being the catalyst for positive change (Coetzee & Klopper, 2010). By bridging the gap between the deaf child and the hearing world, mental health SLIs may be in a position to empower deaf children who may have been discriminated against and ignored in the past, providing the child with a chance to improve their lives. This position of power may consequently reduce the sense of hopelessness associated to their role. Research shows that CF is negatively correlated with CS, implying that the satisfaction acquired may serve as a preventative factor for CF (Kelly et al., 2015; Meyer et al., 2015). However, according to Stamm (2002), individuals may experience CS alongside CF due to the combination of working in a traumatic

situation and the desire to help others. The upsetting nature of hearing about childhood trauma, mental health and injustice may attack mental health SLIs' beliefs about humanity and the purity of childhood, changing their perception of the world (Neumann & Gamble, 1995), possibly leading to CF. Simultaneously, mental health SLIs may have a strong motivation and desire to improve the child's situation, potentially leading to CS if perceived to be successful, or CF if perceived to be unsuccessful. Hence, mental health SLIs may frequently engage in deliberation processes (such as the process of rumination and seeking support from others highlighted in this study) in order to decide whether their interpretation has resulted in a positive or negative impact on the child's life. Nevertheless, the impact of CS on mental health SLIs working with children cannot be accurately postulated here as it was not explored in detail during the interviews, highlighting an opportunity for future research.

The increased risk of developing CF may also be attributed to the high demands of the interpreting role, combined with the low perception of control over those demands, supporting the Demand-Control Theory (Karasek, 1979). In terms of linguistic demands, participants highlighted that mental health SLIs often worry about the quality of their interpretation due to the discrepancies between British Sign Language and English. This subsequently links into intrapersonal demands as SLIs often ruminate on how they could have interpreted better. Due to the nature of freelance interpreting, interpreters are also required to perform to a high standard in order to maintain their professional credentials and remain employed (Schwenke, 2012), fueling the demand to interpret 'perfectly'. Alternatively, interpersonal demands are associated with the higher occurrences of interpreting dilemmas faced by mental health SLIs working with children. Due to interpreting guidelines that discourage interpreters from sharing their opinions or information from previous jobs (Dean & Pollard, 2001), mental health SLIs are often faced with interpreting dilemmas and may feel they have no control over the outcomes of their job. As illustrated in the analysis, mental health SLIs may be frequently required to choose between breaking the interpreting guidelines or risk the possibility of a negative outcome. This perceived lack of control combined with the strive for perfectionism consequently increases the risk of developing CF (Lee et al., 2015).

POTENTIAL CF PREVENTATIVE MEASURES

The analysis demonstrates that the risk of developing CF may decrease as mental health SLIs working with children gain more experience in their field. This may be due to more experienced SLIs becoming used to interpreting emotional and traumatic therapeutic sessions and normalizing difficulties faced by deaf children. According to Jones and Sundet (2014), it is unlikely for less experienced professionals to have had the opportunity to develop necessary coping mechanisms required to manage and process all the emotions associated with their role, supporting this finding. Hunsaker et al. (2015) found that experienced professionals not only had lower levels of CF, but they also had higher levels of CS, further implying that CS may develop alongside CF and could be a preventative factor for CF. This is supported by Craig and Sprang (2010) who found higher levels of CS in more experienced trauma therapists. Consequently, experience may prevent mental health SLIs from developing CF as they become accustomed to interpreting therapeutic sessions and may result in the development of CS.

This study also found that support from others via supervision, debrief, and peer groups is an important preventative factor for CF. All participants spoke about the benefits of obtaining support and being able to reflect on their practices and highlighted the reduction of CF symptoms as a result. This is especially important for mental health SLIs as they are often unable to talk to

their friends and families about the struggles associated with their job due to confidentiality requirements (Dean & Pollard, 2001). These findings are consistent with previous literature demonstrating the benefits of supervision from various fields such as social work, mental health, and child welfare (Chiller & Crisp, 2012; Mor Barak et al., 2009). Moreover, Anderson (2011) investigated the impact of a peer support group on mental health SLIs specifically and found that involvement in the group significantly increased SLIs' perception of control over their emotions and roles, self-care, and positive outlook regarding their role, demonstrating a reduction in CF symptoms as a result of peer support.

IMPLICATIONS

Considering the significant impact of interpreting dilemmas on the wellbeing of mental health SLIs working with children, this study urges professional interpreting organizations such as The Association of Signed Language Interpreters (UK), National Register of Public Service Interpreters (UK), and the Registry of Interpreters for the Deaf (USA) to consider evaluating the current interpreting guidelines to take into account and provide solutions for the dilemmas faced by SLIs, such as those related to sharing vital information from previous jobs.

Moreover, to better equip interpreters for their role, interpreting training courses should consider incorporating topics on coping mechanisms and CS. Interpreting training should also emphasize the importance of supervision and peer support to encourage mental health SLIs working with children to seek out support and engage with the available groups and resources. It should be noted that participants from this study worked in a close-knit hospital community where most of the SLIs had become close friends. Hence, it may have been easier for them to reflect on their practices and find support compared to other interpreters who do not have regular interpreting bookings in the same location. Therefore, peer support may not be easily available for all interpreting roles, prompting organizations requiring SLI services to implement formal supervision or debrief sessions as part of the job specification.

STRENGTHS AND LIMITATIONS

This study is novel in that it is the first study to research the impact of CF on mental health SLIs working with children. The use of a qualitative design is a strength of this study. SLIs demonstrated difficulties in identifying CF symptoms, and the analysis illustrated that although participants claimed they were not experiencing CF, they concurrently spoke about experiencing various symptoms of CF such as flashbacks, distress, and apathy. Participants may thus only have an implicit knowledge of their experiences. This may explain why a self-report quantitative study found that therapists reported high levels of CF, whilst interpreters only reported low levels of CF (Birck, 2001). The qualitative design here allowed a detailed exploration of participants' perceptions and experiences and did not rely on participants knowledge of CF and how they may have been impacted.

In terms of limitations, only seven participants were interviewed. Although these were in-depth and well-focused interviews, findings should be interpreted with care. Moreover, participants were recruited via opportunity sampling. The interpreters who opted to participate in this study may have been those who felt particularly connected and/or intrigued by the research question and topic. Hence, the experiences and perspectives of the participants in this study may not be representative of all mental health SLIs working with children.

Participants also worked across outpatient and inpatient services. Considering patients stay longer in inpatient units, the SLIs may have been in regular contact with the patients. Although participants were asked about their general interpreting experiences during interviews and they did not specify that their experience of higher engagement was exclusive to their inpatient work, such a relationship may result in them being more invested in the outcome of each session. Additionally, interviews were conducted in an inpatient unit and various priming studies have demonstrated the unconscious influences of exposure on responses (Graham & Lowery, 2004; Van den Bussche et al., 2009). Hence, although interview questions were general and asked about participants overall experience, the location of the interview may have prompted them to talk predominantly about inpatient experiences. Future research could consider interviewing participants in a neutral location and exploring whether there are differences in the experience of mental health SLIs who work exclusively at children's outpatient and inpatient units.

CONCLUSION

The current study investigated the impact of CF on mental health SLIs working with children. The analysis suggests that mental health SLIs working with children are at a greater risk of developing CF compared to other interpreters and clinicians due to the nature of working with children in mental health services, the perceived impact of their interpretation, and the frequency of encountering interpreting dilemmas. However, preventative factors such as experience, support from others, and possibly CS, may help reduce their risk of developing CF.

This study urges organizations involved in the development of interpreting guidelines, interpreter training, and those requiring interpreting services, to consider the implications of CF and the measures that can be taken to prevent CF development. Future research in this area would evidently benefit from a larger and more extensive sample, to explore whether the results found in this study could be generalized to mental health SLIs working with children more widely. Additionally, although a qualitative approach was useful and appropriate for the explorative nature of this study, future research could also include quantitative approaches such as using outcome measures for CF and CS, and comparing different SLI populations (e.g., SLIs working exclusively in outpatient and inpatient units).

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Appendix

Interview Schedule

How long have you been a registered British Sign Language interpreter?

What made you become a BSL interpreter.

How do you find it so far?

Prompt: What would you say is your favorite thing about being a BSL interpreter?

Do you work with children with mental health difficulties?

How would you describe this experience?

How would you compare this to working with adults with mental health difficulties?

From your experience working with children with mental health difficulties, are there any experiences that stand out?

Prompt: Why? What happened?

Have you ever had to interpret something you found emotionally difficult?

[If yes] Why do you think you found it difficult?

Did you keep thinking about it or were you able to disengage after your shift ended?

If something negative happened to a child you are working with, how would you feel?

Prompt: Would you be impacted emotionally or would it not impact you.

Prompt: Would you be sympathetic towards the child?

At the end of your shift, how do you usually feel?

Have you heard about compassion fatigue, vicarious trauma or secondary traumatic stress?

[If yes] What do you think are the signs and symptoms?

[If no, provide explanation]

Does this relate to you?

[If yes] How would you describe your experience?

What do you think causes you to experience this?

How do you think this affects you?

Does this have any long-term impact on your life?

What are the reasons for you to continue working in this setting?

[If no] What do you think prevents you from experiencing this?

Is there anything you think I haven't covered that you would like to add or ask me?