Endnote

Shielding Yourself From the Perils of Empathy: The Case of Sign Language Interpreters

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Cross-cultural exchanges between deaf and hearing persons are replete with unintentional misunderstandings and even purposeful acts of oppression. Sign language interpreters routinely bear witness to the negative emotional fallout of these dynamics on the Deaf consumer. It is largely inevitable—a psychological reflex—to experience some degree of empathic pain. One must achieve a healthy balance of empathizing *enough* while shielding oneself from its perils. I describe the psychological effects of juxtaposed extremes of affect, projective identification, and the dual nature of empathy.

I will never forget when my daughter was first stung by a bee. I swear it hurt me more than it did her. This experience of vicarious pain is not only felt by parents but haunts anyone who feels compassion for another human being in distress. In the words of Czech author, Milan Kundera, "There is nothing heavier than compassion. Not even one's own pain weighs so heavy as a pain with someone and for someone, a pain intensified by the imagination and prolonged by a hundred echoes." Sign language interpreters often bear witness to "a hundred echoes" of Deaf people's pain. The following situations were among the 15 structured interviews of interpreters in the Boston area (Harvey & Gunther, 1994) and over 70 responses from a Web-based survey entitled "The Effects of Witnessing Oppression on Interpreters."[1] A Deaf consumer is left out of a conversation or decision making, talked down to and demeaned, treated unfairly, falsely labeled as mentally retarded, or physically or emotionally abused in a treatment or correctional facility; a hearing consumer is uncomfortable with an interpreter and ignores him or her to the detriment of the deaf person; a hearing parent makes fun of a deaf child's signing; interpreters are asked to unethically expand the interpreting role to the detriment of the Deaf consumer; hearing officials discriminate and misuse their power against Deaf citizens.

Though many interpreters noted that "we're supposed to be neutral," they also acknowledged that this goal is psychologically unfeasible on an emotional level. It is possible to *act* neutral in high-stress situations, but one cannot *feel* neutral (Pearlman & Saakvitne, 1995). Internal nonneutrality is an involuntary psychological reflex for well-adjusted persons, particularly when in close proximity to someone seen as being oppressed or otherwise demeaned. As one interpreter put it, "It's difficult to pinpoint how observing oppression has affected me, but it has. I can only begin to imagine Deaf people's helplessness and squelched rage against the onslaught of hearing dehumanization, devaluation, and degradation. It leaves me with chronic indigestion."

Her "chronic indigestion" is quite fitting, as the psychological literature on trauma often refers to unintegrated affect as "undigested material," and, as a result, subsequent material (life experiences) cannot get properly digested or integrated (Herman, 1992). The critical psychological challenge is how to manage one's empathic nonneutrality.

This article is a step in that direction. It explores the

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psychological mechanisms of empathy with specific reference to sign language interpreters. However, from a clinical perspective, the tools for managing empathy appear useful to others who feel that they have to bear witness to oppression of Deaf persons. As I explain, one must achieve a healthy balance of empathizing enough while shielding oneself from its perils to work effectively and ethically with a member of an oppressed minority, such as the Deaf community.

An important caveat: oppression versus ignorance. It is important not to overstate or exaggerate the prevalence of oppression of deaf people by hearing people. Not every instance of apparent malfeasance is driven by oppression, which, by definition, implies intent. Ignorance and naïveté are also common culprits. Indeed, as I have stated elsewhere (Harvey, 2001), to the extent that an apparent incident of oppression is traumatic to an observer, that observer may be hypervigilent for its reoccurrence—he or she may perceive oppression when it, in fact, is not there. This is a hallmark symptom of vicarious trauma (Pearlman & Saakvitne, 1995), a common "cost of caring." From a psychological perspective, anyone who frequently bears witness to oppression is at higher risk for becoming hypervigilent to its occurrence.

Although there are many instances of hearing people who, because of their naïveté or inexperience around Deaf persons, unintentionally act in detrimental or unhelpful ways, (intentional) oppression of various forms and degrees is also prominent in the lives of Deaf people (Glickman & Gulati, in press; Lane, 1984; Lane, Hoffmeister & Bahan, 1996; Pollard, 1998) and, by proxy, familiar to interpreters and others who bear witness to the experiences of Deaf persons.

Contrasting Extremes of Affect

Consider the following dialogue between an interpreter and a Deaf colleague:

> Interpreter: "I can't believe that you weren't promoted at your job. You couldn't get more training because they didn't have an interpreter!"
> Deaf colleague: "Surprise, surprise" [with resigned sarcasm].

The interpreter's heightened sensitivity may have been intensified by its juxtaposition to the Deaf person's apparent *under*sensitivity, much like a bright, iridescent color stands out against a gray background. That deaf person's reaction of "being used to it"—also known as affective constriction or numbing out—is a common adaptation to prolonged stress or trauma, to cultural insensitivity, discrimination, disrespect, disregard, and so on (Figley, 1995). Unfortunately, for many deaf people, these adversities have become a staple of their lives (Lane, 1992, 1984). Continually blinded by the "bright, iridescent colors" of oppression, their world is reduced to shades of gray.

Not so for hearing people, which includes most interpreters. At least when we first enter the field, we are not "used to it." We are appalled and outraged about our "audist" society's subtle and not-so-subtle denigration of deaf people (Lane et al., 1996). In my own work as a psychologist, I was shocked to learn about many deaf persons' experiences of communicative isolation within their hearing families of origin; these images haunted me, angered me, and pained me. They intruded into my leisure time and into my dreams. Many years later, I understood these symptoms as indicative of posttraumatic stress disorder: the cost of my caring (Figley, 1995). I discovered that trauma is contagious.

Projective Identification

We may also feel intensified pain because—in a psychological sense—the deaf person gives it to us to "hold." This psychological phenomenon, called "projective identification," happens quite frequently between any two people emotionally connected to each other.

What part of the self might a deaf consumer displace onto an interpreter? Consider the case of Mattie, a middle-aged deaf woman who had a long history of rejection and painful ordeals. Her parents were emotionally unavailable, her husband had multiple affairs and divorced her, and most of her previous employment settings had failed to provide even minimal work accommodations. On the surface, however, she looked remarkably unscathed; she seemed very confident, remained socially active, was ambitious, and enjoyed high self-esteem. She did not surrender to her pain-engendering hardships.

So was it a coincidence that many competent interpreters found themselves feeling grossly inadequate

while interpreting for Mattie? As one interpreter observed, "I don't know why but I just feel awful about myself when I'm with her. It's nothing she really says or does—or at least I can't pinpoint it. But I feel her critical eye on me; and it's like she makes me feel inept!"[2]

Although Mattie's resiliency was impressive, it is difficult to imagine that she was pain-free. And given that she felt a level of pain, the question becomes what did she do with it? (Pain doesn't just evaporate.) I don't think it was coincidental that many highly competent interpreters felt "grossly inadequate" in Mattie's presence. It seemed that an interpreter became a "container" of sorts for Mattie's unwanted or disavowed affect. Via projective identification, Mattie displaced those pained, incompetent parts of her self onto the interpreter and then acted in certain ways to encourage that response in the interpreter.

Projective identification happens without malice; Mattie did not consciously wish for the interpreter to feel her own pain, nor did the interpreter consciously agree to accept it. Shared pain occurs unconsciously for both parties, without informed consent. In this manner, an interpreter (and any ally or helper) is likely to get "sucked in" before he or she knows what's happening. And its effects are profound, particularly as the pain is intensified by one's imagination or one's own personal background or "baggage."

The Dual Nature of Empathy

By now, the reader may ask, "Aren't we better off protecting ourselves in our own well-defined turf?" "Who needs the weight of compassion or empathy, particularly if we end up 'holding' some of it for another person?" Indeed, empathy in this context catalyzes a psychological crisis for the observer, and, as such, it can crush or strengthen the human spirit.

Perhaps the most basic tool to avoid the danger and reap the benefits is to balance the emotional and cognitive components of empathy (Jordan, Kaplan, Miller, Stiver & Surrey, 1991). This is illustrated in Figure 1.

First, let me clarify the emotional component of empathy. Pure, unbridled emotional empathy, without any cognitive constraints, is akin to achieving a state of psychological fusion with another: the mystical experience of two separate bodies or minds melding together as one. Although elusive and abstract, pure, emotional empathy is perhaps the most sought after of all human experiences.

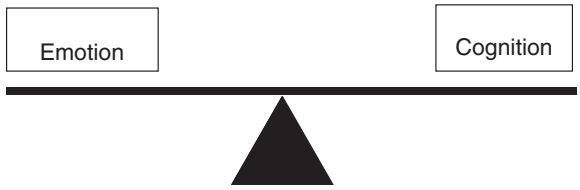

Figure 1 Empathic balance. Admittedly oversimplified, there are three possible consequences of empathy, depending on how one balances components of cognition and emotion: (1) an imbalance with too much emotion, leading to a loss of boundaries; (2) an imbalance with too much cognition, leading to affective constriction (numbing out); and (3) a healthy balance, leading to psychological integration and better interpreting.

There is more good news. By empathizing with another person, without restraint, we overturn author Thomas Wolfe's verdict that "loneliness . . . is the central and inevitable fact of human existence." On the contrary, we experience that "people need people, that empathy is good for your health. In more technical terms, object relations theory emphasizes that empathy satisfies two kinds of essential psychological needs: *merger need,* the need to feel totally at one with another with a complete loss of boundaries and separateness, and *alter-ego need,* the need to feel an essential alikeness with another significant person (Kohut, 1971).

As I noted earlier, many interpreters reported in the survey that they experience empathy as a frequent facet of their jobs (Harvey, 2001). Actors also have such opportunities and provide an important comparison. Perhaps drama coach Lee Strasberg elucidated the most concise description of how professional actors empathize with their characters. He developed a specific procedure, called "method acting," to teach actors this very skill, one that also seems quite relevant to interpreters. Method actor Shelley Winters advises prospective actors to empathize with a character by "acting with your scars." In other words, when an actor portrays the multidimensions of a respective character—including those deepest, most frightening, or painful experiences written by the author—the actor has to find similar experiences and relevant memories in his or her own life, be willing, and then be able to

relive those experiences and memories onstage as the character.[3]

Method acting may be called a "How to Empathize" manual, whether it be for actors, interpreters, or anyone else, for that matter. An important query: if interpreting, like acting, demands or benefits by this kind of affective empathy and if empathy indeed is "good for your health," why don't actors, interpreters, and so on, reap only the potential benefits of empathy? Why isn't the act of empathizing with the deaf consumer all good news: a "win-win"? Doesn't the deaf consumer benefit by accurate interpretation while the interpreter benefits by a growth experience?

It's not that simple. If you experience empathy solely via your emotional faculties, then you're in danger of affectively drowning, of becoming deluged, flooded, and overwhelmed with too many emotions; you lose yourself. Total fusion without boundaries is *bad* for your health. Consider the experience of one high school interpreter:

> I was interpreting a meeting between a deaf student and his hearing teacher. The teacher treated the student in a very patronizing way, very disrespectful. I remember thinking what a total asshole he was. But I had to convey to the student exactly how he was being an asshole: his body language, his facial expression, his tone of voice, etc. Although I know it's my job to give the affect of the speakers, I felt torn portraying this awful teacher's words. I felt dirty being a part of the communication.

Again, to use the analogous case of method actors using relevant memories to empathize with their characters, it is significant that Strasberg himself recommended that the actor use memories that are at least 7 years old in order to avoid risking psychological trauma. Interpreters do not have that luxury. Although it is certainly possible, and often important, to temporarily put aside traumatic memories during an interpreting job, it seems difficult at best to screen out what memories get activated. Whereas actors have many hours of preparation time before going on stage, interpreters interpret affectively laden material in real-time, spontaneous improvisation. To quote one interpreter, "I have enough to worry about without even noticing, never mind worrying about, what personal memories get triggered!"

This is where the cognitive component of empathy becomes important. Whereas the emotional component of empathy has to do with merger and symbiosis—"I feel your feelings, think your thoughts"—the cognitive component has to do with disengagement, with holding on to your integral sense of self as distinct from another (Jordan et al., 1991). The cognitive component is the shield that keeps you safe.

Specifically, while experiencing the emotional fusion of empathy, it is vital to cognitively remind yourself who you are. One interpreter reported that "sometimes when I feel a Deaf consumer's pain so much I rub my forehead just to remind myself that I'm still here." Allowing herself to emotionally feel his pain had to be balanced by her cognitively holding on to her sense of self. "Even though I feel like him, I know I'm *not* him."

It was not coincidental that that interpreter used touch to ground herself. There is an old saying that one way to know you're alive is to stick yourself with a pin, and there is a popular expression that "I pinched myself to make sure I wasn't dreaming." Similarly, the psychological literature on dissociative disorders describes many tactile techniques of "waking a person up" from a trance or dissociative state, essentially to "remind yourself who you really are" (Terr, 1990).

There are many ways to cognitively remind yourself who you are in addition to using physical touch. These are variations of enacting what we can control over our body, mind, and soul. At interpreter workshops, I do an adaptation of the following guided meditation:

> Imagine that you're interpreting for a deaf person who's being oppressed in some way: shafted, cheated, demeaned, ignored. There are many possibilities. You become overwrought and consumed with that person's pain. You're in danger of being devoured by it, drowning in it. You feel your own self becoming smaller and smaller and threatened with total annihilation.
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> As a trusted safety measure, you recite to yourself what you're able to control. I can control the rate of my breathing. I can control where I touch my body. I can control how and when I wiggle my toes (my fingers are too busy interpreting). Focusing on what I can control is one way of reminding myself that I'm me; I'm not the deaf person; I am myself! I

may like chocolate or vanilla, maybe neither. Regardless, I am me. I have a favorite color. I am me. I can control what I learn about myself from this job. About the world. About humanity. Regardless of how much pain I see, I can be curious. These are the parts of me—and many more—that I bring to the interpreting situation.

Balancing the dual nature of empathy—the "I feel your feelings" and "I am still me"—is often easy to say but hard to do, particularly in times of stress and when psychologically traumatic memories get activated. There are inherent dangers of emotionally empathizing with another's pain without the psychological "protection" of self-affirmation. In other words, interpreters, therapists, or anyone who bears witness must ensure that another's pain reflects off our own psyche, that we understand and empathize with another's pain as it resonates within ourselves, as it brings up our own issues, our own life experiences, our own thoughts and feelings: "I can differentiate your pain from my own." It is via this delicate emotional and cognitive balance that we can safely—to use a hearing metaphor—put our ears to another person's soul and reap many profound empathic benefits.

What happens when one's empathic pain is "intensified by the imagination and prolonged by a hundred echoes" without being balanced by helpful self-talk, the shield of cognition?

An Example of Too Much Emotion

I recall a conversation with an interpreter who struggled to regain empathic balance as she felt deluged by emotions while witnessing a deaf patient getting inadequate care in a psychiatric hospital. In the interpreter's words, "Those idiot hearing doctors diagnosing Mary as paranoid was horrible!" In this case, the interpreter had appraised the reasons for oppression as driven by evil and malice as opposed to well-intentioned naïveté.

"And what was that like for you?" I asked.

"I couldn't stand it! She was so helpless! She had absolutely no power; she was raped by the system, put in a cage, imprisoned, labeled. . . . Mary also probably felt . . ."

"I asked you about your feelings, not Mary's. Please say more about you not being able to 'stand it,'" I interjected.

"Watching her being misdiagnosed and labeled was horrible," came her persistent but poignant reply.

"Can you step back for a minute and analyze where your feelings come from? What experiences of yours does Mary's predicament activate?"

After a moment of thought, the interpreter discussed in some detail her own childhood ordeals of being falsely labeled with attention deficit disorder when, in reality, her boredom and inattention were due to incompetent teachers.

"So your sense of Mary's pain of being misdiagnosed is reflective of your own similar experience?"

"Yeah, I know the feelings all too well," she replied.

"Let's examine the similarities and differences between your experience and Mary's; then you can really 'step in her shoes' and interpret as many of her linguistic and emotional nuances as possible, but not melt into her in the process. It sounds like up to now you've been overwhelmed with her pain."

She nodded her head and sighed.

This interpreter had been in danger of empathically drowning, one possible negative consequence of unbridled empathy already discussed. Typically in this scenario, we become depleted of energy; we withdraw from family, friends, and colleagues, perhaps accentuated by the belief that no one could possibly understand our distress; in the case of interpreters, one may also withdraw because of misinterpreting the RID code of ethics as prohibiting the discussion of any thoughts and feelings concerning an anonymous Deaf consumer (Dean & Pollard, 2001). We experience profound alterations of our identity, self-esteem, and worldview; our ability to manage strong feelings suffers; we are vulnerable to intrusive imagery and other posttraumatic stress symptomatology. In short, we are vicariously traumatized (McCann & Pearlman, 1990).

An Example of Too Much Cognition

Another common vicarious trauma response is that of erecting a shell of protective numbness (Harvey, 1996). It is a safety barrier, a way of hiding, a way of shutting one's eyes to the blinding empathic pain of witnessing oppression. We become overwrought with *compassion fatigue:* a self-protective shell of isolation behind which we look out only for number one, caring for nobody else

but ourselves (Figley, 1995). It is a common response among helpers who regularly deal with people's pain without adequate self-care. As one seasoned oncologist put it, "I never thought I'd dehumanize my patients as disease entities, but after witnessing so many deaths, I'm tired of caring!" An experienced acute care nurse observed that "the faces of the patients at the ER become all one big blur." And as one seasoned, highly compassionate interpreter put it, "When I first learned about oppression and deaf people, I was appalled and outraged. But after a while—and I'm ashamed to say this—I sort of got used to it. You ask me about empathy! What's that? *I have no empathy!*"

There is no need for shame. Rather, "getting used to it" is a human response; overwhelmed with grief, we become tired of caring so much. Gradually and insidiously, the stories of Deaf people's isolation and denigration may become a routinized expectation, the norm. What begins as contrasting extremes of affect—and therefore catalyzes reactions of astonishment, shock, distress, concern, and torment—gradually succumbs to the weight of passive resignation. After a while, we come to expect such oppression. And in my case, more often than I, too, can easily admit, I hardly notice its existence.

In marked defiance of Milan Kundera's statement that "there is nothing heavier than compassion," we hide our faces in the sand. We reduce piercing, iridescent vicarious pain to a gray, dull ache, but, in the process, we become nonfeeling machines. Thoughts replace feelings. We tell ourselves, however, that it's a small price to pay, as we revel in never having to ever again agonize over another's sorrow.

Typically, our cognitive retreat does not last long. For one reason or the other—most of the time we don't know exactly what hit us—the intensity of another's pain permeates our self-made fortress, and we again acutely feel the omnipresent malignancy of oppression. The good news is that we again feel alive; and the bad news is that we may not have the tools to find a healthy balance between empathic flooding and empathic drought. That is the challenge.

On Achieving a Healthy Balance

This is one of my favorite principles of healing: "Pain has a size and shape, a beginning and an end. It takes over only when not allowed its voice" (Brener, Riemer, & Cutter, 1993). The more words we have for our empathic pain, the more shape it has, the more it has a beginning and an end. The less words, the less space; the more it takes over; the more we're vicariously traumatized.

It is a common but serious error to assume that one can get helpful support only from those who already understand, who are in "the same (interpreting) boat." First, as many interpreters have noted, there are many ethical ways of sharing one's emotional reactions with noninterpreters without violating the RID code of ethics. Second, as anyone who has been in a long-term committed relationship knows, it is often the struggle to help another dissimilar person to empathize with you that is the healing medicine; that catalyzes you to verbalize and clarify all the nuances and complexities of a particular stressful situation. People from Mars also need people from Venus. We need both supportive others who are similar (peers, consultants, supervisors) and those who are dissimilar (friends and spouses).

In addition to this simple-sounding advice, let me suggest an attitude shift I have found helpful in my own work while witnessing oppression. When I find myself overwhelmed with "isn't this awful, this shouldn't be," and potentially debilitating anger or pain—while continuing to empathize with the victim and asking myself what I can do—I adopt an attitude of a curious anthropologist. I nurture a desire to deepen my understanding of what it means to be human, including the parts of me that I learn about. Emotionally rough encounters then become data, grist for the mill.

Our empathic pain need not be debilitating, nor "intensified by the imagination and prolonged by a hundred echoes." By understanding the inner workings of empathy, we can reap its benefits and avoid its perils; we can accept the personal wisdom and growth that bearing witness to oppression offers. We share our curiosity, compassion, and outrage at the injustice we see. We try to make our world a better place, sometimes succeeding, other times failing. But we learn from our quest nonetheless.

Notes

1. From the following Web site: www.michaelharvey-phd.com.

2. This was disclosed to me by the interpreter during a post-session, following a clinical interview that included Mattie. Naturally, the name and details of this situation are modified to protect confidentiality.

3. From the Web site www.theatrgroup.com/methodM/.

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Received April 16, 2001; revisions received May 29, 2002; accepted June 5, 2002