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# **Preventing vicarious traumatisatisation in mental health settings: a training course for interpreters / Prevención de la traumatización vicaria en entornos de salud mental: curso de formación para intérpretes**

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**Abstract:** Mental health interpreters are often exposed to traumatic material, such as accounts of torture, sexual violence and persecution, and are likely to experience symptoms of trauma themselves. The risk of vicarious traumatisatisation of interpreters can be mitigated by helping them defuse emotional repercussions encountered in their profession. Here, we suggest introducing a four-step psycho-educational course into the training of interpreters, based on theoretical and practical insights from psychology, psychiatry, linguistics, and interpreting studies. More specifically, the training emphasises awareness of vicarious trauma,

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identification of its manifestations, detection of its main triggering factors, and elaboration of individual, interpersonal, and structural coping strategies to be applied before, during and after consultations. Strategies presented here include hypno-imaginative techniques, and interprofessional pre-consultation sessions making the consultation more predictable. The feasibility of certain strategies due to interpersonal and structural constraints is also discussed. This article focuses on mental health interpreting; however, the findings and the proposed coping strategies may be valid for public service interpreting in other high-risk settings.

**Keywords:** Mental health interpreting; Vicarious traumatising; Education and training; Coping strategies; Public service interpreting.

**Resumen:** Los intérpretes en salud mental suelen estar expuestos a material traumático, como relatos de tortura, violencia sexual y persecución, y son por ello susceptibles de experimentar síntomas traumáticos. Para reducir el riesgo de traumatización vicaria mediante la ayuda a los intérpretes para desactivar las repercusiones emocionales de su profesión, esta contribución propone introducir en su formación un contenido psicoeducativo en cuatro pasos, basado en conocimientos teóricos y prácticos desde los estudios de interpretación, la psicología, la psiquiatría y la lingüística: concienciación del trauma vicario, identificación de sus manifestaciones, detección de sus principales factores desencadenantes y elaboración de estrategias de afrontamiento individuales, interpersonales y estructurales para aplicar antes, durante y después de las consultas. Las estrategias incluyen técnicas hipno-imaginativas y sesiones interprofesionales de preconsulta que hacen la consulta más predecible. Se discute la viabilidad de ciertas estrategias debido a limitaciones interpersonales y estructurales. La contribución se centra en la interpretación en el ámbito de la salud mental, pero las conclusiones y las estrategias de afrontamiento propuestas son válidas para la interpretación de servicio público en otros contextos de alto riesgo.

**Palabras clave:** Interpretación de salud mental; Traumatización vicaria; Educación y formación; Estrategias de afrontamiento; Interpretación en los servicios públicos.

**The five authors contributed to all the sections. They drew from practice and theory in their respective professional fields and combined their experience into an interdisciplinary perspective. Nathalie Bennoun and Felicia Dutray drew respectively on their experience as a psychologist and psychiatrist working daily with interpreters in a clinical setting for over 20 years; Orest Weber on his work as a linguist in a hospital setting; Lorine Pierard and Anne Delizée on their experience as interpreters. All five also provide training for public service interpreters, as well as joint training for mental health professionals and interpreters, including a course on the issue of vicarious trauma.**

**We would like to thank Sandra Mazaira, a psychologist who, together with Nathalie Bennoun, has developed preventive courses using hypno-imaginative techniques to protect health care professionals and interpreters from vicarious traumatising.**

## 1. Introduction

Interpreters working with migrants may face emotionally laden narratives as the latter may have had traumatic experiences in the country of origin, during the migratory journey, or in the host country. Being personally affected by these narratives is inherent to interpreters' work; it is not a sign of incompetence or lack of professionalism. Indeed, interpreting in the migratory context has inevitable repercussions on interpreters' physical and psychological health (e.g. Mehus & Becher, 2016). This can lead to a significant deterioration in well-being, a reduction in the quality of interpreting, absenteeism, and a high turnover (e.g., Hordyk et al., 2017), which all can result in increased costs.

In order to break this vicious cycle, it is crucial to raise interpreters' awareness of the emotional risks of their work and to develop their self-care strategies (e.g., Crezee et al., 2015; Korpál & Mellinger, 2022). While nurturing oneself should be a priority rather than a luxury (Bontempo & Malcom, 2012, p. 119), training on this topic remains scarce (Costa et al., 2020). To contribute to filling this gap, we propose a 15-hour psycho-educational course in four stages, drawing on psychology, psychiatry, linguistics, and interpreting studies. Our proposal is based on three foundations: (1) theoretical insights from the four disciplines mentioned above, (2) our professional practice in bilingual health care settings, and (3) our experience as trainers of interpreters and clinicians<sup>1</sup>. Over the past three years, we have developed and tested the four stages of this proposal in French-speaking Switzerland (about 20 interpreters and 35 clinicians per year) and in French-speaking Belgium (about 40 interpreters per year). Informal feedback from participants has been positive: they feel less overwhelmed by emotions and know how to deal with them and where to seek help. However, the effectiveness of our proposal has yet to be formally evaluated (see research perspectives, section 6).

The structure of the proposed course is as follows. First, trainee interpreters are invited to carry out a reflective analysis of the phenomenon of emotional distress related to interpreting, based on existing scientific literature (section 2). Then, they learn to differentiate vicarious trauma from other forms of work-related emotional exhaustion, and to identify its main manifestations (section 3) as well as its triggering factors (section 4). Finally, they are encouraged to develop and try out a range of coping strategies (section 5). This socio-constructivist-inspired proposal therefore offers a phase of theoretical grounding and a phase of personal elaboration and experimentation. Anchoring learning in theory means providing a conceptual structure that facilitates awareness and adaptation of one's own practice (Angelelli, 2008; Pöchhacker, 2010). When this structure is then made concrete through the elaboration of personal solutions and experimentation, it provides a sense of control over learning and facilitates the assimilation of content (Jonnaert & Vander Borght, 2008). The main aim of our proposal is therefore to *educate* the trainee interpreters, i.e. to equip them intellectually by expanding the capacity for critical analysis, reasoning, and informed decision-making, rather than exclusively to *train*, i.e. to automate practical know-how (Merlini, 2017, p. 139).

This article focuses on the risk of vicarious trauma (hereafter, VT) in mental health interpreting because traumatic events are often explicitly evoked by patients in this setting, which increases the risk of VT for the clinician and the interpreter (cf. Knodel, 2018). Furthermore, we hypothesise that, compared to the general population, the prevalence of trauma is higher among interpreters because they may come from a migrant background and have gone through some of the difficult experiences inherent in migration. Consequently,

<sup>1</sup> In this article, "clinician" will be used as a generic term to refer to all categories of mental health professional.

interpreters in mental health face an increased risk of eliciting painful memories and reactivating trauma of their own (e.g. Holmgren et al., 2003). Likely, this explains why the mental health settings are considered to be particularly high-risk (e.g., Doherty et al., 2010). However, more broadly, the pedagogical content proposed in this article can be adapted to any other context that is likely to make interpreters vulnerable, such as physical health care settings, legal settings, and immigration and refugee services.

## 2 Becoming aware of interpreters' potential distress

As a first step, trainee interpreters are invited to read at home and then to discuss in the classroom some studies pertaining to distress among public service (hereafter, PS) interpreters. They are guided to identify the main manifestations of distress and high-risk situations discussed in the readings. Three hours can be devoted to reflective discussion in class.

Indeed, scientific literature shows that PS interpreters are likely to experience physical and psychological manifestations associated with acute distress, such as physical pain, migraines, nausea, vomiting, lack of concentration, insomnia, nightmares, irritability, sadness, anger, helplessness, loneliness, and mood swings (Harvey, 2001; Holmgren et al., 2003; Splevins et al., 2010; Green et al., 2012; Lai et al., 2015). In the current state of knowledge, it is not possible to determine the frequency, persistence, and intensity of these manifestations, because research objectives, methodologies, sample sizes, and settings under scrutiny differ from one study to another, and some do not provide figures. The results depend on many other variables, such as risk factors, which include individual sensitivity (see section 4). Probably not all interpreters experience physiological and psychological repercussions because of their work (Gomez, 2013), but some suffer to such a degree that it has a negative impact on the quality of their services (Lai et al., 2015) or on their private life (Jidong et al., 2020), or even to the extent that they resign (Holmgren et al., 2003). While some interpreters report temporary emotional responses (Splevins et al., 2010), others may feel disturbed for some time (Lai et al., 2015), or find it difficult to accept new assignments (Doherty et al., 2010). Stress levels can be high (Park et al., 2017), but might decrease as the interpreter's professional experience increases (Miller et al., 2005).

Manifestations of distress can be observed whatever the setting, particularly in certain emotionally taxing situations, such as interpreting in mental health for victims of rape (Butler, 2008), of torture (Engstrom et al., 2010) and for minors who are victims of sexual violence (Powell et al., 2014). Depending on the study, manifestations of distress are attributed to VT (e.g. Doherty et al., 2010), compassion fatigue, and/or burnout (e.g. Mehus & Becher et al., 2016). These notions sometimes seem to be used as quasi-synonyms, and stress is used as a generic term (e.g. Anderson, 2011). We will therefore clear up this notional and terminological ambiguity in the following section.

The main goal of this first reflective stage is for interpreters to realise that PS interpreting can make them psychologically vulnerable, and that awareness, i.e. understanding professional risks and reflecting upon their own experiences and needs (Korpál & Mellinger, 2022, p. 277), is key to self-protection.

### 3. Learning to recognise vicarious trauma and its manifestations

As a second step, VT is defined and differentiated from other forms of work-related emotional exhaustion, and its main manifestations are identified. Two hours can be devoted to these aspects.

VT was first described in the 1990s by psychotherapists working with sexually abused patients, when they realised how many professionals working with traumatised people are affected by symptoms of trauma. VT originates in professional practices requiring an empathetic involvement with a person who suffers from trauma issues. Being exposed to traumatic content changes the professional's inner experience, i.e. their identity, world view, psychological needs, beliefs, and memory system (Pearlman & Saakvitne, 1995, p. 31). In comparison to VT, compassion fatigue, coined in the field of the Nurses' Health Studies (Joinson, 1992), is less specific. It refers to the exhaustion experienced by professionals who are empathetically engaged with their patients' suffering. As for burnout, it is associated with any profession that may trigger a physical and emotional fatigue in a person implicated in emotionally loaded situations (Pines & Aronson, 1988), but it is not specifically linked with an empathetic relationship to a suffering person.

The manifestations of VT are similar to symptoms of post-traumatic stress disorder. It encompasses reliving the situation through intrusive memories or nightmares, being hypervigilant and hyperaroused, trying to avoid anything that might bring back painful memories, feeling dissociated and experiencing a modification of the inner world. The shattered fundamental assumptions about the world and oneself when confronted with trauma has been investigated by the psychosociologist Ronnie Janoff-Bulman (1992). According to her, being able to make plans and having relationships with other supposes the belief that the world is meaningful, benevolent, and that the self is worthy (even if a part of the self knows that it is an illusion). When individuals are confronted with trauma, they may instead discover that the world makes no sense and can be harmful; they may doubt their own value. Symptoms of trauma can range from hyperactive (lots of energy involved) to hypoactive (not enough energy available). On the hyperactivated side, people suffer from intrusive imagery of violent scenes they themselves did not experience. They can have nightmares about traumatic events that happened to another person, but in which they have become the main protagonist. They can also be more anxious, for example, about going to places they weren't afraid of before (e.g. in the forest, in the car park). Therefore, they may develop related somatic symptoms like muscular tension (e.g. in the neck, shoulders) or neurovegetative disorganisation (e.g. digestive symptoms, headaches). On the hypoactivated side, they can experience symptoms of depression like sadness, loss of pleasure, lack of momentum, loss of self-esteem, concentration difficulties, or memory loss. They may also tend to self-isolate.

Being aware that there is a risk of VT when interpreting in mental health, and knowing and recognising its main manifestations, is a fundamental first step toward developing protective abilities.

#### 4. Being informed about risk factors

As a third step, trainee interpreters are invited to identify general and specific factors that put them at risk of VT. Throughout the discussion, the trainer builds on their reflections to explain and contextualise the triggering factors. In order to get a better insight into what puts them personally at risk of VT, trainees can then classify the factors in the following way (although most of the factors are interrelated): factors related to (1) the interpreter's background and personality, (2) the rendition of traumatic narratives, (3) the interpersonal and emotional involvement, (4) the patient, (5) the clinician, and (6) structural factors pertaining both to the interpreter's position and to the patient's predicament. Four hours can be devoted to this learning phase. In the following subsections, we expand on each of these six categories .

##### *41. The interpreter's personal experience and personality*

In many contexts, interpreters come from the same country of origin as the patients they interpret for, and they or their relatives may have gone through similar experiences of persecution or traumatising. They may still struggle with mental health problems linked to those events, and thus be more vulnerable to the effects of traumatic contents and less able to actively protect themselves. The patient's symptoms may be a trigger to the interpreter's dormant trauma memory network (cf. Brillon, 2013), which increases the risk of re-traumatisation (Holmgren et al., 2003; Spelvins et al., 2010). Other intrinsically personal factors can lead to greater vulnerability to VT, such as a low degree of emotional stability and adaptability (Bontempo & Napier, 2011), dysfunctional perfectionism, and a poor ability to mobilise positive strategies (Schwenke et al., 2014).

##### *42. Exposure to and transmission of traumatic narratives*

The risk of experiencing negative emotions and vicarious traumatisation is particularly high for interpreters exposed to content involving violence and suffering, such as accounts of war, torture, and death (Engstrom et al., 2010) or discussions about serious pathologies and end-of-life issues (Schenker et al., 2012; Prentice et al., 2014). The increase in manifestations of distress is linked to the frequency of exposure to traumatic content (Mehus & Becher, 2016) and to the very specific type of active listening required for the interpreting task. To perform the cross-linguistic transfer, interpreters may produce mental images of what is meant (Delizée & Michaux, 2019). Both the mental representation and the normative rule of rendering in the first person are likely to intensify the emotional repercussions of interpreting. Some specificities in contents and formal aspects of language in traumatised persons make interpreting for them particularly challenging. These include omissions (involuntary forgetting of a part of the discourse), avoidance tactics (avoiding expressing a part of what should be said in order to be understood by the other), incoherencies (no logical rule seems to connect the expressed elements), and difficulties in retrieving memories (not being able to access a part of what has been experienced). These aspects can accentuate the phenomenon of mental representation. Moreover, traumatic narratives are usually very "film-like", which makes it even more likely that the interpreter will create active images of the patient's trauma (vivid images of traumatic scenes) or to picture oneself or loved ones in the position of the victim. These are risk factors for VT (Pearlman & Saakvitne, 1995; Rothschild & Rand, 2006).



#### 43 *The interpreter's involvement and role conflict*

In recent years, the idea that the interpreter is part of the care process has gained ground; this stance requires a certain degree of interpersonal and emotional involvement (e.g., Chang et al., 2021; Hunt & Swartz, 2017). This involvement, which can be defined as the ability to be touched without being overwhelmed by emotions and to have a controlled relationship with the patient and the clinician (Delizée, 2018), would be one of the factors supporting a positive therapeutic alliance (hereafter, TA). TA is based on the partnership between the caregiver and the patient to achieve set goals, and research in monolingual contexts has established that the quality of the TA is predictive of the success of any type of therapeutic approach (e.g. Falkenström et al., 2013). In bilingual interpreter-mediated contexts, the few studies that have investigated the issue point to the active participation of the interpreter in the co-construction of a triadic relationship as being beneficial to the TA (e.g., Goguikian Ratcliff & Pereira, 2019; Delizée & Michaux, 2022; Hanft-Robert et al., 2023). The paradox of this involvement is that while it is probably beneficial, even necessary, to the therapy, it can make the interpreter psychologically vulnerable. In addition, the involvement requested by clinicians and patients may come into conflict with the normative neutrality/impartiality of the interpreter and give rise to a role conflict, a source of further fragility (Butow et al., 2012). However, the reification of the interpreter, considered as a "translation machine" by service providers and users (Bontempo & Napier, 2011; Prentice et al., 2014), can also lead to a sense of guilt in interpreters who "have feelings too" (Loutan et al., 1999). Tensions between involvement, normative role, dehumanisation of interpreters and the intense emotions they may sometimes feel can affect interpreters psychologically (Goguikian & Suardi, 2006; Green et al., 2012).

#### 44 *The patient's behaviour and situation*

*Habitus* and behaviour of the patient, such as nervousness, fidgeting, being easily startled, re-experiencing the traumatic event(s), as well as non-verbally communicated trauma content and dissociative reactions, may enhance the transmission of trauma content. Verbalising strong emotions such as shame, helplessness, anger, and sadness can be challenging and trigger traumatic memories in the interpreter. The literature suggests that mirror neuron activation, neurophysiological attunement, and shared body states are neuropsychological mechanisms underlying these phenomena (Gallese, 2005; Rothschild & Rand, 2006): in simple terms, when the interpreter engages in an empathetic relationship with a traumatised patient, the two nervous systems may resonate with each other. The interpreter may be activated by the patient's unprocessed manifestations of trauma and literally feel the other's somatic activations in his or her own body. The interpreter may therefore be equally tense, frightened, nervous, anxious, frozen. It is the accumulation of such situations that overwhelms the interpreter's capacity for self-regulation. Moreover, when interpreters notice that the patient's situation is not improving, or when they must relay bad news about the patient or about their own country of origin where they still have a family, they may feel helpless (Holmgren et al., 2003; Becker & Bowles, 2004), which in turn can lead to discouragement, a sense of failure and emotional exhaustion.

#### 45 *The clinician's position and behaviour*

In some cases, clinicians may become disorganised and imprecise, talk a lot, disregard basic rules of the clinical encounter, etc. They may react to the helplessness or loss of power they feel by becoming angry with the patients and/or the interpreters. This is likely to make the interpreters uncertain about who is leading the interview. Depending on their proximity/identification with the patients, the interpreters may want to protect them from the clinicians' reactions, and this situation may lead to a symmetrical escalation of helplessness, which is also a risk factor for VT (Bouvier & Dellucci, 2017).

#### 46 *Structural factors*

Structural factors are those linked to the external world that have an influence on individuals' social and legal status and their chances to live a meaningful life. Interpreters may identify with patients when there are many similarities in living conditions and life events (migration, family history, political opinion, membership of a minority or political group, trauma, etc.). For example, they can experience emotional and cognitive resonance when patients experience difficulties in adaptation and integration into the host society. Certain structural factors are particularly linked to the interpreters' professional status and social situation. These include institutional support and the availability of clinical supervision (reflexive discussion of the situations and emotions experienced, with the help of a psychologist specialised in stress and trauma. Cf. Costa, 2017). The precariousness of the job and the lack of social recognition of the professional status are also at stake.

These six categories of factors all increase the risk of trauma for interpreters. They must therefore be aware of them since some of these factors are controllable when they are brought into consciousness.

### 5. Developing a range of coping strategies

In this final step, trainee interpreters are invited to suggest possible strategies for coping with the risk of VT and to experiment with some of them. Firstly, they can share their tips and tricks in small discussion groups. Secondly, the trainer can elaborate on the suggestions by drawing on the psychological and psychotherapeutic literature and by carrying out exercises in the classroom (see section 5.1). Thirdly, to get a better idea of the whole range of possible strategies, trainees can fill in a double entry matrix, classifying the strategies according to a temporal variable – strategies implemented before, during and after the consultation – and a relational variable – individual, interpersonal, and structural strategies (see appendix). Six hours can be devoted to this last phase.

The strategies proposed below are based on (1) the scientific literature in psychology, (2) solutions suggested by our students, (3) studies on interpreters' distress and (4) hypno-imaginative techniques developed by Nathalie Bennoun and Sandra Mazaira (psychologists at *Appartenances*, Lausanne) to help interpreters and clinicians stay focused and calm their emotions.



### 51. *Individual strategies*

For emotional and physical release, three types of techniques can be identified on the basis of the psychotherapeutic literature (e.g. Saakvitne & Pearlman, 1996; Rothschild & Rand, 2006): body, emotion, and cognitive techniques related to the different parts of the human experience. Body techniques use the self-capacity of the body to soothe itself, for example through breathing exercises. Interpreters can also use their body as an anchor in the present by concentrating on the points of contact between their body and the environment. Emotion techniques often use the imagination to welcome and calm down the arising emotions. Cognitive techniques are mostly focused on how the situation is evaluated and on promoting positive thinking.

As the body can be used as an anchor to remain alert and calm, interpreters are asked to pay attention to their breathing, focusing on exhalations to activate the autonomous parasympathetic nervous system, and to practise cardiac coherence (controlled breathing synchronised with heartbeat cycles. O'Hare, 2012). The attention of trainees is then drawn to the sensations of their back and thighs against the chair, of their feet on the floor. Alternating toe taps, based on EMDR (eye movement desensitisation and reprocessing) techniques, can also be used to help the brain process the information in an adaptive way, reducing the emotional impact of the listened to/produced speech. Interpreters are also invited to imagine themselves (with their eyes open or closed) inside a protective professional bubble that they can adapt to their needs: larger or smaller, thicker or thinner, darker or lighter, etc. These techniques should be regularly trained in a comfortable and peaceful place in order to be efficient in a more stressful environment.

When interpreters have an appointment in a sensitive context, they can take a little time before the assignment to settle in their imaginary professional bubble, rekindling the good sensations they had during their home practice (reactivation of self-hypnosis). During the consultation, they can adapt the bubble to their needs: for example, to make it thicker to reduce the effects of visual or auditory aspects, or bigger if distance is needed. If they are in emotional difficulty, interpreters can also use the environment and their body as anchors. They can have a look around the room to pay attention to the colours and forms around the speaker (reorientation). They can connect to the sensations of their back and thighs with the chair and of their feet in their shoes, move on the chair (crossing legs, reorienting pelvis, shoulders, gaze), breathe according to cardiac coherence principles, and drink water mindfully to activate the parasympathetic system through digestion. They can concentrate on artefacts that make them feel professional (for example, specific clothes, pen, and notebook). They can also insert the image of the scene that their brain is constructing on a mental television screen that they control remotely, and, for example, switch the colour to black and white, blur the picture, turn off the sound, or they can move the screen away so that the image becomes smaller.

After the consultation, interpreters can also use cognitive, physical, or hypno-imaginative techniques: for example, saying to themselves that they are not the person they worked with, breathing consciously, pushing the walls, breathing against a wall, shaking, using washing and purifying rituals, smelling a soothing perfume, putting what has been discussed during the consultation in an imaginary box, etc. They may share their feelings with someone they trust (while ensuring confidentiality), engage in physical activity, go for a walk and connect with nature, turn to spirituality, elaborate on what happened in a diary, etc.

As for linguistic strategies during the consultation, interpreters can switch for a while from normative first-person rendition ("I") to reported speech. The *inquit* (discourse marker announcing direct speech) followed by a first-person rendition ("He says: I saw terrible things") or the indirect reported speech ("He says that he saw...") can be used to protect oneself from some of the emotional burden. Interpreters can concentrate on the linguistic aspects as much as possible, trying to avoid building up mental representations of what is said and what is meant (cf. section 4.2). This "little robot" technical-linguistic approach is easier to adopt in the whispered simultaneous mode than in the consecutive mode when the memorisation process probably generates more mental images. If the primary speakers are resistant to the use of whispered simultaneous, interpreters can adopt the consecutive mode with frequent chunking, so that their focus remains as much as possible at the level of the words, and not at the level of the mental construction of what is said or meant. The difficulty is to find the right balance between providing fluid support for the patient's speech and chunking it to protect the interpreter.

## 52 *Interpersonal strategies*

Interpersonal strategies are part of interprofessional metacommunication between clinicians and interpreters, when both professionals talk about the interaction as it is planned in the upcoming consultation (pre-consultation briefing), as it unfolds during the clinical encounter (discussion during the consultation), and as it was experienced by the participants (post-consultation debriefing). Interprofessional metacommunication is part of general good practice (Faucherre et al., 2010; Costa 2017; Delizée et al., 2021; Weber et al., 2022). Several specific strategies for preventing VT can be used before, during and after sensitive consultations.

Before the consultation, the clinician-interpreter tandem may share information about the case, if possible: context, main goals of the encounter, problem to be solved, topics likely to be tackled, planned activities, the patient's potential behaviour, etc. Depending on the goals and topics, interpreters or clinicians may find it useful to verbalise that the consultation is likely to contain traumatic material. The prior discussion of goals and potential topics makes the consultation more predictable, which in turn enables interpreters to protect themselves if they are aware of the overall risk of VT and of their specific personal vulnerabilities. Briefings also offer the opportunity to agree on relief strategies for interpreters. For example, they can agree that the interpreter may get up and go to the other end of the room for a glass of water to gain physical distance for a few seconds, may switch to the whispering mode or third-person renditions (see section 5.1), or may ask for a break. Debriefing sessions give both the clinician and interpreter the opportunity to talk briefly about emotional moments, to acknowledge that the consultation was challenging for both professionals, to discuss possible individual strategies (see 5.1), and to ensure that the interpreter has access to a resource person in case of distress.

## 53 *Structural strategies*

Improving working conditions at an organisational level is another way to reduce the risk of VT (e.g. Doherty et al., 2010; Mehus & Becher, 2016; Park et al., 2017). The frequency of assignments in mental health could be reduced to find a balance between interventions in low-risk vs high-risk settings for VT. Remuneration could be increased, and more breaks scheduled throughout the day. Emotional resilience training and inter-professional collaborative training that promote greater support from mental health professionals could

be systematically implemented. In order to break out of professional isolation, interpreters could participate in support groups and exchange of best practices, as well as in clinical supervision sessions. In many contexts, especially in countries where PS interpreters work as freelancers, this implies the creation of a professional union to defend their rights and to implement this kind of structural change (e.g. Holmgren et al., 2003).

## 6. Concluding considerations

In many settings, PS interpreters have to convey emotionally loaded content, and this is particularly the case in mental health. During interpreted bilingual consultations, they may be exposed to traumatic material and are therefore likely to experience symptoms of trauma themselves, as shown in the scientific literature. Faced with this observation, and from an interdisciplinary perspective of psychiatry, psychology, linguistics, and interpreting studies, we have proposed a four-stage psycho-educational course for interpreters aimed at raising awareness of the risk of vicarious traumatisation: awareness, identification of manifestations, detection of the main triggering factors and development of coping strategies. In this paper, we have focused on mental health interpreters, but this educational proposal is valid for those working in other high-risk settings.

There are three categories of support strategies aimed at reducing the emotional burden of mental health interpreting: individual, interpersonal, and structural. While individual coping strategies may be easily applied by interpreters who know them from training, concerns remain about the implementation of strategies that suppose interpersonal interactions between interpreters and clinicians (e.g. de/briefings) and structural changes (e.g. working conditions). These strategies may be blocked or constrained by an interplay of several factors, such as communicational routines related to face-work, normative discourses on “good” and “bad” interpreting, and power issues. Face-work, as a set of principles influencing behaviour in interactions of all kinds, has been conceptualised by Goffman (1967) and Brown and Levinson (1978). According to them, interactants use face-work to take care of interpersonal relationships by protecting their own and their interlocutors negative and positive faces. On one hand, negative face corresponds roughly to the person’s personal territory, specifically the right not to be intruded on, and to decide for oneself. Health professionals may, for instance, avoid the topic of the interpreters’ emotions so as not to intrude on their “secret garden”, and interpreters may be reluctant to report their distress so as not to “waste” clinicians’ time. On the other hand, positive face refers to a person’s desire and ability to construct and maintain a socially valued image of self. Positive face-work can interfere with coping strategies, as several of them may be difficult to reconcile with the interpreter’s social image as a competent professional. In some structural contexts, “good” interpreters are still seen as mere language-processing machines rather than full-fledged participants in the triadic interaction (Wadensjö, 1998), which makes it difficult for both professionals to talk about the interpreter’s emotional experiences and needs. This implies that interpreters may see their positive face threatened.

These considerations highlight the potentially blocking or constraining impact of narrow conceptions of interpreting on the prevention of VT in interpreters. They also underline the importance of improving structural working conditions. Risk awareness is the first step toward destigmatising the symptoms, so that interpreters are less ashamed and more likely to seek help. Self-regulation techniques are the basis of self-care. However, all this is insufficient if the working conditions do not allow interpreters to have de/briefing sessions with therapists and to undergo clinical supervision that allows them to constantly monitor

their own mental state. An in-depth reassessment of the working conditions of interpreters would strengthen the legitimacy of their quest for help in the face of VT and the sustainability of their irreplaceable contribution to communication in health care.

Consideration of the risk of VT in interpreters is still in its infancy. Many avenues of research remain to be explored. As far as our educational content is concerned, the next stage will be to objectively evaluate the effectiveness of the proposed strategies through action research, which involves developing tools to measure it. From a broader perspective, the needs of interpreters and the coping strategies they spontaneously implement can be investigated in different countries (Mehus & Becher, 2016; Korpál & Mellinger, 2022). On the one hand, this empirical data could be used to inform training, and on the other hand, it would help to identify the specific features encountered in different working environments, and thus raising the question of the transferability of self-regulation techniques. It also seems necessary to develop a common instrument for measuring interpreters' distress that can be applied to large samples, taking into account the great heterogeneity of profiles in terms of languages, cultures and working environments (Prentice et al., 2014; Tiselius et al., 2020). A mixed qualitative-quantitative method would provide fine-grained results (Lai et al., 2015). The potential influence of interpreters' distress on the medical care of patients (Splevins et al., 2010) and on the quality of interpreting (Mehus & Becher, 2016) can also be investigated. The issue of vicarious traumatisation of interpreters needs to be addressed in research and in practice: the well-being of interpreters and quality of patient care are at stake.

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## Appendix:

### Matrix of coping strategies to prevent vicarious traumatisatisation in interpreters

Temporal dimension F → ----- Relational dimension H ↓	Before the consultation	During	After
<b>With oneself (Individual strategies)</b>	Training/education: Raising awareness and learning various techniques (concentration techniques, self-hypnosis, breathing exercises, hypno-imaginative technics, etc.)	Focusing on the importance and the meaning of the job Linguistic strategies Breathing exercises Asking for a break Hypno-imaginative technics Self-imagery control Etc.	Sharing your feelings with someone close to you or a colleague Finding psychological help Practicing a physical activity Turning to spirituality Writing a diary to rethink consultations Singing Connecting with nature Breathing exercises Hypno-imaginative technics Etc.
<b>Interprofessional mental health professional-interpreter meta-communication (Interpersonal strategies)</b>	Briefing sessions: Sharing information about the case or consultation Discussing worries about emotional burden and vicarious trauma Agreeing on individual and interprofessional strategies to protect the interpreter Fostering mutual trust	Applying the strategies jointly developed during briefings: Metacommunicating on planned activities and topics Metacommunicating to facilitate the interpreter's individual strategies	Debriefing sessions: Talking about emotional moments Talking about the risk of vicarious trauma Discussing individual strategies to be adopted after difficult consultations Ensuring that the interpreter has access to a resource person in case of distress.
<b>With the interpreting service provider, if any, and/or with colleagues-interpreters (Structural strategies)</b>	Improving working conditions: Reducing the frequency of mental health assignments or other at-risk settings Allowing more frequent breaks Participating in resiliency enhancement seminars Training public service providers to collaborate with interpreters		Improving working conditions: Organising supervision sessions with colleagues and a psychologist specialised in stress and trauma Joining or creating a union of interpreters to defend their rights