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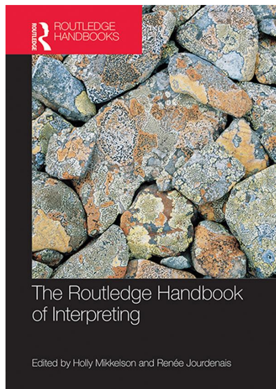

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Vicarious trauma and stress management

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VICARIOUS TRAUMA AND STRESS MANAGEMENT

Justine Ndongo-Keller

"Please, Grandpa, do not kill me; when I grow up I will never be a Tutsi again." The courtroom went silent as a witness in a trial described the events on a fateful day in the hills of Rwanda. Led in examination-in-chief, she narrated how she took her children to her Hutu father-in-law, in the hope that they would be safe. Before her very own eyes, the grandfather butchered all of them one after the other. The last of them to die, after his siblings were killed before him, pleaded with the grandfather to be spared. His efforts were futile. A few minutes later, he lay dead. His Hutu grandfather was not ready to brook any compromise with Tutsis or "cockroaches," as he called them.

How does one recover after hearing and interpreting such gruesome testimonies? There is no doubt that events spanning the 100 days of carefully planned carnage in 1994, and claiming approximately 800,000 lives, left a gaping scar on the African continent. It also dramatically impacted the lives of those who worked in the court sessions of the United Nations International Criminal Tribunal for Rwanda, especially those of the interpreters who carefully listened to and interpreted the narratives of the surviving witnesses. It is they who provided the first-person voices in these stories: "I killed," "I raped,", "I was raped", "I slaughtered", "I beat", "I was stabbed," "I was abused," "I was beaten", "my child was hacked into pieces", "my mother was buried alive", "all my family members were killed". Repeatedly, the interpreters listened, visualised, analysed, understood and re-expressed what they heard.

Research has shown that the effects of covering traumatic events or working with traumatized persons over a long period of time can actually have negative effects on those providing the assistance themselves (McCann and Pearlman, 1990). This chapter is about vicarious trauma (VT) in the context of interpreting, in general, and in the context of community interpreting (criminal justice, education, health, social work, humanitarian work, etc.), in particular. In these contexts, interpreters must personify any variety of the participants in the interactions, including patients and therapists; victims and witnesses, killers or perpetrators, prosecutors and defence counsel – and sometimes all of these – during a single communicative interaction. This chapter will elucidate the effects of being the voice of so many in such difficult circumstances and outline the kind of stress suffered by the interpreter, especially in a criminal courtroom setting. This stress can have an impact on the work and performance of the interpreter, on friends, family, colleagues, on beliefs, and on life in general, especially since unlike the therapist, the social worker, the priest, the counsellor, or the court magistrate who may have direct contact

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with the victims and interact directly to assist them, the interpreter may feel powerless, as he/she sits in the booth and bears witness to the victims' pain more as a spectator. We will begin by defining the key terms that are used in the field, followed by a review of the salient literature on the subject. After discussing the results of research on VT in general we will focus on studies of VT among interpreters in particular. The chapter will conclude with recommendations for best practice.

What is vicarious trauma or vicarious traumatization?

Research has established that those who work with victims of violence suffer serious VT due to their daily contact with these victims and their stories. Among the researchers are Maslach (1982) with her work on burnout; McCann and Pearlman (1990) with their work on vicarious traumatization; Figley (1995) with his work on compassion fatigue; Catherall (1995) with his work on secondary traumatic stress; Dutton and Rubinstein (1995) with their work on post-traumatic stress disorder; Saakvitne and Pearlman (1995) with their work on VT; Ochberg (1988) with his work on post-traumatic therapy; Rothschild (2000) with her work on the effect of trauma on the body; and Richardson (2001) with her guidebook on VT. However, not much research has been done regarding interpreters.

Ochberg has been a leading authority on the treatment of post-traumatic stress disorder (PTSD) since the 1960s. An expert on PSTD and the Stockholm syndrome, he helped define trauma and PTSD. Figley started studying traumatized nurses in 1970. He is the editor of the series on "Compassion Fatigue" which focuses on trauma and secondary traumatic disorder on those who provide therapy to the traumatized, and their treatment. The first book of the series, *Trauma and its Wake*, was published in 1985. Other pioneer work in the field of VT, in addition to that done by authors noted earlier above, includes Pearlman and Maclan (1995), who described the profound effects suffered by professionals exposed to the traumatic experiences and narratives of those they work for and with, in their study titled "An empirical study of the effects of trauma work on trauma therapists". They laid the foundation for most subsequent work on stress, trauma and vicarious traumatization management.

In the literature reviewed, VT is often linked to post-secondary traumatization, burnout, compassion fatigue and countertransference. It is therefore necessary to define these terms in order to understand the signs we may see and differentiate them. For Gilmore (2011, p.4), "*Burnout* refers to extreme circumstances where the worker is suffering personally and professionally from their work; it is usually accompanied by a high degree of negativity. *Compassion fatigue* came from Charles Figley who used it to refer to people who suffer from being in a helping capacity for a long time. "*Countertransference* in the context of psychotherapy is the distortion on the part of the therapist resulting from the therapist's life experiences and associated with her or his unconscious neurotic reaction to the client's transference" (1995, p.9).

Ochberg (cited in Landau 2009) makes a distinction between *compassion fatigue*, which for him is empathy developed by therapists when listening to traumatized persons, and *vicarious trauma*, which goes beyond that. He says the following: "It's not that I am feeling sorry for them and empathizes with them, it's that I am becoming them".

McCann and Pearlman first used the term *vicarious traumatization* in 1990 specifically with reference to the experience of psychotherapists. Talking about vicarious traumatization, McCann and Pearlman (1990, p.133) stated that "Persons who work with victims may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons. We term this process "vicarious

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traumatization". At the vanguard in the field and authors of numerous studies and articles on the subject, Saakvitne and Pearlman defined vicarious traumatization as being:

> a profound change in the therapist sense of meaning, identity, world view, beliefs, and about self and other … Vicarious traumatization refers to a transformation in the therapist's (or other trauma worker's) inner experience resulting from empathic engagement with clients' trauma material. That is through exposure to clients' graphic accounts of sexual abuse experiences and to the realities of people's intentional cruelties to one another and through inevitable participation, re-enactments in the therapy relationship. The therapist is vulnerable through his or her empathic openness to the emotional and spiritual effects of vicarious traumatization. These effects are cumulative and permanent and evident in both the therapist's professional and personal life … [it] is marked by profound changes in the cores aspects of the therapist's self or psychological foundation.
>
> *(Saakvitne and Pearlman, 1995, p.151)*

Primary traumatisation refers to the impact of trauma on the actual victim of the traumatic event. This may be applicable to workers if they have experienced their own trauma. *Secondary traumatisation* is usually about family members or close friends who witness a loved one's traumatic event. It can also refer to workers who actually witness a client's trauma.

A related concept is *vicarious terror*, which emerged after the 9/11 attack in New York (LaRowe, 2007) stated that:

> Since the terrorist attacks of September 11, 2001, the war in Afghanistan and Iraq, and the ongoing war on terror, compassion fatigue may be redefined to include vicarious terror. Vicarious terror may be understood much the same as vicarious trauma, except the method of transmission is the media rather than face-to-face contact. Vicarious terror relies on the repetitive barrage of images and sound bites crafted specifically to induce the physical, mental, and emotional response of vicarious trauma, especially dissociation. Dissociation is another word for feeling separated, isolated, and disconnected from yourself and others – it is a state of emotional and even physical numbing. It is the result of a continual and repetitive barrage of noxious stimuli that slips below our mental radar while registering and accumulating subconsciously as a condition I call "wired and tired".

Other concepts have also emerged: vicarious transformation, survival strategies, and vicarious resilience. *Vicarious transformation* has to do with hope, spiritual growth, a greater appreciation of gifts in one's life. On this topic Saakvitne and Pearlman state that: "The spiritual damage, or loss of meaning, connection, and hope, that can signal vicarious traumatization is profoundly destructive and attending to one's spiritual health is critical to survival and growth. Developing a spiritual life means something unique to each individual; it will entail finding a way to restore faith in something larger than oneself, whether by reconnecting with the best of all that is human, with nature or with a spiritual entity" (1995 p.167). Valent (1995, p.28) talks about survival strategies in dealing with trauma. For him: "stress responses can be adaptive or maladaptive. Adaptive stress responses deal with stresses in such a way that life is not actually or potentially compromised … it is suggested that illness seriousness is determined by the difference between pre-and post-stress equilibria, and that illness nature depends on the components of trauma, including survival strategies. Benefits occur when responses are adaptive and post-stress equilibria are more life enhancing than prestress ones".

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A related concept is *vicarious resilience,* coined by Hernandez, Gangsei and Engstrom (2007), who interviewed psychotherapists who work with victims of political violence and kidnapping about their perceptions of their clients' overcoming of adversity. This led them to speculate that work with trauma survivors has the potential to affect and transform therapists in a unique and positive manner. They thought that introducing this concept into the professional vocabulary may help therapists develop a useful resource to strengthen the work they do by focusing on a process that is different from vicarious traumatization, but is generated in similar relational dynamics. They declared that "[they] noticed that among the psychotherapists working with torture survivors, some made specific reference to the inspiration and strength they drew from working with clients whom they sometimes described as 'heroes'" (2007, p.230).

According to Hernandez, Gangsei and Engstrom (2007, p.234), those interviewed in their study described ways in which witnessing their clients overcome adversity affected or changed the therapists' own attitudes and emotions. Witnessing and reflecting on human beings' immense capacity to heal and reassessing the dimensions of one's own problems were the most common themes in this regard. For example, one of the participants stated, "After working with people who have suffered these kinds of problems, your definition of a problem changes. One takes issues with more ease. One defines what is serious differently" (*ibid.*). Understanding the role of spirituality and religion and seeing clients as sources of learning were also typical responses.

Dutton and Rubinstein (1995, p.83) said that *trauma workers* are "persons who work directly with or have direct exposure to trauma victims, and include mental health professionals, lawyers, victim advocates, caseworkers, judges, physicians and applied researchers among others" (p.83). It is to be noted that the list is not exhaustive, and the term "among others" could easily include court personnel involved in events such as the Rwanda trials. In fact, in self-survey data collected from 105 court judges,

> The majority of judges (63%) reported one or more symptoms that they identified as work-related VT experiences. Female judges reported more symptoms, as did judges with seven or more years of experience. In addition, female judges were more likely to report internalizing difficulties, while judges with more experience reported higher levels of externalizing/hostility symptoms. Coping and prevention strategies were multi-domain (i.e., personal, professional, and societal) and underscored the need for greater awareness and support for judges.
>
> *(Jaffe, Crooks, Dunford-Jackson and Judge Town, 2003, p.1)*

This suggests that interpreters sitting in these same courtrooms face similar challenges. Thus, VT is a professional and occupational hazard for the interpreter in criminal proceedings and should be treated as such and also given the same attention as for judges. Indeed, there is need for greater awareness and support for criminal courts interpreters, and it is thus important for the interpreter to know about VT in order to recognize its signs and symptoms.

Causes of vicarious trauma

According to almost all pioneers in the field, VT is caused by repeated exposure to the stories of trauma, the narratives of traumatized persons and images of traumatized people or graphic images of war zones, and also by the desire to assist, to help. An additional cause is the fact that sometimes one feels useless, especially when one is not in a position to provide that assistance. The "trauma worker" eventually identifies himself with the victim or the patient, the traumatized person.

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Saakvitne and Pearlman (1995) also state that VT in individuals can be exacerbated by personal factors, the nature of the work, the social, political and cultural, family context, past and present circumstances. For them: "Two sets of factors contribute to a therapist's vicarious traumatization: (1) specific characteristics of the therapy and its context, including characteristics of the clients, the nature of the work itself, and the political, social and cultural context within which both the traumatic events and therapy take place, and: (2) particular characteristics and vulnerabilities of the therapist and the way he or she works". (Saakvitne and Pearlman, 1995, p.152). For Valent (1995) "Throughout the whole process, endowments resist while vulnerabilities facilitate the noxious effects of stresses. For example, family may be a social strength whereas isolation may be a social vulnerability" (p.29).

This suggests that the personal circumstances "the personal characteristics and vulnerabilities" of the trauma worker quoted above, are important in VT. It can be inferred from it that those living alone, those who are single, those with family problems are more likely to develop VT; those with issues of alcohol abuse, those who have dealt with infidelity, those who have been in abusive relationships, those from dysfunctional homes, those with fragile health, those new to the profession, etc. Thus, many challenging factors have to be taken into account, especially in view of the absence of prior training for interpreters to be able to deal with traumatic material.

For many analysts and critics of the media, the media itself is at the origin of widespread compassion fatigue in society because they saturate newspapers and news shows with often de-contextualized images and stories of wars, tragedy, calamities, disasters and human suffering. Benedict Carey (2011, p.1), a science reporter for *The New York Times*, in an article titled "Becoming Compassionately Numb", says the following:

> Do we have no more room in our hearts to care for this Haitian earthquake victim? The only thing tanking faster than consumer confidence and the Greek economy would be the global compassion index, if such a measure existed. Consider just a few recent news items: Americans are balking at extending unemployment benefits, and even disaster relief was in doubt for a time last week in another of Washington's budget skirmishes; Europeans are cutting payments to pensioners; and "there's no mood for intervention" to avert famine in Somalia, according to one diplomat. At a recent Republican presidential debate, the audience erupted into cheers upon hearing Texas's nation-leading rate of executions.

This shows that people are tired of seeing images of disasters, violence, floods (in the Philippines for example), earthquakes (Haiti for example), terrorists attacks, plane crashes, wars, boats filled with immigrants sinking, famine, destruction, mass killing, shootings, bombing (9/11 bombing of the twin towers of the World Trade Center in New York for example), hurricane and tornados, tsunamis (Japan), landslides, and of hearing only gloomy reports about the world economy; as a result, they are becoming insensitive, cynical or resistant to helping those who are suffering. For Figley: "Trauma workers are more susceptible to compassion fatigue. This special vulnerability is attributable to a number of reasons, most associated with the fact that trauma workers are always surrounded by the extreme intensity of trauma-inducing factors. As a result, no matter how hard they try to resist it, trauma workers are drawn into this intensity" (1995, p.15).

Beaton and Murphy (1995, p.51) use the term "crisis worker" to speak of others subject to these factors, including "firefighters, paramedics, emergency medical technicians, ambulance drivers, law enforcement personnel [police, highway patrol, sheriff], rescue workers [red cross and disaster workers] and disaster response teams."

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As seen from these descriptions, those affected by traumatic events cover a wide range of professional positions dealing with traumatic events or working or in contact with traumatized persons.

Signs and symptoms of vicarious trauma

The available literature shows that the common signs and symptoms of VT include, but are not limited to, social withdrawal, aggression, greater sensitivity to violence, sleep disorders, exhaustion, headache, nightmares, intrusive imagery, cynicism, numbness, sexual difficulties, eating disorders, helplessness, difficulty in relationships, among others.

Saakvitne and Pearlman (1995) wrote that the effects of vicarious traumatization on an individual "include significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery" (p.151).

Jaffe *et al.* (2003, p.4) classify the signs and symptoms of VT on the basis of time span, i.e. short-term symptoms: sleep disturbances, intolerance for others, physical complaints; and long-term symptoms: sleep disturbances, depression, and a sense of isolation. They state further that:

> The surveyed judges [in their study] indicated a wide range of symptoms that they identified as stemming from their work, including cognitive (e.g., lack of concentration), emotional (e.g., anger, anxiety), physiological (e.g., fatigue, loss of appetite), PTSD (e.g., flashbacks), spiritual (e.g., losing faith in God or humanity), and interpersonal (e.g., lack of empathy, sense of isolation from others) symptoms. Clearly, judges' exposure to the graphic evidence of human potential for cruelty exacts a high personal cost.
>
> *(ibid., p.6–7)*

Remedies for addressing vicarious trauma

A number of studies have been done about measures and mechanisms to prevent and/or treat VT. According to Catherall (1995), institutions dealing with trauma survivors inevitably encounter Secondary Traumatic Stress (STS) and it takes a toll on the functioning of the staff if deliberate measures are not taken and proper mechanisms put in place to prevent or at least limit its effects. Such institutions include: "police departments, fire departments and emergency medical technicians teams as well as those that must deal with trauma survivors such as hospitals, mental health clinics, and employee-assistance programs" (p. 232). For him, "the first rule is that a preventive mechanism should be in operation before incidents actually occur: (1) psycho-education, (2) preparedness, and (3) planning. Exposure to STS cannot always be avoided, but institutions can ensure that (1) the stress is recognized and (2) the exposed members have the best possible opportunity to process the stressful experiences in a supportive environment" (1995, p 233).

Saakvitne and Pearlman (1995, p.153) state, "Fundamentally a therapist's [trauma worker's] sense of self is a critical factor that allows the therapist [trauma worker] to attend to his or her own emotional, spiritual, psychological and physical needs. A strong sense of self and self-respect will allow a therapist [trauma worker] to take the necessary preventive and ameliorative steps".

Murray and Royer (2008, p.80) agree:

> The reality is that work with or on behalf of people who have been caught up in traumatic situations affects those who do the work. The issue is not whether helpers are immune or not, but rather whether the helpers have appropriate and sufficient

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> strategies in place to manage the impact of that traumatic material. If they do, their relationship with the client will have greater value for the client.

Dutton and Rubinstein (1995, p.94) classify possible coping responses:

> Personal strategies might include taking time for play in addition to work, developing a network of emotionally supportive personal relationships, taking time for self-exploration and attending to personal needs, and using personal therapy as a mean of coping with effects of working with trauma. Professional strategies refer to using peer supervision and consultation, working in a professional setting with others rather than in isolation, and diversifying one's professional practice.

According to McCann and Pearlman (1990, p.145), it is essential and important to look for coping mechanism and:

> It is important to tap into potential sources of support in one's professional network. The helper should first avoid professional isolation by having contact with other professionals who work with victims. These contacts can provide opportunities for emotional support for one's work in addition to the professional and intellectual support they offer. Professionals within a geographical area might organize support groups for helpers who work with victims. These support groups can be facilitated by experienced professionals who are sensitive to the personal effects of working with victims. Such groups can be focused around three major issues: normalizing the reactions helpers experience in the course of this work; applying constructivist self-development theory to understanding one's specific reactions; and providing a safe environment where helpers feel free to share and work through reactions that are painful or disruptive.

Vicarious trauma among interpreters

Following up on the research cited above, we will focus here on two studies on the effects of VT specifically on interpreters, and on a narrative of exchanges between a group of interpreters/colleagues of the International Criminal Tribunal for Rwanda (ICTR) and myself in 2013.

The first study is by Martyn Swain (2011), a conference interpreter, who interviewed interpreters employed at the International Tribunals for the former Yugoslavia (ICTY) and Rwanda (ICTR), and at the South African Truth and Reconciliation Commission. He noted that in these courts "testimony is occasionally, if not frequently, emotionally charged … 'Most testimonies are traumatic, we are dealing here with murder and rape most of the time'". Swain wanted to know how "in interpreting situations such as these … interpreters view their professional obligations and in particular the injunction contained in the section on Truth and Completeness in the 1999 Code of Ethics for interpreters at the ICTY" (Swain, 2011, p.50).

The Code of Ethics mentioned above states that:

> a Interpreters and translators shall convey with the greatest fidelity and accuracy, and with complete neutrality, the wording used by the persons they interpret or translate.
> b Interpreters shall convey the whole message, including vulgar or derogatory remarks, insults and any non-verbal clue, such as the tone of voice and emotions of the speaker, which might facilitate the understanding of their listeners.
>
> *(ICTY, 1999, p.14)*

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Swain's objective was to find out if interpreters remained detached from the emotional charge communicated in the original testimony or if they considered it "a professional obligation to reproduce the tone as well as the lexical content of such utterances … If they are affected by the emotional charge of the testimony … if this has an impact on their output" (Swain, 2011, p.50).

Many of Swain's respondents indicated that they sought to maintain a degree of detachment from the speaker, focusing on the technical aspects of message production and on the facts that had to be conveyed. Others, however, felt that it was unprofessional to remain detached and that conveying the emotional content of an utterance was a professional obligation as well. (It should be noted that the interpreters in Swain's study were working in booths, which is rarely the case for interpreters in national courts.) A questionnaire that Swain asked respondents to complete indicated that the interpreters used a range of coping strategies in order to be able to reproduce the harrowing testimony in detail, including such things as pretending the testimony was unreal, connecting the tales to similar accounts read in books, and ensuring that they engaged in completely unrelated tasks when they weren't interpreting. One respondent from the ICTY went so far as to say this: "I only listen to the harrowing account during my half hour and try to do something else when I am not working. It is not very professional, but I feel I can listen and interpret but not just listen" (*ibid.*, p.52). In short, the interpreter was not ready to listen when it was not her turn to work. This reaction can be characterized as the numbness mentioned earlier.

According to Swain (*ibid.*) "this comment reveals that the need to disengage from emotionally charged testimony while not performing the task of interpretation means that the interpreter will not listen to the accounts while they are not on their turn 'on mike'". In line with the rules adopted by AIIC (*Association Internationale des Interprètes de Conférence*), Swain goes on to say that "it is generally accepted in the profession that interpreters work in teams in order to be able to assist each other by, for example, looking up technical terms which the colleague on mike is having difficulty in finding. Obviously, if the second interpreter is not listening, they will not be aware when this is happening; moreover they will not be familiar with the arguments under discussion when it is their turn to be on mike" (*ibid.*, p.52).

The second study, by Lor (2012), explores the experiences of interpreters in mental health settings and examines how working with clients that have experienced torture, trauma, and war can impact their personal and professional lives. Lor states:

> A review of current literature reveals that there is not enough effective and appropriate training for interpreters; that interpreters frequently experience role conflicts while working with clients; and that interpreters are frequently emotionally impacted by the traumatic material they interpret. The literature review also reveals a gap in the research on the use of interpreters with refugee clients and populations.
>
> *(Lor, 2012, p.i)*

She interviewed four interpreters regarding their experiences as interpreters in handling traumatic client material. She found that the majority of these interpreters " … experienced emotional, psychological, and some cognitive impact in varying degrees, and that they struggled to manage and cope with on a regular basis" (*ibid.*, p.i).

Lor's findings suggest that a majority of the "participants have struggled or are struggling with components of VT throughout their interpreting experiences and would benefit from more training; additional coping and self-care strategies; guidance on how to navigate changing relationships in the community; and more focus on the healing and hope that can come from their role" (*ibid.*, p.i).

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Exchanges/conversations with interpreters/colleagues of the ICTR in 2011

The ICTR, located in Arusha, Tanzania, was established by Security Council resolution 955 of the 8th of November 1994: "for the Prosecution of Persons Responsible for Genocide and other Serious Violations of International Humanitarian Law Committed in the Territory of Rwanda and Rwandan citizens responsible for Genocide and other such violations committed in the territory of neighbouring states, between 1 January 1994 and 31 December 1994" (ICTR, 1995, p.1).

The ICTR began indicting a number of higher-ranking persons for their role in the Rwandan genocide in 1995. People from around the world were recruited by the United Nations to work for the ICTR: judges, prosecutors, lawyers, investigators, interpreters, among others. The working languages of the ICTR are English and French, and Kinyarwanda, which is the language spoken in Rwanda, was also used (especially by witnesses and accused persons).

Initially, about eight interpreters were recruited, and I was among them. Our first assignment was to assist investigators in Kigali, Rwanda, in the ICTR Prosecutor's Office, translating statements from interviews with genocide victims and witnesses (1995–1996) and servicing their meetings, and then some of us were subsequently transferred to Arusha, Tanzania when hearings started there in January 1997.

Translating witness statements was already traumatizing, but hearing the victims and the witnesses narrate their ordeal in person was even worse. The training received at school does not prepare an interpreter to work in this kind of environment. After a few years on the job, hearing the same atrocities on a daily basis and repeating everything in the first person, most interpreters could see serious changes in their behaviour and in their life in general, and they witnessed the same phenomena in their colleagues. We wondered what was happening, and following exchanges with a few colleagues on these changes, I put some questions in writing to four of them who had been working with me at the ICTR for a minimum of five years. The questions were as follows:

> You have worked for the ICTR for quite a while and you are still working as an interpreter for the same organization. Could you share with me your experience in the face of all the gory narratives you heard in the courtroom. Were you affected psychologically, physically, professionally, emotionally, spiritually? If the answer is yes, what were the symptoms and their manifestations as a result of what you had to witness in the courtrooms. How would you call it?

Responses were collected and are presented here in five categories based on the type of trauma reported. These categories are psychological, emotional, physical, professional and spiritual trauma.

Psychological trauma

All four interpreters said that at the beginning, during the first two years, they experienced a constant fear of dying a violent death; for one of them, that fear made him reluctant to visit countries like Rwanda, Burundi and the Democratic Republic of the Congo, war zones where some of the atrocities were committed. They had nightmares, were easily annoyed; [They] reflected on the wicked nature of the human being. As a consequence of this experience, they trivialized death, [they had] become insensitive to other people sufferings. They were numb. One of them said he did not wish to die, but he wished he could just "exit", just exit in open air, walk and walk and keep walking ad infinitum.

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Emotional trauma

The interpreters reported feelings of isolation, anger, irritability, deep sadness and frequent tears in the face of the life ordeals and unbelievable stories they interpreted. One interpreter said that during one of the hearings a witness spoke about "A surreal scene of cold blooded murder and cannibalism that interpreters in the different booths had to interpret in the first person singular 'I', that will definitely stick with him for life".

Physical trauma

The interpreters also reported physical sensations that they attributed to their experiences at the tribunal. These included goose pimples, stomach rumbling whenever the subject of violent death or murder was discussed, constant fatigue, exhaustion, irritable bowel syndrome, thyroid problems, sporadic episodes of constipation or diarrhoea, sleeplessness, over-eating, insomnia, headaches, and high blood pressure.

Professional trauma

The experience had an impact on their professional lives as well. They reported: a reluctance to be assigned to work for court hearings; anxiety and stress when entering the interpretation booth in the courtroom, wondering what would be heard; duress while working; a desire to leave the job and do something else; and a deterioration in the quality and quantity of work.

Spiritual trauma

All four interpreters reported having questions related to their religious faiths. They wondered where was God during the genocide, where was He at the time of the genocide? Who was God in the end? If He was a good God, how did He allow such atrocities to happen? They experienced philosophical thinking of this nature, questioning at times, the very existence of God. They also noted mistrust in spiritual leaders (priests and pastors who denounced refugees and participated in mass killings or the destruction of churches). Was religion and Christianity still worth it? Why so much hatred? This culminated in personal soul-searching, as well: Was the money earned at the ICTR worth it? Was it clean money? Or was it, as one interpreter called it, "blood money"?

The findings of this questionnaire were consistent with the observations of McCann and Pearlman (1990, p.140), who noted that "the helper may also find his or her own view of human nature becoming more cynical or pessimistic … This diminished view of humanity may be associated with feelings of bitterness, cynicism, or pessimism".

All four interpreters said they had to find ways to survive and not be completely damaged by the victims' traumatic experiences. One of them said, using the French word "anesthésié", that he decided to "sedate" himself, supress his emotions, in order to survive. In the end, all four recognized that as time went by, this experience had definitively changed their life. They were no longer the same persons. They decided to enjoy everything that life offered, one day at a time, and appreciated the fact that they were alive, even if they feared that some of the things buried within themselves could resurface someday in a way or the other.

This eventual outcome is supported in Lor's findings that:

> According to a majority of the participants, this struggle to manage their own thoughts and emotions does gradually improve with time. Many participants felt that with time,

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> they were able to learn from their mistakes, get further training, become less sensitive to client trauma through extensive exposure, and resolve or affirm their motivation to stay within the interpreting profession. All the participants also stated that as they gained more training, more experience, and more skills as an interpreter, their obligation and feelings of responsibility to continue interpreting for their community also grew.
>
> *(Lor, 2012, p.37)*

Some of the effects described above can be quite severe and I would like, here, to narrate in more detail the story and personal experience of the female interpreter among the four interpreters of the study. After about a year of court sessions at the ICTR, she realized that she was exhausted, stressed out, depressed, frustrated, inhabited by a sense of fear. She had sleepless nights and chronic headaches due to the workload, having to service court sessions four to five days in a week and sometimes for more than six to seven hours a day, but also because of the horrendous narratives of the victims and witnesses, the graphic images in the photos, the footages and, worse still, the fact that at all times she was personifying the victim, the killer, the judge, the defence counsel. When they killed, she killed. When they were raped, she was raped. When they described how they saw people hacked into pieces, she saw it. When babies were cut into pieces or boiled before their parents' eyes, they were her babies and she could see them dying and felt the pain. That pain lingered on and the images haunted her. She had become one of the victims, feeling everything they narrated; she had become the killers confessing their crimes in gory terms, and she was reacting to these narratives. She found the worst scenarios to be those of gang rape cases in which the victims were violently mutilated and then killed. She developed thyroid problems, had problems with her vocal cords and could not speak properly for some time. She did some research to understand what she was experiencing, and realised that she was suffering from VT. She was physically and emotionally reacting adversely to her experiences and was affected by them so acutely that even her body had developed a protection mechanism. The pain in her throat actually prevented her from being assigned to cover court sessions.

The four ICTR interpreters said they consciously started valuing what they had, their families, their lives as a whole. They understood and appreciated how privileged they were not to be the ones sitting in the witness box narrating the atrocities, and stopped complaining about what they termed "trivial things"; one actually said that, looking back at the way he lived before, he wished he could erase everything and start afresh, because he now knew what life was, that it was to be valued and cherished. They ended up admiring the victims, the traumatized persons for their resilience, their capacity to adapt, rebound and revive. These victims had outlived their trauma and rebuilt their lives; some of those who had lost entire families had remarried and built new families, some had even forgiven the perpetrators of the genocide and said they were praying for them. They became some kind of "heroes", true models to emulate. Inspired by their example, the interpreters became stronger and with time, they decided to distress and do their job more efficiently to assist in the administration of justice.

Conclusions and recommendations

In light of the foregoing discussions, while there is no doubt that interpreters in general and particularly those working in the specific settings described in this chapter, as part of society, play a major role in making a better world thanks to communication, it is also clear that they face a major challenge as they engage in their profession: the risk of VT and its consequences.

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1 Identify people who could develop VT

For Yassen (1995, p.178) in his study on *Preventing Secondary Traumatic Stress Disorder*, prevention is key to avoiding vicarious trauma. For him: "unless we prepare, plan or attend to the effects of STS, we can cause harm to ourselves, to those who are close to us, or to those who are in our professional care".

I personally believe that preventive measures should be given priority. Some interpreters are completely unaware of the condition and do not know about VT. As noted in this chapter, some interpreters do not realize the toll that their job is taking on them until it is too late. They must do their homework, know what they are engaging themselves in, know their limits and know when to decline an offer should it jeopardize their physical/mental health. In the event they accept these offers, they need to be aware of what may be awaiting them and find out ways to minimize the trauma, and talk to specialists who can give them advice as to what approach to adopt. It must always be borne in mind that, depending on one's profession and particular circumstances in life, the reaction to the trauma events is different and that individuals may experience different effects. Being informed and ready for the possibilities is crucial.

2 Provide counselling

Based on my 16 years of experience in general interpreting across the African continent plus 17 years in a criminal court like the ICTR, a typically traumatic work environment, my proposal is that counsellors be made available to interpreters before they assume duty, while on duty and after their assignment. Depending on the capacity of each interpreter to manage stress and trauma, he/she should see a counsellor on a regular basis and as often as deemed necessary. The interpreter who is taking up the delicate assignment of personifying traumatized persons on a daily basis, and for long hours, needs to have counselling services readily available.

3 Teach people how to address VT

As we can see from what is elucidated above, there are many ways of addressing VT. In my exchanges and conversations with colleagues of the ICTR, described above, we agreed that it is important to understand and identify the trauma, to exchange tips on how to deal with it, things that work, some good practices. Some said they cried when they were overwhelmed with tension, but they also actively looked for things that would make them laugh. Since there was no support mechanism in the ICTR, we agreed to have some informal peer sessions among ourselves to exchange experiences, talk about our problems, and strive together to look for solutions. We further decided to do some research and apply some of the many solutions proposed and to adopt the ones that work. For us, at the top of the list of measures that lessened the trauma were physical exercise and reviving spiritual life. We also did our best to leave office matters in the office. Another decision was to spend time with our families, joke, laugh and relax. It really made a huge difference.

4 Learn lessons from VT

It is noteworthy that we find solace in the discovery that there is a silver lining to this stress and attendant VT, namely, vicarious transformation and vicarious resilience as defined above. There certainly is something positive in the impact caused by those who manage this situation well and come out enriched. They feel that they are better persons inside for having witnessed all they

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heard, saw and felt in the exercise of their duties. As a result of the resilience developed, they feel victorious and stronger.

As regards the way forward, what emerges is primarily the fact that this situation must be addressed, for it would be preposterous, not to say tragic, if interpreters, like rescue squads, set out to save lives, yet ended up losing their own. Similarities with criminal court judges can easily be seen in the amount of physical, psychological, material and spiritual damage that is revealed in the wake of thousands of hours put in by interpreters in traumatic situations. Just what the future will be for any of us who worked at the ICTR is yet to be determined.

Further reading

Berscheit, K.A., 2013. *A Systems View of Early Interventions for Vicarious Trauma: Managing Secondary Trauma Stress*. MSW at the St. Catherine University and University of St Thomas. Available at <http://sophia.stkate.edu/msw_papers/151> [Accessed 30.03.2014]

The purpose of this study was to identify the best mechanisms of prevention and interventions for STS and VT to develop a systems protocol to shield therapists from the impact of working with traumatized clients.

Munroe, J.F. *et al.,* 1995. Preventing Compassion Fatigue: A Team Treatment Model. In: C. R. Figley, ed. 1995. *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. pp. 209–31. New York: Brunner/Mazel.

This article recommends that treatment teams prevent secondary trauma in therapists by identifying and altering trauma engagement patterns.

Richardson, J.I., 2001. Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers. *National Clearinghouse on Family Violence*, Ontario Canada, [online]. Available at: www.crvawc.ca/documents/guidebook%20on %20vicarious.pdf [Accessed 30.03.2014].

This guidebook focuses on violence against women, the trauma suffered by them and by those helping them and actions to be taken to end that trauma and the suffering.

Rubio-Fitzpatrick, L. LPC. DAPA, Interpreting, Trauma and Vicarious Trauma. [online] Available at: http://www.arlingtonva.us/departments/CountyManager/HumanRights/VT%20LRF%20audience%20final.pdf.pdf [Accessed 30.03.2014].

The author defines the skills and experience required for interpreters working with extremely sensitive information and a wide range of emotions.

Sandage, D. and Boerboom, S., (n.d). Interpreter Care: From Personal to Organizational Strategies for Dealing with Job Stress. *Children's Hospital And Clinics of MN*, [online]. Available at: http://www.docstoc.com/docs/121316371/Interpreter-Care-From-Personal-to-Organizational-Strategies-for [Accessed 30.03.2014].

The authors focus on the stress of the interpreter in a hospital setting, dealing with trauma and traumatic material and suggests ways to cope with stress.

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