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Humanity Crew

Evaluation of Refugee Interpreters' Wellbeing

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Executive Summary

This study aims to examine the relationship between being a refugee with possible trauma exposure who interprets the traumatic experiences of other refugees in mental health settings. To answer this question, a literature review was conducted, and a survey aimed at refugee interpreters was constructed. The goal of this study is to provide a blueprint for establishing the existence of the problem so that if it is determined that there is a problem, subsequent research can be conducted on the scope, magnitude, and best practices for addressing it.

The literature review focused on establishing that there are negative mental health impacts for refugee interpreters. To do this, two main things were established:

1.) There are negative mental health effects associated with working as a mental health interpreter

2.) There are negative mental health effects associated with being a refugee.

Establishing these two facts establishes that the interaction between being a mental health interpreter and a refugee could also create negative mental health impacts. The literature in the literature review was also used a basis for constructing a survey aimed at refugee interpreters.

The survey was constructed to formally establish a connection between being a refugee and a mental health interpreter. The survey was constructed using questions from the Harvard Trauma Questionnaire (HQ-5) and the World Health Organization Composite International Diagnostic Interview based World Mental Health Survey initiative (WMH-CIDI and consulting with Humanity Crew. The questions included in the survey focused on PTSD, depression and anxiety as the literature review shows that those mental illnesses are the most prolific amongst interpreters and refugees.

The survey was not disseminated, so a plan for data analysis was identified in lieu of formal data analysis. For questions that came from the World Health organization, each question was categorized by the WHO as relating to PTSD, depression, or anxiety. Questions included from the Harvard Trauma Questionnaire were not formally categorized into a clear category of mental illness. The DSM-5 PTSD category was used as a means for establishing possible diagnoses from the HQ-5 questions and the questions constructed in consultation with Humanity Crew.

1. Introduction

The world is currently in the midst of one of the largest refugee crises in modern history (Bayes, 2018). These crises are partly the result of conflict and partly the result of the growing effects of climate change. Each crisis comes with stressors that are unique and stressors that may be generalizable to all causes of displacement. It is important to identify these unique and common stressors and how they impact physical and mental health. In 2009, there were 36 million recorded number of refugees for climate change alone (Bayes, 2018). This does not include the increasing number of political refugees (Bayes, 2018). Which means that there are potentially millions of displaced persons who are in need of the provision of medical services.

Humanity crew is an organization that was founded in 2015 in Greece with the purpose of providing mental health services to displaced persons (Humanity Crew, 2015). During the prevision of these services interpreters are sometimes utilized by centers, camps, and other organizations. The interpreters who provide interpretations between local mental health experts and their patients are sometimes refugees themselves. These interpreters are utilized during group therapy sessions and the concern is that having to repeatedly translate potentially traumatic stories may cause the interpreters to relive their own traumatic experiences or at least cause some level of distress. These interpreters may have no formalized mental health support. The research I am doing is twofold. The first element is identifying the magnitude of the problem and the second element is coming up with a guidebook of possible solutions.

2. Literature Review

In order to understand the mental health effects of being both a displaced person and a mental health interpreter, it is important to understand the individual effects of both. There exists relatively little research on the interactions between displacement and providing services to the displaced. Research has shown individually, however, that there are negative mental health implications for both. Given that there are negative mental health effects associated with being displaced and with providing mental health interpretation, this guidebook relies on the assumption that refugee interpreters may experience negative mental health effects.

2.1 The mental health effects of displacement

There are severe physical and mental health problems associated with displacement. Negative mental health impacts include post-traumatic stress, anxiety and depression (Mollica et al., 2011; Farhat et al., 2018). A study conducted by Farhat et al. (2018) found that between 31% and 77.5% of refugees fleeing the Syrian crisis by traveling to Greece experienced at least one violent event while in Syria (Farhat et al., 2018). Between 24.8-57.5% experienced violence during the journey to Greece, and between 5–8% experienced violence within their Greek settlement (Farhat et al., 2018). Additionally, 75-92% of study respondents were diagnosed with anxiety disorder (Farhat et al., 2018). But, only 69-82% of respondents accepted professional mental health intervention (Farhat et al., 2018). Another study conducted in Turkey found that 33.5% of Syrian refugees suffered from post-traumatic stress disorder. And, that number was as high as 71% when participants possessed certain characteristics such as being female and having exposure to 2 or more traumatic events (Alpak et al., 2014).

Women and children are uniquely vulnerable to the negative mental health impacts of displacement as they are more likely to be direct victims of violence (Charles & Denman, 2013). While mortality rates are higher among male refugees, women are disproportionately affected by mental illnesses or disorders (Mollica et al., 2001). A study conducted by Hollander et al. (2011) found that female refugees had worse mental health outcomes when compared to immigrant women while male refugees had the same mental health outcomes as immigrant men. Unaccompanied minors also seem to suffer from the long-term mental health consequences of displacement (Vervliet et al., 2014). Symptoms of depression were less likely to fade for them than non-refugee youth who suffered from depression (Vervliet et al., 2014).

Experiencing the negative mental health effects of displacement is not only contingent on recent exposure to trauma. Negative mental health effects can persist well past immediate exposure. In fact, refugees fleeing conflict may experience detrimental mental health consequences during the resettlement process (Bojic et al., 2015). For example, according to a study conducted by Mollica et el. (2001), 45% of Bosnian refugees who were diagnosed with depression or PTSD retained their diagnoses during the resettlement process. And, even with consistent group counseling, resettled refugees who have been exposed to trauma can experience their symptoms worsening years after resettlement (Drožđek et al., 2013).

2.2 The mental health effects of re-living trauma

Because refugee interpreters are at risk of reliving personal trauma through translating the traumatic events experienced by others, it is important to understand the mental health effects of re-living trauma. Reliving trauma is intrinsically connected to Post Traumatic stress disorder (Nickerson et al., 2014). The core symptom of PTSD is remembering and re-living trauma, but standard definitions of PTSD may not be enough to encapsulate the intensity of reliving the type of trauma experienced by displaced persons, particularly those who were displaced due to war (Nickerson et al., 2014). One major cause of PTSD has been identified as mental conditioning through a combination of experiencing extreme fear with concurrent exposure to a stressful stimulus (Nickerson et al., 2014). The negative implications of re-living trauma can be felt on an individual and community level (Kevers et al., 2016).

Reliving trauma can cause negative mental health effects that go beyond post-traumatic stress disorder or depression (Nickerson et al., 2014). These other negative mental health effects include "profound and impair[ed] changes to self-concept, self-efficacy, and core existential beliefs, as well as pervasive feelings of anger, humiliation, and betrayal" (Nickerson et al., 2014). They also include community distrust, cultural shock, and maladaptation (Somasundaram, 2014). Research suggests that re-living trauma can cause intrapersonal and interpersonal negative mental health outcomes.

Collective trauma is another way of reliving trauma. Collective trauma can result when communities have undergone similar traumatic events together (Somasundaram, 2014). In this regard, trauma is felt not only internally within individuals but also through interactions with community members who have experienced trauma (Kevers et al., 2016). An example of what could incite collective trauma is experiences of war and natural disasters (Somasundaram, 2014). For refugees living in resettlement areas, there is collective trauma because of "family separation, perceived stigma and distrust in the community" (Kevers et al., 2016). Presentation of PTSD and collective trauma vary across cultures as each culture has its own concepts of self, community, death, history, memory, and suffering (Kevers et al., 2016). Given that presentations of trauma can vary culturally, it is important for mental health practitioners and organizations to carefully consider the cultural contexts of the individual interpreters that they utilize. Some interpreters may present symptoms in ways that vary from western clinical interpretations of PTSD (Kevers et al., 2016).

2.3 The mental health effects of interpreting trauma

This section of the literature review mainly focuses on the mental health of interpreters who are not refugees. Little research has been conducted on interpreters who are refugees.

Working as an interpreter can cause a variety of negative mental health effects (Doherty et al., 2010). Recent literature has begun to focus on the mental health effect on those who provide psychological interpretation services. A study by Doherty et al. (2010) found that 56% of interpreters who participated in the study reported negative mental health effects from providing interpretation services. 56% also reported contemplating the information they interpreted for up to thirty minutes after a session (Doherty et al., 2010). And, 22% reported mental distress within the past week of providing an interpretation session (Doherty et al., 2010). A study by Splevins et al. (2010) found four themes emerged for how interpreters responded to interpreting traumatic information. These four themes were: feeling empathy for the client, feeling the contents of what they interpreted were so shocking as to be hard to believe, feeling as if they needed to find their own personal ways to cope with what they interpreted and feeling as if their perspective of the world and themselves had fundamentally shifted (Splevins, 2010). This suggests that there are potential emotional repercussions to mental health interpreting.

The dynamics between interpreters, refugees, and mental health professionals are imperative for healthy professional interactions for interpreters (Holmgren et al., 2003). When asked to provide suggestions for how their work environment could better support their personal mental health, frequent breaks and discussions of the material of upcoming group therapy sessions were provided as suggestions (Holmgren et al., 2003). There can be tension between interpreters and mental health professionals that may contribute to a negative work environment. Interpreters and mental health professionals have expressed concern over the lack of clarity of what the interpreter's role should be (Resera, 2015; Gartley & Due, 2016). Interpreters indicate that they sometimes feel as if they have to play a more therapeutic role to the clients and act as a "cultural broker" to the mental health professionals (Resera, 2014; Gartley & Due, 2016). Mental health professionals have expressed concerns over interpreters providing too much input and not providing direct interpretations (Gartley & Due, 2016). It is clear that best practices need to be established to determine how interpreters and mental health professionals should interact.

3. Data Collection and Methodology

3.1. Data Collection

A survey was constructed to establish a linkage between being a mental health interpreter and a refugee. This survey was designed to be disseminated to the refugee mental health interpreters with the intent of the information provided to inform on how to address these mental health concerns. The goal of the survey is for interpreters, centers/shelters/organizations/camps, and Humanity Crew to be able to identify distressed interpreters. Then, upon identifying distressed interpreters, be able to provide resources that can be utilized to mitigate the distress. Ideally, data would be collected within the centers, shelters, organizations, and camps.

3.2. Methodology

In terms of construction of the survey, the survey consisted of questions from four sources. These three sources included Humanity Crew, the Harvard Trauma Questionnaire (HQ-5) for measuring torture, trauma, and DSM-5 PTSD symptoms in refugee populations and the World Health Organization Composite International Diagnostic Interview based World Mental Health Survey initiative (WMH-CIDI).

The questions selected from HQ-5 were from the sections concerning post-traumatic stress (PTSD), and Skills, Physical, Intellectual, Emotional, Social, and Spiritual/Existential (SPIESS). The PTSD portion of the survey covers general trauma exposure while the SPIESS portion covers questions that can be adapted for specific cultural contexts.

The questions selected from the WMH-CIDI were from the 30-day functioning, PTSD, depression, and general anxiety sections. These sections were selected because the literature suggests that these particular mental health concerns are the most prevalent among refugee populations.

Additional questions were included after consultation with Humanity Crew. These additional questions are based on the assumption that male and female refugees have exposure to different types of trauma and express signs of trauma exposure differently (Daod, Personal Communication, 2019). It was established that male refugees externalize trauma more than female refugees.

4. Plans for Data Analysis

Demographic Questions

1. Gender

After consulting with the client, it was determined that male and female interpreters may have different experiences and may express signs of trauma differently. Therefore, gender is included to determine if men and women indicate different expressions of trauma symptoms. If this is formally determined to be the case, then future studies should be conducted on the best resources to provide for male and female refugees.

2. Country of Origin

This question helps establish the scope of the problem. In particular, it helps to establish if refugee interpreters from specific countries are experiencing higher rates of negative mental health impacts. This question coupled with the questions on fleeing conflict or natural disaster helps establish which global events elicited the greatest mental health impacts.

3. Work Facility and Facility Location

This question was included to understand which facilities that utilize refugee interpreters are in need of the most resources. It is also a way of determining how many refugees work for any given center, camp, shelter, organization.

Tools for Analysis:

Below, the criteria for identifying PTSD, anxiety, and depression are included from the DSM-5. These criteria should be used as guidelines for licensed psychologists for providing mental health diagnoses from the remaining survey questions.

Posttraumatic Stress Disorder

Diagnostic Criteria

309.81 (F43.10)

Posttraumatic Stress Disorder

- **Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
        - **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

    1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
        - **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
    2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
        - **Note:** In children, there may be frightening dreams without recognizable content.
    3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
        - **Note:** In children, trauma-specific reenactment may occur in play.
    4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
    5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

    1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

- **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
    1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
    2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

- **Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

- **With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Source: DSM-5

Generalized Anxiety Disorder

Diagnostic Criteria

300.02 (F41.1)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
    - **Note:** Only one item is required in children.

    1. Restlessness or feeling keyed up or on edge.
    2. Being easily fatigued.
    3. Difficulty concentrating or mind going blank.
    4. Irritability.
    5. Muscle tension.
    6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
B. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
D. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Source: DSM-5

Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- **Note:** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in an MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of an MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of an MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in an MDE. In grief, self-esteem is generally preserved, whereas in an MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently

enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in an MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
E. There has never been a manic episode or a hypomanic episode.
    - **Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Source: DSM-5

World Health Organization Composite International Diagnostic Interview based World Mental Health Survey initiative (WMH-CIDI Questions

The questions selected from the World Health Organization originated from the PTSD, anxiety 30-day functioning and depression sections of the World Mental Health (WMH-CIDI) survey. These questions were edited to increase relevancy to this particular population. These questions were edited further for clarity and to allow for easier translation. The final version that includes edits for clarity is included in the appendix. The questions from the WHO survey include:

4. How many days out of the past 30 did it take an extreme effort to perform up to your usual level at work or at your other normal daily activities because of problems with your mental health?

This question falls under the 30-day functioning portion of the WMH-CIDI. This question was chosen because it demonstrates the frequency of mental health symptoms disrupting refugee interpreters' lives. Guidelines for interpreting the answers from this question were not readily available from the WHO, therefore guidelines were established with consultation from Humanity Crew, in the future, reaching out to the WHO on how they interpret answers to this question should be considered.

5. How many episodes of (worry or anxiety/nervousness or anxiety/anxiety or worry) lasting one week or longer have you had since you first became an interpreter?

This question is also contained within the 30-day functioning portion of the WMH-CIDI. Like the previous question, plans for analyzing this question was established with consultation with Humanity Crew and the DSM-5 in lieu of the WHO. This question was included because it focuses on frequency of anxiety symptoms. As identified from the literature review, anxiety is a key mental health challenge that refugees and interpreters face.

6. Did you ever have a period following an interpretation session of being (sad/or/discouraged/or/uninterested in things) that lasted most of the day, nearly every day, for two weeks or longer?

This question is similar to the other questions selected from the 30-day functioning portion of the WHM-CIDI. It is included because it focuses on the frequency of depressive type symptoms. Answers from this question will also need to be interpreted using measures outside the WHO or even potentially the DSM-5.

7. Were you ever a refugee – that is, did you ever flee from your home to a foreign country or place to escape danger or persecution?

This question was selected from the PTSD portion of the WMH-CIDI survey. This question was included because it provides insight into the type of event that caused the initial trauma. Knowing what type of event caused the initial (and subsequent) trauma could provide insight into what type of trauma exposure causes negative mental health impacts. Particularly if persecution or danger was the initial trauma. This question could be examined using guidelines from the WHO and/or the DSM-5 PTSD criteria included above.

8. Did you ever live as a civilian in a place where there was ongoing terror of civilians for political, ethnic, religious or other reasons?

This question was selected from the PTSD portion of the WMH-CIDI survey. This question was included because it provides insight into the type of event that caused the initial trauma. Knowing what type of event caused the initial (and subsequent) trauma could provide insight into what type of trauma exposure causes negative mental health impacts. Particularly if terror exposure was the initial trauma. This question could be examined using guidelines from the WHO and/or the DSM-5 PTSD criteria included above.

9. Were you ever involved in a major natural disaster, like a devastating flood, hurricane, or earthquake?

This question was selected from the PTSD portion of the WMH-CIDI survey. This question was included because it provides insight into the type of event that caused the initial trauma. Knowing what type of event caused the initial (and subsequent) trauma could provide insight into what type of trauma exposure causes negative mental health impacts. Particularly if a natural disaster was the initial trauma. This question could be examined using guidelines from the WHO and/or the DSM-5 PTSD criteria included above.

Harvard Trauma Questionnaire (HQ-5)

10. Do you experience the following?:

- Avoiding thoughts, feelings, or activities that remind you of traumatic events
- Sudden emotional or physical reaction when reminded of traumatic events
- Strong feeling of fear, horror, anger, guilt or shame when thinking about traumatic events
- Work brings back bad memories

This question was selected from the PTSD portion of the HQ-5. The question was included because it focuses on the internalization of traumatic experiences. It also, contains material on emotional reactions to the work environment which is salient to the experiences of refugee interpreters as their places of work have a high risk of invoking traumatic memories. Responses to this list of questions can be examined using the PTSD criteria contained in the DSM-5 PTSD section referenced above.

11. Do you experience the following?:

- Feeling that the skills you had before your stressful experiences are no longer useful or valued
- Feeling powerless to help others
- Feeling that you are the only one that suffered these events
- Having difficulty dealing with new situations

This question was selected from the Skills, Physical, Intellectual, Emotional, Social, and Spiritual/Existential (SPIESS) portion of the HQ-5. The question was included because it focuses on the externalization of traumatic experiences. It was included after discussion with Humanity Crew. Men may be more prone to externalize trauma therefore this

question was included to encompass trauma response in men. Responses to this list of questions can be examined using the PTSD criteria contained in the DSM-5 PTSD section referenced above.

Additional questions

12. Do you frequently argue with loved ones?
13. Do you frequently argue with strangers?
14. How often do you smoke?
15. How often do you drink?

These questions were included after consulting with Humanity Crew. These questions are centered around external expressions of trauma. These questions were included after it was determined that men may engage in more physical expressions of trauma than women. These physical expressions are actions such as smoking, drinking, or getting into verbal altercations.

5. Recommendations and Limitations

Establish a linkage between the mental health effects of being a displaced person and a mental health interpreter.

This requires a comprehensive literature review of research that could potentially answer this question. This includes research on the mental health of interpreters and the mental health of displaced persons. This first step has been covered by this evaluation and can be used as a basis to establish this linkage.

In addition, data pertaining to Humanity Crew and their associated organizations/centers/camps should be collected prior to the conducting of any field work. This data should include an estimate of the total number of interpreters utilized, the number of interpreters for each organization/camp/center, training guidelines for interpreters, the predominant languages spoken by the interpreters, the turnover and retention rate, the number of participants in a single group therapy session, the structure of group therapy sessions, and mental healthcare options currently available and utilized by interpreters

Upon collecting this information, construction of a survey to be disseminated in the field should begin. Ideally, this survey would be disseminated before and after a group therapy session. When administering the survey, it is important to consider who will disseminate it. If the survey is conducted with the aid of someone familiar to the interpreter, it might influence the answers they are likely to give. Conversely, if the person disseminating the survey is unfamiliar to the interpreter, the sensitive nature of the information collected in the survey may cause a low response rate. This would be particularly true if the number of refugees utilized in each individual camp is low. There is the risk of the interpreters feeling as if their personal mental health struggles will be publicized.

Analyzing the data collected in the survey is an important step in establishing if there are mental health effects associated with displaced persons providing mental health interpretation services to other displaced persons. If after analyzing the survey there are indications of negative mental health impacts, focus groups should be conducted to determine if the survey is able to comprehensively include all of the negative mental health effects of interpreting. If after analyzing the survey no indications of negative mental health impacts are observed, a follow up focus group should still be conducted. This focus group would determine if the survey has failed to capture the negative mental health impacts or if there simply aren't any negative mental health impacts of interpreting. It is important that well-trained and trusted mental health professionals administer this survey if possible. This is because it may not be likely that interpreters will be willing to divulge personal information about their mental wellbeing to their colleagues at the facilities where they work or with persons who are unknown to them. In order to guarantee the most honest responses, utilizing trusted professional mental health practitioners would be highly recommended.

Develop a Guidebook on best practices for mental health professionals who utilize interpreters

Once it has been clearly established that being a displaced person and a mental health interpreter can impact mental health, construction of a guidebook on best practices should begin. This guidebook should target best practices for

community centers on recruitment and training of interpreters, mental health practitioners in engaging with interpreters and identifying signs of mental health concerns, and resources provided by Humanity Crew and other organizations that interpreters can utilize if necessary.

The best approach for this guidebook would be to utilize other clinically established guidebooks for interpreters in mental health settings and adapt them to the context of Humanity Crew. As there are no guidebooks that focus on persons who are displaced who provide mental health interpretation services for other displaced persons, the guide created for Humanity Crew would need to be a combination of two different types of guidebooks. The first type to consider would be centered on utilizing interpreters in mental health settings. The second would be on addressing the mental health of refugees. Given that Humanity Crew already possesses best practices for providing mental health services for refugees, constructing the guidebook would rely on the combination of Humanity Crew's existing training with best practices identified from the aforementioned first type of guidebook. Additionally, the guidebook could target community centers and identify how to screen volunteers (possibly through use of the survey) to determine if they might have mental health concerns and need additional resources before they begin interpreting.

For this guidebook humanity crew may want to consider partnering with other organizations who are engaged in similar work. Partnering with other organizations may be a beneficial way of cross-referencing information to ensure best practices that are suitable for a wide array of organizations and facilities are established.

Create an infographic visualization that can be utilized by resettlement camps and community centers

This visualization should be a synthesized version of the guidebook. It should contain best practices for centers and mental health professionals as well as provide interpreters with mental health resources they can utilize if necessary. A basic draft of the infographic was included. The infographic was based off of the 16 signs of trauma from trauma exposure from 'Trauma Stewardship' by Laura Van Dernoot and Connie Burk. The version of the infographic is a simplified version and should be tailored based on the information collected in the survey to align with symptoms of trauma expressed by refugee interpreters.

Recommended plan for disseminating the mental health survey:

Disseminating the survey will take coordinated effort between Humanity Crew and the centers, shelters, and camps that they work with. The best approach to disseminating the survey may vary by location. Given, that that is the case, it is important to integrate feedback from each facility in the plans for carryout the survey. For this report, X amount of centers, shelters, and camps were contacted. The geographic location of these facilities ranged from Galilee to Greece. The centers, shelters, and camps were asked the following set of questions:

1.) How many interpreters does your facility work with?
2.) How were those interpreters recruited?
3.) Have you ever conducted a mental health survey in your facility?
4.) If yes, how did you conduct the survey? How did you collect the survey?
5.) Has anyone else conducted a mental health survey in your facility?
6.) If yes, how did you conduct the survey? How did you collect the survey?

6. Conclusions

There are many aspects that may affect the mental health of refugee interpreters therefore it is important to conduct additional research. To understand how to best help refugee interpreters it is important to establish the scope and magnitude of the problem. In particular, additional research is needed on the following questions. Are particular groups of refugees more prone to negative mental health impacts than others? If so, who are they? What characteristics make them more at risk? Does it vary by types of trauma exposure (for example: exposure to religious persecution versus natural disasters)? Does it vary by length of time between undergoing personal trauma and beginning a career as a mental

health interpreter? Does the international community currently have the capacity to address the mental health needs of the refugee interpreters that are utilized? What resources are currently accessible for refugee interpreters?

Addressing these questions are the first, but not the only step in establishing the impact of mental health interpreting on refugee interpreters. Once, the scope and magnitude of the problem are established, it may be of interest for the international aid community to establish best practices for hiring and utilizing refugee interpreters. These best practices should be researched based and informed from addressing the aforementioned questions on the scope and magnitude of the problem. Appendix 2 contains a list of 16 warning signs of trauma from trauma exposure (Van Dernoot, 2010) that can be used by centers, shelters, and organizations as a general way of assessing trauma from trauma exposure in colleagues. A simplified version for easy translation and the original version is included in this evaluation. It is important to note however, that these warning signs were not constructed with this particular population as the target therefore it is important for future research to determine if there are warning signs that are additional warning signs that are salient for refugee interpreters.

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8. Appendices

Appendix 1: Survey

Interpreter Wellbeing Survey

1. **Gender**

2. **Country of Origin**

3. **Work Facility and Facility Location**

4. **How many days out of the past 30 did it take an extreme effort to perform up to your usual level at work?**

5. **How many episodes of worry, anxiety, or nervousness lasting one week or longer have you had since becoming an interpreter?**

6. **Did you ever have a period following an interpretation session of being sad, discouraged, or uninterested in things that lasted most of the day, nearly every day, or longer?**

7. **Were you ever a refugee – that is, did you ever flee from your home to a foreign country or place to escape danger or persecution?**

8. **Did you ever live as a civilian in a place where there was ongoing terror of civilians for political, ethnic, religious or other reasons?**

9. **Were you ever involved in a major natural disaster, like a devastating flood, hurricane, or earthquake?**

10. **Do you experience the following:**
    Avoiding thoughts, feelings, or activities that remind you of traumatic events
    Sudden emotional or physical reaction when reminded of traumatic events
    Strong feeling of fear, horror, anger, guilt or shame when thinking about traumatic events
    Work brings back bad memories

11. **Do you experience the following:**
    Feeling that the skills you had before your stressful experiences are no longer useful or valued
    Feeling powerless to help others
    Feeling that you are the only one that suffered these events
    Having difficulty dealing with new situations

12. **Do you frequently argue with loved ones?**

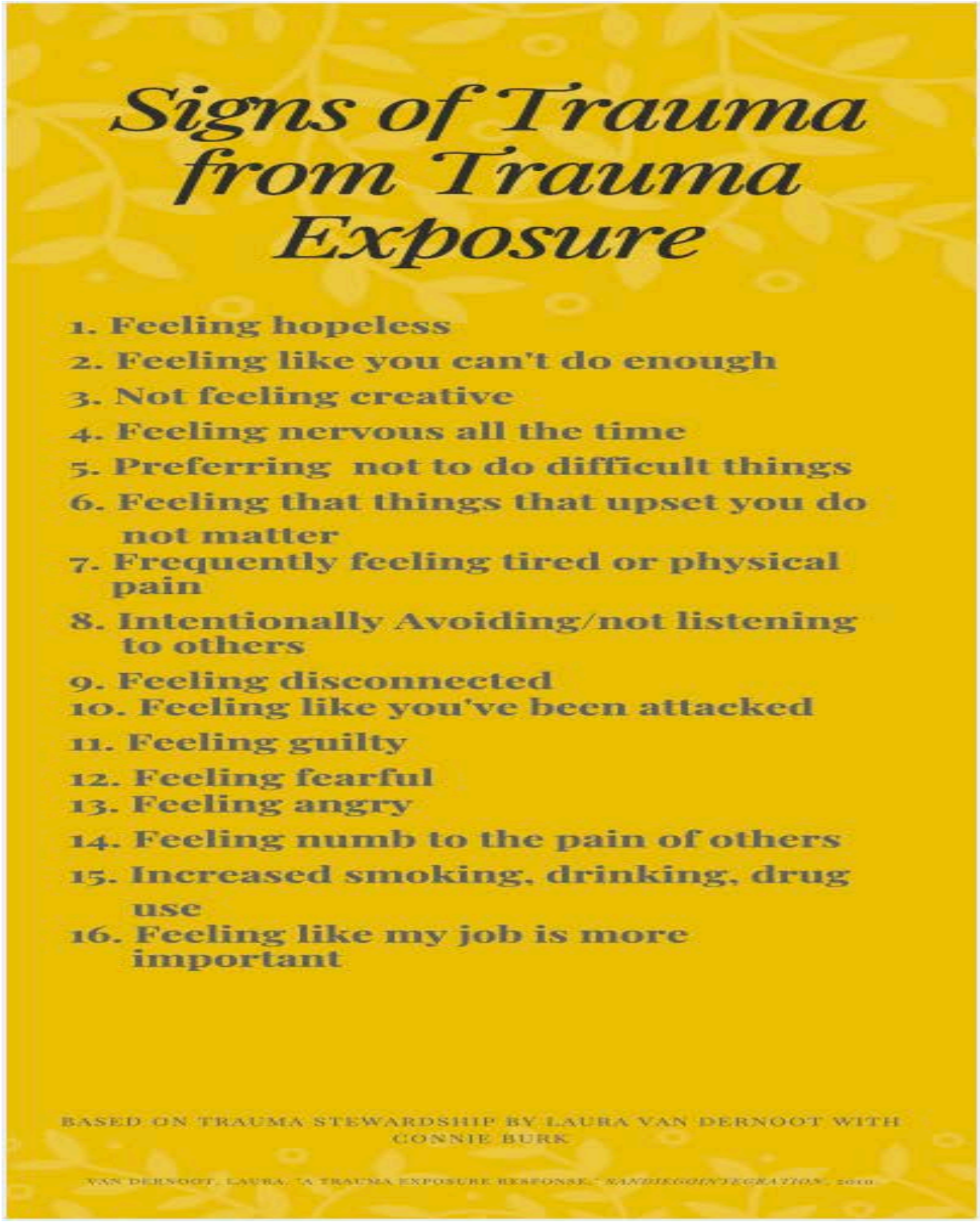
13. **Do you frequently argue with strangers?**

14. **How often do you smoke?**

15. How often do you drink?

Link to Survey Google Form:
https://docs.google.com/forms/d/1OS9g5SA7WRjEYjh8CbuZ7S7NbQ1qlfmnKtADaeT2qQ4/edit

Appendix 2: Infographics



Trauma Exposure Response

A trauma exposure response may be defined as the transformation that takes place within us as a result of exposure to the suffering of other living beings or the planet.