Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect

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ABSTRACT

Interpreting palliative care conversations can be stressful due to the emotions and complex terminology involved, as well as the emphasis on fostering patient autonomy and disclosing prognosis transparently. To improve the quality of care for patients speaking different languages, a palliative care physician and social worker approached the director of interpreter services offering to provide sessions to address vicarious trauma. With interpreter input, they developed a series of monthly Dialogues in Palliative Care. This paper recounts how this supportive educational endeavor became a holistic approach to medical interpreters' occupational safety and health. The relationship between the clinicians and interpreters enabled a smooth transition to weekly emotional support for the interpreters and the modeling of a culture of care during the Covid-19 pandemic. Interpreters are integral members of the health care team and are uniquely vulnerable to emotional stress. They deserve a work environment that mitigates vicarious trauma.

KEYWORDS

Interpreter, occupational stress, vicarious trauma, teamwork

1. Introduction

The four authors of this paper are a clinical social worker in palliative care, a senior attending physician in palliative care, and two directors of medical interpreter departments, one at a large urban teaching hospital and the other at an adjacent cancer institute. The clinical social worker and the physician are part of a division of palliative care which is associated with both the teaching hospital and the cancer institute. Toward the end of 2015, this physician was interested in improving the palliative care provided to patients with limited English proficiency (LEP). She discovered that the then new palliative care social worker had a background in medical interpreting management and training. The physician approached the social worker with a suggestion that they offer education in palliative care to the hospital's medical interpreters. The clinicians understood that treating pain and other symptoms while providing guidance and emotional support to patients with serious and life limiting illnesses can be stressful and emotionally exhausting, for clinician and interpreter alike. They thought that a session on vicarious trauma might be a good way to begin what they hoped would be more opportunities to teach the interpreters about palliative care. With that goal in mind, the two clinicians approached the director of the hospital interpreter services department offering to provide a session on vicarious trauma for the staff.

After months of discussion and planning—including input from the hospital interpreters—the clinicians developed a larger endeavor facilitated monthly: Dialogues in Palliative Care. They created six hour-long Dialogues and structured them to meet the requirements for continuing education units (CEUs) through a national (US) medical interpreter certifying body. The social worker and physician wrote the required CEU application and worked with the interpreter services department's training coordinator to facilitate the application process. The success of the program led to the creation of a second series of monthly Dialogues in Palliative Care for the adjoining outpatient cancer institute's team of medical interpreters. The clinicians designed this series with input from the cancer center interpreters and their director. The design also provided the interpreter participants with national certification CEUs. The facilitators and interpreters continue to have Dialogues at the time of writing.

This paper describes the design, growth and evolution of this educational endeavor between two palliative care clinicians and two medical interpreter departments into a model of clinical education and support. It includes a description of the relationship of mutual respect, teaching and learning that evolved between the facilitators and the interpreters, which grew

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

120

to include other clinicians. The writers include a description of the interpreter services departments and a summary of the curriculum design. They also explain how they adapted the Dialogues and their relationship with the interpreters to support the latter during the Covid-19 pandemic. Finally, this paper describes a holistic approach to mitigating the impact of emotional stress and vicarious trauma on medical interpreters. It illustrates a partnership between health care clinicians, medical interpreter management and medical interpreters that could be implemented in other contexts and regions.

2. Background

Vicarious trauma, secondary traumatic stress, compassion fatigue, occupational and emotional stress, and burnout refer to the detrimental experiences of service providers exposed to the trauma of their clients or patients. Secondary traumatic stress and compassion fatigue have been described as a negative emotional reaction experienced when one is aware of the trauma of another (Geiling et al. 2022). Vicarious trauma has been defined as the changes which occur in a person (often a care provider) who engages in "empathic engagement" (Lai and Costello 2021: 71) with an individual's trauma experience. Burnout results from emotional stress that is experienced over time (American Counseling Association n.d.). It can be caused by ongoing exposure to the trauma of others and the accumulation of the ensuing emotional consequences that lead to emotional exhaustion (Harvey 2001; Sabo 2008). Vicarious trauma, emotional stress and burnout can lead to absenteeism among nurses (Sabo 2008) and decreased cognitive functioning within the prefrontal cortex of the brain, which is essential to interpreting (Park et al. 2017). In the United States, the ramifications of the Covid-19 pandemic highlighted the destructive impact of occupational and emotional stress on physical and mental health, especially among front line health care workers. The pandemic resulted in the resignation of many health care providers in the US, to the extent that the Surgeon General of the United States (2022) published a document highlighting the importance of addressing this occupational hazard.

The literature addressing vicarious trauma or occupational emotional stress among interpreters has traditionally focused on those exposed to the trauma of survivors of violence (Helmerichs 2020), refugees (Muller 2013; Geiling et al. 2022) and forced migrants (González Campanella 2022), and patients in mental health settings (Darroch and Dempsey 2016; Zafirah et al. 2020). Carmen Valero-Garcés (2005) provides a

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

121

detailed description of the various stressful demands made upon public service interpreters, their exposure to trauma and the subsequent mental health consequences.

In health care, it has been recognized that social workers (Figley 1995), nurses (Sabo 2008) and physicians (Smith et al. 2018) are at risk for occupational emotional stress. Yet, interpreters working alongside health care clinicians are often "invisible" (McDowell et al. 2011: 1), with less recognition of their experiences of empathy, compassion fatigue and burnout (Bontempo and Malcom 2012; Srivastava 2017).

Medical interpreters are at risk for secondary traumatic stress because of their exposure to patients' medical trauma and their unique role during the exposure. Medical traumas, whether life threatening illness or treatment, were not recognized as psychological traumas by the American Psychiatric Association in their Diagnostic and Statistical Manual of Mental Disorders until 2013 (Ganzel 2018). Medical interpreters deliver difficult and life-threatening diagnoses and prognoses to patients. They interpret during painful, frightening, and life-altering or physically disfiguring procedures. Therefore, they not only witness patients' pain and suffering, but also co-create or co-deliver trauma with the medical team.

Some of these types of difficult encounters can take place within palliative care. Palliative care teams address the physical, psychological, emotional, and spiritual needs of seriously ill patients, some of whom are at or near the end of life. They attend to the needs of patients' families, who may have to make difficult care decisions for their loved ones who can no longer communicate their wishes. Typically, team members can include specially trained physicians, nurse practitioners, social workers, pharmacists, and chaplains. Patients in their care often experience physical, spiritual and emotional pain and other distressing symptoms.

Further contributing to the challenges of interpreting in palliative care are unique concepts embraced by palliative care clinicians, complex terminology and carefully chosen words which may be difficult to accurately interpret in another language (Bontempo and Malcolm 2012; Brown 2016). An example of a carefully crafted dialogue is the Serious Illness Conversation Guide (Ariadne Labs 2017). This guide is used to teach palliative care clinicians how to compassionately deliver a poor prognosis to a seriously ill patient. It also guides the clinician through a patient centered and carefully crafted conversation about patient hopes, worries and sources of strength with reassurance and a commitment to care.

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

122

Palliative care concepts like patient autonomy or shared decision making may be counter to a patient's and family's cultural norms. Setting-specific conversations about serious illness, pain, and the end of life can be foreign to immigrant patients (Barwise et al. 2019) and laden with opportunities for culturally-based conflict. Well-intentioned yet uninformed clinicians may unintentionally disrespect their patients' cultural norms and expectations (Norris 2005; Periyakoil 2015; Brown 2016). The risk of misunderstanding or offending heightens the importance of accurate interpretation of the intended message, as well attention to culture nuances.

Adding to the interpreter's challenge are clinicians' varying preferences. Some clinicians prefer the interpreter to remain a language conduit with a focus on interpretation only. Other clinicians expect interpreters to help with cultural understanding and mediation (Norris, 2005; Periyakoil 2015; Brown 2016). Moreover, medical interpreters are at risk of identifying with their patients. Previous research (Sabo 2008) has argued that other professionals working in this setting are vulnerable to the emotional stress of caring for patients when they identify with their gender, age, and parental status. Such identification challenges clinicians' ability to professionally distance themselves from their patients, making them more vulnerable to emotional stress. Interpreters may also identify with the race, ethnicity, country of origin, migration story, religion, and cultural norms of their patients. This potential for identification can also increase their risk for vicarious trauma or emotional stress. Due to this risk and others, medical interpreters are expected to maintain professional distance and neutrality with their clients (NCIHC 2005; IMIA 2007). These challenges to maintain professional role boundaries and negotiate their role add to the occupational stress (González Campanella 2022).

Previous training has been developed in response to the recognition of medical interpreters' unique challenges during palliative care encounters. For example, Brown (2016) describes the evolution of a pioneering curriculum initiated and funded by the California Health Care Foundation. With the collaboration of a medical interpreter trainer and palliative care physician, the Foundation developed lessons with a focus on palliative care terminology and unique concepts (Roat 2011). Similarly, Park et al. (2017) created a skill-building resiliency program for medical interpreters at the Massachusetts General Hospital to help them mitigate the consequences of their exposure to vicarious trauma in oncology encounters. The authors explained that ongoing occupational and emotional stress among medical interpreters can

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

123

compromise the quality of their work, by compromising their cognitive functioning. When interpreters are unable to facilitate accurate and effective communication between clinicians and patients, the result can be compromised care for patients with limited English proficiency. According to Green and Nze (2017), this leads to health care disparities for patients with LEP, highlighting the importance of the prevention and mitigation of the consequences of medical interpreters' exposure to trauma, both for their benefit and that of their patients.

2.1 The Interpreters

In the teaching hospital where the Dialogues were created, the interpreter services department consists of about twenty professionally trained, part-time and full-time spoken language and American Sign Language (ASL) medical interpreters. In addition to these staff interpreters, there are about forty per-diem interpreters available for languages of lesser diffusion. The cancer institute's interpreting services department supports over fifty spoken languages and ASL. Their team includes fifteen staff interpreters and thirty per-diem interpreters. The language needs at the two institutions are different yet have some overlap. The full- and part-time staff interpreters at the two facilities combined cover Spanish, Portuguese, Cape Verdean Creole, Haitian Creole, Mandarin, Cantonese, Arabic, Somali, Italian and Russian. The per diem interpreters cover Greek, Khmer, Vietnamese, Albanian, Persian, Armenian, Turkish, Japanese, Hindi and Bengali. Face-to-face interpreter services at the hospital are supplemented by both telephone and video interpreting. Interpreter services at the hospital are available 24 hours per day and seven days per week. The cancer institute is an outpatient facility with face to face, telephonic and video interpretation available during all clinic hours.

The hiring screening process at the two institutions is similar. All applicants are required to have successfully completed a medical-interpretation introductory training course of at least 60 hours. Each candidate must then pass a language-based exam administered by the institution. In addition, an independent external evaluator is employed to assess each candidate's interpreting skills before hiring them. National certification in medical interpretation for spoken language interpreters in the United States is limited to a small number of the more than 300 languages spoken in the country. Some of the interpreters employed by the hospital and cancer institute have full national certification in both English

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

124

and another language. Other staff members have national certification limited to English only while some do not yet have a national certification at all. American Sign Language interpreters are required to have a nationally recognized sign-language credential.

2.2. The Dialogues

The two palliative care clinicians designed six hour-long sessions scheduled during the interpreters' lunch hour to avoid conflicts with outpatient appointments and to reduce the likelihood of inpatient needs. The department provided lunch for the participants. This added to the appeal of the Dialogues, made the interpreters feel valued, and provided a space for interpreters and clinicians to relax together before beginning the session.

As previously established, the goals and objectives of these Dialogues in Palliative Care were outlined to meet requirements of the CEU credits for national certification. Session topics included palliative care terminology, palliative care concepts, ethical dilemmas, difficult conversations and family meetings. The terminology and concept sessions were modeled after Roat's curriculum design (2011). Each participant was provided with a worksheet with a list of terms and space for the interpreters to enter the definition, translation, and any cultural commentary or concerns. The definitions and cultural nuances were then discussed among the group.

Two other sessions were devoted to the carefully scripted Serious Illness Conversation Guide (Ariadne Labs 2017). The first of these sessions focused on the challenges of translating the Guide, which was done by the British Columbia Centre for Palliative Care (n.d.). During this session, the interpreters were initially divided into small groups based on their languages to discuss the translations. They then re-grouped and shared their thoughts on word choice for different cultures and the challenges of translation versus interpretation of the Guide. The second session was devoted to roleplaying and interpreting the Conversation itself. Two other sessions were devoted to family meetings in general and then to family meetings where a change in the goals of care (from curative to palliative) is addressed. Most of the Dialogues included time for reflection, small and large group discussions, and roleplays.

The facilitators planned roleplays as part of the curriculum design so that they reflected the topic at hand. They partnered with the interpreters and engaged with them in these semi-improvisational role plays, followed by discussion. At other times, the facilitators would interrupt a large group discussion and facilitate a real time role play based on the

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

125

hypothetical scenarios being discussed. The change from discussion to role play provided the clinicians and interpreters an opportunity to "see" the concerns of fellow participants and to share their skills with one another to resolve challenging scenarios. This method of impromptu role playing also provided an opportunity for skill-building not anticipated by the facilitators when they designed the particular session. This type of flexibility cultivated participatory education, responding to the needs of the interpreters.

During the second and third year that the initiative was undertaken, the Dialogues included other palliative care clinicians as participants. The interpreters had requested that clinicians be educated in working with interpreters and patients with LEP. One session was devoted to a Dialogue between the interpreters and hospital based palliative care physicians, nurse practitioners and social workers. A session at the cancer institute included nurse practitioners and pharmacists. Other sessions involved guest presenters such as a spiritual care provider, the hospital ethicist and a psychiatrist. In these cases, discussions included resolving ethical dilemmas—especially those unique to the interpreter—, as well as challenges of interpreting prayer and conducting a mental status exam across languages and cultures.

To facilitate an exchange of helpful information, the facilitators began many of the sessions with time for reflection. Interpreters and clinicians were given a set of questions and time to answer them privately. These questions focused on the challenges of interpreted encounters and what each participant found helpful. The facilitators encouraged the participants to teach each other what they needed to improve the communication and care they jointly provided to patients with LEP. After the participants had time to reflect and record their thoughts, they were moved into interdisciplinary partnerships or small groups to share their responses. Then the participants came together again as a large group to share what they learned.

2.3. *Adapting to the Pandemic and Program Evaluation*

Three years into the Dialogues in Palliative Care, during the spring of 2020, the Covid-19 pandemic interrupted the series. The hospital interpreters remained on-site working face-to-face or via video from outside of Covid-positive patient rooms, or interpreted remotely from home. Conversely, all cancer institute interpreters were asked to work remotely from home. Later, the interpreting services department at the hospital began a weekly staff meeting via conference call. The two palliative care clinicians involved in the

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

development of the Dialogues joined these conference calls to offer emotional support and listen to interpreters' anger, frustration and fears about the pandemic, their working conditions, and their colleagues. As the year progressed, the clinician facilitators resumed the monthly Dialogues in Palliative Care online with both the hospital and the cancer institute interpreters.

The authors evaluated the series of Dialogues in a variety of ways. They conducted a formal evaluation (Goldhirsch et al. 2021) surveying all of the interpreter participants at both sites who had completed an entire series of six dialogues. In addition, the facilitators periodically solicited feedback with anonymous online surveys delivered via e-mail. There was a low response rate from the interpreters for these online surveys. However, verbal feedback was also solicited and recorded at the end of the sessions. This article reports on the feedback collected through the online surveys, from session comments, and from feedback given to directors or facilitators outside of sessions.

3. Discussion

The Dialogues in Palliative Care provided interpreters with an opportunity to teach and learn from clinicians while forming mutually respectful relationships with them. The Dialogues created a safe space where interpreters could practice new skills which they could then transfer to the patient care settings. Moreover, the ongoing relationships between facilitators and interpreters provided emotional support to the interpreters during a pandemic. This situation resulted in the expansion of the curricula to encourage emotional support among interpreters.

3.1 Challenges

During the Dialogues, interpreters had a unique opportunity to teach clinicians about their experience and to practice new skills under the mentorship of clinicians. During one Dialogue addressing the importance of pre-encounter briefings, the interpreters switched roles with the physician facilitator during a role play. The interpreter played the role of physician, and the physician played the role of interpreter. In this way, the interpreter "physician" could imitate the challenging responses interpreters had to face when attempting to engage in a pre-encounter briefing or to enter a huddle[1] of clinicians. As the physician

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[1] Huddles are brief gatherings of clinicians during which they brief one another and come up with a plan prior to meeting with a patient or prior to a family meeting.

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

"interpreter" listened, she then responded with what she believed would be effective reasons for asking a physician to take the time to speak with an interpreter. She suggested, for example, that the interpreter may have useful information about the patient which would be helpful to the physician. She also suggested that the interpreter explain that the time taken for briefing would make the encounter with the patient more efficient. Subsequently, the physician and the interpreter resumed their own roles and practiced this new dialogue. Although interpreters may be entitled to pre- and post- encounter briefings with clinicians (Lai and Costello 2020), the Dialogues illustrated that interpreters may not have the skills to successfully negotiate these essential conversations.

> The dialogues were very helpful, especially the role playing... because we are doing actual role plays and this prepares us for situations with patients and providers.

> In the past we did not focus on huddles and now I ask the provider(s) to give me a brief idea of what we will talk about. I initiate the huddle ... (if they do not). Having huddles has provided me with the opportunity to realize that we are all the same, we are all human and we all have feelings and vulnerabilities (re: patients) and this has reduced my past feelings of alienation (from physicians).

During other sessions when the facilitators focused on the unique vocabulary used in palliative care conversations, the discussion led to terms with no direct translation in other languages. Terms such as "goals of care", "hospice", and "health care proxy" require that interpreters have a solid understanding of the concepts to allow them to find an equivalent in the patient's language. These sessions also provided an opportunity to explore the dangers of mistranslation or false cognates, as is the case with "hospice" in English and "hospicio" in Spanish. The interpreters involved explained the latter term as referring to a deplorable place where people without family go and are left to die alone. The group learned about the care that hospice agencies provide and were able to create accurate interpretations of this type of end-of-life care in their working languages.

During the session addressing the translations of Ariadne Labs' 2017 Serious Illness Conversation Guide (BCCPC n.d.), an interpreter explained that, although the word "hope" was translated correctly, it was not used in the same context in her working language. She further explained the difficulties she would have interpreting this word and others in the Guide's narrative. This was a valuable lesson for clinicians who are not

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

128

familiar with the challenges of translating the written word versus interpreting the spoken word in the context of a specific conversation. It also recognized interpreters' expertise and made them feel heard.

> I have been so impressed with Palliative Care's approach that they do not 'use' us but 'work' with us. They are so in tune with what we do. I feel validated and in the past, I felt very unimportant (was treated that way).

When interpreters are not familiar with terminology, concepts and the importance of carefully crafted dialogue, their work may be more difficult and more stressful (Brown 2016). There are many demands put upon interpreters, including their Standards of Practice (IMIA 2007), their Code of Ethics (2005), and expectations of accuracy by providers and patients alike. When interpreters are not informed about the topic of an encounter and are not familiar with vocabulary or concepts, the demands of their work increase along with their stress. Interpreters taught the group about the importance of pre-encounter conversations and huddles including preparing themselves for the topic at hand and the challenges it might bring.

Ethical dilemmas presented another source of stress reported by the interpreters. To address this, the facilitators organized a Dialogue with the hospital ethicist. The Dialogue began with a review of the code of ethics for health care interpreters (NCIHC 2005), as well as the recommended steps for resolving dilemmas in medical interpreting. Interpreters described common situations which create ethical dilemmas for them. Then, they role played a situation where a family member instructed them not to interpret the word "cancer" if uttered by the physician. Other scenarios involved family members approaching interpreters prior to an encounter to implore upon them not to interpret a negative diagnosis or prognosis. In this case, fidelity to a physician's message and commitment to beneficent treatment of their patient—both included in their code of professional ethics—are at odds. In the role play, the physician insisted on telling the patient the truth about their diagnosis of cancer, which would allow for that patient's treatment. With help from the hospital ethicist and the facilitators, the interpreters framed the difficult encounter as an ethical dilemma and practiced a role play to come to an acceptable resolution.

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

129

The Dialogues' flexible design allowed interpreters to create role plays and provided an opportunity for them to teach the facilitators and the hospital ethicist about their unique challenges. This gave interpreters an active role in education and demonstrated respect for their knowledge. These dilemmas, which put interpreters in the position of having to violate their professional code of ethics or a patient's cultural norms, can contribute to their occupational and emotional stress. As many interpreters share their patients' cultural background, the situation can also involve a violation of their own cultural norms. Witnessing the violation of a cultural norm can create trauma for a patient and family, as well as vicarious trauma or emotional stress for an interpreter. Being able to work with a physician to prevent this can reduce an interpreter's exposure to trauma and can empower them to improve their patients' care. Resolving these types of dilemmas can also provide the interpreters with more control over their encounters, which has been shown to reduce occupational stress (Dean and Pollard 2001).

3.2 Teamwork and The Culture of Palliative Care

When the facilitators and interpreters reviewed palliative care concepts such as patient autonomy, quality of life and advance care planning, they included asking a patient's permission to discuss specific topics. These topics may be difficult to talk about, including breaking bad news, sharing a poor prognosis, and planning for future care. Palliative care clinicians are trained to ask a patient's permission to talk about often emotionally charged topics, as this is a way to partner with their patients to offer them some control. This type of patient centered communication may be foreign to patients (and interpreters) from other cultures. Therefore, the Dialogues provided a forum to familiarize interpreters with the culture of palliative care that these concepts and values reflect. Interpreters appreciated having this unique style of communication explained to them.

During one of the Dialogues when the two facilitators role-played "breaking bad news", the physician facilitator role played an oncologist and gave the "patient" a medical update which was not what was hoped for. During the de-brief, interpreters asked the palliative care physician about her previous practice as an oncologist and her experience breaking bad news to her cancer patients. She described the emotional pain and difficulty she had had during such encounters, revealing her own emotional vulnerability as a physician. The experience was powerful for the interpreter participants, as elicited in the following quote:

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

130

> And I really understood that they think the kind of things we think. I never thought that a doctor would feel like [what she] shared with us, that she felt guilty because she did not have any more treatment for the patient. That really changed the way I feel about oncologists and other doctors right now. It's not always just what you see. ... I think as Latinos, we are very passionate, and you can see it on our faces. [I]realize[d] [that] other people; they carry their feelings about what they feel in a different way.

Advice for health care clinicians working with medical interpreters is plentiful (Pham et al. 2008; Butow et al. 2013; Latif et al. 2022). Some authors (Norris et al. 2005; Shapira et al. 2008; Hudelson and Vilpert 2009; Thornton et al. 2009; Hsieh et al. 2010) suggest going further and training clinicians on how to work effectively with interpreters. In this case, the writers observed that the empathic connection between provider and interpreter was facilitated by the time spent learning together in the safe and respectful space of a Dialogue. The authors argue that gaining an empathic connection in the process of learning together, understanding one another's challenges, concerns, and vulnerabilities may facilitate a more effective negotiation of roles and an improved working relationship.

Another example of learning together took place during the Dialogue on family meetings, which offered an example of an effective role negotiation. During this session, interpreters identified their need to have a clinician lead family meetings. A leader was considered necessary to manage the flow of the conversation so as to prevent multiple conversations from taking place at the same time, often in multiple languages, which makes an interpreter's job more stressful. Being able to negotiate their needs and roles prior to a family meeting can give an interpreter a sense of control and reduce stress. Moreover, the Dialogues created a structured space in which interpreters could practice expressing their needs directly to providers.

> I was afraid to talk to certain doctors. Now I use it, the technique, the words that you guys taught me. And it really helped me to talk to those doctors that I was afraid of talking to.

Teamwork is an antidote to physician burnout (O'Daniel 2008) and has been found to improve patient safety (Smith et al. 2018). Education and teamwork between providers and interpreters can also improve the working experience of interpreters (Shapira et al.

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

131

2008; Park et al. 2017; Lai and Costello 2020). Teamwork can further facilitate interpreters being seen, heard and treated as members of the team. When physicians and interpreters partner with one another and work effectively together to communicate with patients with LEP, they may be able to reduce some of the interpreter's occupational stress and thereby improve the quality of care (Lai and Heydon 2015; Park et al. 2017).

> In the past I was more passive…. Now, I ask more questions…. I have more purpose. I am more aware of the physician's goals... From what I learned in the dialogues and from asking the doctors.

3.3 The Covid-19 Pandemic

The palliative care clinicians were familiar with an emotionally supportive team environment through their work within a program with built-in structures allowing for grieving and emotional support. This program included a weekly time to remember those patients who had died, an annual event welcoming surviving family members, and a culture which normalized debriefing, sharing among colleagues and emotional support. The palliative care division had intentionally normalized mutual support and debriefing, especially after difficult cases and during difficult periods such as the pandemic. The aim was to mediate the vicarious trauma and emotional stress of the work while building community. As a result, the two clinicians were ready share their skills and culture of caring with the interpreter services departments during the Covid-19 pandemic.

The social worker and physician facilitators adapted their roles to become supportive listeners during the weekly conference-call staff meetings which began in the early months of the pandemic in the United States. The interpreters expressed concerns about access to masks and other protective equipment, and shared fears of contracting the virus. They feared for one of their colleagues who was critically ill with Covid. They shared the impact of other life-threatening crises taking place alongside the pandemic, increasing their feelings of vulnerability. The physician and social worker facilitators shared their personal phone numbers, welcoming staff members in need of further support to call them. This resulted in a few of the interpreters reaching out to the clinical social worker in crisis and in need of emotional support. As the year progressed, the clinician

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

132

facilitators resumed the monthly Dialogues in Palliative Care online with both the hospital and the cancer institute interpreters.

For the first session, the two clinician facilitators modeled an emotionally supportive dialogue. They asked each other: "What was most difficult during the past year of the pandemic for you?" and "What helped you through it?" They listened silently to one another. Then, the facilitators divided the participants into pairs in virtual breakout rooms and asked each pair to pose the questions one at a time, to listen in silence, and to switch roles. Once the cycle was over, they re-grouped and shared their experiences. The aim was to create a culture of caring which normalized emotional vulnerability and emotional support. This Dialogue also gave the interpreters an opportunity to practice being vulnerable with one another in a safe space.

It was somehow difficult. There (sic) is not always easy to share information with coworkers. I do not really like to share my private life with colleagues.

Never (been asked). It provided a space to open up and talk about what was going on and how we were feeling about it. It was healing.

(Learned that) we all shared the same concerns.

Comfortable and easy in the sense that we were all going through the same new experiences and trying to make sense regarding how to navigate the situation.

3.4 Employee Well-being

Vicarious trauma and emotional stress should be addressed by both employers and individual employees (Darroche and Dempsey 2016). A workplace can and should be evaluated for interventions which can mitigate these occupational hazards. The US Surgeon General (2022) clearly stated the essential ingredients for the well-being of employees. They include protection from harm—both physical and psychological—as well as the normalization of mental health support. Other essential ingredients for employee well-being include the fostering teamwork, feeling dignity and finding meaning, providing opportunities for growth, the creating of a culture of inclusion and belonging, and cultivating trusting relationships. The educational endeavor created by the authors and the adaptations that they implemented along the way speak to these recommendations for

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

133

workplace safety and interpreters' mental health.

Medical interpreters are in a unique position to be valuable members of the health care team because of their unique connection to their patients with LEP. Patients with LEP and their providers would both benefit from the integration of interpreters into the health care team (Schapira et al. 2008). Medical interpreters need and deserve a work environment that supports their physical and mental health.

4. Conclusion

When clinicians and interpreters were given the opportunity to share their experiences and needs in a safe and supportive space, they made empathic connections. They saw each other's vulnerabilities and created a more personal connection. Interpreters felt heard, seen and respected. They gained confidence and felt cared for and supported. Brief, well-designed, and facilitated dialogues changed the relationships between interpreters and LEP-patient care providers.

When clinicians have an opportunity to learn how to "work with" interpreters, they can stop "using" them as tools and start seeing them as integral members of the care team. Clinicians with empathic connections to interpreters can recognize their occupational risk for emotional stress and vicarious trauma. A supportive educational program can contribute to a positive change in the work environment for interpreters.

5. Future Directions

The authors recommend that health care providers support medical interpreters (and other employees) by adding a course addressing vicarious trauma and occupational mental health to the annual required course list. Health care employees in the US are required to take online courses and pass exams demonstrating competencies in occupational safety and in patient care. The authors recommend adding annual competency courses addressing employee mental health and safety including the mitigation of occupational and emotional stress and vicarious trauma. The authors also recommend continuing education courses for managers of interpreter services departments to help them manage the occupational mental health of their staff.

Future endeavors to help reduce medical interpreters' occupational and emotional stress could also include professional clinical supervision (Hetherington 2012; Geiling 2022). Clinical supervision could offer interpreters an opportunity to reflect upon and discuss

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

134

difficult encounters on a regular basis. They could learn from senior interpreters and peers, receive emotional support and address the impact of their exposure to trauma. The Dialogues demonstrated interpreters' interest in learning from each other and from clinicians. They shared challenges, listened to feedback from both peers and clinicians and some sought emotional support during the height of the pandemic. Regular professional supervision for medical interpreters may provide the growth and support they need and deserve.

Jessica Goldhirsch, Nina Scott, Yilu Ma, Janet Abrahm, Addressing Vicarious Trauma and Emotional Stress Among Medical Interpreters Through Care, Partnership and Respect, 119 - 141.

135

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136

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140

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