Interpreters' Resilience and Self-care During Pandemic Restrictions in Australia and New Zealand

Ineke Crezee
Auckland University of Technology, NEW ZEALAND
ineke.crezee@aut.ac.nz

Miranda Lai
RMIT University, AUSTRALIA
miranda.lai@rmit.edu.au

ABSTRACT

The onset of the COVID-19 pandemic in 2020 brought about abrupt and lasting changes to the way community interpreting is organized and delivered in Australia and New Zealand. This paper reports on a qualitative study conducted among community interpreters in these two countries, especially those based in Auckland and Melbourne, as both cities went through several periods of strict lockdowns. The study attempts to understand the experiences of the interpreters working remotely or in-person between early 2020 and late 2021, focusing on how they coped with such significant challenges. The findings of the study point to practitioners' conscious efforts in their self-care behavior and resilience-building strategies, both of which were key to maintaining professional and personal wellbeing. It is argued that self-care practices should be embedded in pre-service training and professional development, and appropriate working conditions should be monitored on an ongoing basis.

KEYWORDS: community interpreter, pandemic, self-care, resilience, remote interpreting

1. Introduction

Previous studies on community interpreting have shown that the private nature of the settings community interpreters often work in and their ethical duties to keep confidentiality can make interpreters feel isolated and distressed (cf. Andres and Falk 2009; Bancroft 2017; Lai and Costello 2021; Lai et al. 2015; Wilson 2010). Before the onset of the COVID-19 pandemic in 2020, most community interpreting assignments in Australia and New Zealand involved interpreters working with clients face-to-face. This changed when lockdowns were imposed in many parts of the two countries across the Tasman, making many interpreting assignments take place remotely, for example, via Zoom or other online meeting platforms, or over the phone.

This paper reports on a joint study conducted on New Zealand and Australian community interpreters, especially those based in Auckland and Melbourne, since both cities went through several periods of strict stay-at-home orders and other restrictions. The study attempts to understand the experiences of the interpreters working remotely or in-person between 2020 and 2021, with a focus on how interpreters coped with such significant challenges and what they did to maintain their resilience in such unprecedented times. It is hoped that this study will shed light on interpreters' resilience-building and self-care behavior, which is critical to maintaining the workforce's wellbeing. The findings are expected to benefit other interpreters nationally and internationally, as well as inform interpreting educators about preparing student interpreters for future practice based on understanding possible work and life stressors and the importance of self-care.

2. Background

On 12 January 2020, the World Health Organization (WHO) confirmed that a hitherto unknown respiratory illness found in people in Wuhan, Hubei Province, in the People's Republic of China, was caused by a novel coronavirus (WHO 2020)—later named COVID-19. On 11 March 2020, the WHO declared a worldwide pandemic of this highly transmissible coronavirus (WHO 2020). Countries around the world scrambled to mount a response to COVID-19, including Australia and New Zealand.

2.1 Australia and community interpreting

The first case of COVID-19 in Australia was reported in the state of Victoria on 25 January 2020 in a traveler who had returned from overseas. As a result, Australia closed all its borders

to non-residents on 20 March 2020. Three waves of community spread of the virus ensued: March-April 2020, June-October 2020, and June 2021 to early 2022. In 2021, the Delta variant of SARS-CoV-2 resulted in further lockdowns, affecting almost half of the Australian population and most of its major cities. The state of Victoria endured the longest (reported) lockdown in the world—262 days since March 2020—which was lifted on 21 October 2021 (Paul and Burton 2021). Victoria also recorded the highest number of COVID-19-related deaths nationally, accounting for 37% (n = 3,823) of the total number in Australia as of 31 September 2022 (Australian Bureau of Statistics 2022b).

Australia has a high cultural and linguistic diversity among its 25 million people. More than three hundred languages are spoken in the community, including indigenous languages and Australian Sign Language (Australian Bureau of Statistics 2017). Over one in every five people (21%) speak a language other than English at home (ibid.). Community interpreting services in Australia are publicly funded for residents with little or no English proficiency when they access public services such as healthcare, education, and social welfare or need to interact with courts or the immigration department (Lai 2018; Eser 2020). There are approximately 16,000 interpreters on the register of the National Accreditation Authority for Translators and Interpreters (NAATI) (2021) who provide language mediation services to community members facing language barriers. Those community members include culturally and linguistically diverse backgrounds (5.5 million) (Australian Bureau of Statistics 2022a), Indigenous people (650,000) (Australian Bureau of Statistics n.d.), or Deaf people (16,000) (Deaf Connect 2022).

2.2 Aotearoa New Zealand and community interpreting

In New Zealand, the first case of COVID-19 was identified on 28 February 2020. Cases continued to grow, and on 19 March 2020, the New Zealand borders were closed to non-citizens and non-residents. On 21 March 2020, the government placed the whole country into lockdown. The measure involved the highest level of restrictions and stay-at-home orders, and borders remained closed for much longer (Ministry of Health n.d.). While restrictions were lifted to some extent in most parts of the country, Auckland remained in a form of lockdown until 3 December 2021.

Similar to Australia, New Zealand also has a high cultural and linguistic diversity level, particularly in its largest urban center, Auckland (Statistics New Zealand 2018). Interpreting

in public service settings is also publicly funded, with Mandarin, Samoan, Spanish, Korean, Tongan, Arabic, Cantonese, Hindi, Punjabi, and Portuguese being the top languages for interpreting services for the country's 5.4 million population (Ministry of Business, Innovation and Employment Newsletter, personal communication, May 2022). Most of New Zealand's approximately 940 interpreters (ibid.) work as freelancers, with a small number working as in-house staff interpreters, mainly at health facilities. Before the pandemic hit, there was no pressing need to resort to remote interpreting, and in cases where this was used, it mainly took the form of telephone interpreting. This mirrors the situation in Australia.

3. Literature review

Previous studies have reported on community interpreters' sense of isolation and shown that they can be negatively impacted by the distressing content of interpreting assignments (cf. Lai and Costello 2021; Lai et al. 2015). Sometimes this negative impact can progress into vicarious trauma (VT), which is described by the American Counseling Association (n.d.) as "the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured". Other scholars refer to it as a result of empathic engagement with clients who experienced trauma (Kim et al. 2021; Isobel and Thomas 2022). Interpreters are often what Bancroft (2017: 195) refers to as "the voice of compassion", in that they may have to interpret highly emotional or primarily negative message content, frequently in settings where the receiving party of the message is in a distraught psychological or debilitated physical state (Bontempo and Malcom 2012). In such cases, "an interpreter's repeated exposure to traumatic information and the traumatized states of others can lead to a significant accumulation of occupational stress" (ibid.: 105) and a risk of VT. In a large-scale survey in the Australian state of Victoria involving 271 interpreters (Lai et al. 2015), respondents were asked about their level of exposure to traumatic material in the course of their work, the perceived impact of that material on them, and any support available to them. The researchers found that the risk of vicarious trauma was real for Australian interpreters, while the awareness of it was lacking. They concluded that possible coping strategies and help-seeking behavior needed to be addressed in interpreter education.

Interpreters work in various contexts across assignments, where distressing content may come up expectedly or, sometimes, out of the blue, as is documented by Lai and Costello (2021). Burn and Wong Soon (2020) discussed this in relation to the more predictable

settings such as forensic psychiatry, while Crezee et al. (2013) remind us of the higher vulnerability of interpreters to be re-traumatized when they have their own traumatic experiences to deal with, particularly in refugee settings. In the context of the COVID-19 pandemic, interpreters may also experience enhanced vulnerability either due to the negative impact of the illness within their circle or the mere accumulation of assignments involving traumatic content relating to the topic, or both. This phenomenon is not unique to the interpreting profession. Aafjes-van Doorn et al. (2022) explored posttraumatic growth and resilience among therapists and found that the COVID-19 pandemic posed additional challenges for therapists. They write: "… besides the general societal impact of the pandemic-related restrictions and personal impact of therapists' own losses and health concerns, the pandemic also increased the likelihood of vicarious traumatization and increased professional self-doubt (PSD)" (Aafjes-van Doorn et al. 2022: S166).

Interpreting is a mentally demanding activity involving a transfer of meaning between two languages in a manner appropriate to the communicative context. Transferential experiences are well-documented due to interpreters' empathic engagement and over-identification reactions through rendering the narratives in the first-person (cf. Bot 2005; Doherty et al. 2010; Gomez 2012; Louis et al. 1999). Interpreters in Shakespeare's (2012) study described how they felt they became their client, using their tone, body language, and words, thus losing themselves in the interaction. Interpreting traumatic stories in the first-person will bring the content of what is interpreted closer to home. Consequently, interpreting becomes far more intense than just hearing the words (Splevins et al. 2010). This may have had an additional impact on interpreters in a situation where all potential work stressors (e.g., traumatic client content, cognitive load) and life stressors (e.g., relationship issues, loss, work-life balance) became magnified during the pandemic, with many services (especially in the health setting) and service users impacted by ongoing uncertainties and adverse events.

3.1 *Vicarious trauma or burnout?*

As stated before, VT is often found in helping professions and relates to the process of traumatization owing to the accumulation of emotional residue in the professional whose work calls for empathic engagement with clients who experienced trauma. However, it should be noted that, while VT can manifest in short-term symptoms, it can progress to deleterious effects in the long term. McCann and Pearlman (1990), who were among the vanguard for VT research in the so-called helping professionals, assert that it alters a person's

cognitive schemas, beliefs, and assumptions beneath consciousness, leading to profound changes in core aspects of the self, understanding of the world, and interactions with others (Pearlman and Saakvitne 1995).

Burnout, on the other hand, is a different phenomenon. According to the WHO (2019), the International Classification of Diseases (ICD-11) defines burnout as a syndrome "resulting from chronic workplace stress that has not been successfully managed" (para. 4). It is characterized by three dimensions: "feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy" (para. 5-7). While the ICD-11 stresses that "burnout relates specifically to phenomena in the occupational context" (para. 1), it is difficult to see how work-related burnout would not also impact individuals in other spheres of their lives.

Burnout and VT can be conceptualized as occupational hazards at different points of a continuum (Argentero and Setti 2011; Sabo 2011; Salloum et al. 2015). However, it is important not to confuse the two, as burnout does not involve traumatic client content, while VT does. What is clear for the interpreting profession is that, like other helping professions, not seeking help while facing work stress may result in burnout (Crezee 2015; Eelen et al. 2014), whereas structured support can improve interpreters' coping skills to address psychosocial stressors at work (Park et al. 2017).

3.2 *Interpreting in isolation*

Earlier studies (cf. Wilson 2010) found that interpreters who work remotely may feel unable to debrief after assignments because they work in isolation from other parties. Some scholars (cf. Andres and Falk 2009) have suggested that interpreters may experience higher levels of stress when interpreting remotely rather than onsite. For example, Schnack (2020) comments on the feelings of social isolation, anxiety, and stress experienced by signed language interpreters undertaking video relay service assignments remotely while working from home (instead of from a call center) during the COVID pandemic. Conversely, Cheng (2015) interviewed and surveyed two small samples of New Zealand-based interpreters and found that the latter did not experience a sense of isolation when undertaking telephone interpreting. All of Cheng's (2015) interviewees undertook a mixture of online and onsite interpreting assignments, which may have prevented them from feeling completely isolated.
During the pandemic, working in isolation became a necessity, aimed at keeping all parties in the interaction safe from infection. In April 2021, Marks wrote about the impact of such

working conditions on medical interpreters. Marks (2021) describes the work of Cerna, a Spanish-speaking interpreter who had been receiving many COVID-19 related calls, often involving end-of-life discussions with patients who were struggling to breathe or delivering bad news to their relatives outside of the United States. Marks (2021) writes: "Each time, when the call ended, Cerna was left alone to absorb the experience. 'I'd have one after the other after the other after the other, and I would feel just sad and drained,' she said. 'Many times, I would cry by myself in my home alone, because there would be nobody to talk to'" (para. 4).

As stated, pre-COVID studies also showed that interpreters are at risk of developing VT and burnout and that this risk is increased when they have to work in isolation. The pandemic thus enhanced the risks of VT and burnout, as interpreters often had to both tackle challenging interpreting assignments and work remotely while in lockdown. Self-care would have been an important coping strategy to help interpreters develop their resilience and maintain their mental wellbeing (Lai and Costello 2021; Park et al. 2017), especially with lockdowns continuing with no clear end in sight. In the following subsections, we will look at the literature on self-care and resilience before moving to studies investigating the effects of working remotely on interpreters.

3.3 Self-care

The concept of self-care has attracted a lot of attention, especially in health research and in relation to the management of chronic illness (Riegel et al. 2021). As Lee and Miller (2013) assert, there is no consensus in the literature for a single conceptualization of self-care, with some describing it as a process and others as an ability. However, most often, it is presented as engagement in particular behaviors that may promote a sense of subjective wellbeing, a healthy lifestyle, stress relief, and resilience, and prevent compassion fatigue. Lee and Miller (2013) further differentiate between personal and professional self-care. They define personal self-care as "a process of purposeful engagement in practices that promote holistic health and well-being of the self" (ibid.: 98), while describing professional self-care as the application of these same concepts for an "effective and appropriate use of the self in the professional role" (ibid.: 98).

Miller et al. (2018) conducted semi-structured interviews with 24 doctors and nurses working in palliative care settings in Australia, and identified barriers to self-care practice, as well as enablers. The authors concluded that self-care needs to be holistic and proactive, achieved

through a range of "personalized selfcare strategies" in both personal and professional settings. For interpreters, Crezee (2015) recommended that educators teach students about self-care, including the ability to recognize the first signs of being negatively impacted by the content of interpreting assignments. In this article, the authors will use the term 'self-care' to refer to practices undertaken by the individual to maintain their resilience and mental health, and to mitigate the risk of developing VT, workplace stress and compassion fatigue (cf. Miller et al. 2018).

US psychologists Saakvitne and Pearlman (1996) emphasize the importance of selfcare and suggest helping professionals to reflect on their selfcare practice using a six-item inventory: physical, psychological, emotional, spiritual, professional, and work-life balance. They assert strategies encompassing these aspects will help the professionals to assess, address, and transform their VT; they will also make them feel less alone when attempting to counter the impacts of the occupational hazard.

3.4 Resilience

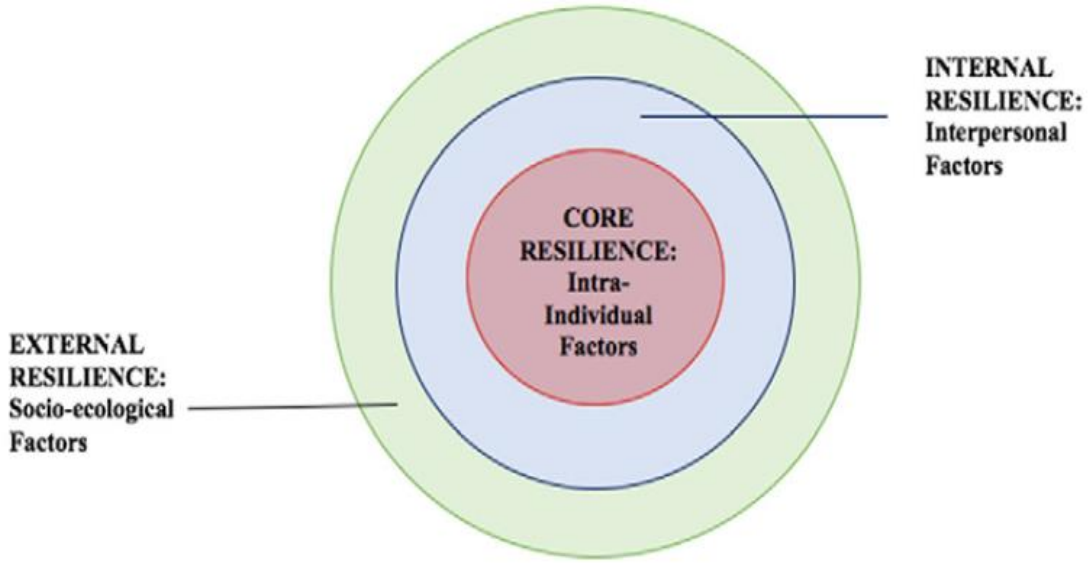
Similar to the construct of self-care, resilience is defined heterogeneously in the literature, including as an outcome, as a coping strategy, and as a trait (Luthar and Cichetti 2000). Whereas no universal definition of resilience exists, there seems to be a convergence on the suggestion that it is "positive adaption in the face of adversity…[and it is] a higher-order construct which draws upon other underlying constructs as part of the adaptive process" (Kunicki and Harlow 2020: 330). In this sense, the definition of resilience by the American Psychological Association (2022) in lay language works well: "the process of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (para. 1). Bonanno (2004) also highlights resilience as a process, arguing that there are multiple and sometimes unexpected pathways to resilience. Similarly, Aafjes-van Doorn et al. (2022: S166) identify the time factor by describing resilience as being "characterized by a temporary decrease in functioning followed by a stable trajectory toward recovery and an ability to adapt and move forward in a positive, integrated way". The American Psychological Association (2022) adds a number of factors that help people adapt to adversities, including access to social support, while Kunicki and Harlow (2020) hold that six constructs underlie resilience: self-esteem, purpose in life, life satisfaction, social support, cognitive flexibility, and proactive coping.

Researchers have further described positive changes in the aftermath of adverse events as posttraumatic growth (cf. Arnold et al. 2005; Linley and Joseph 2005; Tedeschi and Calhoun 1995; Calhoun and Tedeschi 2013). In Spain, Garrido-Hernansaiz et al. (2022) analyzed the presence of posttraumatic growth in healthcare workers during the COVID-19 pandemic, also including spirituality, religiosity and meaning through purpose in life. Interpreters and healthcare workers both work closely with people who are in a vulnerable situation, and the above findings could therefore apply to the former as well.

Park et al. (2017) conducted a two-phase study to test a targeted resilience program with interpreters working at three hospitals in Boston (USA). Phase 1 of their study involved focus groups which revealed that "stressors were patient-based (seeing young patients decline), interactions with medical team (unsure of role), and systems-based (appointment unpredictability)" and that interpreters had low coping skills (Park et al. 2017: 1181). The authors found that their resilience program which targeted the needs of the interpreters identified in Phase 1, resulted in interpreters having improved "stress reactivity". This study suggests that, when offered structured support, interpreters are able to develop skills to better cope with work-related stressors. In a similar vein, research by Goldhirsch et al. (2021) at the same hospitals further implemented a 6-session dialogue-based course involving hospital interpreters and clinicians in palliative care. It confirmed that interpreters became more confident in working with the clinicians to facilitate end-of-life conversations and felt more empowered after the intervention. In other words, interpreters had been able to develop a certain amount of resilience in dealing with the aforementioned stressors.

Liu et al. (2017) present an integrative and multi-system model featuring three layers of resilience (Figure 1). This model distinguishes between core resilience, internal and external resilience. Core resilience is described by the authors as intra-individual factors which consist of characteristics within an individual representative of trait resilience. Internal resilience involves interpersonal factors consisting of personality determinants—developed or acquired over time through social interactions and experiences—representative of psychological resilience. Lastly, external resilience involves socio-ecological factors—consisting of larger formal and informal institutions that facilitate coping and adjustment—representative of community resilience. We will return to these types of resilience in the findings section.

Figure 1. Multi-systems model of resilience (Liu et al. 2017: 114)



4. The study

The current study follows the qualitative paradigm in an attempt to answer four research questions. As both authors work as community interpreters and are, therefore, familiar with the field of community interpreting in the Australian and New Zealand contexts, the study involves the principles of action research. According to said approach, practitioner-researchers reflect on their practice to see whether it is as they feel it should be; when they feel the practice needs attention in certain aspects, they identify a topic to investigate with an aim to improve it (McNiff 2013). The research questions are as follows:

1. How has the provision of interpreting services changed since the pandemic?
2. What are the challenging aspects in response to the changes?
3. Are there any advantages compared to pre-pandemic?
4. How do interpreters maintain self-care and build resilience?

The original project design involved individual interviews in person, followed by focus group discussions. However, ongoing restrictions meant the authors had to change the method to a survey using a questionnaire containing open-ended questions emailed to participants. All participants were sent a summary of the findings and asked if they wanted to have some final input, but only one out of 52 participants replied by expressing support for the study but did not provide any specific feedback to the summary.

4.1 Participants

Advertisements were posted on the website of the New Zealand Society of Translators and Interpreters (NZSTI) as well as in the newsletters of NAATI and the Australian Institute of Interpreters and Translators (AUSIT). Random sampling was used in that interested interpreters were urged to contact the researchers to take part in the survey. The researchers then emailed a questionnaire containing 12 open-ended questions (see Appendix) for them to complete and return electronically. If they held NAATI certification, they were able to claim professional development (PD) points for re-certification, as per NAATI guidelines. NAATI's research endorsement incentivizes practitioners to be involved in relevant studies, which may generate findings relevant to their profession and practice. Ethics approval was gained from the University Ethics Committee at Auckland University of Technology under number 21/178 and included a data-sharing arrangement with RMIT University in Melbourne, Australia.

At the time of writing, a total of 52 returned questionnaires had been received and analyzed. Of the 52 responses reported in this article, 15 practitioners (roughly 30%) were based in New Zealand and 37 in Australia. No further demographic information was collected to avoid being too intrusive, as both researchers were in direct email contact with individual participants. Furthermore, the focus of the study was on resilience and self-care, rather than attempting to analyze reported experiences against linguistic and cultural backgrounds, hence the decision not to ask participants about their working languages.

All Australian participants were certified by NAATI, while the New Zealand practitioners were not. New Zealand is in the process of transitioning to compulsory NAATI certification for interpreting practitioners by 2024 (Ministry of Business, Innovation and Employment n.d.), and the number of NAATI-certified interpreters in the country is currently low. At the time of recruitment, NZSTI membership was granted only to interpreters who had completed interpreter education at the tertiary level, either within New Zealand or overseas. Whether NAATI certified interpreters in Australia have had training about self-care is hard to ascertain, although the awareness of interpreters' possible vicarious traumatization and the provision of counselling support by language service providers is growing (Lai and Costello 2021). At the universities where the current authors are respectively based, vicarious traumatization and self-care are covered in both the vocational and/or master's programs.

4.2 Data analysis

An inductive approach (Willig 2013) under the qualitative paradigm was used to analyze the data, and, therefore, the themes that emerge from this process are "firmly grounded in the data and do not reflect the researcher's theoretical commitments" (Willig 2013: 60). Using Nvivo 12 for the qualitative content analysis, the researchers followed the six steps of thematic analysis recommended by Braun and Clarke (2006), with adjustments to suit the nature of the data collected. They first read all the questionnaires for familiarization (Step 1), followed by independent coding of a random sample of half a dozen questionnaires from New Zealand by the first author and Australia by the second author (a revised Step 2). This, in turn, enabled them to identify what they regarded as central issues from the samples (Step 3). The reason for a revised Step 2 was because the researchers regard the written data collected through open-ended questions via the questionnaire are much more structured than live interviews and focus groups, where discussions tend to be more organic and fluid. When they conferred to review the themes after coding the samples (Step 4), they were proven right, as this process revealed the researchers identified similar meanings from the data. They discussed their differences and arrived at a final agreement about the definitions and themes (Step 5). The rest of the coding followed the agreed coding scheme smoothly, enabling the researchers to construct a holistic context of the phenomenon under study with enhanced trustworthiness.

As action researchers, both authors demonstrate certain sets of beliefs, commitments, and hopes they share with their fellow practitioners (McNiff 2013). The authors, therefore, were mindful of "suspending (bracketing) as much as possible the researcher's meanings and interpretations and entering into the world of the unique individual" (Hycner 1985: 281). In doing so, the authors attempted to let the participants' contribution speak without imposing their own positionality on the data and findings.

Employing an overall inductive approach is deemed appropriate as the pandemic is unprecedented, so data generated from the questionnaire are suitable to be explored from the bottom up (Willig 2013). However, the researchers also regard that aspects relating to the participants' coping in the face of hardship should be understood from existing selfcare and resilience frameworks well established in trauma literature. Therefore, such data collected under questions 8 and 11 in the questionnaire were further analyzed deductively, i.e., from the top down (Willig 2013). Saakvitne and Pearlman's (1996) six-item self-care inventory was chosen to analyze the participants' selfcare strategies, because these two scholars were

among those who pioneered VT studies in helping professions and this inventory has been widely utilized. Further, Liu et al.'s (2017) multi-systems model is used to analyze resilience cultivation in the participants because this model addresses limitations in other existing models, clarifies ambiguity created by heterogeneous definitions of resilience in the literature, and acknowledges resilience as an ongoing process.

5. Findings

Most participants articulated a mixture of positive and negative feelings about the shifts in the modes of interpreting from predominantly face-to-face to remote during the pandemic, and the changing patterns of their work, as a result of the restrictions imposed by the Australian and New Zealand governments. The following analyses outline the themes derived from the data in an attempt to answer the research questions.

5.1 Face-to-face interpreting

Most participants on both sides of the Tasman said that face-to-face interpreting was the predominant mode of interpreting pre-pandemic, largely replaced by remote interpreting during the pandemic. Most participants agreed on the advantages of face-to-face interpreting, regarding it as the superior mode for community interpreting. Reasons cited converged on the notions that body language and visual cues can facilitate more effective communication, and that human interactions can foster better social connections and easier rapport building. One participant captured the positive aspects by saying it is "more dynamic and engaging. Despite wearing PPE and face mask, people would see the interpreter, not just a voice on the phone."

Three interpreters felt reassured by the safety protocols of mandatory contact tracing measures and personal protective equipment provided, and therefore still attended assignments in person. However, more than half of the participants (29 out of 52) expressed concerns and anxiety about their own health and safety regarding this mode of interpreting during the pandemic. One participant said they specifically chose not to accept any face-to-face assignments at all to reduce the risk of exposure to health risks. Their fears included contracting the virus and being asymptomatic, thereby unwittingly spreading the virus. When coming across clients who did not wear a face mask or failed to keep a safety distance, the anxiety was expressly high. One participant reported an adverse experience:

> Caught Covid from first Covid Interpreting assignment I did, had to isolate for 7d. Called the place where I'd interpreted to advise my positive result. They said

> someone would call me. No one did. The client put me in a risky position. There was no duty of care.

In contrast, another participant reported an experience where the court official insisted on abiding by the health and safety rules, creating impossible working conditions for the interpreter providing chuchotage to the non-English-speaking client.

> … the trial lasted for five days. I conducted simultaneous interpreting for the accused with the mask on and was asked by the court officer to sit two seats away from the client…I was exhausted and developed back pain and sore knees from having to bend myself to get closer to the client's ear…I managed to negotiate with the court officer on reasonable grounds and was eventually able to remove the mask and sit closer to the client, but that was the last three days of the assignment. During the struggle where I was required to wear the mask at all times, I decided to switch to the consecutive mode to save my breath and energy before I rendered. I also spoke louder even if the nearby barrister would think I was too loud. I could not bend myself as far as I did in the first two days.

5.2 Remote interpreting

Telephone and video interpreting are the two ways of delivering remote interpreting. Seventy seven percent of the participants (40 out of 52) said that they were minimally engaged in remote interpreting pre-pandemic. Further, they also reported telephone interpreting becoming much more prevalent than it had been in their pre-pandemic experience. The most cited advantage of remote interpreting was the convenience of working from home and the avoidance of road travels, thereby saving on the cost of fuel and parking, as well as the relief of mental stress from sitting in traffic jams before the pandemic. Remote interpreting offered great peace of mind in terms of health and safety, as the interpreters did not need to put themselves in harm's way by venturing out for assignments —particularly if they were required at hospital isolation units or quarantine facilities. In general, more respondents commented favorably on video interpreting as compared to telephone interpreting due to the access to visual cues on screen, although the face-to-face mode was still regarded as the most effective mode of interpreting in community settings. Another advantage of video interpreting was the possibility of instant online searches for helpful resources in an

unobtrusive manner when an unfamiliar term or expression came up during a remote assignment, which was welcomed by some.

Interestingly, two participants specifically mentioned worsening of working conditions and difficulties in maintaining work-life balance. The convenience of quick access to remote interpreting led to an extremely short notice for interpreting assignments and a general lack of briefing by public service providers. As soon as the interpreter came online, they were immediately thrown into the deep end without having any context for the communicative event at hand. One participant also described a telephone interpreting assignment for interviews conducted by Immigration which went on for three hours without any breaks.

On the topic of technical issues, over half of participants (27 out of 52) remarked on experiencing poor connections, therefore poor voice quality and the need to interrupt the communication —sometimes frequently— to ask for repetitions. Participants reported background noises or disruptions interrupting the remote communication. Two participants resorted to buying noise-cancelling headphones to achieve better sound quality input for their remote interpreting assignments. Technical difficulties faced by the non-English-speaking client were also observed by three participants, resulting in client frustration and heightened irritation, because these community members were

> …not familiar or comfortable with video consultations via Telehealth, so this created challenges as consultations had to be changed to phone, and patients sometimes even missed their appointments due to lack of familiarity with Telehealth platform.

Eight participants highlighted the difficulty in following the idiosyncratic accents or enunciation by various speakers. In some cases, there was also a lack of awareness by the English-speaking professionals as to how badly their voice traveled in the remote modality and the need to slow down, causing the participants high levels of stress in trying to cope with the audibility and comprehensibility issues arising from such situations. For telephone interpreting, significant challenges in managing turn-taking were mentioned by close to half of the participants (6 of 15 New Zealand participants; 16 out of 37 Australian participants), where not being able to see the other speakers made talk coordination by the interpreter inefficient. It was particularly challenging when one party (usually the non-English-speaking client) included multiple speakers and the interpreter was unable to see them. Another relevant point raised by ten participants relates to the difficulty in fostering empathy and

developing rapport, particularly in the telephone mode. Given all the challenges reported, it is no wonder one participant noted the higher cognitive load while performing remote interpreting from home, concluding that they preferred the face-to-face mode.

5.3 Getting through challenging times

Two years of the Covid pandemic were not easy on the interpreters. Practitioners shared various things they did to 'get [them] through'. Saakvitne and Pearlman's (1996) six-item self-care inventory was used to analyze the data collected about their self-care strategies.

1. Physical self-care: Some participants explicitly declined face-to-face interpreting assignments to safeguard their own health and safety. Several respondents pursued activities to keep themselves fit, such as eating well, walking, exercising, and engaging in yoga or meditation when strict lockdowns were in place. Doing nothing, resting, and having a good sleep received ten mentions, with one participant sharing: "I sleep, and sleep it over!" Another participant remarked that "…the phone was ringing continuously, and it was stressful when callers were concerned about the pandemic and I could sense their tension and fear", so taking time away from the telephone became this participant's strategy for self-care.

2. Psychological self-care: Some participants expressed appreciation for still being able to work remotely during lockdown and being healthy. Still, they acknowledged the fact that the volume of assignments had decreased. One shared regulating the time spent accessing media updates about daily numbers of COVID infections, deaths, and tragedies so as to maintain some balance between a dose of reality and inner peace. Participants also took the opportunity to reflect on their life journey, which, in turn, helped validate themselves and build their mental strength: for example, one participant possibly from a refugee background, said: "the everyday poverty and the lack of security, education and positive and safe environment that I experienced [in my home country] gave me no choice but to be flexible and resilient to be able to help and support others".

3. Emotional self-care: One participant found shouting out loud in nature or in the wild helped, while another "found a quiet corner and had a good cry" after a terminal cancer diagnosis assignment triggering memories of a similar event involving a loved one. The sense of isolation during the pandemic both for the patient and for the interpreter was so palpable that the traumatizing state of others amplified the emotional impacts felt by the interpreter. Many participants returned to hobbies to reconnect with themselves, such as crafting,

reading, collecting recipes, gardening, playing music, dancing, while others used activities such as reading, watching TV, or doing Sudoku to keep their mind occupied during their downtime. They also mentioned spending time doing things that they never got around to do, or "do things that I never dared to do".

Re-evaluating what is important for oneself featured strongly with fifteen mentions, and therefore many spent time with family and kept in touch with friends to "provide and receive comfort". Many participants accepted the challenging nature of the time and the sad client stories they interpreted and reminded themselves to keep a tab of their emotions by exercising detachment and by putting things into perspective, e.g., "I remind myself that I am there for a purpose and that is to deliver communication." It can be said that some of these strategies are a cognitive response to an emotional challenge. Self-compassion was evident, e.g., "Being kind to yourself, knowing that nobody is perfect and it's ok to make mistakes and learn from them", as well as self-love, e.g., "I took this opportunity to build my character, to look after myself and others. Covid-19 pandemic made me stronger." One participant had to interpret in a difficult and traumatic case but was able to

> … start this in good form and finish it in good form and that is what I exactly did. I felt good about myself having achieved my goal by following the rules of how to keep yourself resilient in times of crisis. Strength and determination to bounce back from difficult life events.

4. Spiritual self-care: Some participants pursued activities related to their spiritual wellbeing, such as praying, practicing mindfulness, meditation, or yoga. Compassion satisfaction also seemed to feature in the data. For example, one participant found comfort in "doing our share in helping understand each other to facilitate communication at a time when it was vital" and experienced awe in the very community members they interpreted for:

> I listened to many of them in my language and I can't explain how impressed I was with the strength and bravery that these people dealt with the situation. I spoke to mothers, widows, and brothers…they were thanking me for having provided them with an opportunity to express their emotions.

5. Workplace or professional self-care: The most prominent theme was the participants' effort to try to stay focused on the job, e.g., "to simply listen to what is being said and interpret that to the best of my ability." Others raised the importance of asking for breaks and

a drink of water while at work, as sometimes interpreters may feel too self-conscious to ask, instead choosing to simply "push on".

Participants also reflected on their skills and ability to identify areas for improvement, and the fact that they engaged in activities to upskill. Examples include listening to English or Language Other Than English (LOTE) news and radio programs, interacting with peers in LOTE Facebook groups, practicing note taking, working on simultaneous interpreting, watching TV in their LOTE and paying attention to subtitles, and the list goes on.

6. Balance: By this, Saakvitne and Pearlman (1996) mean striving for balance among work, family, relationships, play, and rest. Some participants regained work-life balance due to lockdown measures and mainly time saved on the road. Conversely, others struggled to find such balance, as demand for remote interpreting surged to the point that it became hard to demarcate work and life in the same physical space at home.

5.4 Fostering Resilience

The participants were asked what they did to maintain resilience. As the questionnaire did not attempt to provide a definition for resilience, it allowed the participants to answer according to their understanding of the concept. Therefore, it is noted that most participants' answers either overlapped with or were further elaborations of their answers to self-care, suggesting that they may regard resilience as the other side of the coin to self-care, or synonymous with it. For example, many participants talked about practicing meditation, yoga, qi gong, or tai chi on Zoom to reconnect with themselves; others mentioned practicing mindfulness, singing, reading a good book, or "having an easy meal, taking a bath, snuggling up with pets and Netflix, chocolate, and a glass of wine…". Creating a healthy homeworking environment was also acknowledged, so a participant "set up ergonomically at home", while another had created "a workplace-like room and [a] routine in a room in my house".

The relevant data are analyzed using Liu et al.'s (2017) model featuring three layers of resilience as discussed in the literature review section.

1. Core resilience: intra-individual factors consisting of characteristics within an individual representative of trait-resilience.

There were 18 mentions (out of 52 participants) about the importance of emotional detachment, e.g. "I always try to remind myself that it's not happening to me and that I have my own story that is not related to their struggles", "I do not allow challenges to control or

affect my person in my role as an interpreter", and "I accept things as part of life and move on". It was acknowledged by participants that "being extra gentle and kind to myself" is extremely important at difficult times. The notion of taking a break also featured, in the sense of consciously spacing out interpreting assignments to create mental space to cope, although one participant remarked that "I found this could be dangerous as job opportunity would not come your way if you became invisible. However, I need to find that balancing and sustaining point to carry me farther if not perish".

Many participants explicitly mentioned avoiding negativity and affirmed their positive outlook on life, e.g. "I regard things as blessing", "I don't listen to negative things", and "I avoid seeing crisis as something that cannot be overcome". One participant put it: "The Covid time was also an opportunity to pause and understand yourself". Personal healing appeared to be a prominent theme, with participants remarking "training the mind to shut down after each assignment", "getting things off your chest", "working on emotional intelligence", and "having an attitude that I can survive this, had control of myself, and believing in myself that I have the ability to cope through all this".

2. Internal resilience: interpersonal factors consisting of personality determinants—developed or acquired over time through social interactions and experiences—representative of psychological resilience.

Some participants relied on their religious beliefs and cultural values "which are very important for me as a guide to see and respond to any challenges in my interpreting work". There were 14 mentions (out of 52) by participants who made a conscious effort to maintain connections with family and friends, e.g. "I kept chatting with my parents online, just reminding myself that my life is important to the people I love", and "I visited my terminally ill friend, looking back the hard journey we each went through. We had no regrets". Passion for helping others emerged as a strong theme, where empathy for others was regarded as feeding their passion for the profession. For example, they would be "imagining people I interpret for are my blood and derive satisfaction from interpreting for them", and regard being an interpreter as "not just to perform another career, it is matter of loving and caring [about] others, our community…" One participant exemplified it by saying:

> I always ensure that I do what I can in my capacity - interpreting with a kind voice tone, listening attentively and capturing all details without the need for the client to repeat. This more or less might lift up their feelings and faith.

3. External resilience: socio-ecological factors consist of larger formal and informal institutions that facilitate coping and adjustment, representative of community resilience.

Participants were open-minded about taking advice from respected experts. As one participant said: "Everything is possible to overcome. One needs time, and right directions and guidance". Nine participants (out of 52) mentioned they reached out to peers for informal debrief and support. A further ten participants said they would access professional help, acknowledging the importance of reaching out to supervisors, counsellors, or psychologists in a safe environment, as well as staying connected with sources of support—both professional and informal.

6. Discussion

Data from the participants about the mode of interpreting clearly reflect the change from face-to-face as the predominant form pre-COVID to remote interpreting during the pandemic. In Schnack's (2020) study on remote video relay services for sign language interpreters during the pandemic in the United States, participants reported feelings of social isolation, anxiety, and stress. In contrast, the participants of the current study were largely receptive and understanding of the lockdown measures and the consequences on their work and life. The present authors hypothesize that there is a degree of acceptance of isolation *en masse* imposed by governments to minimize the spread of the disease for which there was no vaccine or cure as yet, and therefore there was almost no mention of having a sense of isolation, loneliness, or sadness, but rather a predominant sense of compassion for the people that the participants interpreted for.

Participants' responses focused more on the regret that they could not provide the best service possible to the clients. Most concurred that the face-to-face mode was still by far the best in terms of communication clarity, efficiency, and human interaction. Many reported various difficulties encountered in the remote mode, in particular bad connections hampering the audibility of the communication, lack of visual cues in telephone interpreting, making talk coordination a "nightmare", and the challenges of fostering rapport via telephone or in the two-dimensional screen. Most participants appeared to recognize the importance of self-care to perform their job well under trying circumstances, sometimes under deteriorating working conditions of hours on the phone or in front of a screen with few breaks and bad sound

quality. Thus, they engaged in various activities to look after themselves physically, psychologically, emotionally, spiritually, personally, and professionally.

Scholars such as Bonanno (2004) and Aafjes-van Doorn et al. (2022) conceptualize resilience as a process of adaptation. However, the participants seem to articulate less about such temporal aspects, and define resilience as inextricably bound by the notion of self-care. Looking after one's mind and body featured most prominently when dissecting what the participants did in order to foster resilience. Participants clearly articulated the importance of emotional detachment to maintain their sense of self and to keep things in perspective, pointing to strong evidence of *core resilience*. In terms of fostering *internal resilience* through interpersonal social interactions and experiences, reaching out to loved ones and friendship featured most strongly, with further evidence of religious beliefs and cultural values. Passion and empathy for others seemed to be the manifestation of this middle layer (according to Figure 1) of one's psychological resilience. Lastly, participants' willingness to reach out to peers, mentors, and professionals for their mental wellbeing and professional longevity provided evidence for their *external resilience*.

As explained in Section 4.2, the current study did not attempt to collect demographic data. It is, therefore, hard to ascertain the participants' level of interpreting training, length of practice, and level of qualification and certification. Future studies should consider investigating the correlation between these factors and self-care practice, help-seeking behavior, and resilience development. As resilience has been suggested in the literature to be an adaptive process (Kunicki and Harlow 2020; Bonanno 2004; Aafjes-van Doorn et al. 2022), future research should expand on the methodology from one-off cross-sectional studies, which seem to have dominated the investigation of interpreters and resilience, to longitudinal research designs in order to deepen the understanding of the issue.

7. Conclusion

In summary, what the study participants have told us is a story of resilience in itself, represented by this powerful quote: "We have the passion. That got us through. And now, being [able to get through hardship] is achieving". Despite challenging circumstances in both countries across the Tasman Sea, participants articulated their self-care strategies and a sense of hope to get through the pandemic, with its associated and prolonged lockdowns and restrictions. As one participant put it: "At present, when choosing to be an interpreter or

[more] a successful interpreter with integrity, you have to have that resilience in your heart, mind, and emotions". Although there is evidence of extensive self-care practice and resilience maintenance in the data, it is important for interpreting practitioners to be vigilant about their working conditions. Self-care clearly helped the participants' wellbeing in our study. We would see this as an argument to ensure self-care practices are embedded in pre-service training and professional development. The authors would like to conclude with a more general but no less important comment. That is, the responsibility of ensuring appropriate working conditions should not be placed squarely at the door of the interpreter. No amount of self-care and resilience development can sustain practitioners if they do not have reasonable working conditions. Safeguards for these aspects must be mandated and built into procurement policies. Resilience, both as a process and as an outcome, is a shared responsibility.

Appendix

Questionnaire

1. How did you usually undertake interpreting assignments prior to the 2020 lockdown: in person or remotely?
2. Did the mode of interpreting you engaged in change in 2020? In what way?
3. What were your experiences with interpreting assignments during the Covid-19 lockdown? (e.g., did you switch to interpreting remotely and if so what mode was used; did you continue to travel to the setting (e.g. hospital) to undertake interpreting assignments?)
4. Was there anything you found challenging about interpreting from home, compared with interpreting face-to-face? How did you deal with such challenges?
5. Was there anything you found challenging about interpreting face-to-face during the lockdown? How did you deal with those challenges?
6. Were there any advantages to interpreting remotely as opposed to face-to-face?
7. Were there any advantages to interpreting face-to-face as opposed to remotely?

8. What did you do to maintain your resilience during challenging times? What sort of self-care did you engage in?
9. What would you recommend interpreter educators add to interpreter training to allow interpreters to develop the skills to maintain resilience and engage in selfcare? Why?
10. Were there any settings you interpreted in that were particularly challenging? If so, could you tell us a bit more about the settings, the challenges and how you coped with those?
11. And more specifically: What do you do to maintain your resilience/practise selfcare when interpreting in very challenging settings, such as interpreting in the aftermath of the mosque attacks?
12. What habits would you recommend we teach student interpreters to develop? What got you through?

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