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TRAUMA NARRATIVES IN MENTAL HEALTH INTERPRETING:
A QUALITATIVE STUDY

By

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B.A., University of Louisville, 2014

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A Thesis Approved on

April 9, 2019

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ABSTRACT

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A QUALITATIVE STUDY

Miranda Hale

April 9, 2019

Interpreting Studies has seen an increase in research in mental health, but many questions have yet to be explored. This study seeks to contribute to the literature by considering how interpreters render trauma narratives that clients share in counseling sessions. Semi-structured interviews were conducted with two interpreters who have experience in the mental health setting and one counselor who has worked extensively with interpreters. A thematic analysis of these interviews contributes to a better understanding of the interpreted interactions in this setting, with key points highlighting aspects of the setting itself, the work environment, and interpreters' trauma awareness. It also demonstrates that some participants in these encounters already have a basic awareness of how trauma affects language. This study concludes that interpreters' renditions of these narratives can have diagnostic value in this setting. As a preliminary study, these findings can serve as a basis for further research on the topic.

TABLE OF CONTENTS

ABSTRACT	iii
INTRODUCTION	1
1. Statement of the Problem	3
2. Research Questions	4
3. Purpose of the Study	5
4. Strengths & Limitations of the Study.....	6
5. Interdisciplinary Nature of Study and Organization	7
6. Basic Concepts and Terminology	9
6.1. Concepts from Interpreting Studies	9
6.2. Concepts from Psychology: Trauma and Therapy	13
LITERATURE REVIEW	17
1. Language and Trauma.....	17
2. Trauma-Informed Interpreting	21
3. Interpreting in Mental Health.....	26
4. Mental Health Perspective on Interpreters	30
METHODOLOGY	34
1. TIMIS Project Creation and Development.....	34
2. Funding.....	36
3. Project Development and Feasibility	36
4. Ethical Research.....	38
5. Personnel and Subjects in the TIMIS Study	39
6. Sampling Methods.....	41
7. Data Collection.....	43
8. Data Analysis	44
9. Methodological Strengths and Limitations	44
10. Methodological Principles.....	45
RESULTS	47

1. Background Information	47
2. Mental Health Setting.....	48
3. Work Environment.....	53
4. Trauma Awareness.....	56
5. Language of Trauma Narratives.....	59
DISCUSSION.....	64
1. Mental Health Setting.....	66
2. Work Environment.....	69
3. Trauma Awareness.....	72
4. Language of Trauma Narratives.....	75
CONCLUSION.....	81
REFERENCES	85
IRB APPROVAL.....	93
CURRICULUM VITA	96

CHAPTER I

INTRODUCTION

Imagine that someone you know has just experienced a negative life-altering event: she was robbed at gunpoint and beaten by her assailants. After a short hospital stay, she survived the confrontation without lasting physical injuries. However, the incident has impacted her in other ways. She is trying her hardest to stay strong for her children, but every area of her life has been affected. As she tries to go on with her daily routine, she finds that it is difficult to do simple tasks. On top of this, she feels paralyzed by fear when she hears sounds that remind her of the attack. You know there are resources out there to help her, but there's one problem: she's only been in the United States for a year and doesn't speak English well enough to communicate with a therapist.

While the above anecdote is fictional, it mirrors the experience of many in this country who have experienced some sort of trauma and don't know where to turn for help. Many immigrants and refugees could benefit from receiving psychological services to cope with such debilitating circumstances, but a language barrier prevents them from accessing these services. A range of solutions exist, but one of the most common involves using interpreters to facilitate communication between the trauma survivor and the mental health professional. Although using interpreters is a valid solution, it poses its own challenges. Will the interpreter be able to tell the survivor's story well? Will the therapist be able to maintain control of the session in the presence of a third party? How

will the interpreter respond to the traumatic content they are hearing and subsequently interpreting?

The process of thinking through these questions and seeking answers to them has led to the TIMIS project (Trauma-Informed Mental Health Interpreting Services). This study was created with the two-fold approach of providing these interpreting services to victims of trauma and looking at these questions further. As I have sifted through some of these questions in my interpreting classes and while assisting with this study, I have developed an interest in a specific aspect of this issue: trauma narratives and their interpretations. In this thesis I will primarily look at trauma narratives and how they are interpreted, while situating it within the broader context of the TIMIS project.

Before diving into the details of this study, I would like to comment on the exceptional opportunity that interpreting provides. Whereas the theoretical nature of research can often feel far removed from the practical solutions it seeks to provide, applied research on interpreting has the potential to immediately impact the lives of those who receive interpreting services. As an interpreter and a researcher in this field, I can simultaneously be the voice for people like the woman mentioned above while also contributing to knowledge that will help others be better equipped to serve in the same capacity. There is a tension there, and it does come with its limitations, but it is a rewarding work. I resonate with the reflections of other researchers in neighboring fields: “I am aware of the potential problems involved in trying to fulfill two roles at the same time... I see myself as a researcher *and* a social activist, and I see these roles as complementary rather than contradictory (Phipps 2012)” (Ladegaard “Coping” 192).

1. Statement of the Problem

As previously mentioned, the TIMIS project was intentionally designed both to provide interpreting services to trauma survivors and to further the research on interpreting in mental health. The first problem it seeks to address is social in nature. Although Louisville, Kentucky has a large population of Spanish-speakers, there are very few mental health services available to them in their own language. Sometimes these services can be accessed through interpreters, but due to lack of funding and available resources, organizations may rely on bilinguals who are untrained in interpreting and in trauma-informed care. The TIMIS project makes it possible for this Spanish-speaking population to access these services for free using trained interpreters. The additional social benefit is that the interpreters receive further training and practice in interpreting in mental health, and counselors get the professional experience of learning to work with interpreters.

The second problem the TIMIS project seeks to address is scientific in nature. There is limited research on interpreters working in mental health. This is indicative of a broader trend within Interpreting Studies, as noted by scholars: “Indeed, the body of research in Interpreting, especially community interpreting, is so small that most questions are yet to be formulated and researched” (Hale and Napier 20). With this said, there are relatively numerous publications centering around legal and medical interpreting, but far fewer focusing on mental health. Most of the questions about interpreting in mental health have yet to be asked, and those that have been asked are accompanied by a scant body of research.

2. Research Questions

While the TIMIS project was designed to cover a broader scope of research questions about this setting, covering topics such as interpreter visibility, interpreter agency, and trauma-informed protocol, this thesis is addressing one area in particular: interpreting trauma narratives within this setting. How do interpreters process and then convey these trauma narratives from one language to another? Since trauma narratives have different linguistic characteristics than regular discourse, do interpreters unintentionally repair the message as they convey it? Does the rendered message maintain the same characteristics as the original, to the greatest extent possible? And, consequently, does this make a difference in the way mental healthcare professionals perceive, and possibly even diagnose, their clients with limited English proficiency?

Languages vary on many levels: lexicon (vocabulary), morphology (word-level), syntax (sentence-level), semantics (meaning), to name a few. As such, interpreters cannot produce an exact equivalence of what they heard in the source language, because the differences in languages do not allow for this. Beyond considering the words themselves, they must also take into account how they are spoken, which is represented in the paraverbal aspects of communication. My hypothesis is that interpreters may unintentionally try to repair language they hear and produce a rendition that is less accurate than desired. If the language sounds different or unnatural, on a verbal and paraverbal level, they may want to reproduce something that makes sense, but ends up losing some of the characteristics that made the original message distinct from ordinary speech.

Interpreters in mental healthcare are already facing a host of expectations and pressures: they must listen intently to stories of clients' most traumatic experiences and repeat them, they have to remain calm in the midst of such heavy content and emotional reactions from the clients, and they must conform to the counselor's therapeutic style, while simultaneously navigating other personal and professional pressures. Why should we put more pressure on them to get all the nuances and paraverbal aspects of these narratives correct? In mental healthcare, words are the only means professionals have to diagnose their clients' problems. The interpreter is the only one in the room who can hear the original message exactly as it is being said, nuance and all. In order to do their job well, to be the voice of the victim and give the counselor access to that voice, they must ensure that the voice is being conveyed accurately. If interpreters are not even aware that trauma narratives are distinct from everyday speech, and the implications this could ultimately have for diagnosis and treatment, they may not pay careful enough attention to produce a faithful rendition. This research is intended to better understand this problem and shape further training for interpreters who will interpret these narratives.

3. Purpose of the Study

The purpose of this study is to learn more about interpreters' and counselors' perceptions of interpreter-mediated counseling sessions, with the aim of gathering information about trauma narratives. To understand the research questions, it first looks at the interactions: who is participating, where the sessions are taking place and how often, what they are like. Then it indirectly observes the trauma narratives that are shared during the sessions. It explores whether the listeners have perceived any differences in trauma narratives as compared to everyday speech. The study seeks to identify

characteristics of these narratives based on the literature and the perspective of interpreters and counselors. This research also looks to describe how interpreters have handled these narratives while interpreting and to make recommendations for future training.

4. Strengths & Limitations of the Study

The methodological approach to this study will be described in detail in chapter three; however, it is important to address some of the strengths and limitations early on. Semi-structured interviews were conducted with two interpreters and one counselor, all with at least one year of experience in the mental health setting. The study is qualitative in nature and, as such, some of its strengths are also limitations. While the sample size was relatively small, the method utilized allowed the participants to describe their experience with trauma narratives in depth.

As a researcher, I have personally had to wrestle with some of the limitations to this study. My original plan was to do discourse analysis on interpreted trauma narratives. These would have come from transcripts of real-life interpreted counseling sessions through the TIMIS project. I considered this to be the ideal approach because there are limitations to relying on reflections about interpreting instead of looking at the interpreted encounters themselves. Not only that, but since my hypothesis is that interpreters are unintentionally altering the messages, I was counting on having actual transcripts to answer my questions. If interpreters are unaware that they are doing something, they will not likely be able to report on it. Although there are currently counseling sessions scheduled to happen through the project, at the time of writing these sessions have yet to take place due to various logistical challenges.

In thinking through this limitation and having to come to terms with the interview method I ultimately chose to utilize, I have noted a strength in it. With the transcripts, I would have been limited to data from a small number of counseling sessions, and trauma narratives may not have even appeared in those sessions. With the interview method, the participants were reflecting on years or even decades of experience that I would not have otherwise had access to. Even with the limitations, since this is such a new topic of study, the data collected is useful in determining the relevance of this issue, and will help pave the way for further research. .

5. Interdisciplinary Nature of Study and Organization

The primary aim of this paper is to contribute to the field of Interpreting Studies, an academic discipline which focuses on the oral or signed transfer of messages across languages. This will be accomplished by studying a specific linguistic phenomenon, trauma narratives, within a given context (mental health settings) and describing how interpreters have handled them in the past. This information will allow recommendations to be made for best practices in the future. The field of Interpreting Studies in and of itself is diverse, as highlighted by the broad range of categories researchers can study: medium, setting, mode, languages (cultures), discourse, participants, interpreter, and problem (Pöchhacker 23-24). Given the diversity of topics within the field, it naturally lends itself to interdisciplinary work (47-51).

This study, while maintaining Interpreting Studies as a central focus, will also pull from the fields of psychology and linguistics for foundational concepts, theories, and data analysis. This intersection happens organically. Looking at the list above, one can see how these research categories in Interpreting Studies overlap with other fields of study:

discourse is logically linked with linguistics, languages and cultures with cultural studies, interpreting settings such as legal or medical with their respective academic disciplines. The possibilities are endless. In an effort to narrow my study, I have chosen to limit its overlap primarily with psychology and linguistics because they are most relevant to the questions at hand. I do this with the awareness that some questions may be left unanswered, paving the way for more research in the future.

Psychology as a discipline is helpful in contextualizing both the setting and the problem in this study. Since trauma narratives are shared in therapeutic settings, the psychological branches of counseling psychology and clinical mental health psychology give a framework for understanding the communication that takes place in counseling. Scholarly work from psychologists provides a definition of trauma, a central theme in this study. They are also referenced to define trauma-informed care, a foundational basis for trauma-informed interpreting. Publications from psychology dealing with working with interpreters are mentioned. Lastly, psychological studies that have commented on unique features of trauma survivors' language are referenced, especially where linguistics has not yet done so as comprehensively.

The field of linguistics is consulted within this study to show the connection between language and trauma. This discipline helps shed light on which aspects of speech are affected by trauma and how trauma manifests itself in language. Of particular relevance are the subfields of discourse analysis, pragmatics, and applied linguistics. Although discourse analysis, used to study different aspects of naturally occurring speech, is not employed here as a methodological approach, prior work using discourse analysis on trauma narratives is mentioned to show the relevance of the problem.

Pragmatics, which studies the meaning of words within a given context beyond their semantic meaning, while not the main emphasis of the research, can play a role in helping understand how the trauma narratives and the interpreter's rendition of them are perceived in the counseling sessions. Lastly, the subfield of applied linguistics studies linguistic problems. This is applicable to this study because it examines the linguistic problem of how to interpret speech affected by trauma.

Works from the above disciplines make up the literature review, which covers the following topics: language and trauma, trauma-informed interpreting, interpreting in mental health, and mental healthcare's perspective on working with interpreters. A detailed overview of the methodology used for this study follows the literature review. Then, there is an analysis and discussion of the collected data. Before reviewing what the applicable literature from Interpreting Studies, psychology, and linguistics reports, some basic concepts are introduced in the following section to assist in an understanding and interpretation of the findings.

6. Basic Concepts and Terminology

6.1. Concepts from Interpreting Studies

In the following paragraphs I introduce some basic concepts found within Interpreting Studies, such as interpreting, the people involved in the interpreting encounter, modes, settings, codes of ethics, and protocols. Although interpreting is different from translation, it is common for laypeople to mistakenly refer to both as translation because of their similarities. Both involve transferring messages from one language (the source language) to another (the target language). Typically, translators and interpreters convert messages from their B language, a language they have a high level of

fluency in, into their A language, or native language. In spite of these commonalities between interpreting and translation, there are characteristics which distinguish them from one another in their respective professional and academic fields.

Interpreting is distinct from translation in that the language transfer always happens orally or, in the case of sign language interpreting, through signs. Interpreting also involves a personal, sometimes face-to-face, synchronous communication. In contrast, translation projects are typically worked on privately and asynchronously. The professional implication is that interpreters must be prepared to render messages on the spot, whereas translators can take more time and consult resources before translating the message. This is one of the key elements that distinguishes research in both fields. While translation studies naturally focuses more on texts, Interpreting Studies looks not only at the message that is conveyed, but also the interaction between the participants.

One of the most relevant factors shaping these interactions is the setting in which the interpreting takes place. A typical division of interpreting settings is as follows: legal, healthcare, public service/community, and conference. New settings continue to be added as the field expands, and these can include interpreting in asylum proceedings, mental health care, education, interpreting for the mass media and in conflict zones, amongst others (Mikkelson and Jourdenais). While there are some generally accepted principles about interpreter role and conduct, scholars often debate the finer nuances of these issues within the context of each setting. This is part of the reason why my study is limited to one setting: mental health. Although the mental health setting is sometimes included within the broader healthcare setting, I will later discuss why I think it should be kept separate.

Due to the different interactions that take place across these settings, interpreters must train and prepare themselves accordingly. Being bilingual is a first step to interpreting, but it is not enough. Typically, interpreters must engage in serious study to specialize in one or more of these settings, beyond learning basic interpreting skills. This is because, in addition to the specialized terminology they must learn, they must also be mindful of pragmatic considerations regarding communication. A lawyer in a courtroom could ask someone, “What happened?” seeking to elicit a guilty response from a defendant, whereas a doctor in a hospital could ask the very same question out of sincere concern for a patient. The interpreter must learn to distinguish these types of communication being mindful of the setting. These skills can be learned through professional and academic training. The level of training required for interpreters to enter the profession may differ depending on the country and organization where they are working. There are also different institutional expectations and professional conduct and protocols required of them.

Since interpreters are engaged in a professional task, they often abide by codes of ethics. These vary slightly based on the setting and the perceived role of the interpreter within that setting. For example, interpreters are always supposed to be impartial, but this would be implemented more stringently in legal interpreting, which is inherently adversarial, than in a medical setting interpreting between a doctor and a patient.

Interpreters are also expected to be accurate, to render the message accurately and adequately, without any omissions, additions, or modifications. Again, these expectations can vary slightly by setting. In a courtroom, if witnesses hesitate on the stand and the interpreters do not include these hesitations in their renditions, they are not accurately

conveying what was said. This lack of accuracy could be detrimental to the cases.

Medical interpreters would still seek to convey these hesitations to promote accuracy, but the consequences of not doing so in this setting would likely not be as grave. Closely aligned with interpreter codes of ethics are protocols, specific actions interpreters should take in determined situations. Sometimes codes of ethics will allude to these protocols, sometimes they are outlined elsewhere, and sometimes the interpreters simply use common sense to adapt to the situations.

Interpreters also use different modes of interpretation depending on the nature of the setting, the specific goals of communication, and the challenges presented in each situation. The modes are typically broken down into three types: consecutive, simultaneous, and sight translation. Consecutive interpretation occurs when one speaker conveys a message then pauses to give the interpreter time to interpret into the target language. In the second mode, simultaneous interpretation, the interpreter listens to the original message in the source language and reproduces it in the target language at the same time, with just a slight lag time. Sight translation occurs when an interpreter is presented with a written document and must reproduce its contents orally in the target language on the spot.

Dialogue interpreting, consisting of two-way back and forth conversations that are conveyed through interpreters, are typical to interpreting in public services. The most commonly used mode in these encounters is consecutive, since it best corresponds with the natural turn taking of a two-way conversation. In the study presented here, interpreters may choose to use either consecutive or simultaneous interpretation, depending on what is the best fit to meet the specific communicative goals of the

counseling sessions. In some cases, specifically when considering trauma narratives, which could involve longer segments than interpreters normally handle in consecutive interpreting, they may switch to the simultaneous mode so as not to omit any major parts of the narrative. Sight translation may also be used in these sessions if the counselors want to incorporate any documents that have not been translated into Spanish, or if they ask the clients to write something out in Spanish to then be read aloud and shared with the counselor.

The last major set of terms relevant to interpreting has to do with the participants involved in the communication. The interpreter has already been identified. In public service interpreting settings, there is a professional providing some type of service, such as social work or therapy. This person is referred to in a broad sense as the service provider. In this study, since it focuses on the mental health setting, I will generally refer to the mental health care providers under the broad umbrella of counselors. This is not intended to diminish any distinctions in training or approach, but rather will serve to simplify the discussion. The one who receives this service, while called a client or patient by the service provider, is often referred to in Interpreting as a service user. Since this study is contextualized in mental health, I will mostly refer to them as clients. Now that we have a foundational understanding of interpreting in its various settings and modes, interpreter ethics and protocols, and the parties involved in the exchanges, we can move towards an understanding of trauma from a psychological perspective.

6.2. Concepts from Psychology: Trauma and Therapy

Trauma is a broad concept and thus difficult to define. There are a plethora of definitions and each one has its own nuances. For the sake of this paper, the following

definition will be used: “Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (SAMHSA 7). The three “e’s” are highlighted in this definition: events, experience, and effects. “Events” refers to the fact that trauma can happen as a result of a single or repeated occurrence. “Experience” refers to one individual’s experience and the fact that the same difficult event may be experienced as traumatic for one person and not for another. Lastly, the word “effects” corresponds with the adverse effects, which can happen immediately after the event or come about later, but are always present, affecting the person’s daily life (8). Examples of potentially traumatic experiences can range from but are not limited to sexual molestation, child abuse, domestic violence, wars, and natural or man-made disasters (van der Kolk 1).

Since trauma leaves such a profound impact on individuals, it has been the subject of psychological study and interest for over a century. Near the end of the 19th century, notable figures such as Jean-Martin Charcot, Pierre Janet, Josef Breuer, and Sigmund Freud began looking into this phenomenon. Freud and Breuer’s “talking cure”, getting patients to discuss their traumatic past events, was thought to be the solution for recovering from trauma and integrating back into daily life (van der Kolk 182). This idea has evolved over the years, but talking is still seen as a fundamental element of the widespread cognitive behavioral therapy (CBT) psychological technique (182).

Alongside the top down approach of talking through traumatic experiences through CBT or some other method, mental health professionals have other ways to help

treat trauma. They may approach treatment using medication to help mitigate trauma's effects on the mind and body. Sometimes, since trauma can have a sensory impact on the body, a bottom up physical approach is used. This can include involve promoting activities such as yoga, which are intended to help the patient focus on reconnecting with his or her body in positive, healthy ways (3). A combination of all three approaches can be used, but this particular study will highlight the talking approach as it is most relevant to interpreters and trauma narratives, and naturally connected to the linguistic nature of this study.

While trauma in and of itself is not a new topic of study, the concept of a trauma-informed approach to care has grown in recent years. A trauma-informed approach within an organization or system understands what trauma is and how it affects people, and adjusts its standard practices accordingly. It realizes that trauma has a widespread impact, recognizes its signs and symptoms, responds by developing trauma-awareness into their structures, and takes measures to avoid re-traumatization (SAMHSA 9-10).

Traditionally trauma-informed care has been associated with psychology-based professions, but it has gained more traction recently and has expanded into different professions and services. It is not uncommon to hear of trauma-informed medical practices, trauma-informed educational practices, or even trauma-informed policing. This trend will likely continue, since the events that can provoke trauma cover such a wide range of the human experience and there is a high likelihood of trauma victims accessing various services and institutions. The concept of trauma-informed interpreting that is rooted in this trend will be discussed in the literature review. While a trauma-informed approach in one domain differs from therapeutic practices focused specifically on

overcoming trauma, both are relevant to our discussion in terms of protocol and setting. Now that these basic concepts have been introduced, a literature review will follow to examine the works and theories relevant to this study.

CHAPTER II

LITERATURE REVIEW

1. Language and Trauma

For the aims of this paper, we are primarily concerned with theories specifically relating to the linguistic manifestation of trauma in spoken language and then to look at how this is handled by interpreters. When trauma was outlined in the above section, it was introduced initially as a concept of particular interest to psychological studies. However, trauma has also been an emphasis in other fields of academic studies, as it has been approached from within literature, cultural studies, sociology, medicine, social work, history, even theology, amongst other fields. Although it would not be productive to delve into all the existing theories on trauma from these disciplines, it has proven to be a topic of merit across them. This stands in contrast to the lack of work on trauma done from a linguistic perspective in comparison with other fields. Since trauma is often related orally through narrative form, it by nature should be of interest to linguists. At the time of writing there is not a comprehensive theory of the linguistic manifestation of trauma.

Many of the observations about trauma and language have come from psychological studies. It has been asserted that “traumatic events are almost impossible to put into words” (van der Kolk 231). Early on, trauma was associated with a lack of language, or an inability to describe their traumatic experience, and language was seen as an essential component to overcoming it (177-182). While those who have directly

worked with patients have seen the benefits and challenges of language in their treatment, it was not until the 1980s that some of the first comprehensive tests studying the connection between language and trauma were conducted (Pennebaker). The goal was to evaluate the effectiveness of language in treatment, but in the process of doing so, they noticed some interesting patterns in the language itself.

In these studies it was observed that, when subjects wrote about trauma, there was a notable change in their handwriting; it would go from one style to another, such as cursive to block letters. In the recorded spoken accounts, the participants' voices changed so much when recounting personal traumatic stories that the researchers questioned if it was the same person (van der Kolk 241-242). Although the emphasis has not yet been on specific linguistic units that can be analyzed, this "switching," or changing vocal patterns and the narrative style of trauma experiences, has been reported in clinical practices (241-242).

More recently, the events of September 11, 2001 caused interests in researching traumatic experiences to resurface. One study from a clinical perspective delved heavily into discourse as it relates to trauma (Brockmeier). This was a groundbreaking study, considering that even in 2015 it was noted that "most of the existing trauma narrative research has been done by people in the health professions, and these studies tend to pay little attention to language" (Ladegaard "Coping" 189-90). Surveys were distributed to eyewitnesses of the events of 9/11. The resulting analysis of the data showed a "traumatic gap" in their ability to recount these traumatic histories (Brockmeier 16). Observations were made about the linguistic resources people utilized, such as figurative speech and ignoring traditional structures of narrative coherence, even metalinguistic reflections of

how limited their words were to describe their experiences. The researcher speaks of traumatic experience as “a break not just with a particular form of representation but with the very possibility of representation at all. This representational break culminates in the breakdown of narrativity” (33). It is interesting to note that the observations made in this particular study are coming from written answers, when the people ideally had time to think about the answers they wanted to write down. How much more might this lack of narrative cohesivity come out in spoken accounts?

Even philosophers have examined the relationship between trauma and speech. One scholar, a trauma victim herself, says that through the process of experiencing trauma, victims feel as though they’ve lost their voice (Brison 48). Their sense of agency has been taken away from them as a result of being harmed by others, in the instance of trauma where a perpetrator is responsible. After the event, the victims are left with a traumatic memory, which is distinct from other types of memory in that it produces an involuntary emotional and physiological response in the victims (41-45). When memory itself has been affected, this naturally leads to an altered form of speech, which also manifests itself in incoherent narratives. Narrative memory, in contrast, is an active construction of past events, and victims want to try to transform traumatic memories into coherent, narrative ones (45-47). Working through this process reveals “the performative role of speech acts in recovering from trauma: under the right conditions, *saying* something about a traumatic memory *does* something to it” (48).

This gets at the heart of what many types of trauma therapy aim to do: to get people to explore their traumatic memories so they can overcome the trauma they experienced. It is a current practice in trauma therapy to ask clients to describe these

moments audibly or write about them and then read the stories aloud to the counselor (Briere and Scott 127). Through this process of revisiting the original memory, responding to follow-up questions from the counselor, and repeating those steps as many times as necessary, the clients are helped to think through these memories with more clarity. Clients with less coherent narratives--ones that are fragmented, lacking a clear timeline of events and cause-effect relationships--typically suffer from higher levels of anxiety, insecurity, and confusion (131). In the same way, "it is likely that narrative coherence is a sign of clinical improvement" (130). In other words, the characteristics of these narratives can be an indication of how much trauma is affecting them, where they currently are on the spectrum of healing.

The literature reviewed here has shown some of the ways trauma can manifest itself in language and its relevance in trauma-focused therapy. While it is true that most research on trauma and language has been done by researchers in psychology, some researchers are beginning to look at trauma narratives from a sociolinguistic perspective (Drakos; Grazia Guido; Ladegaard "Codeswitching", "Coping", "The Discourse"; Trinch "Recalling"). In spite of these growing efforts to further the study of trauma as a linguistic phenomenon, more research needs to be done to help us better understand how trauma manifests itself through language. This study hopes to not only contribute to a linguistic understanding of trauma, but also to an understanding of how this language is processed by and conveyed through interpreters. Some of the practical concerns of interpreting for trauma victims will be considered in the next section.

2. Trauma-Informed Interpreting

With an awareness of the commonality and profundity of trauma on the rise, the drive towards trauma-informed approaches in society has also begun to shape interpreting practice. The profession, often through trial and error, has recognized the need for interpreters to be equipped to respond to trauma proactively and reactively. These best practices address both the after-effect of the exposure to the emotional content shared by the service users and the linguistic and practical challenges that present themselves during interpreted encounters. In recent years, trauma-informed interpreting has been coined and defined as “a young yet vital... specialisation of interpreting that integrates research on trauma into the professional practice of interpreters” (Bancroft 195).

In this section, I will address the way emotional challenges related to trauma have been addressed in Interpreting Studies literature before this term was coined. I will look at the populations the discussion has centered around thus far. I will also highlight the recent trend towards a survivor-focused approach and, respectively, how trauma-informed protocols can support such an approach by preventing re-traumatization and encouraging communicative autonomy. Lastly, I will explain how these concepts are relevant to my study.

While trauma-informed interpreting in and of itself is a newer concept that is gaining traction, the literature has previously recognized the emotional and psychological strain of the profession on its practitioners. Various studies have considered different aspects of these emotional and psychological challenges, especially within public service interpreting (Loutan et al.; Baistow; Valero-Garcés “Emotional”, “The Impact”). Two themes that commonly arise in this conversation are interpreter burnout and vicarious

trauma (Knodel; Splevins). These are distinct experiences; whereas burnout is a gradual emotional wearing down from the job, vicarious trauma can affect someone instantaneously without warning (Harvey 89). Many interpreters find themselves surprised and unprepared for their personal emotional and psychological response to the traumatic content they are exposed to while interpreting.

Since trauma covers such a vast range of experiences, it comes up in conversations in the literature when talking about interpreting for distinct groups. This can center around a particular type of violence, such as gender violence, which has been addressed through the creation of resources to help interpreters work with these victims (Toledano Buendía and del Pozo Triviño). Others have highlighted the centrality of trauma awareness in the context of working with refugees, since this group is by definition seeking refuge from a dangerous situation (Crezee et al. “Issues”; Jiménez-Ivars and León-Pinilla). Some have argued for a subcategory of Interpreting in Refugee Contexts within Interpreting Studies that would expand across different settings, in large part due to common experience of trauma many refugees have faced (Jiménez-Ivars and León-Pinilla). Other studies on interpreting with refugees have also highlighted trauma as a primary concern both for interpreters and those they are interpreting for (Crezee et al “Issues”).

This last study understood the essence of trauma-informed interpreting before the term was even used. This is twofold: it considers the impact on both the interpreter and on the survivor (Bancroft 210-211). Most of the studies mentioned above have centered around the psychological and emotional impact on the interpreter. This emphasis on interpreters is valid because it aims to raise awareness about the possibility of vicarious

traumatization, something that could potentially drive interpreters away from the profession. However, the interpreter is not the only one at risk, because trauma can continue to have adverse effects on the survivor, and this should be taken into account when interpreting for them. A central goal should be protecting them from re-traumatization, or reliving their traumatic experience (Crezee et al. "Issues"). One of the means by which interpreters can make these service user-centered decisions is by adjusting their protocol.

The concept of interpreter protocols was mentioned in the introduction. While these protocols vary depending on the situation, a case has been made for establishing trauma-informed protocols for interpreters (Bancroft et al. 206-224). These protocols would first and foremost make efforts to protect the survivors from re-traumatization (Bancroft 214). Specific adjustments could include being mindful of the seating arrangement, eye contact, and tone of voice (Bancroft et al. 211-215). These may deviate from what is typically expected behavior of interpreters. For example, whereas interpreters might typically decide the seating arrangement without consulting the service users, a trauma-informed approach could entail asking the service users which seating arrangement they are more comfortable with (211). Other protocols become more complex: in some situations where interpreters would typically be expected to seek clarification of an utterance, the service providers might actually prefer to take the responsibility in doing so, since they are the ones who best understand trauma and how it could have affected this person (Bancroft 206).

Along with taking the trauma-informed approach to try to prevent re-traumatization of the survivor, interpreters should also work proactively to promote the

survivor's communicative autonomy. Communicative autonomy can be nurtured when interpreters "support clear communication where all parties have the power and authority to make their own decisions without interference by the interpreter" (Bancroft 212). In situations where the interpreter is aware of the trauma, interpreters as compassionate human beings have a natural desire to want to help by giving unsolicited advice to the client or the service provider or acting as a cultural broker (201). While the interpreter's intentions are often good, this can contradict a trauma-informed approach, since one of the goals in working with trauma survivors is helping restore the autonomy that was taken away from them as a result of the traumatic event(s) (200-201). In trauma-informed interpreting, interpreters work alongside the service providers for the benefit of the service user.

While trauma-informed intervention and protocols have been addressed in some of the literature and detailed suggestions such as the ones listed above have been made, more research must be done to determine which approaches best protect all parties while allowing the interpreter to appropriately convey the needed information. There is a delicate balance when considering the emotional and psychological needs of the parties involved in the communication and the need for linguistic clarity provided by the interpreter. The training programs and manuals previously referenced (Bancroft, Bancroft et al.), while based on extensive research, are very recent seminal works in this self-proclaimed young specialization. These resources were created on the premise that few practicing interpreters had prior trauma-informed training because very few such programs were available, and even those in existence were not extensive (Bancroft 202). Thus, now that this training has been disseminated, further research is needed to see how

these suggestions play out and impact the involved parties in interpreter-mediated communication. The need for more research in this area is one of the reasons this project has been launched.

Another way this project fulfills a need in the literature is by focusing on a broader scope of trauma. As detailed above, oftentimes trauma is discussed in the context of refugees or a particular type of violence. However, we have seen that there is a vast range of traumatic events that people can experience, and it is not limited to refugees or violence. Interpreters should be better equipped to understand the different ways trauma can impact people and their language in a general sense. While this study will not be able to definitively address all types of trauma and all the populations it impacts, it hopes to broaden the conversation.

Specifically, the question about interpreting trauma narratives corresponds to the idea of communicative autonomy. If the goal is to help the survivor regain their voice by communicating directly with the service provider with as little interpreter intervention as possible, then one element of promoting that autonomy is through interpreting trauma narratives as the survivor has uttered them. While this concept is not unique to trauma-informed interpreting, it may have greater implications in this type of interpreting than in other situations, given its sensitive nature. This focus on communicative autonomy overlaps with the idea of accuracy, which will be addressed in the next section on interpreting in mental health. Up to this point, the discussion around trauma-informed interpreting has covered a range of settings, but I will now focus on interpreting in a mental health setting, where trauma is often the basis of the need for communication.

3. Interpreting in Mental Health

This study will address a specific need within Interpreting Studies for more research on interpreting in the mental health setting. It has only been in the past two decades that Interpreting Studies has begun to look extensively at this setting. The first article I found that specifically looks at interpreters in therapeutic encounters was published in 2001 (Wadensjö “Interpreting”). In the same year, the role of interpreters in mental health was addressed at the third annual *Critical Link* conference (Bot and Brunette). This foreshadowed the more extensive work that would be done in *Dialogue Interpreting in Mental Health*, the seminal monograph on the topic (Bot). There have been additional studies done in this setting, many focusing on role (Bot “Role”; Zimányi “Somebody”), but it has also been approached from the perspective of communication (Zimányi “Conflict”), pragmalinguistics (Echauri Galván), and even the reciprocity based on eye tracking (Vranjes et al.). While mental health interpreting is a newer area of research for the field compared to other settings, we are beginning to see more researchers pay attention to it.

Mental health interpreting has traditionally been categorized under the broader category of healthcare interpreting. This categorization is still common, but more people are beginning to recognize its distinctions and moving towards viewing interpreting in mental healthcare as its own setting. We begin to see steps towards this shift in a 2010 article on the rapport between interpreters and service providers in healthcare, where a review of the literature points towards differing expectations of the mental health interpreters’ actions on the part of the service providers due to the nature of the care given (Iglesias Fernández 219). In 2015, the book *Introduction to Healthcare for*

Spanish-speaking Interpreters and Translators, which encompasses healthcare interpreting in a broader sense, details the unique features of interpreting in the mental health setting while still categorizing it under the healthcare setting (Crezee 159).

The Routledge Handbook of Interpreting, published in the same year, seems to represent a change in this trend, dedicating separate chapters to interpreting in healthcare and mental healthcare in the Settings section. However, upon a more careful reading of the text, the respective authors still categorize these settings together while highlighting their differences. Interpreting in mental health care is introduced as a subcategory of healthcare interpreting (Bot “Interpreting” 254). Meanwhile, interpreting in mental health is discussed in the healthcare chapter, but the authors predict that there will be a need for professional medical interpreters to specialize in mental health interpreting. They explain why this is so: “healthcare includes a broad set of services, with extensive specialized vocabulary, goals and techniques. The purpose of a primary care doctor’s interview and that of a mental health practitioner are often not the same” (Roat and Crezee 250). If this specialization of the profession develops, it is feasible that academic research will follow suit and continue to distinguish them from one another. In this paper, I will refer to interpreting in mental health as its own setting.

Interpreter training in this setting focuses primarily on the nature of the counseling sessions that will take place and how the client may respond (Crezee et al. *Introduction* 159). Although interpreters should familiarize themselves with some terminology in the field, most of the sessions will use simple language (159). This is in direct contrast to legal or broader medical settings, where interpreters will inevitably encounter a vast range of specialized vocabulary from those areas. Interpreters who work

in mental health are, however, encouraged to study the difference in therapeutic approaches, professional titles and job descriptions of mental health service providers, and to understand the most common mental health disorders, along with their respective symptoms, causes and treatment (162-168). This training for interpreters places less emphasis on what words will be used, and instead on how they will be used pragmatically in this setting. “In general, in order to interpret the words in an encounter well, one should have knowledge of the encounter’s interactional purposes and the specific conversational techniques that will be used to meet this purpose” (Bot “Interpreting” 261).

These encounters can be divided in two very broad categories, with many variations within the categories themselves: protocolized treatments which tend to be more structured, and counseling therapies, which in comparison are less structured (262). In regard to the terminology used in these sessions, the protocolized treatments may employ specialized terminology with meanings contextualized to that system of therapy. In contrast, in the less structured counseling therapies, talk is more spontaneous, although there is an emphasis on “re-wording experiences” (262). One way in which accuracy is evaluated within mental health interpreting has to do with the interpreter’s rendition of this specialized terminology. Interpreters may hinder the effectiveness of the therapy if terms are not being translated as the counselor intended them to be within those protocolized treatments. This can happen when interpreters do not understand the goal of the session and the intended use of these terms (262).

Another consideration of accuracy in mental health interpreting is how well the client’s message is conveyed by the interpreter. In this setting, language is used as a tool

for diagnosis; additional tests cannot be ordered to confirm what the patient has said (Crezee et al. *Introduction* 159-60). Thus, words in all of their nuance carry a weight that is not uniform in every interpreting setting. The literature has mentioned how this can be particularly challenging when clients are dealing with psychotic patients with more severe diagnoses than perhaps a typical client seeking therapy for grief or to mitigate the stress of life. The talk of these psychotic patients has been described as disorganized and incoherent, using words and expressions that may not be frequently used by others or even make sense (Bot “Interpreting” 262). These present challenges for the interpreters, but their accuracy matters because “the mental health practitioner is interested to hear what the patient has to say and how he says it” (262).

Aside from the interpreter’s personal preparation, practical recommendations have been made to help improve interpreter performance in this setting. It is highly recommended that interpreters request a pre-session or briefing and debriefing session with the mental health provider. The pre-session can serve to orient the interpreter to the service provider’s goal for that appointment and any information about the case that is relevant. In the debriefing, the two parties, especially the interpreter, can reflect on relevant details about the client’s speech that may not have come out in the session itself (Crezee et al. *Introduction* 160).

Despite all of the recommendations for professional interpreters working in this setting, little research has been done to explore these issues in depth. Although medical and judicial interpreting research has grown since the 1990s, empirical research “in interpreting in mental health is still very rare” (Bot “Interpreting” 255). This study seeks to encourage research in this direction by further highlighting this setting as one of

academic merit. Moreover, the emphasis on interpreting trauma narratives is a new angle that the literature regarding this setting validates.

We have seen how words are essential in the mental health setting, not just for communication, but for diagnosis and even treatment. The interpreter is even more valued in this context than many others because the mental health professionals would have no way of working with speakers of other languages without them. The literature has highlighted the value of language in this setting, but most of the challenges of the renditions have thus far only focused on psychotic patients. *Interpreting Studies* has not yet considered how trauma narratives from non-psychotic patients are distinct from regular language and can present challenges for interpreter accuracy. This study will seek to highlight this issue in particular while forwarding the research in this setting. Before doing so, we will look at the literature from psychology that discusses therapists working with interpreters.

4. Mental Health Perspective on Interpreters

In this final section of the literature review, I will present a brief overview of publications from psychology that refer to mental health professionals working with interpreters. The amount of publications on this topic from within this discipline stands in stark contrast to the paucity of scholarship from interpreting studies on working in mental health settings. Whereas the first publication on this topic I could find from *Interpreting Studies* was from 2001 (Wadensjö “Interpreting”), there are studies dating back to 1975 from the mental health perspective (Price). Most of the earlier studies dealt with problems and challenges in working with interpreters (Price; Raval; Cornes and Napier). This is not surprising considering that interpreting was an even younger, less established profession

at the time of those publications, and the interpreters may not have even been qualified or received prior training. They may have had no prior exposure to mental health training, which would pose even greater challenges for the counselors.

Some of these studies focus specifically on language and translation. In some cases, interpreter language competence was questioned by the author (Price). The oldest published study I found provides some interesting insights into the research questions presented in this paper. In this study, it was discovered that interpreters committed the most omission errors when interpreting for psychotic patients, since their language was more challenging for the interpreters to process (Price 266). There is little modern research on interpreting with these types of patients, and it is unlikely that there will be more given the ethical considerations of working with this population (Bot “Interpreting” 262). Other studies that focus more on language have examined the concerns mental health professionals have about establishing empathy through translated messages, since the way they word their communications with their patients is very intentional (Pugh and Vetere 316). One study even considered the use of interpreters in research, noting that using them to help conduct survey research in mental health may not produce accurate results because of the limitations of language transfer and difference in cultural concepts (Ingvarsdotter et al.).

Another focus of mental health professionals working with interpreters has been on the therapeutic alliance and the change from a dyadic, two-way communication to a triadic, or three-way, one (Boss-Prieto “Differences”, “The Dyadic”). The therapist’s connection to clients, through words but also through “the unconscious stimulation of feelings towards a person” is impacted with a third person in the room (Costa “When” 3).

While in Interpreting Studies pre-sessions are often mentioned to help the interpreter prepare to understand the language and use the appropriate terminology, mental health professionals talk about how this time can be beneficial to contribute to a working alliance between the interpreter and counselor that will help when the client is in the room (3). This alliance was of major concern in another study, and was found to be challenging but rewarding for those who participated in it (Fidan ii). Sometimes the mental health professionals find it difficult to grow in this therapeutic alliance because the patient is naturally more drawn to a trusting relationship with the interpreter, who speaks the same language. This tension is escalated when interpreters do not remain neutral towards the patient (Raval 34).

One study is particularly notable because it puts the responsibility of specialized mental health interpreter training on the mental health professionals instead of trainers from within Interpreting Studies. It highlights how using interpreters to administer tests and mediate during certain types of therapy has its limitations. Pre- and post-sessions are encouraged as a way to prepare the interpreter for the interpreting assignment. According to the authors, federal law and psychological codes of ethics place the responsibility to find and subsequently ensure the competence of interpreters on the mental health providers (Searight and Searight 444).

Coming from the perspective of the interpreter, it is surprising to read this, because so often interpreters are the ones asking these things of the service providers they work with in public services. However, if the counselors are the ones who must rely on interpreters to carry out the functions of their job in a multilingual context, they feel a greater pressure and responsibility to provide high quality services. I think this is part of

the reason why there is more work done on interpreting in mental health from the mental health providers' perspective. Interpreters often have the freedom to choose the settings they work in and could avoid mental health interpreting if they wanted. Psychologists who want to communicate with their patients through a language barrier inevitably have to use interpreters, a reality that has fueled significant research in the discipline.

Lastly, there are many practical resources available to mental health professionals on best practices and trainings for working with interpreters. One such resource covers topics such as their collaborative relationship, the triadic communication, and how to delineate responsibilities (Costa "Team"). The author is a strong advocate for providing supervision with interpreters and counselors together, so they can learn more about the other's role and increase their working relationship (66). Research from the mental health perspective on working with interpreters has grown in recent years, and it is likely that this trend will continue to cover more questions that arise from the interpreted therapeutic encounters. It is also likely that more trainings and models for collaboration will be developed. Before revealing what the counselor I interviewed said about working with interpreters, I will outline the methodology used in my study.

CHAPTER III

METHODOLOGY

Now that the basic concepts and theoretical framework have been introduced, the methodology will be described. As previously mentioned, this thesis is being written in the context of a broader study, Trauma-Informed Mental Health Interpreting Services (TIMIS). In this section, different aspects of the TIMIS project will be outlined, along with the methods used to collect and analyze the data most relevant to the research questions highlighted in this thesis.

1. TIMIS Project Creation and Development

Before explaining the emphasis on interpreted trauma narratives, I will describe the creation of the TIMIS project to provide a better understanding of the context and parties involved. The first stage of the project design happened in the Spring 2018 semester and involved discussions with university and community partners. Since the research is interdisciplinary in nature, it was designed with the input of different experts in their respective fields. Dr. Lluís Baixauli Olmos, Assistant Professor of Translation and Interpreting from the Department of Classical and Modern Languages at the University of Louisville collaborated with Dr. Katie Hopkins, then Assistant Clinical Professor and director of the Cardinal Success Program to design the project. Their respective expertise allowed them to consider the linguistic and clinical needs of the project. Involvement from a community partner, the Center for Women and Families, a

local organization that provides advocacy and support from trauma victims, was also involved in these initial conversations about the project design.

The study, although created with the intention of providing the direct benefit of counseling services to users through the mediation of an interpreter, also intended to answer specific research questions. These questions were centered around interpreter interventions, trauma-informed care shaping protocols, communicative adjustments from interpreters and counselors working together, and interpreter visibility, all within the mental health setting. These questions continued to be the driving emphases of the research, but as I became involved in the project, other questions of a more linguistic nature arose. Other factors, such as feasibility, personnel changes, and securing research approval from the university's Institutional Review Board (IRB), caused the project to change its shape over time.

Although I was not involved in the initial phases of the project design, I was made aware of the project through a class I was taking in Spring 2018, Interpreting in Educational and Social Service Settings. In Fall 2018, I did an Independent Study with Dr. Baixauli-Olmos entitled Introduction to Interpreting Studies. Since this class emphasized research methods in the discipline, I was able to learn which ones were applied to the TIMIS project while observing and assisting with some stages of the project development. In Spring 2019, I was officially hired as an interpreter and research assistant for the project, which will be discussed in further detail below. As I developed my thesis proposal, it became clear that this project would align well with my research interests if the research questions could be expanded to include trauma narratives. This adjustment was made and I also requested and secured permission to be considered a co-

investigator on the study. Currently, along with conducting the research and analyzing the data most applicable to this thesis, I am involved in nearly all aspects of managing the TIMIS project.

2. Funding

The second step of the project development centered around securing funding for the research. A grant proposal was written and submitted to the University of Louisville's Cooperative Consortium for Transdisciplinary Social Justice Research in Fall 2017. The Consortium "exists to incubate, support, and promote faculty-led, community-driven research teams across many disciplines" and "funds projects dedicated to understanding and finding new, innovative solutions to complex, intransigent social justice problems with a special emphasis on structural inequalities" ("Cooperative"). Since this project aligned with the Consortium's goals, specifically in addressing the structural inequality of linguistic barriers in access to mental health, funding was awarded. These funds provided for a research team for the 2018-2019 academic year: two interpreters concurrently working as graduate-level research assistants and one undergraduate research assistant. A small amount was also set aside as honoraria for community partners. No additional funding was needed to conduct the research presented in this thesis.

3. Project Development and Feasibility

The interpreting sessions were initially expected to start in Fall 2018, but several complications caused a delay. Our initial partner, Katie Hopkins, the supervisor of the counselors in training, left the university and was replaced by Dr. Patrick Pössel. He was still interested in continuing the partnership and invited us to an interest meeting at the Shawnee Academy, where one of the counseling offices belonging to the Cardinal

Success Program is located, in September 2018. Unfortunately, two factors prevented the counseling sessions from beginning right away: (1) the counselors were just beginning their practicums and did not yet feel comfortable adding a third party to the meetings and (2) there were no Spanish-speaking clients immediately in need of counseling services. We continued to work to develop other aspects of the project while looking for solutions to those two problems.

By Spring 2019, there were counselors willing to work with the interpreters on the project, but there have still been many challenges in recruiting service users for the study. The Cardinal Success Program has limited office hours so coordinating multiple schedules is a challenge. Additionally, there is a stigma towards mental health in many of the Spanish-speaking populations we are trying to serve, which can prevent them from seeking out the services. Another barrier is that many undocumented immigrants are afraid of what information could be shared with the governing authorities. Also, because of the vulnerable and personal nature of what is shared in counseling sessions, potential clients may be hesitant to allow us to access that content for a research study.

Some referrals of potential Spanish-speaking clients have been made to the Cardinal Success Program, but at the time of writing no service users have consented to participate in our study. Another obstacle was that some of the referrals were minors, so adjustments had to be made to secure ethical permissions to work with them, which will be discussed in the following section. In the midst of these obstacles, it was clear by the midpoint of the semester that my initial plan to use discourse analysis on interpreted trauma narratives for this thesis was not going to be feasible given the time limitations. I chose instead to interview interpreters and counselors who had worked in mental health

to gather information about their experiences and perceptions of trauma narratives. Information about the subjects and interview method will be described later, but I will first comment on the way ethical research approval was obtained.

4. Ethical Research

This research works with human subjects and therefore permission must be secured from the University of Louisville's Institutional Review Board (IRB) to be able to conduct the study. A protocol which outlined the goals and steps of the study was written and submitted. The study was granted approval by the IRB office on December 13, 2018. However, once potential clients were identified, modifications had to be made in the IRB application to include minors in the study. Final approval including these modifications was received on March 1, 2019.

The study was considered for Expedited Review by the IRB since there is a minimal risk to the human subjects participating in the study. Most of the risks to the clients have to do with the nature of the therapeutic process itself, which requires them to speak about difficult experiences, and are not a result of the interpretations. However, one additional risk of including an interpreter in this process is that the interpreter could unintentionally say something that provokes re-traumatization of the client. To try to prevent this, there is an interpreter training built into the study design. No foreseeable risks are identified for the counselors. The interpreters are potentially exposing themselves to vicarious traumatization and burnout, but measures have been set up to help prevent or mitigate these possible consequences of the work. These risks are outlined in the consent forms that each of the subjects must sign. Minors who may

participate in the study in the future will sign an assent form in the presence of their parent(s) or legal guardian(s), who will also sign a consent form.

5. Personnel and Subjects in the TIMIS Study

There are five members of the TIMIS research team. Dr. Lluís Baixauli-Olmos is the Principal Investigator, and Dr. Patrick Pössel and Miranda Hale (myself) are co-investigators. There is a graduate level research assistant who helps with data collection and a bilingual undergraduate research assistant who helps transcribe and de-identify the data. All members of the research team have received training in ethical research practice with human subjects. The research assistants have bi-weekly meetings with the Principal Investigator to discuss their role in data collection and the general progression of the project.

The interpreters and counselors are also considered subjects in the TIMIS study. The interpreters were chosen by a committee formed to hire two graduate-level interpreters who would also serve as research assistants. The qualifications for these positions included having taken previous graduate-level courses in interpreting and being familiar with trauma-informed interpreting principles. Both have had previous experience volunteering as interpreters in the community in mental health and other settings.

At the time of writing, for the TIMIS project, two counselors have enrolled in the study to provide counseling sessions mediated through the project's interpreters. The counselors who expressed interest in working with the project came from a pool of graduate-level clinical psychology students conducting their practicum through the Cardinal Success Program at the NIA Center. They were recommended by their supervisor and chosen based on their interest in working with an interpreter and

availability. They are both new in their counseling practice and have not worked with interpreters previously.

Training both interpreters and counselors in trauma-informed interpreter mediated counseling is an essential component of the project due to the sensitive nature of the sessions taking place. The interpreters had received previous exposure to trauma-informed interpreting in their graduate level courses, including an introduction to the basics of trauma and how it can manifest itself in an interpreting session. They had practiced with roleplay materials specifically designed for interpreters working with people who had experienced trauma. However, additional training is also provided as part of the study, and weekly meetings with the research staff allowed the interpreting techniques to be continually discussed. Since interpreters typically do not have as much training in traumatization prevention techniques, supervision is provided by Dr. Pössel to allow them to discuss how the difficult nature of the sessions is affecting them while still maintaining confidentiality.

Given that the counselors had not worked previously with interpreters, it was necessary to orient them to interpreting practices and protocol. This was accomplished through an initial training session with the counselors and interpreters present led by Dr. Baixauli-Olmos, in a discussion-based format. They were introduced to the role of the interpreter in communication and the standard interpreter protocol, and were given space to mention any questions or concerns they might have in terms of working with the interpreters. They were also invited to help shape any trauma-informed protocol for the interpreter based on their expertise in the area of trauma-informed care and counseling. After this meeting, communication was encouraged to remain open throughout the

duration of the study. Counselors and interpreters could also discuss areas of misunderstanding or problems that arose in the counseling sessions during the pre-sessions and debriefing which took place before and after the counseling sessions, respectively.

The inclusion criteria for the clients are as follows: Spanish-speakers who have suffered some sort of trauma. In the original stages of the project, the inclusion criteria were limited to adult women who had experienced domestic violence, but this was found to be too narrow. The new criteria only excludes those who have not experienced trauma, based on the definition given in Chapter 1. Originally, we only expected to work with adults, but because of a need in the community, this has been expanded to include minors age seven and up. These clients are referred to the Cardinal Success Program through their normal referral channels, through social workers or organizations in the community familiar with their work. The Center for Women and Families also has the option of referring clients to the study, but they have not yet done so.

6. Sampling Methods

Since I was unable to rely on recordings from the counseling sessions to answer my research questions in the allotted timeframe, I decided to modify my original strategy. I had to use indirect observation, a qualitative interview method in this case, to collect data. In order to choose relevant subjects, I used purposeful sampling, a process in which participants are chosen based on predetermined criteria. As an inclusion criterion, I chose people who had been working in mental health settings for at least one year. The underlying assumption was that people who met these criteria would have had multiple exposures to trauma narratives. It was not required that the interpreters have a certain

level of qualification since there is not a standardized certification process for mental health interpreting in the United States, but I was made aware of their training and experience beforehand and this information was later confirmed in the interviews.

I will now detail how the subjects were recruited to participate in the interviews for this thesis. Since the other interpreter working for the TIMIS project had volunteered in mental health settings for around a year, she fit the inclusion criteria and agreed to be interviewed. The biggest constraints to securing more subjects were accessibility and time. Thus, I had to think through which of my acquaintances could fit into this category. I was referred to another interpreter who has been practicing professionally in mental health settings in another state, and she consented to be interviewed. As part of my work identifying potential partners in the community for the TIMIS project, I had been in contact with a counselor who regularly conducted her therapy sessions using interpreters. She also agreed to be interviewed. Having her perspective along with the interpreters' perspectives was an advantage in terms of having a triangulation of sources, and these subjects provided helpful information in addressing the research questions. Although the TIMIS project had more than three subjects, in this thesis I will primarily refer to these three who were interviewed, the two interpreters and the counselor.

No other subjects were interviewed due to the constraints previously mentioned. Since the research question is exploratory in nature, and since I am studying a phenomenon that interpreters and counselors may not even be aware of, I hoped to bolster my findings by also using expert sampling. I requested an interview with a sociolinguist who has done substantial work on trauma narratives in the past and also has experience working with interpreters. We were unable to set up a time for this interview,

so the data is limited to the perspective of two interpreters and a counselor. Now that the subjects have been introduced, I will explain the process of data collection in detail.

7. Data Collection

The process of data collection for this thesis varied slightly for each individual interview. The Principal Investigator had already scheduled an interview with me and the other interpreter hired by the TIMIS project. This was intended to shed light on our prior experiences and perceptions about interpreting in mental health settings, before we began interpreting for the project. Instead of conducting two separate interviews, one addressing general TIMIS research questions and another about trauma narratives, we consolidated the questions into one interview. I helped design some of the interview questions, but the Principal Investigator edited them and conducted this first interview. I participated both as a subject in this interview and an observer. I had never conducted a semi-structured interview before, and this gave me the opportunity to experience one before using this interview method myself to collect more data.

I conducted the second and third interviews myself. The second interview was with the counselor. I was able to use the general format of the first interview, but adapted the questions so they were more appropriate for her role as a mental health professional. I also focused more on the questions most relevant to trauma narratives and did not emphasize the broader questions from the TIMIS study, although the content shared occasionally overlapped. I followed the same pattern with the second interpreter, adapting the questions further because I entered the interview with the knowledge that she had more experience working with children. The semi-structured nature of these interviews made these adaptations easy and also allowed for more flexibility as different

topics arose during our conversations. These interviews were recorded with their permission and then transcribed using automatic transcription software so they could be used for data analysis.

8. Data Analysis

The transcripts from the three interviews were analyzed using thematic analysis, which allowed for the creation of a network of conceptual relations. I first reviewed the data set extensively, which allowed me to better understand the content of the interviews. This was followed by an initial coding stage where I selected relevant utterances and labeled them using concepts from the literature review and of my own creation. In the second coding stage, I edited these initial labels and connected similar ideas to create codes of broader concept categories. In the last stage of coding, I consolidated the previously grouped information, leaving a reduced and more manageable number of codes. Throughout this process, I tried to ensure consistency and logical connections between the overlying themes. Although these steps were followed, the process was not always linear, as some themes were easier to connect in earlier steps.

9. Methodological Strengths and Limitations

The study's qualitative nature lends itself to certain strengths and limitations. The semi-structured interviews that were conducted allowed the participants to go into detail about the questions asked and any other information they found relevant. Instead of answering yes or no to close-ended questions about trauma narratives, they were able to provide details and examples about their observations and perceptions. The interviews were designed with the research questions in mind, but I tried to leave room for the participants to share new insights by first asking open-ended questions about trauma

narratives and then prompting for more specific details. Practically, this looked like asking the subjects if they noticed anything different about people's language when they share trauma narratives, and then giving specific examples if they could not initially respond with specific details.

Another limitation of this study is the small sample size; only three people were interviewed in total. Given the small number of participants, the data collected cannot be used to make generalizations about trauma narratives or interpreting in mental health. However, it can help confirm if what has been discussed in the literature has also been observed by people practicing in these professions. Although the sample was small, the study includes multiple perspectives, that of two interpreters and one counselor. Due to the limited time frame, a purposeful sample was used. However, all of the participants had worked extensively in the mental health setting, so they had a range of experiences to comment from.

10. Methodological Principles

There are a few underlying principles driving this research, both through the TIMIS project and this thesis. One of these principles is social justice. Beyond obtaining data solely for the sake of scientific knowledge, the project is intentionally designed to address structural inequalities, specifically in helping overcome the language barrier that prevents Spanish-speakers from accessing mental health services. While the interpreting will address this need for a short period of time, the duration of the funding, we are also helping make structural changes that will facilitate language access in the future. This is accomplished in part through the training that the organization and individual counselors are receiving in how to work with interpreters. It was also provided through the

translation of documents used in counseling, not directly related to the data collection needs of our study.

Complementing the focus on social justice, this project has also been influenced by the spirit behind an action research approach. Instead of approaching the questions in a linear way, starting with a problem and aiming for a direct solution, we are aware that new questions may arise throughout the duration of the study. This is especially true with trauma-informed protocols, as we seek to work with counselors and clients to determine which protocols are most effective. We may try new solutions and find that they work in some cases, but not in others. This thesis has a narrow focus of looking at trauma narratives, and it is currently in an early stage of learning about them. The overarching goal is to understand them with more clarity so that interpreters can be trained to interpret them more appropriately, ultimately giving counselors less hindered access to their clients' voices. However, it is possible that as we learn more about trauma narratives and shed light on alternative ways to interpret them, further questions will arise. This approach gives us the flexibility to work with interpreters and counselors to address these issues as they appear and adapt our solutions to meet the needs at hand. In the following section, the contents from the interviews will be analyzed to give us a better understanding of these issues.

CHAPTER IV

RESULTS

1. Background Information

Before delving into an analysis of the data, I will briefly provide some context about the informants, which will inform an understanding of the experiences and examples they gave. As previously mentioned, all three informants had worked in a mental health setting for at least one year. At the time of the interview, Interpreter 1 had volunteered weekly as an interpreter at a community health clinic for a little over a year. The clinic offered mental health services one to two times a month, and she estimated that she had interpreted in over 50 individual therapy sessions. She typically used the simultaneous interpreting mode, whereas the other informants used or worked with other interpreters who used the consecutive mode. Interpreter 2 had been working as a professional freelance interpreter for a child advocacy center since 2013. Although she sometimes worked with law enforcement and other professionals, she also had extensive experience working with therapists there. The counselor had been practicing since 1974 and first worked with professional interpreters in 2010 at an inpatient unit of a hospital. In her current position, she provides mental health services weekly at a center that also offers other medical services. She regularly works with volunteer Spanish-speaking interpreters.

The informants were asked a series of questions about their experience either interpreting or working with interpreters and what kind of content they had heard in the

sessions. All of them had exposure hearing about trauma in mental health, the types of trauma ranging from physical and sexual abuse, violence and death, to challenging life circumstances that deeply affected the clients. After conducting a thematic analysis of the interviews, the data has been divided into four categories. I will present the findings in terms of what the informants said about the mental health setting, the importance of trauma awareness, the work environment, and the language of trauma narratives.

2. Mental Health Setting

One of the common themes in all the interviews was how the mental health setting is unique in comparison to others. Oftentimes these comparisons were made in direct contrast to interpreting in medical settings, because that was the other setting the informants were most familiar with. In some cases, these observations were elicited from direct questions asking them about the setting, but many of them were shared with no prompting from the interviewer. Reflections were made about the purpose of the therapeutic sessions, the types of activities done in the sessions, and the unique linguistic nature of the setting.

All the informants made observations about the purpose of the counseling sessions and how their roles contributed to that purpose. Interpreter 1 highlighted recovery as the objective and specified that her role in that process was helping the clients “get one step closer to recovery.” Both interpreters mentioned being the voice of the victims. Interpreter 2 also spoke multiple times about “helping people” and specified that she did so by connecting the clients with the mental health professionals who were qualified to assist them. While the interpreters emphasized the communicative aspects of the sessions, along with general references to help and recovery, the counselor went a

step beyond those elements. As the mental health professional, it was of more value to her to be able to “do something useful” with the information that was shared as opposed to simply providing a safe place for the client to talk. Some examples she gave were checking to see if a person was suicidal, conducting other psychological evaluations, and determining the need for further care or hospitalization. Everyone described their role in relation to the overall good of the client seeking these services. While the reflections about helping the client and promoting recovery are abstract, all of the informants reported specific activities conducted in the counseling sessions to help promote this end.

Besides the typical talk that is a fundamental part of therapy, counselors also lead their clients in other types of activities. Interpreter 1 and the counselor both referenced deep breathing exercises used to relax the clients. Interpreter 1 commented that she didn't quite know what to do as the interpreter in those situations, but she interpreted the instructions and also participated in the breathing exercises herself. The counselor said that during this activity, since it is intended to be relaxing, it can be counterproductive to have two voices giving instructions, especially when the client does not understand one of the languages. Her solution was to have the interpreter pre-record the instructions in Spanish. That way, clients would listen only in a language they understood, and they even had access to it at home, so it was a tool they could take with them beyond the session. In contrast, Interpreter 2 did not mention any activities intended for relaxation, but she did mention some techniques used with children to help explain concepts using images. The example she gave was when the therapist would draw a male or female body and ask the child where the private parts were. This was used as an instructive tool for the

children but would also serve to help them open up about their experience, a technique which will be explored in the following paragraph.

Two of the informants referenced intentional pragmatic moves unique to mental health settings that the counselors would make to instill trust in the clients, one being proactive and the other preventative. Interpreter 2 stated that the therapists would often begin talking to the adolescent clients about something simple such as their day at school, to help make them feel more comfortable, before encouraging them to speak about the trauma they had experienced. The counselor said that she was very cautious to ask clients about their physical symptoms before diving into the psychological symptoms they were experiencing. Interpreter 1 did not go into much detail about the specific contents of the conversation between the counselor and her clients. All of them did, however, go into great detail about the terminology needed for the sessions.

There seemed to be a discrepancy in the informants' opinions of the level of difficulty of the terminology used in the mental health setting. Interpreter 1 said it was easy on a semantic level. In contrast to medical settings, she did not have to study to acquire specialized terminology for the sessions. Most of the content was about what people were going through, "what was affecting them and their lives." She reported that she found herself intervening less working with counselors as opposed to doctors, because the terminology was less complex. However, later, she shared that the emotional and violent nature of the words often affected her. Having to interpret things such as "he pushed me" and "he shoved me", although easy on a semantic level, affected her personally, even to the point of causing her to lose sleep. She interpreted these statements in first person, which is typical interpreting protocol, but wishes she would have done so

in third person to protect herself from some of the emotional weight of the words themselves.

Interpreter 2 similarly categorized the terminology in mental health as easy, but later mentioned other linguistic challenges. When asked what the easiest part of interpreting in mental health was, she reported that it was the terminology because it's "more or less the same" in each session. She qualified that statement by pointing out that conversations are always unpredictable. Later in the interview, she gave examples of some of the challenges of interpreting the terminology common to this setting. These challenges can be categorized into two groups. The first has to do with the sexual nature of the words and their impact on the hearer. In the context of sexual abuse, often with children, she has to interpret words like 'penetration,' 'semen,' and names for sexual organs. Although at the beginning of the interview she expressed that the terminology used in mental health was easy, she seemed to have struggled with these words earlier in her practice. She said, "After all these years I've become much more comfortable with the terminology they use," indicating some prior discomfort. Part of this discomfort seemed to be because the children often struggle to talk about these concepts. She used phrases like "uncomfortable," "awkward," and "tension in the atmosphere" to describe the interpersonal dynamics during these parts of the conversation.

The second group of words she found difficult to interpret were ones that she was unfamiliar with because they are used in different varieties of Spanish. Interpreter 2 states that parents, especially when talking about sexual abuse of their children, will use euphemisms instead of common names for concepts. For example, instead of using the biological names for genitalia, they will often use colloquialisms that are not mutually

intelligible between different varieties of Spanish. If these words are completely unknown to her, she has to stop and ask the client what they mean. She recounted a time when she distorted the meaning of what someone had said because she thought one of these colloquialisms was referring to a different body part than what the speaker intended. This was not an isolated experience; it has happened many times and caused confusion during the sessions.

While the interpreters viewed the terminology as easy in the sense that it was less technical than in other settings, the counselor interviewed said the opposite. In her opinion, the interpreters who work with mental health professionals in direct contrast to those working with primary care physicians need a higher level of “fluency” in both languages “because you hear more words and more nuance.” She mentioned that words such as ‘depression,’ ‘mood,’ and other similar language were words the interpreters “might not have heard in other places.” She illustrated a time when not understanding this nuance led to confusion.

At the medical practice where the counselor also works, the doctors were referring patients to receive her mental health services because these patients were determined to be at risk for suicide. However, when they came to see her, she realized they were only experiencing physical exhaustion as a side effect of a new medication. It turns out that the interpreters’ rendition of the Spanish word ‘desesperación’ was being interpreted as a feeling of hopelessness, one possible translation of the word, when they were really just talking about a change in their mood. Reflecting on this situation, she said that words can have different meanings in psychiatry than in other contexts, and these are important both in referrals for services and diagnoses.

The interpreters seemed to agree that the pace of the conversations in the mental health setting tends to be slower, and they viewed this positively. Interpreter 1 felt that in medical settings, physicians “just want to hurry up and see the next patient,” but the counselors are not in a rush. Interpreter 2 made the same observation, comparing doctors’ treatment of their patients to mechanics repairing cars, as though they were machines. But in mental health, she thinks treatment is more profound and personalized.

Throughout the interview, the counselor mentioned wanting to listen to and understand her clients, and did not talk about them in any way that could fit into Interpreter 2’s machine analogy that referred to physicians, in spite of her busy schedule. However, she did perceive the pace of the conversations to be fast at times. Sometimes her clients will start talking and not want to stop; the words just tumble out of them. She has a hypothesis that the three-way communication between the client, interpreter and herself can actually benefit clients because it forces them to slow down the pace. This could make the act of opening up “less frightening,” but the counselor is still formulating her opinion about this. She attributed the fast pace of the mental health setting to the clients speaking quickly; she did not give any indication of trying to rush them so she could move on to her next client.

3. Work Environment

Above we saw how the informants described the mental health setting in general, and now we will see how they described their work environments. Beyond the distinctive features of interpreting in mental health settings, another common theme mentioned in all the interviews was the work environment more specific to their experiences. This can be broken into two categories. The first category will center around the stress factors which

make the interpreting task more difficult. The second will explore the interpersonal relationship between the counselors and interpreters.

The emotional content in these sessions made interpreting difficult, as previously mentioned, but there were other factors which also contributed to the challenge of performing the task at hand. When initially describing what made interpreting in this setting so difficult, Interpreter 1 mentioned that she barely had any time for a break. This seemed to be one of the most recurring and prominent challenges for her, as she alluded to it four times throughout the duration of the interview. The counselor did not mention this in terms of challenges for the interpreter, but did say that her schedule is also very booked, with clients coming in every half-hour. She sometimes tries to fit other clients in between her previously scheduled sessions. Interpreter 2 did not give any indications of having to interpret for back-to-back sessions but did comment on the length of some of them. If there were multiple family members involved in a case, each of them would have to be interviewed separately. This often caused the sessions to go on for a very long time.

The interpreters also commented on what the space was like and how the facilities presented unique challenges for them. Interpreter 1 worked in a very small clinic and would often have to stand behind the client while interpreting. Although she perceived this had a positive outcome of preventing the clients from directing their gaze at her, it was not the most comfortable working environment. Interpreter 2 also worked in a small space, and this meant she often found herself in the same waiting room as the clients, a problem she hasn't encountered in other settings. Interpreters are trained to avoid these interactions with the clients when the service provider is not present, and this has led to an ethical dilemma for her as clients often talk to her in the waiting room. While she was

facing ethical problems from the space, Interpreter 1 has felt unsafe at her facility. Her most shocking experience was when a woman's abuser made his way to the back of the clinic and knocked on the door where the counseling session was taking place, demanding that the client leave the room. The counselor did not make mention of any limitations regarding the space.

The other common theme throughout the interviews was the work dynamic between the interpreter and the counselor. This often centered around establishing trust between the two professionals. From the interviews, it did not seem as though the interpreters entered the sessions already lacking trust in the counselors or questioning their professional judgment. There seemed to be much more hesitancy from the counselor regarding interpreters, and that trust had to be established. When asked if she had ever had a negative experience with an interpreter, she told of a time when the client spoke for a long time and the interpreter rendered the message in one word. Because of this negative experience and some others she shared, when she works with a new interpreter, she questions their linguistic abilities. Her organization interviews the interpreters that work with her to try to measure this beforehand, but they rely on volunteers and are limited in their options. The ideal for her is when she gets to work with the same interpreter consistently and can build that professional trust over time.

An occasion for gauging the presence of this trust is when conflicts or misunderstandings arise between the interpreter and counselor. When these situations are handled well, potential points of tension can resolve in a sense of trust. When Interpreter 2 had her first session working with children, she was following the standard interpreter protocol of repeating everything that was said in first person. The counselor perceived

that this was not working well, so stopped the session, pulled her aside, and asked the interpreter to be more engaged with the child. This could have caused a great deal of tension, but because the counselor handled it professionally, they were able to continue working together. One of the reasons that Interpreter 2 continues interpreting in mental health despite the challenges is because she feels respected. She reported that the therapists understand her job, consistently thank her for her work, and make her feel important.

Interpreter 1 shared a similar experience of being questioned by the counselor for following standard interpreter protocol. The first time she worked with this counselor, she brought a notepad to help write down terms and interpret accurately. The counselor was suspicious of this and concerned for the client's confidentiality but waited until after the session was over to address it with Interpreter 1. The counselor asked to see her notes and reminded her that confidentiality is important. However, she seemed reassured once she saw that there was no personal information written about the client in the interpreter's notes. This trust seems to have developed over time because the interpreter now values the chance to talk to the counselor after the sessions and discuss how she is being affected by the traumatic content. This exposure to traumatic content will be discussed in the next section.

4. Trauma Awareness

Everyone expressed a desire for interpreters to be better prepared for the traumatic content they are exposed to in the counseling sessions. Despite Interpreter 2's academic training in interpreting, she commented: "I wish there was more training, more workshops." She has found it extremely challenging to be exposed to the traumatic

narratives, especially when the victims are children. She shared that after each session, she replays these conversations in her head for the following 24 hours, and wonders what it would be like for her or her child in the same situation. Even with her many years working in this field, this has not gotten easier over time. She wishes there were more resources to help prepare interpreters for the type of work she does.

Interpreter 1 was caught even more off guard by the traumatic narratives she was exposed to. She showed up at the clinic one day expecting to interpret for medical appointments and was asked instead to work with the counselor. She had no clue what to expect and had never been exposed to anything like it before, so much so that it affected her sleep for the first month. She strongly recommends that interpreters who are considering working in this setting do a lot of research beforehand, know their limitations, and take advantage of the resources available to them, especially the mental health professionals they are working with.

The counselor also commented on how unprepared some of her interpreters were for the contents of the sessions. When asked for an example of when an interpreting session went poorly, she recounted a time when she worked with a new interpreter. “The interpreting went fine” but the interpreter was visibly impacted by the violent content shared in the session. The problem was that the interpreter was not prepared for the type of information that would be discussed in a counseling session. While the counselor does feel a professional duty to help interpreters discuss their emotional responses to these sessions, she thinks interpreters working in mental health need to have a certain level of maturity before taking on these assignments.

When listing the most important qualities a mental health interpreter should have, she rated maturity right after a high level of “fluency.” In her words, this person should be responsible, “a little bit older and have some life experience.” This life experience will help the interpreters cope with the traumatic stories they are hearing in the sessions. In the past, she’s been assigned interpreters who are there to fulfill a requirement for an undergraduate program, and she does not believe that those students, if they do not have a certain level of maturity, should expose themselves to what her clients are sharing. This comment corresponds with her third requirement for interpreters: that they have some sort of interest in the psychiatric field. Interpreters who meet these qualifications will be prepared to respond appropriately, both professionally and emotionally, to mental health interpreting.

Even though all the informants mentioned the importance of interpreters being aware of trauma prior to working in mental health settings for their own sakes, only the counselor mentioned how the lack of this awareness could also negatively impact the client. “Why would you want to re-traumatize people?” she asks. Interpreters who are unaware of trauma and its impacts could act in such a way that it causes re-traumatization of the clients. This is not unique to mental health settings; she believes all interpreters should be trauma-informed. This is because, regardless of the setting, interpreters are going to find themselves in contact with trauma survivors. In many cases, the interpreters will be unaware of the trauma the service users have experienced because “so many people who’ve experienced trauma don’t talk about it.” In summary, understanding trauma is important both for the emotional and psychological protection of the interpreter

and the client. Lastly, I will look at how this trauma manifests itself when trauma narratives are shared.

5. Language of Trauma Narratives

After describing their general experience interpreting in mental health, the informants were asked specifically if they noticed anything different about the language people use when sharing trauma narratives. They were all able to point out different aspects of speech that come out during these narratives, some in more detail than others. These included pace, tone, and emotion. The counselor made a general observation that, when sharing these narratives, “sometimes the way people sound just sounds different... it’s sort of like they’re caught up in something.” Interpreters had different solutions for trying to understand and interpret these narratives, and the counselor also gave recommendations.

When asked if she perceived differences in the language of trauma narratives, Interpreter 1 had to think about it before answering. One of the first things that came to her mind was the pace of speech. She stated that when sharing trauma narratives, clients would often speak with a slower pace. Interpreter 2 stated that she had not observed a pattern in regard to pace; it differed for each individual. The counselor commented that she has seen both extremes of the spectrum: sometimes people speak slower, but other times it is as though someone has stuck a pin in them. In the latter instance, they also tend to speak faster and louder.

The counselor was the only one of the informants who mentioned a louder tone of voice, but all of them said a lower tone was common, often to such an extreme that the client was mumbling. Interpreter 1 gave an example of someone simultaneously speaking

low, mumbling, and crying. Although Interpreter 2 was unable to recognize a pattern for the pace, she said that the clients “absolutely” mumbled and spoke in a lower tone of voice when sharing their trauma narratives. The counselor resonated with this experience. Oftentimes in English, she struggles to hear what her clients are saying. Sometimes she is only able to pick up on certain words. In Spanish, this is even more challenging with the presence of an interpreter.

A third element pointed out in the trauma narrative language was emotion, present both in the words themselves and in the act of crying. The counselor mentioned that there can be a lot of affect in the narratives, which is important for her to pick up on. Interpreter 1 said that crying was a common occurrence, although not so for every client. Interpreter 2 also mentioned frequent crying on the part of the clients. However, this was often from the parents as they talked about the details of their child’s abuse, and not necessarily from the trauma victims themselves.

Aside from the pace, tone, and the emotional nature of these narratives, Interpreter 2 also highlighted the fact that that the sheer amount of detail can cause these stories to be confusing. This was mentioned in the context of the parents of the abused children. When they are going through all the details of what happened, they tend to use a lot of pronouns (“she said this” and then “she did that,” etc.) and it can be difficult to follow. She noted that the details of what happened get more confusing when they get into “more touchy issues.” She wasn’t sure if this was out of nervousness, a reluctance to talk about what happened, or simply a cultural difference in narrating stories. None of the other informants made a similar observation.

Various suggestions were given about how interpreters handled this language or how they should do so. In the example of the crying, mumbling woman, Interpreter 1 said there was a segment that she did not understand, and she told the counselor “the interpreter doesn’t know what she said.” Interpreter 2, when faced with mumbling, said “I just say what I hear because I’m not understanding anything,” although it is unclear if this means she also explained to the counselor that she could not understand or if she only interpreted the segments she did understand clearly. Looking at the client when they were mumbling or speaking in a lowered voice was a technique she used in those moments to improve her understanding. This, in her opinion, was not ideal, and often caused the clients to direct their speech towards her instead of the therapist.

In the case of confusing speech, when the narratives were about many people and the pronouns were occasionally ambiguous, Interpreter 2 tried to produce a rendition that sounded just as confusing as in the source language. In these cases, the therapist was often confused by this and looked at the interpreter for clarification. During a break or after the session, the interpreter would remind the therapist that she was only interpreting what she heard. In her opinion, “it’s the therapist’s job” to clarify any misunderstandings and ask for further explanation. This is how she handles interpreting language that is challenging in the sense that the narrative flow is hard to follow. However, when the language is challenging on a semantic level, and the clients use terminology or euphemisms that she does not understand, she does see it as her responsibility to ask for clarification before continuing with her interpretation.

The counselor expressed a similar sentiment about wanting to maintain control over communication in the session. Hypothetically, if the interpreter could not understand

something that was said, the counselor would want to take the lead in clearing up any confusion. “It sort of needs to be my session, it needs to be my responsibility to sort out what’s going on.” As the mental health professional, it can be difficult to have an interpreter present because “they’re the person who’s having the reaction, they’re the person who’s listening.” She explains the reason why this can be so difficult: “it makes me feel like I’m not sort of involved in a way that might be important for me to be involved in.” She views it as essential that interpreters repeat everything they hear and do not pick and choose what might be important for her to hear.

The counselor was asked what the ideal response would be if a client opens up for the first time and shares a traumatic narrative, but the interpreter cannot understand it, or it goes on too long for the interpreter to interpret it accurately. She first said that she would tell the client to pause or ask the interpreter to do so, to determine what was just said. She was asked whether this interruption could negatively affect the client or cause them to close up, and in her response, she reflected on her role. She as the counselor needs to know the actual words that are being said so that she can determine the appropriate next step in their treatment: “...if there is a lot of affect and I don’t understand what’s going on then I’m worried about, you know, if this is somebody who might need hospitalization or some sort of emergency room evaluation or who might need medications...” If the most important part is simply giving the client the opportunity to talk, “you could say, ‘Well, let’s not have an interpreter and just let the person talk if the talking is what’s important.’” From the mental health professional’s point of view, talking in and of itself is not the ultimate end, but rather using those words to determine the next action steps to provide the help they need.

Although everyone gave examples of how speech was changed during trauma narratives, the interpreters had to think about the question for longer and were more hesitant to make general observations. Interpreter 1 gave very short descriptions and, when asked if she had ever encountered incoherent speech, responded that she did not know. Interpreter 2, although she did give many examples after thinking through the question, hesitated to make generalizations. After listing some characteristics of the trauma narratives she had heard and elaborating on examples, she explained why it was hard for her to answer:

...I cannot remember, you know since sometimes it gets very intense, and sometimes where they're talking for hours, like I tend to forget the whole session. You know like there is so much concentration involved that right after the session I just get the main 'what was this about' and 'what happened' but I don't really know all the specifics, they're gone. I don't know why, they just disappeared from your mind because I was so concentrated saying the right thing and seeing what's going on.

This reflection by the interpreter about the language used in these sessions is useful in approaching the research questions presented at the beginning of the study. In summary, the interviews provided a wealth of interesting information about different aspects of interpreting in mental health and trauma narratives. In the following chapter, I will draw some conclusions from the data and highlight where it shows the need for further research.

CHAPTER V

DISCUSSION

The principal motive for conducting this study was to learn more about the trauma narratives that are shared in a mental health setting and discover how interpreters process and subsequently interpret them. The interviews have shed light on a counselor's and interpreters' perspectives on the characteristics of the mental health interpreting setting, the work environment, the importance of trauma awareness, and the language of the trauma narratives themselves. Although much of this information was not a direct answer to the research questions presented in the introduction, this new body of knowledges gives us a clearer framework for looking at the topic of interpreted trauma narratives. This is because, although we want to consider the final translations of the narratives, they are happening in an interaction with real people in a specific context. Approaching the question from the perspective of a dialogical model, "which treats interpreting as interaction between participants in a social event" (Wadensjö *Interpreting* 275), gives a more complete view of the question at hand.

Before moving into an extended discussion of the data, I want to point out one of the most unexpected results of the study: the counselor's willingness to interrupt a client during a traumatic narrative. To her, hearing the details are vital in determining her next steps. This was surprising to me because I have spent the past year pondering what it looks like to implement trauma-informed interpreting protocol in therapy, and assumed that it could be counterproductive to interrupt someone who may be opening up for the

very first time about their traumatic experience. In my mind, it could tear down the initial trust that allowed them to share in the first place. Training manuals even warn that asking victims to repeat segments of these narratives can be traumatizing (Bancroft et al. 211). The interpreters interviewed were concerned with “giving voice,” a concept also mentioned in the literature (Bancroft 201), so the thought of doing something that could potentially hinder a person from speaking would be shocking to them, and likely to other interpreters around the world.

Although the act of sharing a trauma narrative with another can be beneficial to the client, it is not always an end in and of itself. The mental health providers need the information that is being shared in order to help their clients holistically, beyond the initial step of providing a safe place where they can share their story. Trauma-informed interpreting is moving the interpreting profession in a positive direction and providing new insights, namely in that it encourages interpreters to focus on the emotions and wellbeing of the people involved in the interaction instead of just the language. However, adhering too strictly to a people-centered model could cause interpreters to lose sight of the purpose of the interpreted encounter. Just as words from witness testimonies in legal settings are used to convict or acquit, words in counseling sessions in the mental health setting serve as a roadmap for the counselor to diagnose and treat. Care should still be given to protect trauma survivors, but the solutions may be more complex than initially thought.

It is exactly this kind of insight which motivated this research. Since trauma-informed interpreting is a new specialization that has developed in recent years, many aspects of it have not yet been explored in depth. Trauma-informed interpreting can take

place in a variety of contexts, but may look different in a mental health setting. This setting, unlike many others in interpreting, has also received little scholarly attention. Looking specifically at trauma narratives and how they are interpreted is a new focus in Interpreting Studies. That is why the interviews were conducted with interpreters and a counselor with experience in mental health. Through their descriptions, we can get a better understanding of what this setting is like, how these narratives are interpreted, and make recommendations for the future.

1. Mental Health Setting

Not only were the informants in agreement that the mental health setting was unique, but they all contrasted it directly with the broader field of medical interpreting, which supports the distinction that was highlighted in the literature review. Their answers coincided with literature pointing out the difference in the goals of doctor's interviews versus mental health professional's interviews (Roat and Crezee 250). They also seemed to support the specialization of interpreters in mental health, as evidenced by the different selection process for the counselor's interpreters. At the very minimum, with this specialization, interpreters showing up expecting to interpret for standard healthcare procedures wouldn't be thrown into a counseling situation without any mental or emotional preparation as Interpreter 1 experienced.

The interpreters had negative experiences interpreting with physicians and expressed a preference for working with counselors. A possible explanation for this preference could be that the more rushed nature of the medical appointments made the task of interpreting more difficult. This could also be based on their relationship between the medical providers they were working with. However, the counselor spoke positively

of the collaboration at her workplace and the continuum of care she was able to offer by working at a place that provided general health services along with her specialized mental healthcare services.

This care gets at the heart of what healthcare and mental health services have in common. “In healthcare, the interactions are collaborative, meaning that all the participants want the same outcome; they want the patient to get well and stay well” (Roat and Crezee 243). This statement was made comparing healthcare encounters to adversarial legal proceedings in an attempt to answer the question of whether healthcare interpreting is different from interpreting in other settings. In their answer, they continue to describe healthcare settings. One of characteristics they discuss in arguing that healthcare settings are different is the relationship between the providers and their patients. They believe that healthcare providers have more power and preparation than their patients, which can cause the patients to feel disempowered (243).

I do not think this relationship could equally be ascribed to counselors. While mental health providers do want patients to “get well and stay well,” similar to physicians, the process of going about this looks very different from other medical treatments. Although there is a great diversity of techniques used with clients, counselors typically recognize that this healing will take time. Instead of writing a prescription and asking the person to come back in six months, counselors are typically slower to diagnose and more willing to see their clients frequently. Additionally, though they do often hold the power and preparation, they are intentional about yielding these things in a way that empowers their clients. This was exemplified in the breathing exercises two of the

informants mentioned; this is an activity the clients can continue doing independently at home, equipping them to take ownership of their recovery.

Counselors are also different in that they rely almost solely on language to diagnose. Doctors ask questions about symptoms and medical histories, but they rely on the use of other medical instruments to determine the diagnosis and subsequent treatment plan. Counselors, on the other hand, do not have stethoscopes or x-ray machines to tell them what their clients are going through. They listen to what their clients are saying to figure out how to best help them. They may refer to some outside testing, but words are their most powerful tool. With such distinctions in the goals and the means of these types of care, it would seem that interpreting in mental health is vastly different from interpreting in broader healthcare settings.

In this setting, since language holds such a diagnostic and therapeutic power, interpreters should still work hard to seek training to help with the linguistic challenges they will encounter. The fact that the terminology in these sessions can be perceived as easy, as expressed in the interviews with the interpreters, could draw newer interpreters to this specialization because the amount of specialized terminology is not as overwhelming as in legal or medical settings. However, the nuance of the language is extremely important, as the counselor pointed out, and interpreters must train themselves to listen for and convey this nuance in their interpretations. With that said, regardless of their amount of experience in this setting and how much they may have learned about what language indicates certain conditions, interpreters should not be the ones to determine what is or is not important diagnostically. Instead, they should seek to do their

best to convey the messages accurately so that the provider can have all the information needed to make those determinations.

2. Work Environment

Interpreting requires a great deal of concentration; “virtually no other profession undergoes a similar cognitive load” (Riccardi et al. 97). The interpreters in my study highlighted how their physical surroundings such as space limitations contributed to the already difficult task of interpreting in these settings. Although they did not point out any perceived decline in their performance due to these stress factors, it is something that could be explored in further studies on this setting. If interpreters are forced to stand while the other parties are seated or if they feel that their safety is in jeopardy because they are forced to directly confront an abusive person, this stress could hinder the interpreter’s ability to concentrate and interpret well. It is worth studying this phenomenon further and seeing what impact these conditions might have on interpreter performance.

The other major feature of the work environment that came to the surface in the interviews was the relationship between the counselor and interpreters. Since interpreting is a more newly established profession, those from other sectors who work with them often do not understand their purpose or significance, and this can create a lack of trust. Other professionals’ limited knowledge of what interpreters are supposed to do was a concern raised by interpreters in previous studies (Crezee et al “Issues” 266). Counselors, even if they recognize the value of interpreters, may not have a clear understanding of their role. In the data presented here, the counselor who was interviewed seemed to be distrusting of interpreters because of some negative past experiences with them. While

any professional could have a negative experience working with an interpreter, it is worth pointing out that she has been working with volunteers. Although these people are screened by the organization before working with her, it is unclear whether they had any previous interpreting training, or whether they possessed the skills required to interpret well. Perhaps some of the mishaps she shared could have been prevented if she were working with more qualified interpreters.

When the interpreters reported the initial mistrust towards them that they detected in the counselors, it seemed to indicate ignorance about how interpreters typically carry out their job functions. It also hints that they felt a potential loss of control in the session. Counselors are typically “very mindful of the dynamics of power” and “may feel wrong-footed by having an interpreter in the room” (Costa “Working” 61). Whereas they typically have a great deal of control in managing communication with their clients and in developing a therapeutic alliance, they are now relying on a third party to help them do so. It is understandable that they would feel uneasy about this. As the counselor who was interviewed shared, she is aware that when she works with an interpreter, she is no longer the first one hearing her client’s stories, and she needs that information to do her job. Having to rely on an interpreter for something that is typically within her power is challenging.

While this finding coincided with the literature, the interpreters interviewed did not express any mistrust towards the counselors they were working with, something that has also been previously documented. This could be because, unlike with interpreters, society is typically aware of the role and importance of counselors, at least on a superficial level. It is also likely that the counselors’ intentional efforts towards

establishing trust with the clients during the sessions also fostered a sense of trust in the interpreters. Most of the incidents of mistrust that have been documented in the literature have to do with interpreters not understanding specific therapeutic strategies that are being used in the sessions (Bancroft et al. 172), a situation these interpreters had not experienced yet.

This working relationship between counselors and interpreters is vital for the success of the sessions. When it is not there, both parties may compensate in a way that can negatively affect the clients, who are already vulnerable and seeking help (Costa “Working” 64). To prevent this and foster a positive working relationship, the author recommends hosting supervision with both professionals. “Where possible clinicians and interpreters should be trained together so that they can understand the extent and limits of each other’s roles and responsibilities” (68). Regardless of how this is ultimately implemented, we can see from the informants’ stories how valuable their communication and understanding of each other’s profession is in making the partnership work.

The above quote mentioned that counselors should learn the interpreter’s role, but role is a complex idea in Interpreting Studies, and is debated in each setting. There are not many opposing views on the interpreter’s role specifically within the mental health setting because few authors have explored this topic. The most prominent model for the interpreter’s role in this setting is a restrictive version of the interactive model of interpreting, where the interpreter is valued as a person in the interaction and seen as more than simply a translation machine, but still prioritizes the therapist’s control over the session (Bot *Dialogue* 88-91, 254-255). The comments the counselor made in the interview align with that view, but she was not asked extensively about this topic.

Interpreter 2's decisions to only intervene for semantic clarifications, but to defer other types of clarifications to the counselor also seem to fit within this model.

While this model of role seems to work for the interpreting encounters, the mental health setting allows for flexibility in its application. Because of the unique characteristics of each encounter, "interpreters have to adapt their role according to the type of patient and type of session, and also to the idiosyncratic preferences of each individual mental health provider" (Bot "Interpreting" 254). If the communicative needs of this setting mean that the counselor is to take the lead, then interpreters should be more flexible in their application of their training and understanding of their role, without doing anything they consider to be unethical. Although Interpreter 2 is "breaking protocol" in interacting more with the children than she would with a typical client, this is a justifiable communicative adjustment that can be made in agreement with the counselor. Navigating these complexities with the counselors is further argument for pre-sessions and debriefings to occur regularly in this setting. If these adjustments are agreed upon but turn out poorly, they can be discussed in these set-aside times. This also points further to the need for further research to be conducted in this setting.

3. Trauma Awareness

The emotional reaction the interpreters had to the traumatic narratives they were being exposed to is consistent with the studies cited in the Literature Review. They did not show current signs of burnout, but the mention of symptoms such as replaying the stories consistently in their minds after the sessions and losing sleep thinking about these narratives are vivid examples of the strong potential this work has to wear interpreters

down. Without the proper training and coping strategies, it is easy to see how interpreters in similar situations would be tempted to despair and leave the profession.

The interpreters' desire to prepare for the assignments, both through personal research and more structured trainings, seem to agree with the recommendations of other scholarly articles (Bancroft et al.; Valero-Garcés "The Impact"; Crezee et al. "Teaching") and existing resources (Bancroft et al.; Toledano Buendía and del Pozo Triviño). However, providing even more resources and trainings would be helpful to continue equipping interpreters to face these situations.

The literature encourages interpreters to use their debriefing time with the counselors to not just discuss the case and the interpreting, but also any reactions they are having to the content of the sessions (Bancroft et al. 94-95). It was an interesting finding that the counselor I interviewed instinctively perceived a need for this. She felt an ethical responsibility to provide that kind of help to her interpreter, and it is likely that other mental health providers will be open to this. Given the confidential nature of the sessions, these debriefing times may be the only opportunity the interpreter has to discuss what they've just heard. If the interpreter respectfully requests this from the counselor, and is mindful of the provider's time and other pressing work duties, I think many would be open to dedicating some time to this. One study found that counselors were the most likely practitioners in the healthcare field to debrief with interpreters (Crezee "Health").

While it is true that interpreters can grow in resilience after being exposed to these stories, it is also important for them to recognize their limitations. The counselor suggested imposing an age limit on interpreting in mental health settings or allowing only interpreters with certain life experiences to do so. While it would not be feasible to

strictly implement these restrictions, the spirit behind her comment points to a principle most interpreters already follow: saying no to assignments they know they are unprepared for. Just as interpreters are trained to do this when they aren't prepared linguistically for an assignment, they could also be trained to consider which cases they are not emotionally prepared for. The challenge in that, however, is that many interpreters are not briefed about the assignments beforehand. Counselors could help provide some of this information so that the interpreter can make an informed decision about their level of preparedness for a session.

Just as the majority of studies related to interpreting traumatic content have focused more on its impact on the interpreters, this was a prevalent theme in the interviews. When Interpreter 1 reflected that she perhaps should have interpreted traumatic narratives in the third person, modifying typical interpreting protocol, she was demonstrating an awareness of how not doing so could provoke vicarious trauma. However, as we have seen from the literature, the other side of trauma-informed interpreting is also avoiding re-traumatization of the client (Bancroft 210-11). The counselor was likely the only one who understood that because she has received far more training in trauma and trauma-informed care. It is highly unlikely that the interpreters are apathetic about client re-traumatization; rather, they were probably just unaware of how easily it can happen.

Awareness of potential re-traumatization is not intuitive. Even though both interpreters had received extensive interpreting training and had worked with trauma victims, this was not on the forefront of their minds. In fact, re-traumatization can be counterintuitive to interpreters who are used to practicing their craft in a certain way and

then are asked to modify their protocols taking trauma into account. In one of the trauma-informed interpreting training programs, it took a series of roleplays, discussions, film clips, and hands-on practice to get interpreters to finally grasp how their behaviors could trigger re-traumatization and how negatively that would impact the survivors (Bancroft 212). Their natural instincts of what seemed helpful in the communication actually had the power to harm the people they were seeking to help. More training in trauma-informed interpreting is needed to help interpreters realize how their actions can impact clients.

Despite these challenges, interpreters working in this setting find it very rewarding; the interpreters who were interviewed in this study found great satisfaction in their work. They sacrificially expose themselves to content that can negatively impact their wellbeing in order to help the survivors have their voice heard. As more research is done on trauma-informed interpreting, and interpreters receive more training in recommended practices, they will be able to perform their job in a way that promotes healing to trauma victims. They can experience firsthand the “compassion satisfaction” that has been spoken of by others (Bancroft 2018).

4. Language of Trauma Narratives

In the literature review, it was noted that the vast majority of scholarly work on language and trauma has come from psychology. The practitioners and researchers in this field are the ones working most closely with trauma victims as they seek to work through what has happened to them. Thus, it was not surprising that of the three informants the counselor provided some of the most insightful comments about trauma narratives. Her decades of experience working in this capacity have given her the opportunity to hear

many such stories from her clients. Her reflections confirm the presupposition that these narratives are significant moments in the counseling sessions, both to shape the provider's understanding of the situation and to provide insight into possible routes for treatment.

An interesting finding was that the interpreters had observed a change in language during trauma narratives. It was unclear at the start of the study if interpreters would be able to reflect on their experiences hearing these stories and pinpoint characteristics of how the language differed from ordinary speech. They were able to make observations about pace, tone, and emotion. While I have not been able to find extensive explanations of these topics in regard to trauma narratives, their examples of trauma impacting speech in these ways are supported in the literature. In some of the earlier studies on trauma and language, a change in tone was mentioned (van der Kolk 241). Interpreters have reported that a difficult aspect of interpreting for refugees, many of whom have experienced trauma, is that they speak in a low voice or mumble (Crezee et al. "Issues" 260). In a therapeutic setting, trauma narratives that engage the emotion of the speaker are more effective clinically because they allow "the client to more directly relive the traumatic event" and address it more effectively with therapeutic interventions (Briere and Scott 127). One scholar has explored crying during trauma narratives as a way in which victims transcend the traumatic gap of the horrific event they have experienced (Ladegaard "Coping" 191).

It would seem as though some of the language of trauma narratives that scholars write about is observable even by those who are not researchers in the area. Based on the results, we cannot infer that pace is always faster or slower in trauma narratives, that tone

is always higher or lower, or that emotion always manifests itself in a specific way such as crying. Even if all the informants had been in agreement on these aspects of language, the study design with its small sample would not lead to these conclusions. What can be confirmed, however, is that it seems that trauma narratives do differ from ordinary speech. As the counselor stated, “Sometimes the way people sound just sounds different.”

Although the informants spoke of the speaking style clients utilized while sharing trauma narratives, little mention was made of the structure of the narratives. There were no findings in this study to support the literature about incoherent speech. One possible explanation for this is that the average person is not typically attentive to analyzing the language they hear. If they hear something that sounds odd, they may try to make sense of it and move on. Trauma narratives have been documented to be different from ordinary speech, but this difference may not strike the listener as so strange that they remember it. An exception to the rule might be the speaking style of a psychotic person, which can also be incoherent, but these incoherencies are coupled with associative speech and utilizing uncommon words or expressions that may not even exist (Bot “Interpreting” 262). It would seem that trauma narratives are less extreme on the continuum of affected speech and thus not as noticeable to the listener, but this hypothesis would need to be explored in further research.

I have just stated that there were no findings which unquestionably support the incoherent speech, but there is one finding that could potentially fit in that category. Interpreter 2 described how stories could be fraught with so much detail that they caused confusion to her and the counselor. The interpreter herself stated that this could have been due to a cultural difference in narrative styles. Culture is not an issue that has been

taken up extensively in this study, but could be relevant in further research on this topic, especially given that narrative styles can differ drastically across cultures and languages (Blommaert; Grazia Guido).

The other reason I am hesitant to categorize Interpreter 2's example as incoherent speech is because it came from parents, not from the children who had experienced the abuse. Although the parents were telling narratives about trauma, this trauma was not necessarily personally experienced by the narrators. This distinction matters because when traumatic memory is recalled, it provokes the physical sensations and emotions of the initial traumatic event (van der Kolk 219). If the parents did not experience trauma personally, then this example may not qualify as a trauma narrative. However, finding out about or witnessing the abuse of their children could have been a personally traumatic experience for them, so this interpretation cannot be completely discarded. There is not enough information from the data to make a conclusion. Future studies that continue to pursue this line of investigation will perhaps need to have an even clearer criterion for trauma narratives to help work through these problems. The involved selection process behind determining what types of data can be labeled as trauma narratives has been addressed in other studies (Ladegaard "Coping" 194); there is not an easy solution.

While this confusing language cannot definitively be considered a trauma narrative, we can learn from how the interpreter handled it. She produced an equally confusing rendition and relied on the counselor to seek clarification from the client. This is an example of following the "golden rule" in mental health interpreting: "To interpret whatever the patient says, no matter how odd this may sound to the interpreter" (Crezee et al. *Introduction* 159-160). Despite the interpreter's confusion and heightened

concentration, she made an effort to produce an accurate rendition of the original message. Interpreters should also seek to do this as they are being exposed to trauma narratives which may sound different from ordinary speech. This would the counselors to hear the nuances of what their clients are saying and still maintain control of the session.

Perhaps one of the greatest limitations of this study, and of others that rely on interpreters reflecting on past experiences instead of analyzing the actual text from the interpreted event, is that it relies heavily on the interpreter's memory. As Interpreter 2 stated, interpreting is such a mentally demanding task that it is hard to call to mind what was said in the session. Remembering specifics about how they interpreted trauma narratives and other utterances may prove to be even more challenging. Consequently, there is no clear answer to the research question of how interpreters modify the trauma narratives in their renditions. This study was not able to answer whether these renditions maintain some of the same characteristics as the original. It is unknown at this time if these renditions have made a difference in counselors' understanding and diagnosing clients.

We do know, however, that interpreters are faced with a host of psychological and emotional pressures in this setting, along with the cognitive load interpreting places on them. One way to ensure that interpreters are appropriately rendering trauma narratives is by educating them about the features of these narratives. If they are aware that the narratives may utilize a different type of language than interpreters are used to hearing, and that this language can be diagnostically relevant for the counselors, they could be trained to interpret them more accurately. One way to do this is by training them to better monitor their speech and renditions in this setting (Dimitrova and Tiselius 204). With that

said, although the accuracy of the renditions is important, perfection is not expected. An exact equivalence would be impossible, as “investigations of naturally occurring interpreting show that renditions in practice never are unambiguously equivalent with the preceding originals” (Wadensjö “Dialogue” 113).

CHAPTER VI

CONCLUSION

Throughout this paper, I have provided information as to the background of this study and how the research questions regarding trauma narratives were investigated in the context of the broader TIMIS project. Since trauma narratives are different from other types of communication, I sought to explore how interpreters handle these narratives in the mental health setting, and if their renderings can make a diagnostic difference when working with counselors. To do so, I first outlined some basic concepts within Interpreting Studies and psychology to give context to the research. Then, I examined four different topics within the literature: language and trauma, trauma-informed interpreting, interpreting in mental health, and the mental health perspective on working with interpreters. This literature review revealed that more research is needed on interpreting in the mental health setting with trauma survivors, especially from a linguistic perspective as it relates to trauma narratives.

After introducing the project and summarizing relevant points in the literature, I gave a detailed explanation of the methodology. I explained how these particular research questions were examined in light of the TIMIS project, and as such, how funding and ethical research approval were obtained. After discussing the project development in a broader sense, I detailed the methodology used to address the research questions highlighted in this thesis. This involved including information such as how the subjects, two interpreters and a counselor, were chosen for semi-structured interviews, and then

how the data from those interviews was analyzed qualitatively using thematic analysis. I have reflected on the strengths and weaknesses of this methodological approach.

The strength of this approach gave me exposure to a vast set of reflections on interpreting within the mental health setting. I categorized this information in the Results section into four overarching groups, summarizing what the informants shared about the mental health setting, the work environment, trauma awareness, and the language of trauma narratives. After reporting on these interviews, I tied what the informants shared back to the literature review in the Discussion, mentioning points of agreement and variations from what has been previously documented, then giving some possible explanations as to why.

To return to what was stated in Chapter 1, this study set out to respond to a social and scientific problem in Interpreting Studies by looking at trauma narratives in the mental health setting. The data collected provided rich points of consideration, and particularly helped shed light on the context of the interactions in which these trauma narratives are interpreted. The findings about the unique nature of mental health interpreting with its elevation of language, the challenging physical and interpersonal aspects of the work environment, and the importance of a trauma awareness which considers the client and the trauma survivor are all useful considerations when approaching trauma narratives. Interpreters are already able to distinguish some differences in the language used to report these experiences. As further research gives us a clearer understanding of this phenomenon, interpreters can be trained to have a heightened awareness of it and carefully consider how to interpret it in a way that will produce accurate linguistic renderings of diagnostic relevance to the counselors.

This study has also served to help fill a gap in the literature. There are few studies on interpreting in mental health, and there are very few on language and trauma outside of psychology. This study has been able to contribute to both. It has taken a topic that is slowly growing as an area of research interest (trauma narratives) and shown its value with a different angle in a new context: interpreter-mediated counseling sessions.

Although the data did not provide a thorough answer to all the research questions, it has laid the foundation for further studies. In the interviews, the interpreters were able to reflect on the language of trauma narratives and share some strategies they have used to handle them in the past. However, the methodological approach of this study in and of itself prevented a comprehensive understanding of the way interpreters render trauma narratives. To continue to find answers to this question, more research must be done. One advantage is that, after finishing this thesis, I will still be involved in an active research project seeking to do just that. These interviews have shed light on the significance of trauma narratives; hopefully the data we eventually obtain from the counseling sessions offered through the TIMIS project will give further insight.

As I mentioned in the introduction, Interpreting Studies has the potential to immediately take what has been learned from the body of research and apply it to real people in need. The insights from this study will help our team as we make decisions about trauma-informed interpreting care throughout the duration of our study. In addition, this information has been valuable to me. Conducting this research has been a rewarding experience, and I will be able to take what I have learned from the literature and the interviews and put it into my own practice as an interpreter. This will help me as I seek to

give voice to those who are hindered by a language barrier when accessing mental health services.

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APPENDIX 1

IRB APPROVAL

**UNIVERSITY OF
LOUISVILLE**

Human Subjects Protection Program Office
MedCenter One – Suite 200
501 E. Broadway
Louisville, KY 40202-1798
Office: 502.852.5188 Fax: 502.852.2164

DATE: December 13, 2018
TO: Lluís Baixauli Olmos, Ph.D.
FROM: The University of Louisville Institutional Review Board
IRB NUMBER: 18.0478
STUDY TITLE: The TIMIS Study: Trauma-Informed Mental Health Interpreting Services
REFERENCE #: 673350
IRB STAFF CONTACT: Jackie Powell 852-4101 jspowe01@louisville.edu

This study was reviewed on 12/13/2018 by the Chair of the Institutional Review Board and approved through the Expedited Review Procedure, according to 45 CFR 46.110(b), since this study falls under Category 7: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

The following items have been approved:

Submission Components				
Form Name	Version	Outcome		
Submit for Initial Review	Version 1.0	Approved as Submitted		
Review Response Submission Form	Version 1.0	Approved as Submitted		
IRB Study Application	Version 1.1	Approved as Submitted		
Study Document				
Title	Version #	Version Date	Outcome	
Research proposal	Version 1.0	12/12/2018	Approved	
Rating Scale in English	Version 1.0	11/28/2018	Approved	
Focus group questions	Version 1.0	11/27/2018	Approved	
Session Rating Scale (adapted, in Spanish)	Version 1.0	10/03/2018	Approved	
Field observation notes	Version 1.0	10/02/2018	Approved	
SBE Informed Consent_TIMIS Project_Spanish	Version 1.0	12/12/2018	Approved	
SBE Informed Consent_TIMIS Project_English	Version 1.1	11/27/2018	Approved	

This study now has final IRB approval from 12/13/2018 through 12/12/2019.

For guidance on using iRIS, including finding your approved stamped documents, please follow the instructions at <https://louisville.edu/research/humansubjects/iRISSubmissionManual.pdf>

Please note: Consent and assent forms no longer have an expiration date stamped on them. The consent/assents expire if the study lapses in IRB approval. Enrollment cannot take place if a study lapses in approval. For additional information view Guide 038.

Site Approval

If this study will take place at an affiliated research institution, such as KentuckyOne Health, Norton Healthcare or University of Louisville Hospital/James Graham Brown Cancer Center, permission to use the site of the affiliated institution is necessary before the research may begin. If this study will take place outside of the University of Louisville Campuses, permission from the organization must be obtained before the research may begin (e.g. Jefferson County Public Schools). Failure to obtain this permission may result in a delay in the start of your research.

Privacy & Encryption Statement

The University of Louisville's Privacy and Encryption Policy requires such information as identifiable medical and health records: credit card, bank account and other personal financial information; social security numbers; proprietary research data; dates of birth (when combined with name, address and/or phone numbers) to be encrypted. For additional information: <http://security.louisville.edu/PolStds/ISO/PS018.htm>.

Implementation of Changes to Previously Approved Research

Prior to the implementation of any changes in the approved research, the investigator will submit any modifications to the IRB and await approval before implementing the changes, unless the change is being made to ensure the safety and welfare of the subjects enrolled in the research. If such occurs, a Protocol Deviation/Violation should be submitted within five days of the occurrence indicating what safety measures were taken, along with an amendment to revise the protocol.

Unanticipated Problems Involving Risks to Subjects or Others (UPIRTSOs)

In general, these may include any incident, experience, or outcome, which has been associated with an unexpected event(s), related or possibly related to participation in the research, and suggests that the research places subjects or others at a greater risk of harm than was previously known or suspected. UPIRTSOs may or may not require suspension of the research. Each incident is evaluated on a case by case basis to make this determination. The IRB may require remedial action or education as deemed necessary for the investigator or any other key personnel. The investigator is responsible for reporting UPIRTSOs to the IRB within 5 working days. Use the UPIRTSO form located within the IRIS system to report any UPIRTSOs.

Continuation Review Requirements

You are responsible for submitting a continuation review 30 days prior to the expiration date of your research study. Investigators who allow their study approval to expire have committed significant non-compliance with federal regulations. Such lapses may require reporting to federal agencies, a program audit by compliance auditors to ensure that subjects were not enrolled during the expired period, and may lead to findings of serious and continuing non-compliance if expiration were to occur a second time.

Full Accreditation since June 2005 by the Association for the Accreditation of Human Research Protection Programs, Inc.



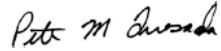
Payments to Subjects

As a reminder, in compliance with University policies and Internal Revenue Service code, all payments (including checks, pre-paid cards, and gift certificates) to research subjects must be reported to the University Controller's Office. For additional information, please contact the Controller's Office at 852-8237 or controll@louisville.edu. For additional information:

<http://louisville.edu/research/humansubjects/policies/PayingHumanSubjectsPolicy201412.pdf>

The committee will be advised of this action at a regularly scheduled meeting.

If you have any questions, please contact the IRB analyst listed above or the Human Subjects Protection Program office at hsppofc@louisville.edu.



Peter M. Quesada, Ph.D., Chair
Social/Behavioral/Educational Institutional Review Board
PMQ/jsp

We value your feedback. Please let us know how you think we are doing:

<https://www.surveymonkey.com/r/CCLHXP>

Full Accreditation since June 2005 by the Association for the Accreditation of Human Research Protection Programs, Inc.



CURRICULUM VITA

Miranda Hale

Contact: mdhale00@gmail.com

Education

- MA** University of Louisville, Spanish Expected May 2019
Graduate Certificate in Translation & Interpreting
MA Thesis: “Trauma Narratives in Mental Health Interpreting:
A Qualitative Study”
- BA** University of Louisville, Spanish May 2014
Graduated Magna Cum Laude
Minored in Philosophy

Teaching Experience

I. Higher Education

University of Louisville, Louisville, KY Aug 2017 to current

Graduate Teaching Assistant, Department of Classical and Modern Languages

- Instructor:
 - SPAN 121: Spanish Language and Culture I, 2 sections (Fall 2018)
 - SPAN 122: Spanish Language and Culture II, 1 section (Spring 2019)
- Teaching Assistant:
 - SPAN 121: Basic Spanish I, 1 section (Fall 2017)
 - SPAN 123: Advanced Basic Spanish Distance Ed, 1 section (Spring 2018)
- Substitute Lecturer:
 - SPAN 122 (Spring 2018), SPAN 123 (Spring 2019), SPAN 305: Grammar in Context (Fall 2018), SPAN 202: Intermediate Spanish II (Fall 2018)

University of Louisville, Louisville, KY Jan 2012 to May 2013

Peer Tutor, Reach (Resources for Academic Achievement)

- Peer tutoring in the following subjects: Spanish (200-level and below), Philosophy (300-level and below, select courses: Contemporary Ethical Problems, Ancient Philosophy, Philosophy of Religion), ESL

II. Other

JCPS Adult Education, Louisville, KY Oct 2015 to May 2017

ESL Teacher, Seneca High School

- Instructor: Low-Beginning/High-Intermediate Level
- Substitute Instructor: Literacy Level

Interpreting Experience (Spanish-English)

I. Professional

Kentucky Court of Justice, Louisville, KY Feb 2019 to current

Intern, Language Access Program

- Duties involve shadowing other interpreters and observing courtroom procedures to train for official job duties. Sometimes interprets with supervision.
- Official Certification Process: Interpreter Orientation completed in October 2018, passed written exam in December 2018, passed oral proficiency exam in January 2019, waiting to schedule interpreting portion final stage of certification.

TIMIS Project (University of Louisville), Louisville, KY Jan 2019 to current

Interpreter, Cardinal Success Program

- Interpreting in therapeutic sessions between therapist and clients

Terri Sparks State Farm, Louisville, KY Apr 2015 to May 2016

Bilingual Customer Service Representative

- Served as an interpreter to provide auto, home and life insurance quotes during meetings between sales personnel and Spanish-speaking

KY Cabinet for Health and Family Services, Frankfort, KY May 2015

Certificate of Qualification

- Passed evaluation of proficiency in Spanish language and practical consecutive interpreting portion
- Completed CHFS Interpreter Training; however, did not officially do any interpreting work for them

Sunrise Children’s Services, Mt Washington, KY

March 2014 to June 2014

Interpreter

- Interpreted in therapeutic sessions between therapist and clients (minors) and family reunification evaluations between social workers and clients

II. Volunteer

Immanuel Baptist Church, Louisville, KY

Apr 2018 to current

Interpreting Coordinator/Interpreter

- Completing internship for academic credit; Duties involve shadowing other interpreters and observing courtroom procedures to train for official job duties. Sometimes interprets with supervision.

La Casita Center, Louisville, KY

Apr 2018 to current

Interpreter

- Interpreting for Latino community at different events such as consular visits; primarily interpreting with lawyers doing consultations at free legal clinic

Research Experience

Fulbright U.S. Student Program, Louisville, KY

Sept 2019 to June 2020

Independent Researcher, University of Granada

- Status: Finalist, pending final documentation
- Proposal Name: “Trauma-Informed and Culturally Competent Interpreting in Social Services”

TIMIS Project, Louisville, KY

Jan 2019 to current

Co-Investigator and Interpreter, University of Louisville

- Project Title: “Trauma-Informed Interpreting in Mental Health”
- Duties: Research design, data collection, data analysis

- Using for MA Thesis
- PI: Dr. Lluís Baixauli-Olmos

Presentations

I. Conference Presentations

- Baixauli-Olmos, Lluís & Hale, Miranda (2019, April). “Interpreter Role and Protocol in Mental Health.” KFLC: The Languages, Literatures, and Cultures Conference (Lexington, KY).
- Hale, Miranda (2019, February). “El discurso minoritario en la poesía de Blas R. Jiménez: un análisis de ‘Todo negro’ y ‘Cántame poeta negro’ (Minority Discourse in Blas R. Jimenez’s Poetry: An Analysis of ‘All Black’ and ‘Sing to Me Black Poet’).” The Louisville Conference on Literature and Culture Since 1900 (Louisville, KY).
- Hale, Miranda (2018, February: Proposal accepted, unable to present). “Latino Panethnicity in *In the Heights*.” The Louisville Conference on Literature and Culture Since 1900 (Louisville, KY).

II. Other

- Hale, Miranda (2019, April). “Interpreting Trauma Narratives in Mental Health.” Graduate Network of Arts and Sciences: GRADtalks (Louisville, KY).
- Hale, Miranda (2018, November). “Trauma Informed Interpreting in Mental Health.” Graduate Network of Arts and Sciences: GRADtalks (Louisville, KY).
- Baixauli-Olmos, Lluís & Hale, Miranda (2018, September). “What is Interpreting?” Cardinal Success Program training for counselors (Louisville, KY).

Funding and Awards

I. Funding

Graduate: Graduate Teaching Assistantship: full funding of MA coursework; 2019 Dean’s Citation; Alice Eaves Barns Award; Outstanding Student of Spanish in MA Program
 Undergraduate: Vogt Scholarship, KEES Award, Ronald McDonald House Charities Scholarship
 Study Abroad (undergraduate): Cards Abroad Award, Lewis Educational Award

II. Awards

Undergraduate: David R. Hershberg Award for Outstanding Student of Spanish

Professional Training

GTA Publishing Academy

University of Louisville (School of Interdisciplinary Graduate Studies & University Libraries Learning Commons), Spring 2019

- Competitive program to help graduate students from a variety of disciplines navigate the challenging world of academic publishing.
- Topics covered: citation metrics, copyright & licensing, open access, selecting publishing venues, critical publishing questions.

PLAN Workshops (Professional Development, Life Skills, Academic Development & Networking)

University of Louisville (School of Interdisciplinary Graduate Studies)

Sessions attended:

- “Approaches to Successful Grant Writing” (March 2019)
- “Leveraging LinkedIn for Career Exploration and Job Searching” (February 2019)
- “Strategies for Writing for Publication” (November 2018)
- “Power Literature Searching” (October 2018)
- “IRB from the Inside” (June 2018)
- “Workshopping your C.V.” (September 2017)
- “Reading and Responding to Graduate Level Writing” (September 2017)
- “Introduction to Endnote” (January 2017)

Social Justice Research Symposium

University of Louisville (Cooperative Consortium for Transdisciplinary Social Justice Research), November 2018

- Attended Symposium as part of TIMIS research team to network and learn more about issues relevant to social justice research and the community.

Reframing Autism Training: “Collaborating to Help Students on the Spectrum Thrive in College”

University of Louisville (Dean of Students Office, Delphi Center for Teaching and Learning, & CEHD KY Autism Training Center), September 2018

- Training provided to help instructors identify the characteristics associated with Autism Spectrum Disorder (ASD), learn strategies for collaborating with students with ASD, provide University and community resources for support, and share information about accommodations through the Disability Resource Center.

University Events

I. Within Department

- Study Abroad Panels (March 2019 & Nov 2018)
 - Participated in a panel to share my experience learning a foreign language and studying abroad to motivate Spanish 123 in their language learning
- Celebremos (Sept 2017 & Sept 2018)
 - Helped with planning, set up, break down, hospitality, and interacting with students from Spanish classes and wider university students.
- Celebration of Languages (March 2018)
 - Helped with planning, set up, and serving food.
- Cesar Chavez Social Justice March (March 2018)
 - Assisted with logistics of the event and participated in the march itself.
- Día de los Muertos Exhibit (Nov 2017)
 - Created a display of students' projects in the library to showcase Hispanic traditions to the wider university community.
- “Reel” Latin American Film Festival (Oct 2017)
 - Assisted with promotions and logistics, volunteered to greet students at movie showings.

II. Outside of Department

- GNAS: Graduate Network of Arts and Sciences (Aug 2018-current)
 - CML Departmental Representative, Social Committee Member
 - Events:
 - Planned and volunteered at Annual Chili Cookoff & Pumpkin Carving Event (Fall 2018)
 - Currently planning Paint & Plant Event (Spring 2019)
- International Welcome Lunch (Aug 2017)
 - Interacted with new international students to welcome them to the university.
- Freshman Move-In Day (Aug 2017)
 - Volunteered to help freshmen move in to campus housing.

Certifications

- Human Research Training
CITI Program: Human Research, Human Subjects &
HIPAA Research Basic Course
July 2018
(exp: 7/15/22)

- CASAS Implementation Training January 2016
Comprehensive Adult Student Assessment Systems, for ESL position
- ACT Critical Thinking Certificate Spring 2014
- Literacy Works ESL Tutor Essentials Training Summer 2013
- CRLA Advanced Certified Tutor--Level II Spring 2012
College Reading and Learning Association, for REACH position