

Interpreters' Experiences of Transferential Dynamics, Vicarious Traumatization, and Their Need for Support and Supervision: A Systematic Literature Review

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Abstract

Using thematic analysis, this systematic review aimed to explore sign language interpreters' experiences of transferential dynamics and vicarious trauma. The notion of transferential dynamics, such as transference and countertransference, originate from psychodynamic therapy and refer to the mutual impact that client and therapist have on one another (Chessick, 1986). Psychodynamic models of therapy are predominantly concerned with unconscious processes and theorise that such processes have a powerful influence over an individuals' thoughts, feelings and behaviours (Howard, 2011). In contrast to countertransference, which is an immediate response to a particular client, vicarious trauma is thought to develop as a result of continuous exposure to, and engagement across, many therapeutic interactions (Pearlman & Saakvitne, 1995a). A search of the available literature uncovered a striking lack of literature into the experiences of sign language interpreters, and in all, only two of the 11 identified empirical studies addressed sign language interpreters. The vast majority of the literature analysed reflected the experiences of spoken language interpreters. The results indicate that interpreters experience transferential dynamics as part of their work as well as suggesting the presence of vicarious trauma among interpreters. Additionally, a unique contribution to the fields of interpreting and psychology is offered, as it is consistently demonstrated that 'service providers' and 'mental health workers', which are umbrella terms for psychologists, immensely under-estimate the role of interpreters, as they fail to consider the emotional impact of their work and ignore the linguistic complexities of translation by failing to appreciate their need for information in order to ensure an effective translation.

Keywords: sign language interpreters, vicarious trauma, transferential dynamics, supervision, equal access, psychological therapy

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Background and Rationale

In the UK, it is estimated that over 10 million people are hard of hearing or deaf and that between 50,000 and 70,000 people use British Sign Language (BSL) as either their first or preferred language (Action on Hearing Loss, 2011). The British Psychological Society (BPS) states that 'Avoiding discrimination by ensuring equal access to psychological therapy to non-English speakers must be a fundamental aim' (Tribe & Thompson, 2008, p. 2).

Within the UK, BSL/English interpreters make an invaluable contribution towards satisfying the above stated aim, by enabling psychologists and other professions to communicate with clients from the d/Deaf and hard of hearing community through their specialist skills, cultural understanding and expertise. However, despite their contribution to the d/Deaf and hard of hearing community, and the associated mental health professions, there is a striking lack of literature examining the emotional experiences of Sign Language Interpreters, with BSL/English interpreters in particular being severely underrepresented. Studies by Sexton (1999) and Pearlman and Saakvitne (1995) in-

investigating trauma therapists suggest that there is a risk of vicarious traumatisation as a result of exposure to distressing material and the transference dynamics which occur during psychotherapeutic interactions. Supervision and support has been strongly advocated as a result. However, little is known as to whether this is also the case for BSL/English sign language interpreters, despite the possibility that they may also be exposed to distressing material, as part of their work.

Interpreting is often considered from multiple viewpoints. Metzger (2006) suggests that differentiating interpretations on the basis of paradigm, modality, task and research methodology together provide a useful foundation upon which research, teaching and studying can contextualise the relevant taxonomies in a profession which originally had its dynamic nature overlooked (Metzger, 2006). A clear difference between the work of sign language interpreters and spoken interpreters is their mode of communication, which has practical implications. While most spoken language interpreters work between two spoken languages, most sign language interpreters work between one spoken language and one signed language, a process known as dual modality. Sign language interpreters must use their hands and eyes linguistically, in contrast to spoken language interpreters, who engage simultaneously with audio input and output (Metzger, 2006).

Furthermore, Roberts (1987) suggested that due to some of the settings in which they work, spoken language interpreters are granted a high status and treated with respect, whereas sign language interpreters are often exposed to, and must deal with, the linguistic misunderstandings and prejudices regarding the significance of sign language as a language and linguistic system in its own right, as well as some of the discrimination and oppression faced by the d/Deaf and hard of hearing community (Austen & Jeffery, 2007; Du Feu & Fergusson, 2003; Kyle & Pullen, 1988).

Additionally, studies have identified high levels of chronic stress, injury, fatigue, burnout and early professional departure among sign language interpreters (Schwenke, 2012a). Dean and Pollard (2001) theorised that sign language interpreters are commonly exposed to work situations involving high demands and low-control; thus the interpreter often experiences high-strain situations.

Moreover, if work demands continually outweighed interpreter control, interpreters may be at risk of emotional exhaustion, perceiving a lack of personal accomplishment and depersonalisation, all of which are associated with burnout (Maslach & Jackson, 1981; Schwenke, 2012b). Burnout is known to frequently occur among individuals who work interpersonally with others and is the result of excessive demands from work. It is described as a syndrome of emotional exhaustion, cynicism, diminished perceived personal accomplishment and depersonalisation (Cordes & Dougherty, 1993; Maslach & Jackson, 1981). Emotional exhaustion is considered to be the core of burnout. It is characterised by an individual feeling depleted of the emotional resources needed to psychologically give themselves to the work, and combines stress with negative evaluations of oneself, and of interpersonal relationships. Work overload and limited support have been consistently related to the progression of burnout (Deville, Wright, & Varker, 2009). Dean and Pollard (2001) suggested that perceived lack of control, leading to high occupational stress, is linked to the confidentiality standards of the sign language interpreting profession, which limits interpreters' opportunities to receive support, either socially or through supervision, when faced with processing challenging and difficult work experiences, which in turn contributes to increased injury, illness and burnout rates in sign language interpreters (Schwenke, 2012a).

A construct conceptually related to burnout is vicarious trauma (Jenkins & Baird, 2002). Like burnout, vicarious trauma is the result of exposure to demanding interpersonal work and emotionally engaging clients; however,

whereas burnout is predominately related to workplace strain, vicarious trauma was originally applied to therapists and is defined as 'the permanent transformation in the inner experience of the therapist that comes about as the result of empathetic engagement with clients' traumatic material' (Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995, p. 31). Symptoms of vicarious trauma include disturbance of the individual's cognitive frame of reference/identity, as well as their psychological needs, beliefs about self, internal imagery and interpersonal relationships (Pearlman & Saakvitne, 1995). It is theorised that verbal exposure to traumatic material changes cognitive schemas associated with safety, trust, control, esteem and intimacy, and symptoms associated with Post Traumatic Stress Disorder, such as intrusive imagery and distressing emotions and thoughts connected with a client's story can appear and can be long-lasting, sufferers may then need help to cope with hearing such disturbing experiences (American Psychiatric Association, 2013; Pearlman & Saakvitne, 1995; Sexton, 1999).

The field of psychodynamic models and concepts is wide and varied, and there has been much debate in the literature surrounding the use and definition of transference and countertransference. For the purpose of this research, the concept of transference dynamics is viewed as useful in exploring the experiences of interpreters and the psychological aspects and impact of their work; however, they are not the core focus of the paper. Thus, a critique will not be offered; readers interested in a detailed critique of the theory should refer to the writings of Handley (1995).

Transference dynamics, such as transference and countertransference, originated in psychodynamic therapy and are traditionally considered to describe the shared impact that the therapist and client have on each other (Chessick, 1986). Howard (2011) describes transference as the process of the client's unconscious inner world revealing itself through the intimate therapeutic relationship in which the client transfers their expectations about how they will act around or experience the therapist, as well as how the therapist will act or experience them. Such expectations develop from our experiences or fantasies of our care givers, siblings or other important people while we are children, referred to in psychodynamic therapy as our 'objects' (Howard, 2011). Howard (2011) explains that such intimacy elicits early memories of other intimate relationships in the client, with the result that they subconsciously become active in attempting to recreate such relationships. Meanwhile, countertransference refers to the therapist experiencing affective, physical and ideational responses to their client's transference, clinical material and expression (Pearlman & Saakvitne, 1995). When exposed to highly emotional or traumatic material, the ideational, physical and affective responses of countertransference can include fear, sadness, grief, shame, self-doubt, anxiety, horror, nightmares, confusion, agitation, insomnia and drowsiness (Pearlman & Saakvitne, 1995; Sexton, 1999). These experiences can often be confusing and distressing due to the unconscious nature of the underlying mechanisms, so the individual may react to them in an attempt to cope.

Two types of therapist countertransference defences have been identified: avoidance reactions and over-identification reactions. Avoidance reactions include numbing, avoidance, denial, detachment and disengagement from an empathetic stance, whereas over-identification responses include enmeshment, idealisation, excessive advocacy and guilt (Wilson & Lindy, 1994). Although transference dynamics are thought to feature in every psychotherapeutic interaction, countertransference is seen as a temporary response to a particular client. However, the accumulation of, and continuous exposure to, such emotionally challenging dynamics can lead to vicarious trauma, the effects of which travel beyond therapy with a singular client across all of the therapist's client relationships, as well as potentially affecting their professional and personal life (Sexton, 1999).

Interpreters must simultaneously embody the role of client, interpreter and therapist, while, faced with the linguistic challenge of keeping up with the sheer volume and diversity of the information exchanged during communication that must be processed, as well as the emotional challenge of interpreting distressing content (Gomez, 2012; Harvey, 2003; Tribe & Thompson, 2008). Additionally, as burnout and other occupational illnesses have already been identified within the sign language interpreting profession, the notion that they also may experience potentially distressing transference dynamics and vicarious trauma is therefore likely to be well-founded, as they are potentially exposed to similar experiences as those faced by therapists, due to the nature of their work.

Literature reviews systematically identify and critique all studies which are relevant to a distinct question. Data that is included from the literature is collected and evaluated, and the pertinent findings summarised, to establish if they are consistent and to identify gaps in the literature (Abalos, Carroli, Mackey, & Bergel, 2001; Mulrow, 1994). This systematic review aims to investigate, and to build on, the literature about interpreters' experiences of transference issues and vicarious trauma, to assess their need for support and supervision and to identify any gaps in the literature which require further investigation. By providing this summary, it is intended that sign language interpreters, therapists, and other professions will be made more aware of interpreters' experiences and be able to acknowledge the emotional strain and risk of vicarious trauma that interpreters can potentially face, and advocate their need for support.

Methods

Search Strategy

Eight electronic information databases were used to search for published peer-reviewed papers, articles and theses (Google Scholar, Wiley Online, Science Direct, Taylor & Francis online, Web of Science, Sage Journals and PubMed Central) as well as any relevant grey literature (OpenGrey). This search was conducted using the following keywords; support, supervision, vicarious trauma, transference dynamics, transference issues, transference, countertransference and burnout. Additionally, all search terms were combined with either: Interpreter, British Sign Language (BSL) interpreter or Sign language interpreter. A full list of search terms can be found in the [Appendix](#).

Inclusion Criteria and Screening

The process of screening and selecting studies began with consideration of the titles and abstracts of papers revealed by the search, followed by an assessment of the titles and abstracts and then finishing with an examination of the full text. Studies were assessed and selected based on predetermined inclusion and exclusion criteria, which centred on providing successful coverage of the topic. The papers that were found to most closely meet the criteria were retained, while those determined as insufficiently doing so were excluded.

Due to the lack of research specifically focused on to countertransference and vicarious trauma in sign language interpreters, studies relating to spoken language interpreters were also included in the selection. However, studies focusing solely on interpreters who are refugees were excluded. The present author was predominantly interested in exploring how, despite having never directly experienced trauma themselves, someone could still come to experience symptoms related to posttraumatic stress disorder as a result of continuously being exposed to emotionally distressing content overtime, as interpreters often are. This phenomenon is arguably different from the expe-

rience of being reminded of one's own past experiences of trauma through interpreting others' stories of trauma, leading to symptoms of Post Traumatic Stress Disorder, after one's own trauma has become reactivated.

Furthermore, practitioners have already been made highly aware of this issue, as demonstrated by [Tribe and Keefe \(2009\)](#) who state that 'the issue of employing interpreters who are or have been refugees and the issue of possible re-traumatization or secondary traumatization requires careful consideration, bearing in mind employers' duty of care to all their staff' (p. 420). However, the issue of vicarious trauma amongst interpreters who are not refugees, and have not experienced trauma directly themselves, may not be as well known and the risk therefore not as obvious. Thus, the author argues that research into this area is well founded in order to confirm whether or not a risk of vicarious trauma exists among these professionals, so that the practitioners working with them can be made aware of it, and guidelines to protect them created. Readers who are interested in the experiences of interpreters who are refugees may consider the writings of [Green, Sperlinger, and Carswell \(2012\)](#), [Johnson, Thompson, and Downs \(2009\)](#), [Sande \(1998\)](#), [Tribe \(1998\)](#), and [Tribe and Thompson \(2009\)](#).

The assessment of articles was based on their relevance and comprehension of the review's aim, accessibility, availability and conception of defined key terms. The inclusion criteria applied was as follows: a) the experiences of spoken and/or signing interpreters, qualified or unqualified, are considered; b) the study addresses countertransference and/or vicarious trauma phenomenon c) includes male or female participants, of any ethnicity, or age (excluding interpreters who are refugees); d) includes either published or grey literature (excluding books, and book chapters); f) which are written in English. Based on the inclusion criteria, the initial search was conducted using 30 search terms and 179 studies were found. Following this, the search was refined using the keywords "vicarious trauma", "countertransference" and "supervision", resulting in 12 articles being selected for review, with only 1, relating to vicarious trauma, countertransference and the supervision of sign language interpreters, fully meeting the research question's needs (see [Figure 1](#)).

Analysis

The definition provided by the Division of Counselling Psychology (DCoP) of the British Psychological Society (BPS) states that Counselling Psychology adopts a 'firm value base grounded in the primacy of the counselling;' however, it also endeavours to 'develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology' ([British Psychological Society, 2008](#), p. 1). It has been proposed that this can be achieved by adopting a philosophically pluralistic stance in relation to epistemology – that there is no single approach to knowledge that is all-inclusive, and that to attempt to discover such an absolute will unavoidably create gaps in our knowledge, whereby informative and valid forms of knowledge are disregarded ([McAteer, 2010](#)). Philosophical pluralism aims to engage in a dialogue with epistemologies, in order to respect, confront and embrace differing perspectives, and to enhance our knowledge of our intricate world ([McAteer, 2010](#); [Safran & Messer, 1997](#)). In agreement with this philosophy, this systematic review aims to explore and synthesise both quantitative and qualitative studies, as focusing on one investigative approach risks overlooking valuable insights. This view is supported by [Michael and Cooper \(2013\)](#), who suggest that combining studies with differing epistemologies strengthen the systematic review of a topic by allowing researchers to identify findings which are supported by multiple methodologies.

Although there are a multitude of approaches to data analysis and synthesis, the thematic approach is distinctive for its theoretical freedom. Thematic analysis is a research strategy used to identify, analyse and report themes within data, which it does by organising data in a flexible manner that describes the researcher's findings in detail,

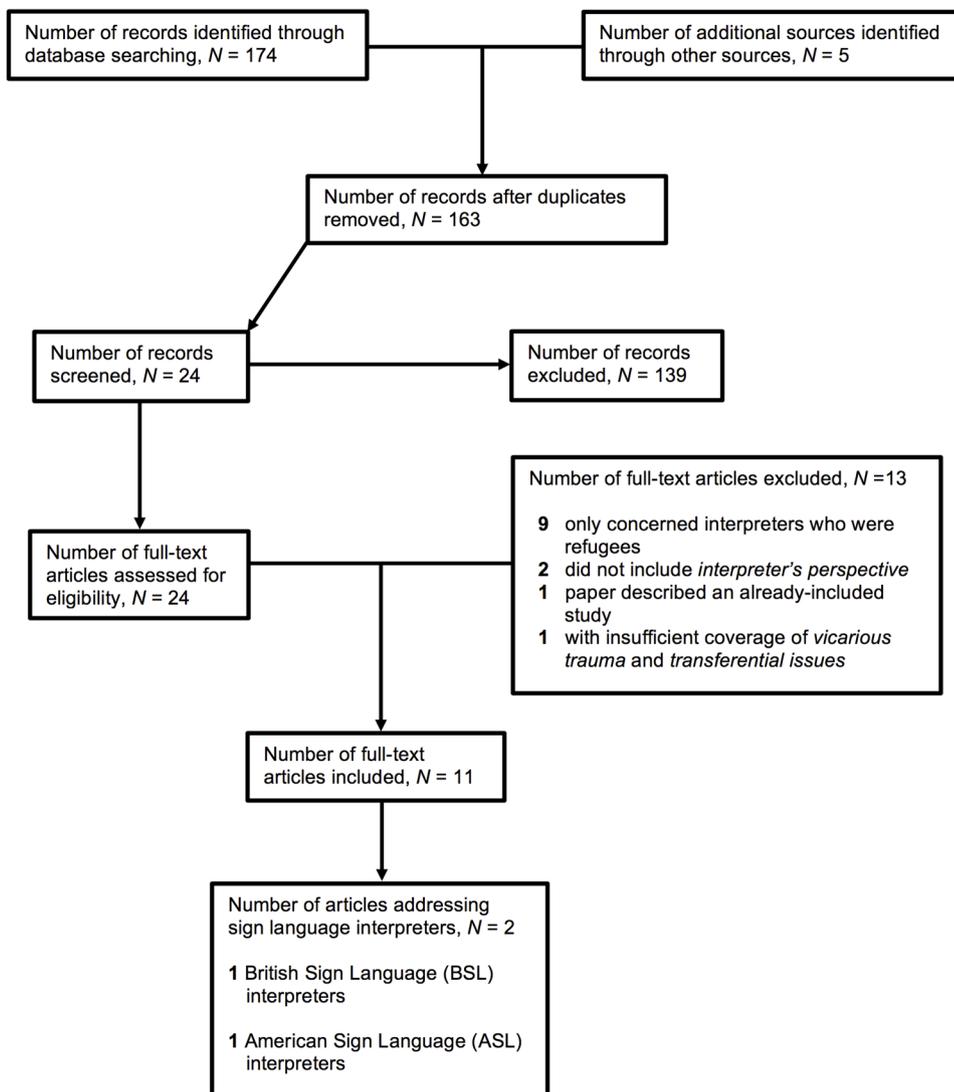


Figure 1. Flow of information through the different phases of the systematic review (Moher, Liberati, Tetzlaff, & Altman, 2009).

while interpreting numerous features of the research topic. A theme is described as capturing ‘something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set’ (Braun & Clarke, 2006, p. 82), and the theoretical freedom of the thematic approach permits the researcher to search across a wide range of data sets, such as texts or interviews, from differing epistemologies, in order to investigate repeated themes and specific research questions (Braun & Clarke, 2006).

Qualitative research has been criticised as a type of enquiry under the perception that it is an approach where “anything goes” (Braun & Clarke, 2006, p. 95) compared to quantitative approaches, which are seen as stricter and more structured (Braun & Clarke, 2006). However, Braun and Clarke (2006) argued that a rigorous thematic approach to research can also produce insightful, valuable and valid answers to specific research questions. Furthermore, as discussed, counselling psychology recognises validity in all approaches to knowledge, and the theoretical freedom of thematic analysis seems to be well-suited to the philosophically pluralistic position of counselling psychology. Therefore, the data in this investigation has been sourced and summarised from the rel-

evant existing research using a thematic approach, which has enabled the author to identify and analyse significant themes.

Results

A search of the available literature identified 11 empirical studies alluding to interpreters' experiences of counter-transference and vicarious trauma, and their need for support and supervision. Table 1 presents the biographical details, main aim, research design and key findings of the included studies. Accordingly, four key themes emerged, which are identified below and accompanied by appropriate subsections. The results present a vast array of inter-related factors, as there is such a striking lack of research in this area, it would be an injustice not to include them in this review.

Table 1

Papers Included in the Review

Biographical Details	Aims	Design	Key Findings
Baillot, Cowan, & Munro (2013)	To explore the risk of suffering vicarious trauma faced by the professionals involved, working in law contexts with asylum seekers.	Qualitative	Interpreters reported the need to negotiate personal and emotional consequences of listening to prosecution stories. Reported extreme emotional difficulties. Distancing and detachment coping strategies identified. Anxiety about expressing emotion, as concerned they would be judged unprofessional and not resilient.
Doherty, MacIntyre, & Wyne (2010)	To explore the impact of mental health interpreting and establish the presence, nature and degree of emotional distress and coping strategies.	Qualitative	Interpreters reported being emotionally affected by their work, experiencing difficult emotions in relation to their work and thinking about clients' issues hours, even days, after sessions. Additionally, interpreters also reported avoiding mental health interpreting and feeling unable to move on to their next appointment, due to them feeling upset.
Gomez (2012)	To study how interpreters experience their work with refugees and asylum seekers.	Qualitative	Most interpreters felt emotionally impacted by their work, were aware of the importance of self-care and reported conflict between professional and personal self.
Harvey (2003)	To describe the psychological effects of affect, projective identification and the dual nature of empathy.	Descriptive	Sign Language Interpreters reported being emotionally affected by their work, experiencing projection and transference and being exposed to the oppression of deaf people.
Hetherington (2012)	To gain a deeper understanding of how sign language interpreters make sense of their experiences and the meanings these experiences hold for them.	Qualitative	Interpreters reported main source of job-related stress as lack of respect and understanding of their role, expectation that they work as conduits and being viewed as an accessory. Code of conduct was perceived as too prescriptive. Interpreters recalled conflict between their professional identity and emotional reactions, feeling powerless and lonely. Supervision was reported as part of a hierarchical line management; hence viewed with suspicion.

Biographical Details	Aims	Design	Key Findings
Loutan, Farinelli, & Pampallona (1999)	To explore medical interpreters' experiences of their work with refugees and asylum seekers in the Geneva Red cross.	Quantitative	Interpreters reported experiencing difficult feelings and symptoms, such as insomnia, due to their work, which increased with number of sessions with victims of violence. Majority of sample reported strong need to share feelings with medic colleagues after sessions.
Molle (2012)	To gain an in-depth understanding of the experiences of interpreters working in a medium secure forensic mental health unit (MSU).	Qualitative	Interpreters reported feeling emotionally affected by the environment and content of their work, and struggled with their emotional reactions in trying to maintain professionalism. Furthermore, interpreters reported feeling uncared for, demeaned, unrecognized and devalued by other professions.
Shakespeare (2012)	To explore how community interpreters experience mental health interpreting and the emotional impact of their work.	Qualitative	All participants reported strong empathetic engagement and projective identification with clients. Some awareness of the dangers of over identification. Participants reported feeling overwhelmed with distress from empathetic engagement with clients and being caught up in transference dynamics.
Shlesinger (2007)	To discover if interpreters working with trauma survivors show significant high scores of vicarious trauma	Quantitative	No significant results of higher levels of vicarious trauma in relation to working with survivors of trauma, previous trauma, less experience or more exposure. However, significant results of previous trauma, receiving supervision and less experience of burnout.
Splevins, Cohen, Joseph, Murray, & Bowley (2010)	To explore the vicarious experiences of interpreters who work with asylum seekers and refugees in therapeutic settings.	Qualitative	Interpreters reported shock and distress through identifying with clients. Also, positive experiences of growth, learning and development through work with clients. Coping strategies were reported to develop over time and through experience as a result of becoming overwhelmed.
Valero-Garcés (2005)	To review papers which address the influence of the emotional and psychological impact on interpreters in public services.	Descriptive	Reviewed papers reported distress among interpreters caused by interpreting, due to content and dynamics with clients and service users. Social support commonly reported as a coping strategy and knowledge and access of support from organization was varied.

Key Themes

The Emotional Impact of Interpreting

Empathic engagement and indicators of vicarious trauma — The seriousness of this issue is demonstrated by the ubiquity of this theme across all the included studies. Results from both quantitative and qualitative studies suggest that interpreters reported strong negative feelings arising from their work. Specifically, interpreters frequently described having felt: overwhelmed, shocked, exhausted, sad, stressed, frustrated, miserable, angry, lonely, distressed, irritable, anxious, powerless, fearful, hopeless and conflicted. Additionally, interpreters reported prolonged emotional distress and symptoms, which had an affect on both their personal and professional lives (Doherty, MacIntyre, & Wyne, 2010; Molle, 2012; Shakespeare, 2012; Splevins, Cohen, Joseph, Murray, and Bowley, 2010; Valero-Garcés, 2005).

Shakespeare (2012), who interviewed eight interpreters with experience working in mental health settings, found that they all mentioned strong feelings of empathy for their clients. However, they also reported feeling overwhelmed with distress, as they could intensely feel what their clients felt. Several of the interpreters also described the prolonged effect of their empathetic connection, as they ruminated about their client's situation. One interpreter recounted experiencing distressing symptoms for up to several years after interpreting for a particular client. Concurrently, Splevins, Cohen, Joseph, Murray, & Bowley (2010), interviewed eight freelance interpreters working in community settings and also found that they all described strong empathetic connections with their clients, whereby they experienced shared emotions. These experiences were linked with intense negative emotions, such as rage and deep sadness, and some interpreters reported symptoms suggesting vicarious trauma, such as insomnia, irritability, preoccupation and intrusive thoughts and ruminations related to their clients stories, as the result of being exposed to previously unimaginable atrocities.

Coinciding with the previous studies, interviews conducted with six interpreters who work at a Medium Secure forensic mental health Unit (MSU) revealed that some interpreters could not attend their next assignment after undergoing an intense session, while others recounted how their experiences stayed with them and impacted their personal lives, with one interpreter describing their client's words and images as being 'dug into their head' (Molle, 2012). Correspondingly, Baillot, Cowan, and Munro (2013) investigated the experiences of professionals working in a legal context with refugees and found that interpreters reported that their client's narratives had a long-term impact on them; one stated that some of the things she had translated would stay with her forever. Adding strength to the previous studies, a study that combined summary statistics with qualitative analysis of survey responses from 18 interpreters working in mental health services revealed that 56% reported being emotionally impacted by their work, 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. Furthermore, 33% stated that interpreting had had an impact on their personal lives and 28% reported difficulties in taking other assignments, and described feeling weary, distracted and in emotional turmoil (Doherty, MacIntyre, & Wyne, 2010).

Of the two quantitative studies analysed in this review, one revealed that six out of 18 interpreters reported symptoms associated with vicarious trauma, such as nightmares, depression and insomnia, after working with victims of violence. Furthermore, these symptoms increased with the number of sessions interpreters had with victims of violence (Loutan, Farinelli, & Pampallona, 1999). In contrast, a study in which 52 interpreters completed the Trauma & Attachment Belief Scale (TABS), and the Professional Quality of Life: Compassion Fatigue Scale, found no significant results of interpreters working with survivors of trauma or having more exposure to trauma showing higher levels of, or to be predictive of, vicarious trauma (Shlesinger, 2007).

Overall, the literature exploring interpreters' experiences seems to consistently support the notion that exposure to distressing material and interpreters' empathic engagement with their clients, can lead to interpreters experiencing negative emotions and distress, and symptoms associated with vicarious trauma. Thus, this study continues by exploring the relationship of transferential dynamics with negative emotions and symptoms associated with vicarious trauma (Pearlman & Saakvitne, 1995; Sexton, 1999).

Transference experiences — Alongside sharing their clients' feelings through empathy, experiences of transference, projective identification, countertransference and over-identification reactions were either suggested or explicitly noted by 10 of the 11 papers examined here (Baillot, Cowan, & Munro, 2013; Doherty, MacIntyre, & Wyne, 2010; Gomez, 2012; Harvey, 2003; Hetherington, 2012; Loutan, Farinelli, & Pampallona, 1999; Molle,

2012; Shakespeare, 2012; Splevins, Cohen, Joseph, Murray, & Bowley, 2010; Valero-Garcés, 2005). Harvey (2003) described how a sign language interpreter, through the process of projective identification, came to 'hold' the pain of her deaf client, which resulted in her feeling grossly inadequate in comparison to her client. The client had subconsciously displaced her own painful feelings of incompetence and then acted in a way which encouraged that response in the interpreter, who subconsciously accepted it.

In concurrence, Gomez (2012), Molle (2012) and Shakespeare (2012) also described transference encounters of interpreters, whereby sharing the same language of their clients triggered a transference reaction in the client where they saw the interpreter as an ally, friend or family member. In order to maintain boundaries and impartiality, the interpreter has to resist responding to such transference, risking emotional conflict and feelings of guilt. One interpreter recalled an experience of transference whereby a client, who became upset, turned to the interpreter as if she was a relative. The interpreter was unaware of what was happening and became upset during the session. This interpreter described that she was so distressed and alarmed by this encounter that she had to seek support from a counsellor herself; she still continues to think about it (Gomez, 2012).

Becoming someone else — Of the studies analysed in this review, four made reference to the emotional impact on interpreters of having to use the first person while translating (Gomez, 2012; Shakespeare, 2012; Splevins, Cohen, Joseph, Murray, & Bowley, 2010). Interpreters interviewed by Splevins, Cohen, Joseph, Murray, and Bowley (2010) described how verbatim translation of a client's material increases their involvement and empathetic connection. The material must be processed by imagining the client's perspective, so interpreting becomes far more intense than just hearing the words. In line with this account, a study by Gomez (2012) into interpreters working with refugees and asylum seekers reported that interpreters felt as though they hold, and carry, the emotional impact of their client's words before passing it to the therapist, with one interpreter explaining that they must say 'I was raped' and therefore carry whatever pain the client's words have, before passing them on. Interpreters described using the first person as emotionally straining, not only during sessions but potentially for days afterwards.

In accordance with the previous studies, community interpreters interviewed by Shakespeare (2012) described becoming the speaker, adopting their tone and body language as well as their words in order to convey the intensity of their feelings. Thus, they essentially transform and become someone else, losing themselves in the interaction. This process is narrated as being accompanied by overpowering anxiety by some interpreters. One interpreter recounted experiencing extreme conflict through saying the words of another:

"I have to become that person, so everything what she or he says to me, I have to say it, and you know, we're only humans, you can't sort of completely switch yourself off or detach from an emotions and when people sometimes say things like 'oh my life is not worth living', 'I don't want to live no more', and obviously I can't say that my life is wonderful and I'm...but generally speaking I'm quite a happy person, so saying things like that, I find it quite difficult because it doesn't agree with me, you know, saying 'oh, my life is so bad, that I want to kill myself', or 'I want to kill myself and my daughter'... uhh I find it quite difficult because I've got a daughter, I'm a mum myself, and I'm saying out loud I want to kill myself and I want to kill my daughter, which is like hold on, you know, the light is flashing, don't say that, don't even you know say it out loud, but obviously this is my role" (Shakespeare, 2012, p. 122-123).

This account demonstrates the extreme emotional demands that interpreting distressing material can involve; again, this interpreter described how these stories would stay with her for days afterwards. Another interpreter

said she could not remember her name after a long and intense session, further indicating the overwhelming nature of interpreting.

However, it is not just adopting the role of the client that elicits emotional strain and conflict. Interpreters also recounted that adopting the voice of the service provider could be emotionally taxing, especially when this involved hostility towards the client or translating bad news. The interpreters in [Shakespeare's \(2012\)](#) study asserted their pain in translating an inappropriate and insulting message from a service user, which they felt could appear to have come from them. In addition, one interpreter described an assignment as 'excruciating' when she had to translate news from a doctor that a patient was dying, stating that the message was heard by the interpreter and not the doctor, thus placing the emotional burden onto the interpreter. Likewise, [Harvey \(2003\)](#) recounted the pain and distress that sign language interpreters experienced in witnessing the oppression of their deaf clients and often having to be involved, as they must interpret the message and portray the effect. One interpreter described feeling 'dirty' after being part of a communication between a teacher and a deaf pupil where the teacher was being discriminatory; meanwhile, another became overwhelmed with emotion after an assignment where a deaf patient received inadequately care. All in all, the literature exploring interpreters' accounts seems to prove that they experience transferential phenomena as part of their work, which is consistently recounted as being accompanied with negative emotional reactions, as well as symptoms associated with vicarious trauma.

Transferential avoidance reactions — In addition to the over-identification reactions described in the above themes, examples of avoidance reactions by interpreters were also recorded across the studies. Avoidance reactions are seen as the second type of countertransference defence, in coping with transferential experiences. Avoidance reactions include numbing, avoidance, denial, detachment and disengagement from an empathetic stance ([Wilson & Lindy, 1994](#)). Most studies identified avoidance reactions whereby an interpreter would try to block their experiences, avoid thinking about them and distract themselves ([Baillot, Cowan, & Munro, 2013](#); [Doherty, MacIntyre, & Wyne, 2010](#); [Molle, 2012](#); [Shakespeare, 2012](#); [Splevins, Cohen, Joseph, Murray, & Bowley, 2010](#)).

Other reactions included disengaging and detaching from the situation. Legal interpreters in [Baillot, Cowan, and Munro's study \(2013\)](#) were observed doodling while relaying an account of rape, and others recalled detaching from responsibility by being 'just the interpreter' as a way of coping with processing their clients' situations. Similarly, other studies recorded that interpreters avoided certain jobs due to their impact ([Doherty, MacIntyre, & Wyne, 2010](#); [Molle, 2012](#)). Equally, one study reported that 28% of interpreters interviewed said they avoided mental health assignments ([Doherty, MacIntyre, & Wyne, 2010](#)). Conclusively, then, reports of interpreters' attempts to cope with the impact of their work further suggest that interpreters experience transferential dynamics so adopt avoidance defences in an attempt to lessen the effects.

Vicarious posttraumatic growth — Over half of the studies exploring the emotional experiences of interpreters have also reported positive experiences and growth as the result of empathetic engagement with their clients ([Splevins, Cohen, Joseph, Murray, & Bowley, 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 ([Gomez, 2012](#); [Shakespeare, 2012](#); [Splevins, Cohen, Joseph, Murray, & Bowley, 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 ([Gomez, 2012](#); [Splevins, Cohen, Joseph, Murray, & Bowley, 2010](#)).

In agreement with these findings, one study revealed that 80% of interpreters felt good about the work they do, describing it as rewarding and fulfilling (Valero-Garcés, 2005). Further supporting these findings, the interpreters expressed their appreciation of the knowledge and insight they had gained from their work, describing how they had almost received therapy for free, having learned useful skills, coping mechanisms and knowledge for their own daily lives, reducing stress and encouraging them to think more positively (Gomez, 2012; Splevins, Cohen, Joseph, Murray, & Bowley, 2010). Compatibly, others reported that learning about mental health issues had given them a better understanding of sufferers (Shakespeare, 2012). Thus, it seems from these accounts that although interpreters often vicariously experience negative emotions and distressing symptoms, they sometimes also experience positive emotional reactions and even, in some cases, experience vicarious growth.

Working With Service Providers

All but one of the studies explored in this review reported various findings concerning interpreters' relationships with service providers.

Service providers' conduct towards interpreters — The results of this review are mixed regarding the relationship that interpreters have with service providers. Some studies have suggested that service providers' lack respect and value for, and understanding of, interpreters, and the strain their work imposes on them (Molle, 2012). One study revealed that 30% of interpreters' emotional difficulties were linked to dealing with service providers (Valero-Garcés, 2005). This finding is further supported by Hetherington (2012) who conducted interviews with sign language interpreters and found that most reported service providers' underestimation, and lack of acknowledgement and recognition of the complexity and difficulty of interpreting to be a significant source of stress. Interpreters expressed the belief that service providers' lack of understanding of their role led to a lack of respect for the profession, as many providers assumed that they work as conduits, not recognising the effort that must be taken to enable effective and accurate dialogue, especially when faced with linguistic non-equivalents and the complexities of human dialogue. Interpreters described feeling as though they were viewed and treated as accessories by service providers, to be used and discarded.

In accordance with the previous findings, the interpreters interviewed by Molle (2012) described being viewed as a machine or common consumable, without regard for their emotional wellbeing or physical safety, with many being put at risk when working at an MSU. They were surprised that the care and empathy shown to clients by mental health workers was not extended to them and that their personhood was forgotten as they were left to struggle with processing the emotionally-charged content of their sessions. Interpreters believed they were not granted the same rights, values or respect as other service providers, leaving them feeling personally and professionally demeaned, and not deemed worthy of introduction or care. Interpreters also felt some service users were resentful at having to use interpreters, which further established feelings of being devalued.

Consistent with the previous studies, Shakespeare (2012) reported interpreters viewed practitioners as desensitised by the emotional hardship of their work and observed that they did not seem to recognise that such intense exposure was not usually a daily occurrence for interpreters. Coinciding with the previous literature, interpreters again recalled feeling dehumanised, as though they are viewed as commodities rather than people; thus, there was little acknowledgement of the emotional and physical strain of their work by service providers, with few breaks offered and their wellbeing rarely considered.

Contrastingly, some interpreter accounts appeared to suggest that not all interpreters experienced such negative interpersonal interactions with service providers. Several interpreters suggested that practitioners were aware of interpreter vulnerability and that they had not received training on how to cope with patients. Furthermore, one interpreter described a supportive environment at his place of work, although he felt 'lucky' to work there. Adding to this contradiction are findings from [Gomez \(2012\)](#), that interpreters reported the therapists with whom they worked to be very supportive and approachable, as well as having been offered specific training and peer support groups organised by the service. Furthermore, they recalled good working relationships with their therapist colleagues. Therefore, findings from multiple studies suggest that interpreters are sometimes treated disrespectfully or without consideration by service providers, which can contribute to negative feelings and low professional and personal self-worth. Nevertheless, some accounts indicate that this is not always the case in interpreter/service provider relationships.

Lack of protocol, information and service providers' understanding — Many of the studies analysed in this review made reference to the lack of information interpreters were offered by service providers, the absence of clear protocols and the lack of practitioner knowledge about interpreter needs, as sources of work strain and negative emotional reactions ([Doherty, MacIntyre, & Wyne, 2010](#); [Molle, 2012](#)). When surveyed on aspects of their work they found particularly difficult, 78% of interpreters reported not being briefed prior to sessions as particularly difficult, and when asked about the difficulties experienced in their relationships with staff, mental health workers' poor communications skills when using an interpreter was identified. Participants were asked for suggestions to help ease the demands of mental health interpreting, and replied: advance briefings, expectations (of the interpreter) made clear before sessions, debriefing after sessions, professional sensitivity regarding the impact on the interpreter and information regarding therapists' expectations of the therapy ([Doherty, MacIntyre, & Wyne, 2010](#)).

Adding depth to these findings, interpreters reported feeling incredibly uneasy and fearful due to the lack of information or answers to their questions when working at an MSU, due to not knowing what to expect. One interpreter described how she cried for days after being sent unprepared to a session. Moreover, other interpreters recalled feeling that they were often thrown in the deep end and that it depended on who you worked with as to whether you received a briefing. If they took it upon themselves to prepare, they found that they were not deemed to have enough authority to ask or receive information. Interpreters perceived the lack of information or briefing provided to arise from service providers' lack of respect, understanding or recognition of the complexity of their role. They explained that it is important for them to have background information in order to understand the context and meaning of what is being said; therefore, entering a session without information hinders their work and compromises effective communication ([Molle, 2012](#)).

In concordance with the previous findings, the interpreters interviewed by [Shakespeare \(2012\)](#) reported similar perceptions, stating that they rarely received information about their assignment from service providers, which left them with no idea what to expect. They also believed that the lack of preparation offered by service providers was due to a lack of appreciation of the process of interpreting and the skills and effort that it requires. The interpreters in this study wanted clear and robust protocols regarding briefing and debriefing, and information for both interpreters and service providers on how work together and how to deal with certain client situations, as currently they felt without guidance. Accordingly, the call for clearer protocols or guidelines was also made by the interpreters in [Gomez's study \(2013\)](#), as despite being well informed and regularly debriefed by staff, they still encountered difficulties with practitioners and clients knowing how to communicate through an interpreter, as well as in gaining

therapists' trust around language issues. One interpreter observed that his language is more ornate than English; it therefore can appear that he is not translating all of the client's content, resulting in the therapist's mistrust. The literature reviewed indicates that interpreters are aware of their need to be well-informed and briefed in order to protect their well-being and to perform efficiently. However, understanding and provision of these needs appears to be inconsistent among service providers, resulting in emotional and work stress.

The Professional Self vs. the Personal Self

The majority of the studies explored in this review (from both the UK and the USA) have reported the theme of conflict between maintaining professionalism and experiencing emotional difficulties. Both countries have developed codes of ethical conduct ([National Registers of Communication Professionals working with Deaf and Deafblind People, 2010](#); [Registry of Interpreters for the Deaf, 2005](#)) which ask interpreters to maintain confidentiality and remain impartial ([Dean & Pollard, 2001](#); [Hetherington, 2012](#)). However, these requirements appear to be challenging. One study revealed that 67.5% of interpreters reported maintaining impartiality as a prominent difficulty ([Valero-Garcés, 2005](#)). Likewise, [Hetherington \(2012\)](#) described the emotional turmoil and conflict that British sign language interpreters face when witnessing discrimination against, and poor service provision for, deaf people, as they experience a sense of responsibility to act but are left feeling powerless and with other negative emotions, due to having to remain impartial according to their codes of conduct. The interpreters in this study expressed frustration at their code of conduct, describing it as being too inflexible, with most preferring the ethical precept of 'do no harm.'

Compatibly, [Harvey \(2003\)](#) also detailed how American sign language interpreters' requirement to remain neutral could cause physical symptoms when they face deaf oppression. One interpreter mentioned developing chronic indigestion after such an occurrence, commenting that although it may be possible to act neutrally, it is psychologically unfeasible to remain emotionally so. In agreement with these findings, British interpreters have explained how the rules of interpreting prohibit independent thought and demand neutrality, with one interpreter describing being told during her training that she must always remain objective and professional. The accounts of the interpreters in this study suggest that they have understood 'always' to mean 'at all times,' even outside work. They described denying their feelings, since they are not permitted to have an emotional reaction and perceive any disclosure of personal feelings to be unprofessional. Yet, they also reported that they struggled to block these emotions and felt conflict, as they could not speak of them. Hence, as seen previously, because they are human beings with emotions, they continue to be affected by what they must hear and say; however, they struggle to contain and manage their accounts alone, believing that they are not permitted to share them ([Molle, 2012](#)).

Many interpreters believed that showing vulnerability would compromise their position in employment ([Gomez, 2012](#)). Aligning with previous studies, [Shakespeare \(2012\)](#) reported that British interpreters described feeling restricted, powerless, helpless, frustrated and conflicted by having to keep to their code of conduct and remain impartial. Interpreters described how these feelings were often heightened when they felt they should challenge staff on their treatment of their clients, due to feeling a responsibility to stand up for their rights, especially when the client is vulnerable. These feelings were also triggered when they believed they had information, or linguistic or cultural understanding, which could aid the interaction between client and practitioner; however, they felt unable to say anything, as this would compromise their neutrality. Furthermore, interpreters in this study also reported feeling emotionally affected by their work, yet obliged to mask their reactions in order to remain professional. Most said they did not want to take negative emotions away after sessions but that they often did, and they also reported not being allowed to talk about them. However, contradicting these accounts, [Harvey \(2003\)](#) noted that sign lan-

guage interpreters knew of ethical ways in which they could share their feelings without compromising their professionalism.

Despite experiencing uncomfortable feelings due to the professional/personal conflict, interpreters have stated that maintaining such boundaries was necessary to do their jobs well and also crucial in order to protect them. This notion is supported by the interpreters in [Doherty, MacIntyre, and Wyne's \(2010\)](#) study, which recorded remaining objective, reminding oneself of the limited involvement of the interpreting role, and being professional as coping strategies. On the whole, it would appear that interpreters' impartiality places them in an uncomfortable position. Clearly, these professionals take their commitments to ethics and professionalism very seriously; however, this apparently requires sacrifices. The findings seem to consistently prove that the upholding of codes of ethics and conduct causes emotional turmoil and moral dilemmas for interpreters, further fuelled by the perception that seeking support from others could be regarded as breaking confidentiality.

Coping Strategies

This theme was reported by all the studies. Both qualitative and quantitative studies reported that interpreters felt a need for support and realised the importance of self-care in order to cope with the impact of their work; however, findings regarding how the interpreters met these needs varied and included exercise, yoga, writing, cooking, spirituality, religion, engaging in extra learning and training, psychological preparation, positive self-talk and laughter as forms of coping strategies ([Baillot, Cowan, & Munro, 2013](#); [Doherty, MacIntyre, & Wyne, 2010](#); [Gomez, 2012](#); [Shakespeare, 2012](#)).

Experience (familiarity), gender and personality — Some studies suggested that certain variables might act as mediators of coping ability. Participants regularly reported familiarity and experience to be protective factors, as through experience they learned what to expect, became familiar with the occupational environment and the processes of services, and acquired different strategies helping them to handle their emotions and difficult scenarios ([Gomez, 2012](#); [Molle, 2012](#); [Shakespeare, 2012](#); [Splevins, Cohen, Joseph, Murray, & Bowley, 2010](#)). Gender was also suggested to have an effect on the interpreters' coping, with males seemingly becoming less enmeshed with their clients, or experiencing less emotional impact than females ([Molle, 2012](#); [Shakespeare, 2012](#)). Furthermore, personality was hinted to be a mitigating factor, with some participants stating that not all interpreters can cope with working in mental health or secure settings, while others mentioned the importance of strength and humour ([Molle, 2012](#); [Shakespeare, 2012](#)).

Social support — The need to be heard and supported was also disclosed across a number of studies, and all but two identified interpreters' use of social support to cope with the impact of their work ([Loutan, Farinelli, & Pampallona, 1999](#); [Molle, 2012](#)). Many interpreters described talking to family friends and colleagues about their experiences ([Loutan, Farinelli, & Pampallona, 1999](#); [Splevins, Cohen, Joseph, Murray, & Bowley, 2010](#)). Correspondingly, responses to a survey conducted by [Doherty, MacIntyre, and Wyne \(2010\)](#) revealed that 22% of interpreters talked to friends and family as a coping strategy, and 17% reported talked to other interpreters. Compatibly, an interpreter interviewed in a study by [Gomez \(2012\)](#) stressed the importance of socialising, explaining that it was important to stay connected to others. Harmoniously, [Valero-Garcés \(2005\)](#) reported that 54% of interpreters talked about their work as a form of coping and 43% of interpreters said they had increased their number of social relationships to strengthen their support network.

However, in a study exploring the emotional experiences of legal workers, interpreters saw working in isolation as a difficult aspect of their work, as they struggled to receive the same emotional support from co-workers as the rest of the legal team did (Baillot, Cowan, & Munro, 2013). Furthermore, Hetherington (2012) reported that although sign language interpreters working in England expressed the importance of their informal support networks of co-workers, these co-workers were often also friends, so they felt too cautious to challenge each other, limiting their opportunity to develop, and change, their practice. They therefore felt that formal supervision might offer them more opportunities for career and personal development.

Professional support and supervision — This theme was demonstrated across the chosen studies; however, the findings were inconsistent. Participants in the studies by Loutan, Farinelli, and Pampallona (1999) and Baillot, Cowan, and Munro (2013) expressed a strong need to negotiate the personal and emotional consequences of their work with a professional. However, in Baillot, Cowan and Munro's study, the researchers discovered that a support structure had been set up by the organisation, yet participants' were unaware. Whereas, the interpreters interviewed by Gomez (2012) expressed their appreciation of having been offered specific training by their organisation, as well as a monthly peer support group. Three of the five interviewed interpreters reported attending this support group and shared their delight that it allowed them to support each other and kept them feeling positive. Contradicting the previous study, other interpreters expressed that a lack of support from their employers left them with low self-worth and high stress, and that staff seemed to be aware of the lack of the support (suggesting that the issue was not being overlooked completely); however, it seemed that little action was being taken by either party. Intriguingly, one interpreter reported receiving supervision from his employer and that he was able to take a reflexive stance during his work and monitor his emotions during sessions. This allowed him to become self-reflective after sessions offering him clarity (Shakespeare, 2012). Similarly, one of the six interpreters interviewed by Hetherington (2012) received formal supervision. They reported that supervision had facilitated self-awareness, which they were able to apply during their assignments. Other interpreters in the study explained that they would value and appreciate feedback and guidance from a trusted, non-judgemental professional.

Discordantly, the interpreters interviewed by Molle (2012) stated that they did not receive any support and one interpreter expressed her appreciation of being listened to by the researcher, describing this process as therapeutic. Furthermore, the same interpreter explicitly stated that being listened to was not something 'we' have, speaking as a collective; thus suggesting a shared need and desire for support among interpreters (Molle, 2012, p. 60). Statistical findings from two of the studies analysed provide an indication of the presence of support and supervision for interpreters. Valero-Garcés (2005) reported that 12% of interpreters in their study had received training in stress management from their employers and in another study cited by Valero-Garcés (2005), 34% said that their employers provided support services including support groups and telephone counselling, with 20% stating that they used them. Whereas, Shlesinger (2007) found that 60.4% of interpreters did not receive supervision, however counter intuitively the 39.6% who said that they did receive it scored significantly higher on a scale used to measure burnout (Professional Quality of Life: Compassion Fatigue Scale). Thus, the findings from these studies suggest that the provision of support and supervision, and the use of it, is inconsistent. However, interpreter accounts consistently prove that interpreters are exposed to, and experience, emotional and vocational difficulties, which they need support in processing in order to cope with their experiences.

Discussion

There are a number of limitations to this systematic review. First, due to the lack of literature on sign language interpreters, nine of the 11 papers focused on spoken language interpreters, so the findings may not be directly applicable to sign language interpreters as had been intended. Additionally, the two papers addressing sign language interpreters made reference to previous studies and made suggestions and descriptions, rather than offering their own findings, but as these were the only papers located which focused on the emotional experiences of sign language interpreters, they were deemed too valuable to exclude. Similarly, there was also a lack of quantitative data found for this review, so the majority of findings are based on qualitative data and, therefore, [Valero-Garcés's study \(2005\)](#) was included, despite only offering a descriptive review of quantitative studies. Again, the findings were considered too relevant for the paper to be excluded. The inclusion of these studies meant that a sufficient amount of papers were analysed to perform an effective review.

The present review represents a significant first step in bringing together the relevant literature on the emotional experiences of interpreters and has identified significant gaps in the prior research, opening up new avenues for investigation. To my knowledge, this is the first systematic review aimed at researching the vicarious trauma and transference experiences of sign language interpreters, and the first to synthesise both qualitative and quantitative data on such experiences of interpreters. Therefore it is vital that more research is conducted in this area. The results of this review support that interpreters experience transference dynamics and are emotionally impacted by their work, the manifestation of which suggests that some interpreters can experience vicarious trauma. Additionally, the findings show that interpreters can experience vicarious posttraumatic growth and use social support and other coping strategies to deal with the impact of their work. Mixed prior findings indicate that there is confusion as to what constitutes confidentiality and professionalism, which causes interpreters emotional turmoil in their perceptions of the appropriateness of supervision and sharing their experiences.

The findings offer a unique contribution to the fields of interpreting and psychology by highlighting a number of concerns. Firstly, it is consistently demonstrated that other professions and service providers immensely underestimate the role of interpreters, often treating them as machines due to ignoring the linguistic complexities of translation. By treating interpreters as a commodity, service providers often fail to consider the emotional impact on interpreters, or to value their need for information in order to ensure an effective translation. The British Psychological Society (BPS) published 'Working with Interpreters in Health Settings' guidelines for psychologists in 2008, which state that psychologists should offer interpreters support through briefing, debriefing and supervision. Although none of the papers made direct reference to psychologists, many interpreters interviewed since 2008 have mentioned their shock that mental health practitioners lacked consideration, care or empathy for them, and that they rarely received information or briefing ([Molle, 2012](#); [Shakespeare, 2012](#)). Furthermore, interpreters' perceptions of supervision and support were inconsistent across the studies, causing confusion. Some reported receiving supervision either privately or through their employers, while others stressed that their code of conduct and ethical guidelines forbade them from accessing the support they needed ([Gomez, 2012](#); [Molle, 2012](#); [Shakespeare, 2012](#)). Additionally, one study revealed a lack of understanding as to what supervision constitutes, with many perceiving it as a hierarchical system representative of line management structures ([Hetherington, 2012](#)).

The results of the reviewed studies offer firm evidence that interpreters are exposed to potentially distressing and traumatic material. [Tribe and Lane \(2009\)](#) stated that while a one-off exposure to traumatic material may not

compromise an interpreter's mental wellbeing, vicarious trauma could build up if the interpreter must translate such conversations daily. Additionally, [Harvey \(2003\)](#) suggested that constant exposure to such situations may result in tension that could wear on the interpreter and lead to vicarious trauma. [Mitchell and Braham \(2011\)](#) proposed that specific issues of vicarious trauma exist for sign language interpreters who work with deaf offenders, as their description and disclosure of crimes and abuse can be more distressing for interpreters due to the visual expression involved in sign language. Furthermore, some findings suggest that interpreters experience transferential issues, which can be distressing ([Gomez, 2012](#)). [De Bruin and Brugmans \(2006\)](#) state that interpreters' neutrality positions them between the emotional exchanges between service providers and users, which causes them to become included in the transferential exchanges that can occur. Interpreters' lack of knowledge of such transferential dynamics and their own emotional reactions during their assignments can further fuel these dynamics, leaving them at risk of negative emotions which, if persistent, could lead to vicarious trauma ([Molle, 2012](#); [Shakespeare, 2012](#)). Concurrently, the limited studies on sign language interpreters have revealed that they experience considerable stress and emotional turmoil due to having to translate and witness the oppression of d/Deaf and hard of hearing people, as interpreters are profession-bound to withhold personal feelings while remaining neutral and relaying information exactly, or equivalently to meaning, as stated by each party ([Dysart-Gale, 2005](#); [Harvey, 2003](#); [Hetherington, 2012](#)).

[Sexton \(1999\)](#) argues that when countertransference reactions are experienced it is vital that they are understood, acknowledged and processed. However, countertransference reactions are firstly unconscious, making them difficult to identify. Therefore, it is essential that individuals engage in self-analysis through supervision to work through these difficult reactions. Furthermore, [Pearlman and Saakvitne \(1995\)](#) advocated that trauma work is too demanding to undertake without supervision and that the arrangement of regular supervision is essential not just for self-care, but also for professional accountability. Supervision is considered to mean a confidential, supportive and professional relationship which helps therapists to work through difficult issues raised in their work, thus facilitating self-care and professional development. In this respect, supervision provides the opportunity to express, acknowledge and process graphic imagery and the horrific stories that are an inevitable part of trauma therapy ([Sexton, 1999](#)). The professional guidelines for psychologists state that regular supervision is an ethical requirement and should start at a minimum of 1.5 hours per month and increase; furthermore, additional supervision must be sought if the psychologist has concerns regarding their professional practice ([British Psychological Society, 2008](#)).

However, in the UK, the principles of professional practice produced by the professional and registry body for sign language interpreters state that interpreters:

“treat all information you receive in the course of your duties as confidential, unless required by law to disclose information”

“are impartial, maintain integrity and professionalism, keeping a professional distance, even in challenging situations”

“intervene only to clarify meaning or to manage situations, e.g. to prevent misunderstanding and incorrect cultural inference, or to ensure that participants do not all speak at once”

“if appropriate, request a briefing session and sight of documents to be used in advance”

“do not bring the profession into disrepute” ([Association of Sign Language Interpreters, 2014](#)).

Thus, it appears that, despite potentially being exposed to emotionally challenging and distressing content from various aspects of their work, sign language interpreters have limited access to the support and supervision found to maintain health and wellbeing and to mitigate the risk of vicarious trauma in the mental health professions (Jordan, 2010). Therefore, it would appear that although the BPS guidelines advocate that supervision and support must be offered, this might clash with interpreters' own code of conduct, rendering it inapplicable. Furthermore, accounts of how interpreters are treated by mental health workers, a term which includes psychologists, suggests that although the BPS published this charter, the infrastructure to support it is scarce (Molle, 2012; Shakespeare, 2012; Tribe & Thompson, 2008). However, as no studies have yet investigated the experiences and perceptions of sign language interpreters, whether they experience this kind of treatment or if they do receive support remains unknown. Therefore, it is crucial that more research is undertaken, to ensure that interpreters are respected and receive vital support.

The medical model treats differences in sensory, mental and physical capabilities as ailments which need to be 'cured' through treatment or remediation. Hearing problems fall into this category and a diagnosis of deafness indicates long-term provisions of remediation, rehabilitation and care, which then translates into a societal view of deafness as a disability (Kyle & Pullen, 1988). Du Feu and Fergusson (2003) report that those affected by full or partial absence of hearing find that their difficulties as much concern the attitudes society has towards them, as the direct effect of their sensory impairment. However, most individuals affected by d/Deafness or who are hard of hearing view themselves as members of a linguistic and cultural minority, known as the Deaf community, and not as part of a disabled group, which offers a positive identity, confidence, support and self-esteem. Nonetheless, access to services such as healthcare and education can be restrictive due to the invisible nature of the impairment and frustrations in communication. To make needs known, one must communicate and others must receive the message. Thus, in circumstances where communication must occur between those with full hearing ability who lack sign language proficiency, and those who communicate using sign language within the d/Deaf and hard of hearing community, their communicative competency in the sign language is overlooked and one must rely on interpreters. Understandably, this can leave individuals feeling frustrated and powerless. Such frustration can sometimes be transferred onto the interpreters, whose profession and livelihood depends on their apparent communicative 'handicap' (Kyle & Pullen, 1988).

Tribe and Thompson (2008) highlight that when working with sign language interpreters, it should be remembered that the interpreter is also a hearing person; the dynamics in the interaction may therefore be affected, as the two hearing people could be seen as holding a privileged and dominant position in hearing society, whereas the single deaf person may feel they hold a less privileged position and might have experienced exclusion by the hearing community. Thus, sign language interpreters may have to deal with situations and resentment which spoken interpreters do not encounter. However, research into the experiences of this working group is scarce, causing a huge gap in our knowledge.

Interpreters are vital to the profession of counselling 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 (Tribe & Thompson, 2008). From the findings presented, a number of implications for counselling psychology and for spoken and sign language interpreting emerge. The field of interpreting would benefit from clearer and consistent codes of confidentiality, which take into consideration the wellbeing of the interpreter and allows formal support structures to be accessed. Psychology, and other professions which commonly use interpreters, would benefit from education about the interpreting profession and the process of translating in

order to encourage good working dynamics and that interpreters are respected and supported. This could be facilitated by the production and enforcement of guidelines which complement the interpreting profession and its code of ethics.

The findings from the literature analysed in this review consistently suggest that interpreters are vulnerable to vicarious traumatisation as the result of being exposed to distressing material, and to transference dynamics, which can occur through being the voice for others. As such, supervision and support has been advocated (Berthold & Fischman, 2014; Gomez, 2012; Splevins, Cohen, Joseph, Murray, & Bowley, 2010; Tribe & Thompson, 2008). However, the lack of literature specifically concerning sign language interpreters means that the situation for BSL/English sign language interpreters in Scotland remains unknown. The current research into the emotional experiences of spoken language interpreters and the research into occupational stress in sign language interpreters suggests that an investigation into the emotional experiences of Sign Language Interpreters is essential to fill this research gap.

Notes

i) The use of the Small d deaf generally signifies that the person does not associate with other members of the deaf community, but strives to identify themselves with hearing people, regarding their hearing loss solely in medical terms. "Big D" Deaf people tend to identify themselves as culturally deaf, and have a strong deaf identity. The Big D Deaf may have attended schools for the deaf, while the small d tend to have attended mainstream schools and/or never attended a school for the deaf. When writing about deafness, many writers will use a capital D when referring to aspects of deaf culture, and a lower case d when speaking solely about the hearing loss, and some just simply use D/deaf. (www.adcommunications.org.uk)

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Appendix

Search Terms Used During Every Electronic Database Search

1. Interpreter Support
2. "Interpreter Support"
3. "Support for Interpreters"
4. Support for Interpreters
5. Emotional support for British Sign Language Interpreters
6. Emotional Support for sign language interpreters
7. Emotional support for "BSL interpreters"
8. Emotional support for "BSL signers"
9. Supervision for interpreters
10. "Supervision for interpreters"
11. Clinical supervision for "British Sign Language Interpreters"
12. Clinical supervision for "sign language interpreters"
13. Clinical supervision for "BSL interpreters"
14. Interpreter vicarious trauma
15. Interpreter burnout
16. "Interpreter burnout"
17. "BSL interpreter" vicarious trauma
18. "BSL interpreters experience of vicarious trauma"
19. "Sign language interpreter" vicarious trauma

20. "BSL interpreter" burnout
21. "British Sign Language Interpreter" burnout
22. "Sign language interpreter" burnout
23. Transference and countertransference experiences of interpreters
24. Transference dynamics experienced by interpreters
25. "Transference dynamics experienced by interpreters"
26. Transference and countertransference experienced by "Sign Language interpreters"
27. Transference and countertransference experienced by "BSL interpreters"
28. Transference issues experienced by "BSL interpreters"
29. Transference dynamics experienced by "BSL interpreters"
30. Transference issues experienced by "Sign language interpreters"