JUSTISIGNS

empowering people who experience domestic, sexual & gender-based violence

SILENT HARM

A review of support for survivors of gender-based violence

CONTRIBUTORS

Jemina Napier, Lorraine Leeson, Maribel Del-Pozo-Triviño, David Casado-Neira, Haaris Sheikh, Gill Harold, Lucy Clark, Lianne Quigley, Leonie O'Dowd, Beatriz Longa-Alonso, Silvia Pérez-Freire and Carmen Cabeza-Pereiro

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...
GLOSSARY

FULL TERM	ABBREVIATION
British Sign Language	BSL
Deaf Interpreter	DI
Divisional Protective Service Units	DPSUs
Gender Based Violence	GBV
General Data Protection Regulation	GDPR
Intimate Partner Violence	IPV
Irish Sign Language	ISL
International Sign	IS
Post-Traumatic Stress Disorder	PTSD
Spanish Sign Language	SSL
United Nations	UN
Violence Against Women and Girls	VAWG

CHAPTER

01

INTRODUCTION

Embedding principles of Equality, Diversity and Inclusion (EDI) in public service provision and education is critical to ensuring that society recognises and values the diverse experiences and perspectives of people at all stages of the life cycle and in different contexts. An active EDI agenda gives consideration to people from minoritised or disadvantaged backgrounds, the potential intersections between different characteristics that might disadvantage them further, and what steps can be taken to mitigate those disadvantages. For example, recognising that minority ethnic women from low socio-economic backgrounds may experience more challenges in access and staying in higher education or employment. Another part of embedding EDI into everyday practice also encourages discussion of traditionally taboo topics concerning gender, such as menstruation and menopause.

One such taboo topic is Gender-Based Violence (GBV). Violence against women is a major public and clinical health problem and a violation of women's human rights. It is rooted in and perpetuates gender inequalities. This project focused on women who experience a double disadvantage because they are victims of GBV and they cannot, or struggle to, access support services in the majority language of their country either because they are migrant, refugees or asylum seekers, or because they are deaf signers.

This report details the results of a survey conducted as part of the Justisigns 2 project, which was co-funded through the European Commission's Erasmus+ fund to explore best practices for support service providers and interpreters working together, in order to ensure that women who report GBV can access services and support in their own language. Before going into the findings of the survey study, we provide a definition of Gender-Based Violence and an overview of the Justisigns 2 project, a brief review of relevant literature, details of the methodology used to design, distribute and analyse the survey, and discussion of the implications of the findings with recommendations for training and further research.

1.1. Defining Gender-Based Violence

The United Nations (UN) defines violence against women as ***"any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life***[1]." According to Amnesty International, domestic abuse is one form of Gender-Based Violence. Domestic abuse/violence is an incident or a pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence and economic abuse, in the majority of cases by a partner or ex-partner, but also by a family member or carer. As such, it can be considered that GBV is an all-encompassing term to include any kind of domestic (physical, emotional or mental) or sexual violence/abuse. In the vast majority of cases, it is experienced by women and is perpetrated by men. The Justisigns 2 project focuses on the experiences of women, adopting the UN convention definition of violence against women, but we recognise fully that men also experience and are harmed by GBV.

It is important to note that alternative terms are used in different parts of the world, often influenced by the language used in national legislation. For example, in the UK, the updated Domestic Abuse Act (2021) applies to England, Wales and Northern Ireland and Scotland has the Domestic Abuse (Protection) (Scotland) Act 2021 as well as the Scottish Government 'Equally Safe' strategy that seeks to prevent and eradicate violence against women and girls (VAWG). Ireland has the Domestic Violence Act (2018); Spain has a law to 'protect against gender violence' and in the USA the term 'intimate partner violence' is more commonly used.

The Council of Europe's Convention on Preventing and Combating Violence Against Women and Domestic Violence, better known as the Istanbul Convention (2011), is a human rights treaty. This is the first legally-binding instrument which set out to create a comprehensive legal framework and approach to combat violence against women, focused on the '3 P's' – prevention, protection and prosecution[2]. That is, ***preventing*** GBV, ***protecting*** victims and ***prosecuting*** accused offenders. The Convention provides the following definitions[3]:

---

1 Declaration on the Elimination of Violence against Women. Proclaimed by the United Nations General Assembly resolution 48/104 of 20 December 1993. https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.21_declaration%20elimination%20vaw.pdf

2 We note that the European Commission's Horizon funded project, UniSafe presents the 7 P model which includes: policies, prevention, prosecution, provision of services, and partnerships. https://unisafe-gbv.eu/blog/unisafe-7p-model/

3 https://en.wikipedia.org/wiki/Istanbul_Convention

Violence Against Women

is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life;

Domestic Violence

shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim;

Gender

shall mean the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for women and men;

Gender-Based Violence Against Women

shall mean violence that is directed against a woman because she is a woman or that affects women disproportionately;

Victim

shall mean any natural person who is subject to the conduct specified in points a and b;

Women

includes girls under the age of 18.

In European countries, the term GBV is more commonly adopted; as Justisigns 2 is a cross-Europe project funded by the European Commission, for the purposes of this project and report, we also use the term **Gender-Based Violence**.

1.2. The Justisigns 2 Project

Justisigns 2 is a follow-up project to the JUSTISIGNS project which focused on providing access for deaf signers to the police through sign language interpreting[4]. The project was conceptualised and coordinated by Interesource Group (Ireland) Limited. The JUSTISIGNS project surveyed the training provision available for sign language interpreters in legal settings across Europe (Napier & Haug, 2016) and found that there was a need for resources to support deaf signers and interpreters (Leeson, et al., 2021). Discussions with police officers also identified that there is varied understanding of accommodations needed when interviewing deaf signers (Skinner & Napier, 2023). As such, training modules were developed that can be delivered to police officers or interpreters about best practices for working together (Napier, et al., 2022).

The JUSTISIGNS project identified that there was a distinct lack of knowledge and resources for deaf women who experience GBV and interpreters were wary of working in GBV contexts as they did not feel they had sufficient training or expertise to work in this sensitive context. Thus, the Justisigns 2 project was developed to concentrate specifically on access to GBV support through interpreters, and to supplement the work already carried out in Ireland, Spain and the UK to support people who have experienced GBV (for example by the Dublin Rape Crisis Centre, one of the partners on the project, or by the EU-funded project SOS-VICS , carried out by the University of Vigo). In Justisigns 2, the target audience can be described as:

01. Deaf signers as a linguistic and cultural minority

02. Migrants, refugee and asylum-seeking women and girls who use a language other than that of their host country (languages of lesser diffusion)

03. Service providers who engage with migrant, refugee, asylum-seeking women and deaf signers who have experienced GBV

04. Spoken and Sign Interpreters who work in GBV related settings.

In an ideal world, language concordant services would be offered which align to cultural and linguistic needs, which, for example in the case of deaf signers, would be services delivered by deaf signers in sign language (De Meulder & Haualand, 2019). Typically, though, access to information and support for minority language communities who have experienced GBV are offered in mainstream services through the provision of interpreters.

This raises the important question of whether professionals who work in various support services understand the needs of women and girls from minority communities who have experienced GBV, in terms of their linguistic and cultural backgrounds. Do interpreters working in GBV contexts understand the sensitivities of working with women and girls from minority

[4] http://www.justisigns.com/

communities who have experienced GBV? Do interpreters understand the goals of the various service providers in these settings?

With this as a backdrop, the Justisigns 2 project aims to develop a better understanding of the needs of women and girls who have experienced GBV and who come from communities using languages of lesser diffusion in accessing information and services via interpreters.

Our goal is to make evidence informed recommendations about the resources needed and the training needs of associated professionals. Across the UK, Ireland and Spain, we set out to:

- collect an evidence-base from different professional stakeholders (i.e., interpreters and support service providers) perspectives through a survey and focus groups;
- collect an evidence-base from women from deaf and minority language communities who have experienced GBV about their experiences in accessing support and information in their home/preferred language through interviews and focus groups
- develop and deliver training materials and resources in relevant languages (English, Spanish, British Sign Language, Irish Sign Language and Spanish Sign Language).

We map our work to the Istanbul Convention (2011). While the Istanbul Convention (2011) is based on four pillars:

Our project aligns with pillars (1), (2) and (4) as pillar (3) is outside of the remit of a research/training project.

When it comes to (1) Prevention, if a country has ratified the Istanbul Convention, it is required to take the following measures:

i.	Training of professionals	ii.	Participation of media and private sector
iii.	Awareness raising campaigns	iv.	Role of men and boys in perpetuating/preventing GBV
v.	Programmes for perpetrators	vi.	Promoting women's empowerment
vii.	Challenging gender stereotypes		

The Justisigns 2 project sought to address (1-i), (1-iii) and (1-vi) specifically with communities using languages of lesser diffusion, and, particularly deaf communities who have had extremely limited access to information around GBV to date.

With respect to (2) Protection, the safety and needs of all people who have experienced or witnessed GBV must be at the heart of all protective measures adopted by a country. Their rights include:

i.	Regional and national complaint mechanisms	ii.	Shelters
iii.	Rape crisis or sexual violence centres	iv.	Reporting violence to authorities
v.	Emergency barring orders	vi.	Protection or restraining orders
vii.	Safe custody and visitation rights for children	viii.	Free telephone helplines
ix.	Rights and needs of child witnesses	x.	And most importantly for people who cannot access the country's majority language
xi.	Information on their rights	xii.	Support services

Where information or support is not available in the home/ preferred language of a person who has experienced GBV, then there is a reliance on accessing information/services through interpreters rather than directly. The Justisigns 2 project thus supports (2-x) and (2-xi) specifically with those using languages of lesser diffusion (including sign languages) in the UK, Ireland and Spain.

Finally, countries that have signed up to the Convention have a responsibility to ensure (4) Coordinated policies, which includes:

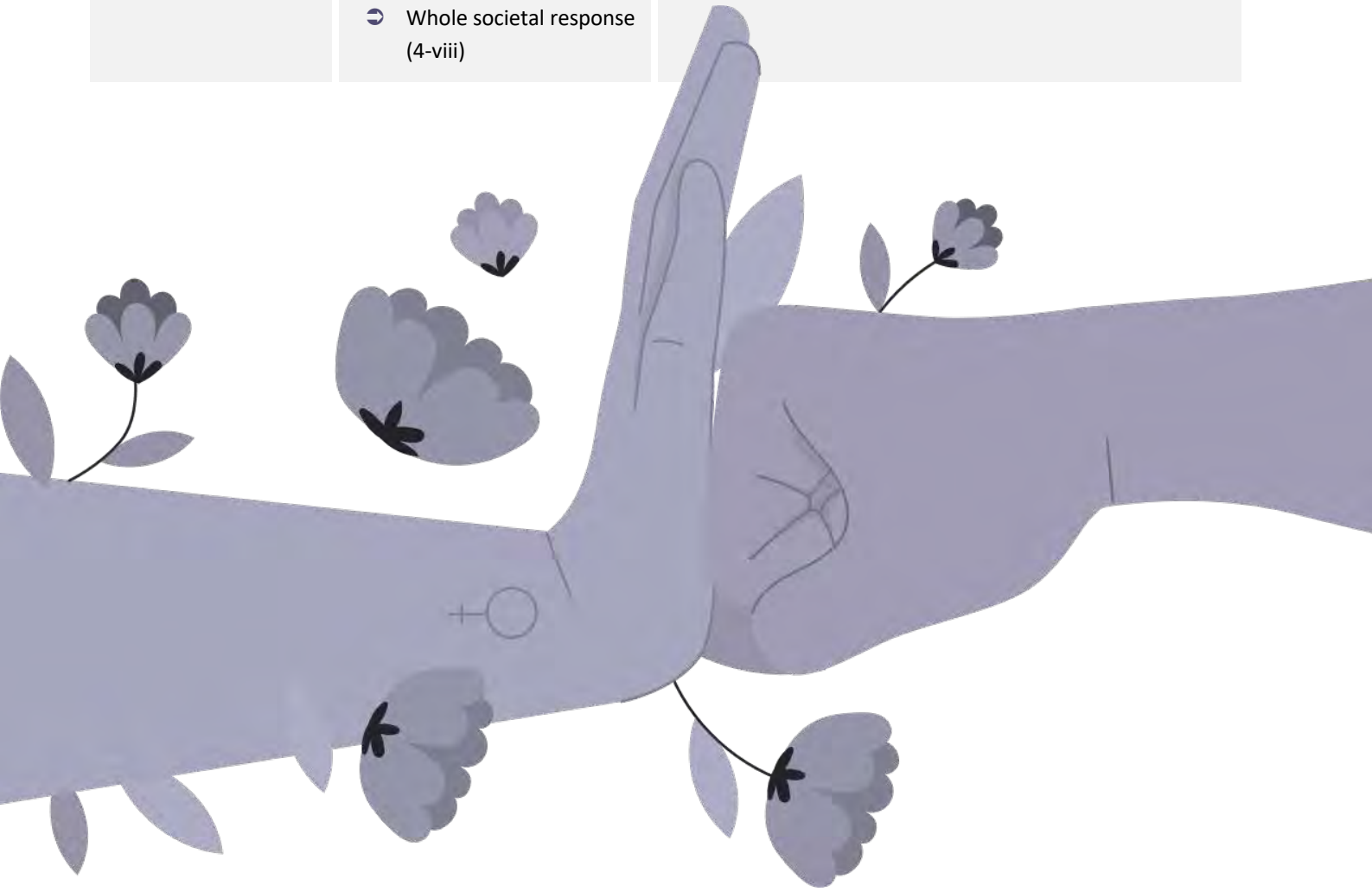
i.	Research and data collection	ii.	Inter-agency cooperation
iii.	Work and support with civil society and NGOs	iv.	Coordinate action and monitor implementation
v.	Human rights-based policies	vi.	Funding for policies and support services
vii.	Comprehensive legislation and gender sensitive policies	viii.	Whole societal response

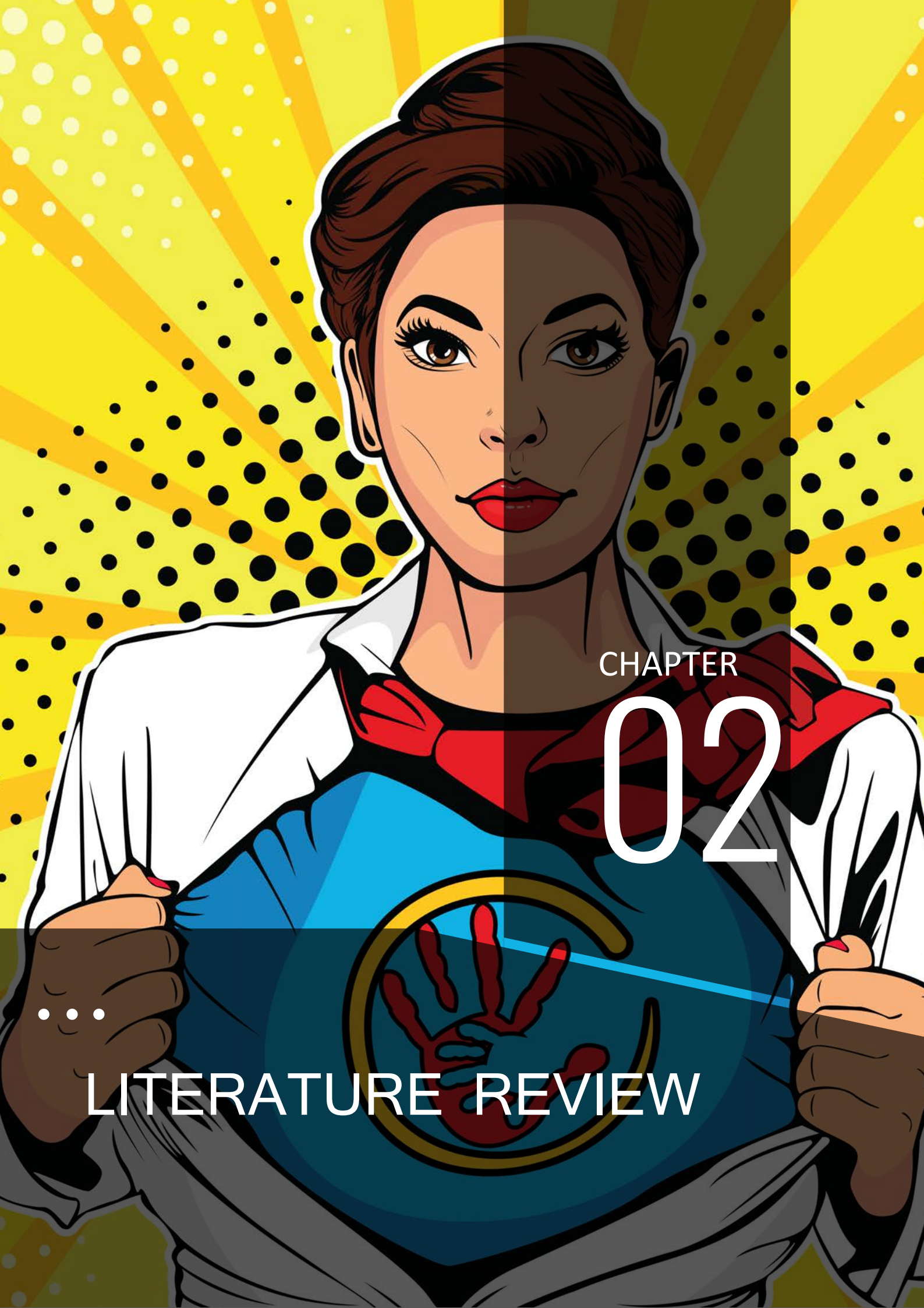
Justisigns 2 links to (4-i) and (4-ii), with the goal that our work may have an impact on (4-iii) to (4-viii), to increase understanding of, and provision for those using languages of lesser diffusion (including sign languages) who have experienced GBV.

■ **Table 1: Justisigns 2's work to support the goals of the Istanbul Convention**

Key headers of Istanbul Convention (2011)	Sub-sections we worked to meet	We did this by…
Prevention 	➲ Training of professionals(1-i) ➲ Awareness raising campaigns (1-iii) ➲ Promoting women's empowerment (1-vi)	➲ Piloting elements of our evidence-based training in Ireland, UK, Spain and Belgium. ➲ Leveraging social media effectively to share key messages with our partners and affiliates. ➲ Working with key organisations to ensure accessibility of information to those using languages of lesser diffusion (including sign languages). ➲ This entailed the co-creation of glossaries of terms for GBV in Irish Sign Language and British Sign Language with community partners.
Protection 	➲ Information on rights (2-x) ➲ Support services (2-xi)	➲ Working with partners an affiliate to ensure that information is available to those using languages of lesser diffusion (including sign languages). ➲ Working to raise awareness that support services have to be accessible for all and pointing to best practices in this regard.
Coordinated Policies	➲ Research and data collection (4-i)	➲ Collecting data and completing research.

Key headers of Istanbul Convention (2011)	Sub-sections we worked to meet	We did this by…
	➲ Inter-agency cooperation (4-ii) With potential for Justisigns 2 impact on: ➲ Work and support with civil society and NGOs (4-iii) ➲ Whole societal response (4-viii)	➲ Working collaboratively with a broad range of governmental and non-governmental agencies, in partnership with civil society and NGO groups. ➲ Engaging in symposia/conferences/to raise awareness of the need to build an Access-for-All approach into responses to GBV.





CHAPTER

02

LITERATURE REVIEW

In this chapter, we present a range of themes that reflect those identified in the relevant literature. Our goal is to offer some conceptual scaffolding for the issues of interest and concern under broader discussion throughout this report.

It is important to note that there are significant and important ontological, linguistic and cultural differences between the experiences of migrants, refugees, asylum seekers and members of deaf communities as regards availing of interpreter services in situations connected to GBV; this is true not only between cohorts but from person to person also. This review of literature combines an exploration of themes which will acknowledge shared and common issues of concern across these cohorts while also considering matters which pertain uniquely to each of these communities.

2.1. Incidence of GBV Among Migrants, Refugees, Asylum Seekers and Deaf Communities

While there are considerable variations between the circumstances and specific GBV experiences of migrants, refugees, asylum seekers and deaf signers, there is a common risk of increased incidence of GBV being perpetrated against them. Compounding the evidence from international research about the increased susceptibility of disabled and deaf individuals to violence, McQuiller Williams and Porter's (2015) study based around deaf and hard of hearing college students finds that these students are 'significantly more likely to experience psychological abuse and physical violence at the hands of a partner than hearing students' (p.2317). The authors identify coercive control linked to a deaf person's use of communication devices as a form of exposure to "disability-specific forms of violence" by partners; actions such as the destruction of devices or the surveillance of device use contribute to isolation of victims and act as a barrier to their access to supports (McQuiller Williams & Porter, 2015, p.2318). Mastrocinque et al's (2017, p.3756) work expands this idea, with the authors stating that:

> *an abuser who exerts communication control over a deaf victim can deliberately misrepresent the situation or impede direct communication between a deaf victim and hearing service providers or hearing first responders (e.g., when an abuser who is hearing or who speaks better than the victim serves as an interpreter between the victim and the police). Service providers and first responders commonly trust the translation was done accurately.*

A historical lack of access to comprehensive sexual health information among deaf communities is recognised as a further contributory risk factor linked to increased incidence of GBV (see for examples Anderson & Leigh, 2011; Anderson, Leigh & Samar, 2011; Crowe, 2017; Obinna, et al., 2005; McQuiller Williams & Porter, 2015), and the dearth of information available in sign language can contribute to lack of understanding of what actually constitutes abuse/violence (Anderson & Kobek Pezzarossi, 2012).

With specific reference to the case of migrants and refugees, Keygnaerta, Vettenburg & Temmermana (2012) outline their vulnerability to GBV; their study provides evidence that refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands are extremely vulnerable to violence and, specifically, to sexual violence (p505). Freedman (2016, p.18) asserts that "the current refugee 'crisis' in Europe has created multiple forms of vulnerability and insecurity for refugee women including various forms of sexual and gender-based violence", citing lack of adequate accommodation or reception facilities and closure of borders as factors which exacerbate violence and insecurity due to the increased the need for smugglers to help migrants reach Europe (ibid.).

Crowe's (2017) US-based study found higher prevalence rates of GBV among deaf women as compared to hearing non-signers (30-57% higher for physical abuse and 72% for emotional or psychological abuse), and they report GBV regardless of whether they have a deaf or hearing partner. Crowe noted that their inability to hear may be a factor that contributes to vulnerability or a perceived barrier to communicate, for example when reporting to the police.

Some limited discourse on the intersectional experiences of deaf migrants is available; Admire and Ramirez's (2021) research with 60 deaf signers from developing countries seeking asylum in the USA is a notable example. The authors outline how a lack of access to interpreters for this cohort facilitates violence because "respondents believed perpetrators would strategically target them because they would be unable to report their victimization afterward" (p.15). This specific intersection of deaf and refugee experience is also considered by the National Deaf Women of Ireland in their 2018 submission to Ireland's Third National Action Plan on Women, Peace and Security; in that submission, the NDWI highlights the particular concern of a scenario where limited communication access in the host jurisdiction intersects with cultural gender norms to create a situation where an individual's access to information and supports may be jeopardized or diminished.

2.2. Interpretation

The issue of interpretation is critical to the experiences of migrants, refugees, asylum seekers and deaf women impacted by GBV in their interactions with justice professionals and support organisations. Access to all proceedings in a timely and safe manner is crucial. Furthermore, the quality and reliability of interpretation is key; as Del Pozo Triviño (2017, p.39) states,

"unprofessional behaviours by interpreters can cause serious damage to victims and lead to waste of valuable public resources", so the importance of this cannot be overstated. This section of the review will explore some of the key ideas emanating from research and policy innovation in this regard.

2.2.1. Importance of Engaging the Services of Qualified and Accredited Interpreters

There is unanimity across the literature, policy and guidance about the inappropriateness of engaging interpreting services from children, carers or any persons known to victims and survivors. The trauma to children (Neave, Faulkner & Nicholson, 2016; Pathfinder Survival Toolkit, 2020), the risk of the 'known person' being the perpetrator of violence (see for example Mastrocinque, et al., 2017) and the resulting lack of reliability or accuracy of interpretation in such circumstances, are among the warnings signalled across the literature against the use of unqualified interpreters. It is important to note that even when the services of qualified and accredited interpreters are engaged, deficiencies can persist in terms of their preparedness to work in situations relating to GBV, with an associated need for specialist training, as discussed below.

2.2.2. Specialisation Versus Mainstreaming; Navigating Issues of Trust, Privacy and Confidentiality in Interpreted Interactions

Anderson (2014, p.2) notes that "many agencies for hearing survivors of [GBV] do not provide communication accessibility for deaf survivors (i.e., ASL interpreters, accessible hotlines, videophones)". This presents an obvious barrier from an accessibility point of view but, furthermore, it precludes a deaf individual from choosing not to engage with a mainstream support service. This can be problematic because, as Cerulli et al. (2015, p.151) note, "some deaf individuals may not want to receive services specifically established for deaf individuals because of concerns that these service providers are usually part of the close-knit deaf community and that their privacy might therefore be compromised". Even in the event of accessing services via a mainstream support GBV service provided by non-signing professionals, a concern about confidentiality can arise through the use of sign language interpreters who are regarded as members of the deaf community (Barber, Wills, & Smith, 2010). Consequently, Cerulli et al. conclude that "deaf individuals with such heightened privacy concerns may essentially be precluded from receiving any IPV [Intimate Partner Violence] services" (ibid.). This concern can be compounded due to the limited supply of available sign language interpreters and concerns around confidentiality arising in a context where there is a result of the small pool of interpreters (Mandl, Schachner, Sprenger, & Plantizer, 2014; Woodin & Shah 2014). In the Irish context, Rape Crisis Network Ireland noted the issue of interpreter supply and stated that it would not be feasible for its services to have sign language interpreters on staff (2011).

2.2.3. Interpreter Impartiality

The issue of interpreter impartiality is signalled by Del Pozo-Triviño and Toledano-Buendía (2016) as an important factor in gaining a victim's trust and getting her to talk about her pain and suffering. On the same topic, Norma and Garcia-Caro (2016) offer the caveat that legalistic interpretations of impartiality can lead to inaccurate and constrictive understandings among interpreters of the requirements placed upon them when working in GBV settings. They call on the community of interpreting professionals to "alternatively imagine itself in dialogue with

survivors of violence and as part of society-wide 'collective action' against gender-based violence, in order that migrant women might be better served by professionals who have a commitment to their welfare and their ability to live in a society that upholds their right to live free of violence" (2016, p.1321).

2.2.4. Financing Interpretation

The issue of financing sign language interpretation is among the provision concerns addressed in the literature. Obinna et al. (2005) outline how community-based agencies sometimes lack the money in their budget for interpreters, which in turn prompts a reliance on email or writing for communication; in light of the findings from Admire and Ramirez (2021) about coercive control pertaining to communication devices, it's apparent that this is not ideal[5].

2.2.5. Interpreter Training

The need for specialist training for interpreters working in GBV contexts is echoed across the literature. In the Irish context, Rape Crisis Network Ireland (2011, p.102) suggested instead that "specialist training on disclosure and sexual violence can be provided to a small number of interpreters nationwide, who will be available to the sexual and domestic violence sector as required".

Del Pozo-Triviño and Toledano-Buendía (2016) recognise some overlap between existing legal interpreter training and the requirements pertaining to interpreting which were identified by the service providers they surveyed. They draw attention to specific areas which need to be addressed in training to ensure that interpreters are well-equipped and suitably placed to work effectively in GBV settings. These include knowledge of how to gain victims' trust and reassure victims of confidentiality in the process; awareness of cultural values and stereotypes; how to behave in the presence of victims; the management of stress and emotional burden associated with working in these contexts, to ensure it does not impede professional performance; and the ability to maintain neutrality while demonstrating empathy.

Alongside the training needs of interpreting professionals, it is also important to note that a parallel need for training of criminal justice agency workers and support professionals is also required in order to ensure interdisciplinary understanding and to ensure effective inter-agency co-working. Valero Garcés and Lázaro Gutiérrez (2016) explicate some of the core concerns in this regard, including lack of procedural knowledge around working with interpreters and a sometimes misplaced trust in the agencies tasked with interpreter provision.

[5] The issue of payment of interpreting is one that makes its way into some best practice guidance documentation, e.g., the British Association for Counselling and Psychotherapy (BACP) (2019) note that "Responsibility to pay the interpreter rests with the service provider where that is an organisation. Private practitioners who choose to work with clients who require interpreters, should consider how to contract for payment of fees, and whether the interpreter will be arranged by the client or counsellor. Practitioners should consider how they will accommodate interpreting costs in the counselling fees they charge clients and be clear and transparent about this with clients at the outset." (p.7).

Building such requirements into policy and practice seems slow. For example, while the Australian Royal Commission into Family Violence (RCFV) (Neave, Faulkner & Nicholson, 2016, p.34) has argued that "professional accreditation standards for interpreters should be amended to incorporate minimum requirements relating to understanding the nature and dynamics of family violence", we are not aware of any similar discourse in European partner countries to date.

2.2.6. Interpreter Experiences

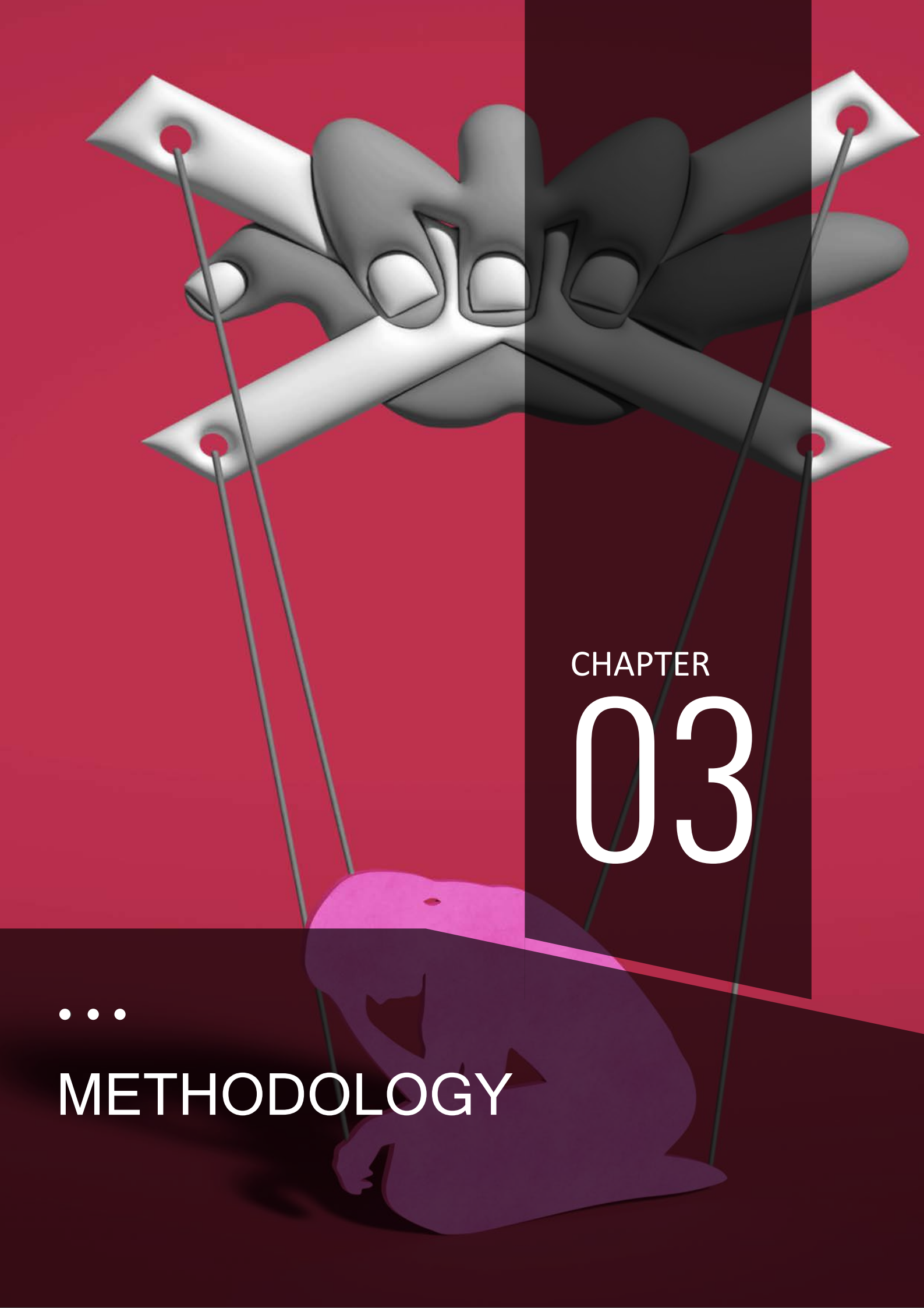
Rajpoot, Rehman and Ali (2020) present a systematic review of the literature presenting empirical studies of interpreters' experience working with clients with traumatic histories or situations. While their initial focus was to look at studies of interpreting for those who have experienced GBV, no empirical publications were found and so they broadened the scope of their review. Thus, from an initial set of 2452 articles, they found 18 that met their inclusion criteria. These focused on the emotional and psychological impact on interpreters. Their review highlights the dearth of research and understanding about interpreters' experiences of working in GBV contexts, specifically the coping strategies that they employ to support their resilience and mitigate vicarious trauma. The authors further note that there is insufficient understanding of the impact of qualification and registration on service provision specifically concerning the capacity to disclose, the preparedness of interpreters to support them in the disclosure process and the perceptions held by interpreters of men and women with domestic violence histories. Particularly relevant to our Justisigns 2 work, Rajpoot et al. note a range of themes in the literature that map to our findings. These include consideration of the role and impact of the interpreter, the psychological and emotional impact of interpreting, workplace challenges faced by interpreters, coping strategies used by interpreters, interpreters' support needs, and a range of suggestions that includes the need for peer support, clinical supervision and training (p.7).

2.3. Summary

There is robust consensus across the literature reviewed that migrants, refugees, asylum seekers and members of deaf communities who experience GBV should have timely access to interpretation by competent and specially-trained professionals. There is also consensus that this should happen in a respectful framework of practice based upon integrity, which respectfully upholds the human rights in order to facilitate full and equitable engagement with the legal system and relevant support services.

There is a noticeable dearth of literature on the direct first-hand experiences of migrants, refugees, asylum seekers and deaf signers accessing interpreting services in circumstances relating to GBV. The focus within the literature reviewed is more broadly relating to the identification of gaps in service provision by support agencies and interpreting professionals, and the formulation of solutions to address them.

Nevertheless, the literature review confirms the imperative to better understand the needs of women who are migrants, refugees and members of deaf communities in receiving support when reporting GBV. A series of further questions that arise: Is it ideal for women to receive language concordant services (e.g. direct from deaf signers in their own sign language or spoken language)? If language concordant services are not available in their area what are best practices for support service professionals (namely police officers, social workers, healthcare professionals, etc.) and interpreters for working together? What are the training needs of support service professionals and interpreters in working with female victims of GBV? What is the impact of training, qualification and registration on the quality of interpreting provided to those who access GBV services via interpretation?



CHAPTER

03

METHODOLOGY

The Justisigns 2 project has, as its core goal, the aim of designing training materials that are evidence-informed. While our literature review, presented in Chapter 2, offers some input in this regard, the project team also set out to gather input from service providers and interpreters working with victims of GBV who cannot access support in mainstream services via language congruent services in Ireland, the UK and Spain. To secure this input, it was essential that we use a homogenous data collection tool that could be rolled out across the project partner countries, and, by extension, to any geographic context. In light of this, we developed a survey that can be scaled for use in a range of different countries and contexts. The findings from the survey were complemented by qualitative data collected through interviews conducted with deaf survivors, police officers and social workers, and a roundtable with interpreters and deaf Independent Domestic Violence Advisors in the UK. The focus in this report is on the questionnaire results, although key themes from the UK interview data with deaf women are touched on in section 4.3.

3.1. Objectives

The objectives of conducting this survey were to:

- Know the current situation of communication with victims of GBV (in accordance with the objectives of Justisigns 2);
- Identify, analyse and determine the training needs for support service providers working with women who have experienced GBV;
- Identify, analyse and determine the training needs for interpreters working with women who have experienced GBV;
- Carry out a comparative analysis of the partner countries of the project: victims' profile, types of GBV they experience and training of professionals;
- Leverage our findings to inform evidence-based training for those working in this realm.

3.2. Method

■ **Table 2: Our Methodology**

	**Geographical Scope** Ireland, Spain and the United Kingdom (UK).
	**Target Population** Interpreters and support service providers with experience of working with victims of GBV when interactions are interpreter-mediated (i.e., migrants, refugees, asylum seekers and deaf women).
	**Sampling** Mixed sample (convenience stratified random sample).

Our starting point was the requirement that our data collection tool would allow for comparison of data between interpreters and support service providers, and be able to handle data from all countries in a homogeneous way. We decided to prepare a common questionnaire for both groups, with small formal adjustments for its distribution in the three different geographical areas, and in the corresponding languages. Two different questionnaires were developed: one for interpreters and the other for support service providers. In the case of interpreters, those of spoken (foreign) languages and signed (national) languages, as well as foreign signed languages, have been considered. For support service providers, we included consideration of professionals who carry out their work in the fields of intercultural mediation, education, social work, police, health, judicial, NGO intervention.

Research ethics approvals for this study was secured via all partner universities and via An Garda Síochána's Research Ethics Committee.

The questions were presented in four sections.

For Interpreters	For Support Service Providers
➲ Basic characteristics of interpreters (19 questions);	➲ Basic characteristics of service providers (18 questions);
➲ Interpreting for victims of GBV (6 questions);	➲ Support to victims of GBV (7 questions);
➲ Aspects related to communication with victims of GBV (4 questions);	➲ Aspects related to communication with victims of GBV (14 questions);

For Interpreters	For Support Service Providers
➲ Considerations concerning interpreting (14 questions).	➲ Considerations concerning interpreters (14 questions).

Access to the questionnaire was provided through an online link (one for interpreters and one for support service providers). The questionnaire was hosted on a platform subject to the data protection and privacy requirements in force in the EU and in the UK. Settings were established to allow for access to the questionnaire and the responses collected to conform to anonymity requirements.

3.3. Sample

We adopted a mixed sampling method. We did this because the number of interpreters and support service providers working with GBV victims in Ireland, the UK and Spain is unknown – it is currently impossible to determine the number of people working in this domain due to the lack of regulation of people who work specifically with GBV victims.

The total number of completed responses obtained across all three countries amounted to 374, of which 267 were support service providers and 107 interpreters. Incomplete or inconsistent responses to the questionnaire have been excluded from the total number (see Table 3).

- **Table 3. Responses by countries and groups**

Country	Target Group	Total
Ireland	Service Providers	85
	Interpreters	11
Spain	Service Providers	173
	Interpreters	57
UK	Service Providers	13
	Interpreters	45

The questionnaire was open for both groups in Ireland and the United Kingdom for two months (from the beginning of May to the beginning of July 2021), and in Spain for interpreters for two months (also from May to July), but for other service providers for six months (from May to the end of October 2021), following from local research ethics approval timelines and associated dissemination processes.

3.4. Limitations of the Study

While there are limitations to the findings of this study arising as a result of various factors that may have impacted on the response rates which we discuss further in Sections 4.1 and 4.2., nevertheless, the results presented here offer for the first time a snapshot of the training needs and demands for support service providers and interpreters working in the GBV domain. It also opens up the possibility of international comparison.

This research was carried out jointly by 3 countries (Ireland, Spain and the United Kingdom), which meant that agreements had to be reached when drafting the questionnaire. For example, we had to define what we meant by gender-based violence in the questionnaire because each country has a different position regarding this kind of violence and regarding the use of terminology. Moreover, the three countries have different legal, academic and healthcare systems, and therefore the questions had to be quite general to account for this (e.g., We did not include the names of specific qualifications or organizations).

However, the different languages present in the three countries have been taken into account, we included reference to the spoken and signed languages of each country (English, Irish, Scots, BSL, ISL, Spanish, Galician, LSE, etc.), as well as the most used migrant languages in each of the partner countries (Polish, French, Arabic, Portuguese, etc.)

The second limitation was that the sample size is rather small because the sampling period coincided with the pandemic which meant it was impossible to hold face-to-face meetings and we know that there has been a generalised survey-fatigue reported across the pandemic (e.g., Field, 2020). Sample sizes are also different in the 3 countries (58 participants in the United Kingdom, 96 in Ireland and 230 in Spain). Moreover, the country wise sample is uneven in terms of the different profiles of service providers and interpreters: 85 service providers and 11 interpreters in Ireland; 173 service providers and 57 interpreters in Spain; 13 service providers and 45 interpreters in the United Kingdom.

Lastly, very little research has been done on this topic and it is mostly restricted to the United States (particularly in the case of signed languages) and to Spain (in the case of spoken languages), which, although a limitation, can also be considered as an opportunity to identify gaps and to describe the need for further research.

CHAPTER

04

RESULTS

Here we present a breakdown of the responses from support service providers and interpreters, drawing on and contrasting the results from each country: UK, Ireland and Spain. We then provide a summary discussion of the most salient themes that emerged from across all datasets.

4.1. Support Service Providers

Despite several attempts to circulate the call for survey responses in the UK through direct contact with relevant government, policing, charity and third sector organisations and through social media (Facebook and Twitter) and tagging the relevant organisations, in total, only 13 responses were received from service providers across the UK. This was a disappointing response, which was obviously impacted by the Covid-19 pandemic. Anecdotal reports confirm that service providers working in the GBV sector have experienced a significant intensification of their workload during the pandemic, with more calls on their time to support the exponential increase in reporting of GBV in the UK, Ireland (Doyle, Ashe and Lawler, 2021), and around the world6.

In addition, at various stages during the pandemic there were several surveys of support workers that work with women who have experienced GBV (Davidge, 2020), which may have led to survey fatigue7. As such, it is not surprising that such a low response was received.

Ireland had a larger response (n= 85 service providers), which is reflective of the high level of response from members of An Garda Síochána (Irish Police Force). We note here that an additional round of research ethics approval was required to facilitate the distribution of the survey via Garda channels. However, with ethics approval from the Gardaí in hand, the survey of Gardaí was processed in a highly effective manner, with 65 members of An Garda Síochána responding. The remainder of Irish respondents were from a range of NGOs and service providers working in the area of GBV.

Spain received responses from 173 service providers, which is testament to the relationship that they had built with key stakeholders through their SOS-VICS project (2012-2014, European Commission JUST/2011/JPEN/2912), a project dedicated to exploring the communicational reality and any challenges associated with interpreters in the communication between service providers and victims of GBV who do not speak any of the co-official languages in Spain (Del Pozo-Triviño et al., 2014a, 2014b).

An important consideration to note in the evaluation of the number of responses is the respective size of population of each country. It would be expected that the UK and Spain would have a larger raw number response rate given their country size as compared to Ireland.

As such, the combined survey results from across the three countries provide insight into communication barriers faced and the training needs of support service providers in working with women who use languages of lesser diffusion, spoken and signed, and who engage with GBV service providers via interpretation.

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6 See https://www.unwomen.org/en/news/in-focus/in-focus-gender-equality-in-covid-19-response/violence-against-women-during-covid-19

7 Personal communication, Dr Claire Houghton, Lecturer in Social Policy and Qualitative Research, University of Edinburgh, 4 May 2021.

4.1.1. Profile of Support Service Provider Respondents

UK respondents were primarily female (75%), which is unsurprising given that support services typically recommend that women are employed to meet the needs of women who have experienced GBV. The situation is similar for Spanish respondents, with a majority participation of women (86%), a consequence of the feminization of care services, primarily in the social and health fields. In Ireland, the response was gender balanced, comprising 50% male respondents and 49% female, with 1% who preferred not to say. The significant response from members of An Garda Síochána should be taken into account here as the Irish police force remains a predominantly male organisation. Women comprise less than 28% of sworn members of An Garda Síochána (Casey, 2021). Of the 17 service providers who come from other domains, 15 self-declare as female, 1 as male, and one preferred not to say. These 17 respondents report working across the charity/NGO sector, in health settings, in intercultural mediation, or in legal contexts.

UK respondents were spread across age groups but grouped mostly between 36-55 years old (33% aged 36-45 and 33% aged 46-55), with 25% aged between 56-65, and 8% aged between 26-35. The age groups in the Spanish case present the same profile, where the age group 36-55 represent the majority (25% aged 36-45 and 39% aged 46-55), followed by the 26-35 group (18%) and the 56-65 (14%), with very low presence of people under 25 years old (3%). As with UK and Spanish respondents, the Irish data shows a preponderance of responses from those aged 36-45 years (50%). 29% of respondents were aged 46-55 years. In Ireland, we see a slightly higher rate of response from those aged 26-35 years (12%) and a lower rate of response from those aged 56 years or over (6% for 56-65 years).

The majority of respondents' highest level of education in the UK was from university (36% Bachelor's degree, 36% Master's degree) with 18% and 9% who had completed a vocational or secondary level qualification respectively. The academic profile in Spain shows a greater presence of graduates with a Master's degree (61%). 34% hold a Bachelor's degree (34%), while the rest (5%) hold vocational or secondary level qualifications (2%) or a PhD (3%). Among Irish respondents, 49% hold a Bachelor's degree, and 22% hold a Master's degree. Vocational educational qualifications were reported as the highest level of education completed by 11%, while, for 18%, this was secondary level education.

All the UK respondents stated that their first language is English, with the majority having minimal or no skills in other languages, although three respondents stated that they had average or very good skills in British Sign Language, and two respondents said they had average skills in French or German. The situation in Spain reflects the Spanish hegemony (84%) with the presence of other co-official languages (Catalan: 7%, Galician: 6%, Basque: 2%), and a minimal representation of Spanish Sign Language (1%). Regarding foreign languages skills (very good to average), English (116 cases) and French (83 cases) stand out. Irish respondents predominantly report English as their first language (92%), with 4% reporting Irish, 4% reporting German and Portuguese as their first language; 1% reported ISL in this regard. The vast majority of Irish respondents say that they have minimum to average skills in German or French. Only 3 respondents self-reported as being "very good" in French; 1 reported being "very good" in Brazilian Portuguese. For other languages, Irish respondents reported skills in Irish, Italian, Spanish, Welsh, Swahili, Indonesian and International Sign, but with no indication of level of proficiency. This variance in language skills and knowledge points to a gap in the linguistic capacity of support service providers to engage with non-local language speakers/ signers effectively when discussing the delicate topic of GBV and is a barrier if considering the provision of language congruent access to services for those who have experienced GBV.

4.1.2. Work Experience of Support Service Providers in the Sector

UK respondents report 10-28 years' experience working in the sector, with a distribution across the different fields; most respondents work in social services (33%), the police (20%) or charitable/NGO/third-sector organisations (20%), with the remaining 27% working in intercultural mediation (working with people who use different languages or cultures), education or other non-stated areas. For those UK respondents working in the three main areas, they represented a range of roles, as seen in Table 4.

■ **Table 4: Range of Roles of Respondents (UK)**

Service Manager	Detective constable – sexual offences unit	Detective constable – rape investigation unit	Lawyer
Evaluation & Impact Officer	Social worker with deaf & hard-of-hearing	Deaf service CEO	Student support officer, Service improvement officer

Experience is also a characteristic in the Spanish context. While 45 respondents report that they have less than 10 years' experience, 128 respondents report having more than 10 years' experience. Of these, 72 report more than 20 years' experience in the field. Length of experience seems to be aligned to sector: social services (30%), followed by health (24%), NGO (16%) and judicial (15%), education and police (8% and 7%, respectively). Social and health services constitute the pillar with the greatest presence. All sectors are represented and includes responses from a range of professionals including lawyer(s), equality officer(s), social worker(s), psychologist(s), police officer(s), family doctor(s), forensic doctor(s), prosecutor(s), nurse(s), social educator(s), and shelter coordinator(s).

The Irish respondent profile is quite different to that of the UK and Spanish, given the robust response from members of An Garda Síochána. The majority of respondents had no more than 6 years' experience, with thirteen respondents reporting 12 years' experience. To unpick this a little more, it is worth noting that the majority of Gardaí canvassed for the purposes of this study work in the Divisional Protective Service Units (DPSUs) under the Garda National Protective Services Bureau (GNPSB). The

GNPSB was established in 2015. An additional six DPSUs were established in a range of regions across Ireland in 2020 - Mayo, Roscommon/ Longford, Kildare, Laois/ Offaly and Wexford. This helps us to explain why respondents (who are mostly Gardaí) working in those areas report having less than 6 years' experience. We should add that Gardaí also require a minimum number of years' experience prior to applying to work in a specialised area on top of their probation period (two years). Those working in this area apply to work in a specialised unit and then complete an interview process. At the other end of the experience spectrum, we note that the retirement age for An Garda Síochána members is 60. If they joined the force after 2004, they can choose to retire as early as age 55. Thus, the window of potential years of experience must be viewed through the lens of the career pathway for Gardaí when considering the Irish response.

■ **Table 5: Range of Roles of Respondents (Ireland)**

Detectives	Police officers attached to Divisional Protection Services Units	Garda Sergeants
Garda Inspector	Domestic Violence Refuge & Support Centres	Working in Human trafficking
Working With Charities/NGOs	Working in legal contexts	Healthcare
Working In Social Services		

4.1.3. Support Service Providers' Training Experience

We asked respondents to note what specialised training they had received to work with women who have experienced GBV. They could select more than one response and given that there were only 13 UK respondents to the survey overall, but 26 responses were received to this question, we can assume that each UK respondent on average selected two different types of training. The spread of UK respondents' training experience can be seen in Figure 1.1.

■ **Figure 1.1: Range of Training Experience - UK**

Gender-based violence training in Spain is fairly widespread, and 53% report that they have completed this. This represents a significant deviation with respect to other training options, which together represent a relatively balanced remainder of responses (human rights and protection legislation:18%; diversity:17%; and intercultural communication:12% (see Figure 1.2).

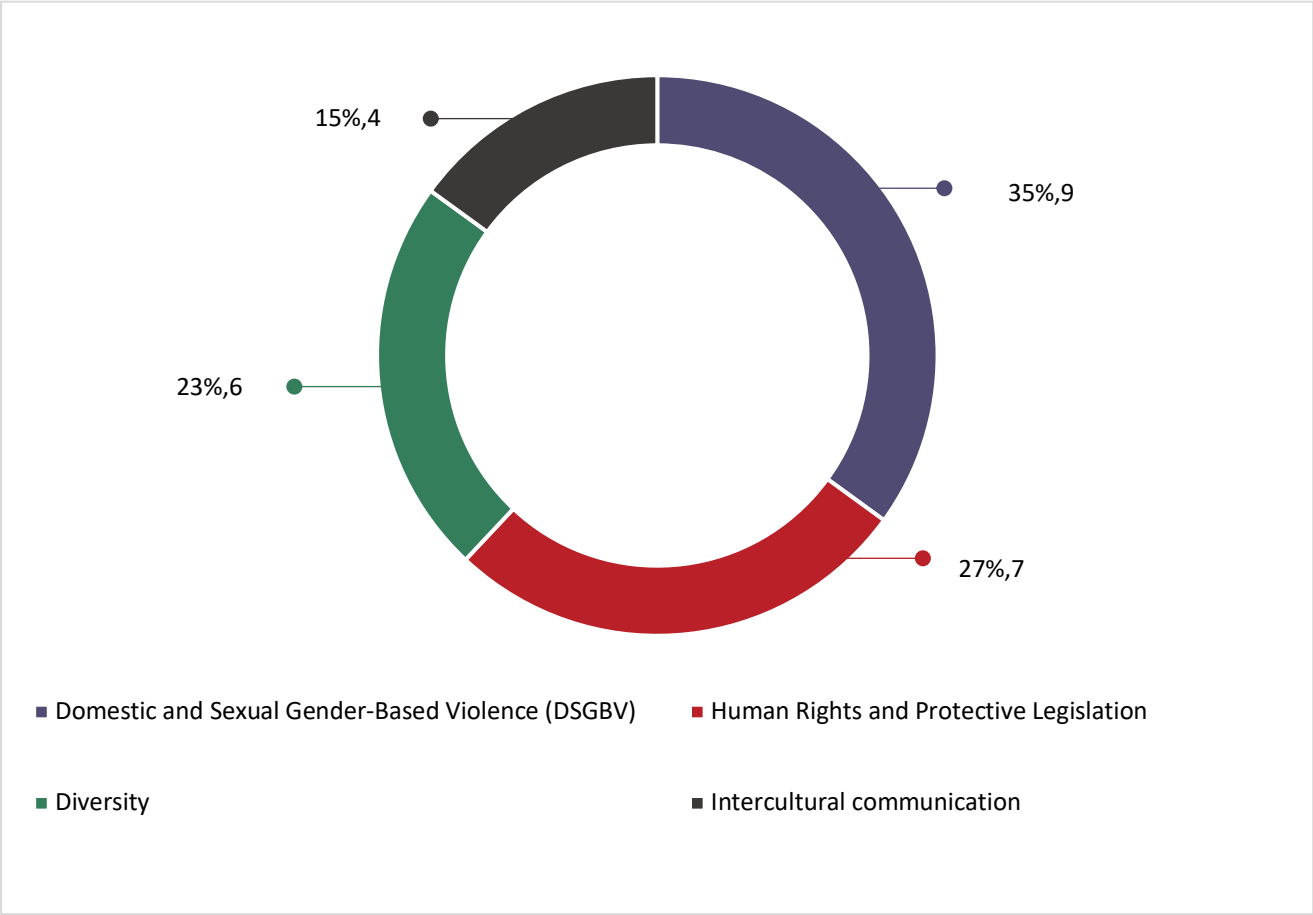
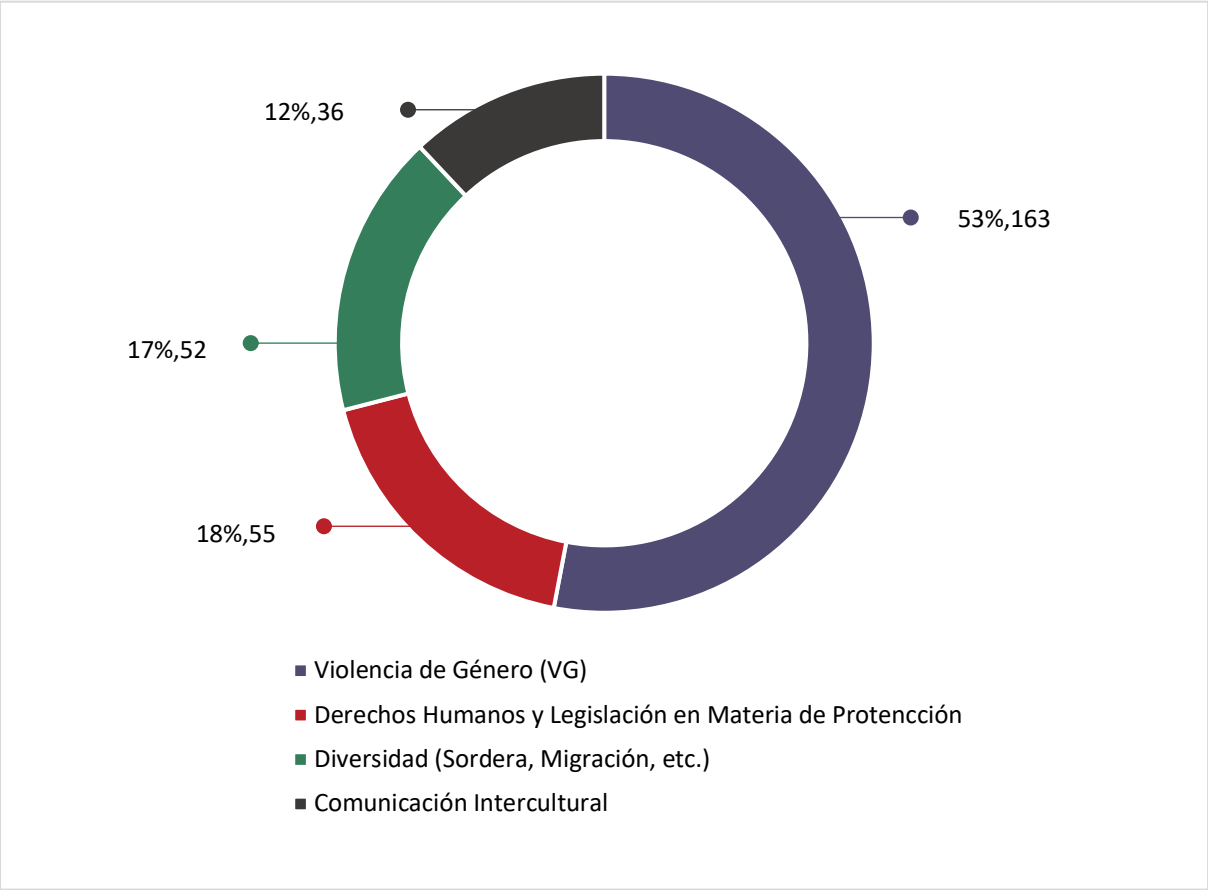


Figure 1.2: Range of Training Experience - SPAIN

For Irish respondents, 41% report that they have completed GBV training, with 29% reporting completion of training relating to human rights and protective legislation. 16% have completed some training relating to intercultural communication, while 14% have received some diversity training. We can add here that Gardaí assigned to DPSUs are provided with a bespoke training course consisting of a number of modules that address issues such as investigation of domestic abuse, online child exploitation and sex offender management. Further, all training provided within An Garda Síochána is developed around the Garda Decision Making Model, which places constitutional and human rights, and the organisational Code of Ethics at its core[8].

[8] See: https://www.garda.ie/en/about-us/our-policing-principles/garda-decision-making-model.pdf.

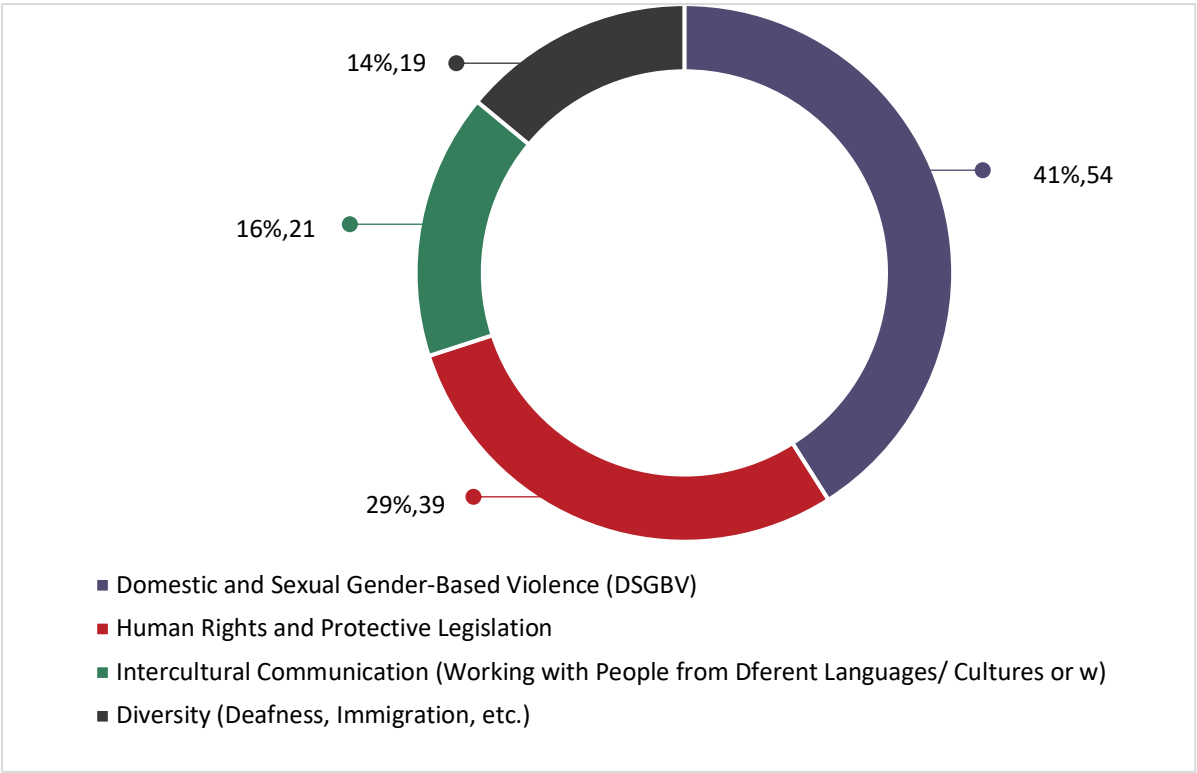


■ **Figure 1.3: Range of Training Experience - IRELAND**

When asked to break down the nature of the training experience, the majority of UK respondents had accessed specialised content through professional development workshops (60%) and the remainder through official formal studies (20%) or conferences/ presentations (20%). Respondents were asked to estimate the approximate total number of hours they had spent attending these training events, and the estimations from UK respondents differed significantly, ranging from 10 to 250 to 1000 hours. Similarly, specific courses in Spain account for 50% of the continuous training completed; smaller training units (conferences) represent 37%, while official formal studies account for just 13%. In terms of time-load, the Spanish respondents report completing between 5 and 4000 hours of training. For 23%, this maps to between 50 and 250 hours of training completed. The majority, 48%, have completed between 250 and 500 hours training while 21% of Spanish respondents say they have completed more than 500 hours of training in this area. For Irish respondents, 53% have completed professional development workshops, with 30% reporting accessing training via conferences/talks. Some 17% had completed formal training programmes. For Irish respondents, the number of hours of training completed is hard to capture accurately as only 54 Irish respondents completed this section of the survey. Of those who did respond, only four had completed 100 hours of training (the maximum reported), with four reporting 4 hours of training (the lowest number reported). Another 18 had completed between 5-20 hours of training; 15 had completed between 25-45 hours of training; 11 had completed 50-60 hours of training.

We were interested in the quality of training experiences, so respondents were given the option to rate how useful they found the training in performing their job functions in general, with 4 equating to extremely useful, 3: very useful, 2: useful and 1: somewhat useful and 0: not useful. Sixty percent of the UK respondents stated that they had found their training extremely useful, 30% as very useful and 10% as somewhat useful. In the Spanish case, the response is also very positive: 54% reported their training to be extremely useful, 31% very useful and 12% somewhat useful, only 3% assessed it in non-positive terms. Thirty two percent of Irish respondents said they had found the training extremely useful with 42% saying it was very useful. Another 20% said it was useful; 5% said it was somewhat useful, and 1% said the training was not useful. However, we should note that only 66 of the Irish respondents completed this question.

In order to create a picture of what was most valuable in their training, an open question was used to offer respondents the opportunity to tell us three most important topics covered during their specific training sessions. Eight UK respondents chose to complete this question, and their answers can be seen in Table 6.



- **Table 6: Most important topics covered during training (UK Respondents)**

Tools to support Listening Skills, Vocabulary, Responsibilities
Interviewing victims of domestic and sexual violence, awareness of support available, law, investigating domestic and sexual violence, evidence, and suspects. Domestic Abuse, Equalities, Trauma
Witness interviewing, support processes, cultural considerations BSL is not the same as English (regarding NHS Tayside EHRC case); GBV is a consequence of gender inequality; gender inequality is compounded by other inequalities e.g., disability, race, etc.
Understanding, adapting & delivery Understanding the cultural barriers women experience when seeking information on GBV, having information on where to go for specific information on specialist support services, having bespoke training that is relevant to my local community

In this case, for Spain, there were a wide range of responses, which can be grouped as follows: training in specific aspects of gender-based violence (attention, diversity, causes and awareness), applicable legislation (human rights and legal framework), intercultural communication, and intersectionality (coordination and communication between different areas).

Fifty-six Irish respondents replied to this question. They pointed to the following as the training areas they felt were most important (see Table 7):

- **Table 7: Most important topics covered during training (Irish Respondents)**

Engagement with victims/survivors	➲ How to talk to a victim ➲ How to interview children ➲ How to interview vulnerable people ➲ "Walking in her shoes" ➲ Understanding the victim perspective ➲ What steps to take to protect victim/s
Information	➲ Information about domestic violence, coercive control, sexual violence, gender-based violence and child protection, trauma, immigration processes

	➲ Psychology of victims ➲ Information about what services are available to victims ➲ High Risk Indicators and risk assessment ➲ Cultural differences across groups ➲ Impact of domestic violence on children ➲ Irish processes regarding supporting those through reporting GBV ➲ Self-care
Legislation 	➲ Local legislation updates ➲ What legislation governs domestic violence ➲ what legislation governs how to engage with victims ➲ what legislation governs how to interview vulnerable victims ➲ legislation on immigration ➲ European Convention on Human Rights and other Human Rights Legislation ➲ Domestic Violence Orders ➲ Human Rights Case Law - EU
Policing Protocols 	➲ Interview techniques ➲ Statement taking ➲ Understanding the Garda response ➲ Police procedures re GBV ➲ Supporting victims through reporting process
Ethics 	➲ General ethics
Communication 	➲ Intercultural Communication -Communication Styles ➲ Working with minorities with language barriers ➲ How to communicate with those who have cultural differences (e.g., a Muslim woman in presence of/ without her husband; someone who is a sign language user, etc.)

Using the same rating scales, respondents were asked to rate how useful they thought training would be to fulfil their role. Eighty percent of UK respondents stated that it would be extremely useful. When asked what topics would be most useful in any training offered, three UK respondents suggested the following: access to female interpreters; having specific information and guidance about how to support women affected by GBV who are blind, deaf, or do not speak English; and understanding and recognising GBV, how to effectively support victims, and how to effectively raise awareness within minority communities.

If in Spain, the training received is valued very positively, the usefulness of more training is also considered useful. Sixty-seven percent say it would be extremely useful and 23% say it would be very useful, comprising 90% of the responses received. Regarding content, requests are very specific. All suggestions related to general aspects about gender-based violence, communication skills, diversity awareness, and legal framework.

Similarly, the majority of Irish respondents (67%) say that additional training would be very helpful.

4.1.4. Characteristics of Women Seeking GBV Support

In addition to asking support service providers about their own profile, experience and access to training, we were interested to know if they already had experience of working with women seeking GBV support, and to learn a little about the languages those women used. In relation to nationality, 10% of UK respondents noted that the women they had worked with were foreign, 90% stated that their clients were primarily British. In the Spanish context, national citizens (70%) comprised the majority of women encountered by service providers while 30% report engagement with non-national. Fewer than 1% do not know the nationality of the women they had engaged with. Irish respondents report that the women they met were predominantly Irish (62%). Fourteen percent of respondents had worked with non-national women. Twenty-four percent of respondents report the nationality of their clients as unknown.

The ages of the women who UK respondents worked with ranged from 18 to 66 years and above. In Spain, most women encountered are reported as falling mostly into the 18-55 age range: 18-35 (25%), 36-45 (29%), 46-55 (22%). A reported 6% of women encountered were under 18 years and we also see a tapering off for older women: 56-65 (13%), 66 years and older (5%). In Ireland, just 1% of cases reflected on included women or girls who were under 18 years of age. 40% were judged to be aged 18-35 years; 29% aged 36-45 years; 29% aged 36-45 years; 12% aged 46-55 years, 4% aged 56-65 years and those over 66 years, 15%.

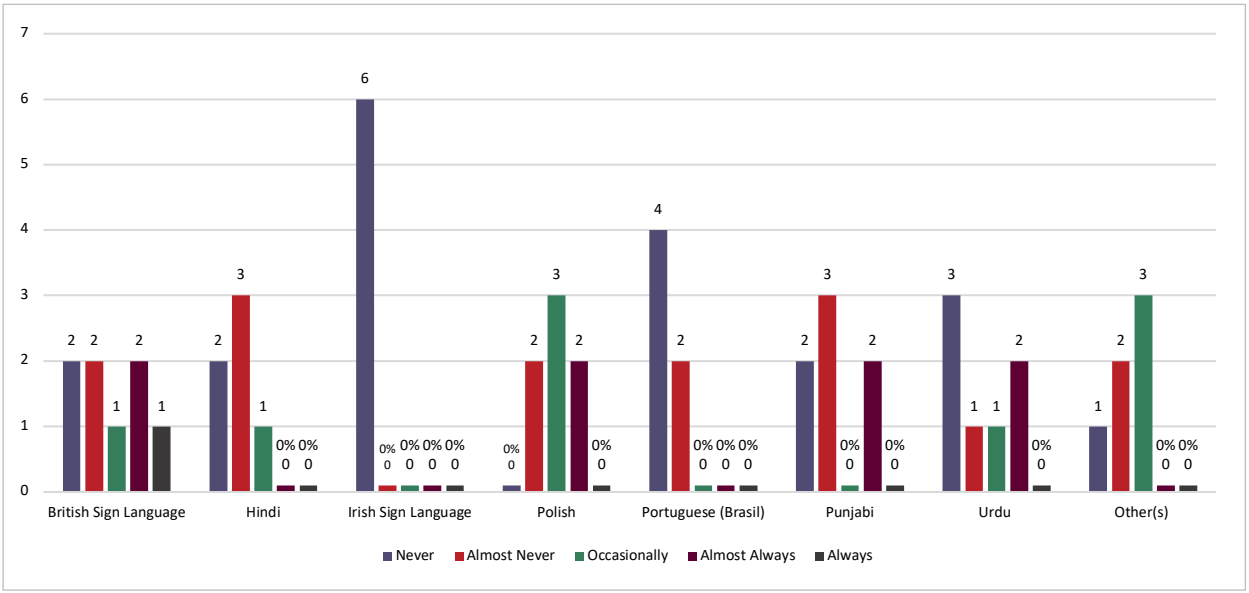
When drilling down to better understand the characteristics of the clients that they had worked with, we asked respondents to identify what proportion of their clients were (to the best of their knowledge) immigrants, refugees, asylum seekers, deaf signers, deaf/hard-of-hearing non-signers, had disabilities, or none of these characteristics. UK respondents noted that their clients were generally migrants (17%), refugees (9%), asylum seekers (9%), deaf signers (6%), hard-of-hearing non signers (1%), had disabilities (17%), or had none of these characteristics (41%).

Seventy five percent of Irish respondents reported that that the characteristics of their clients were unknown. Other responses indicated that 8% of those encountered were migrants; 1% reported working with refugees; 3% had worked with asylum seekers; 0% had supported deaf signers or hard-of-hearing non-signers; 2% had worked with disabled people; 11% confirmed that none of their clients had any of these characteristics.

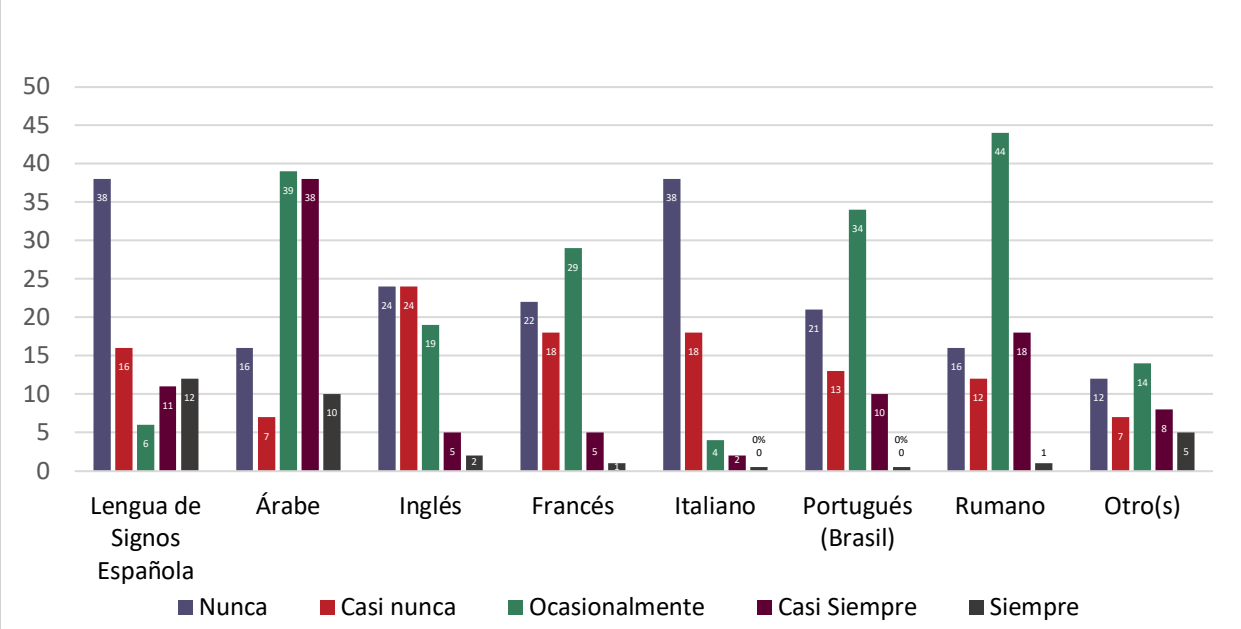
The situation in Spain offers a different picture, possibly due to the characteristics of the service providers in the sample: most report working with immigrant women (69%), while respondents report having encountered women from other groupings to a lesser degree: refugees (3%), asylum seekers (3%), deaf signers (2%), hard-of-hearing non-signers (1%). A further 6% of women encountered had a disability.

In addition to this detail, we asked about the languages that service providers' clients used if they did not speak the national language (i.e., English or Spanish) or were deaf. We provided a list of possibilities based on the most commonly used languages in the UK, Ireland and Spain, including Arabic, Brazilian Portuguese, British Sign Language, French, Hindi, Irish Sign Language, Italian, Lithuanian, Polish, Punjabi, Romanian, Spanish Sign Language, Urdu, or others. Respondents were asked to rank whether their clients used any of these languages. (Responses possible included: never used these languages, or used them almost never, occasionally, almost always or always). The spread of languages used can be seen in Figures 2.1 to 2.3.

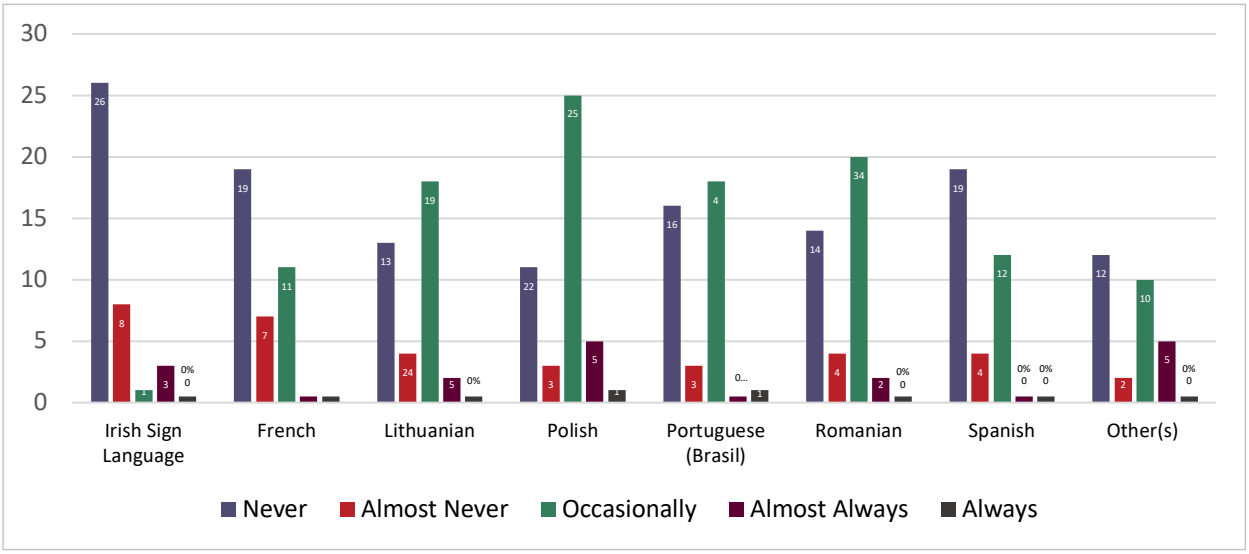
■ **Figure 2.1: Range of languages used by clients - UK**



■ **Figure 2.2: Range of languages used by clients – SPAIN**



■ **Figure 2.3: Range of languages used by clients - IRELAND**



If we collapse the 'always, 'almost always' and 'occasional' responses, we have a clearer indication of the languages most frequently encountered at present by service providers.

In Ireland, such combined reporting suggests that these are: Polish, Romanian, Lithuanian and Brazilian Portuguese. For Spain, the combined overview suggests that the most frequently presenting languages are Arabic, Romanian, English and 'other languages. For the UK, the languages most frequently encountered by service providers in this survey are: Polish, BSL, Urdu and 'other languages.

4.1.5. Giving Support to Women who have experienced GBV

When considering the support offered to women who have experienced GBV, we wanted to elicit information on what knowledge and skills support service providers feel is important, in order for them to effectively give support. The options offered included:

- Specific training in GBV
- Understanding of psychology in GBV
- Specific terminology in GBV
- Communication skills
- Recognising and managing emotions
- Knowledge of legal issues/ rights
- Knowledge of medical issues
- Knowledge of social resources

- Knowledge of the cultural context of the victim
- Intercultural communication
- Understanding of potential for victims' experience of trauma/Post Traumatic Stress Disorder (PTSD)
- Vicarious trauma / Personal implications
- Professional conduct and ethical code

Respondents were asked to rank from a five-part Likert scale ranging from not important, to a little important, important, quite important, and very important.

For UK respondents, the most important knowledge and skills (ranked by 50% of respondents or more as very important) were considered to be: communication skills (82%); professional conduct and ethical code (82%); specific training in GBV (64%); understanding of potential for victims' experience of trauma/PTSD (64%); and knowledge of the cultural context of the victim (55%).

For Spain, the most valued skills correspond to: specific training in GBV (79%), communication skills (77%), emotional management (76%), notions of psychology in GBV (64%), victims' trauma (60%), professional conduct and ethical code (59%), knowledge of social resources (58%), specific terminology in GBV (51%), vicarious trauma/personal implications (50%).

Irish respondents identified communication skills as most important (76%), along with specific terminology in GBV (69%); professional conduct and ethical code (62%); understanding of psychology of GBV (60%); knowledge of legal issues/rights (59%); understanding of potential for victims' experience of trauma/PTSD (52%); and then a slight drop for the next highly regarded item, recognising and managing emotions (45%).

Building on the knowledge needed to provide support, we wanted to better understand what challenges service providers experience in doing their job. We presented the list of options below and asked respondents to rank from not challenging, to a little challenging, challenging, quite challenging and very challenging:

- Presence of cultural barriers
- Presence of linguistic barriers
- Difficulty of understanding between service providers and interpreters
- Difficulty finding appropriately qualified interpreters in certain language combinations
- Presence of religious barriers
- Victims unaware of available services
- Victim seems suspicious or uncooperative
- Victim's circumstances make it difficult to provide support

➲ Presence of problems due to illegal status	➲ Not enough training to work with GBV victims
➲ Inadequate working space	➲ Lack of prior information about the case
➲ Poor working conditions and/or lack of resources	➲ Insufficient staff support/supervision

Interestingly, UK respondents indicated that most of these items are not particularly challenging, with 40-60% of respondents stating that 11 of the 14 items are not challenging. The maximum response for items that were marked as challenging, quite challenging or very challenging was 30%. Breaking this down we can see that 80% of UK respondents see that clients being unaware of available services as either challenging, quite challenging or very challenging; 30% regard suspicious or uncooperative clients as challenging; 60% note that clients' circumstances that make it difficult to provide support as challenging or very challenging; 50% report not having enough training to work with people who have experienced GBV as either quite challenging or very challenging; and finally 30% shared that having an inadequate working space was quite challenging.

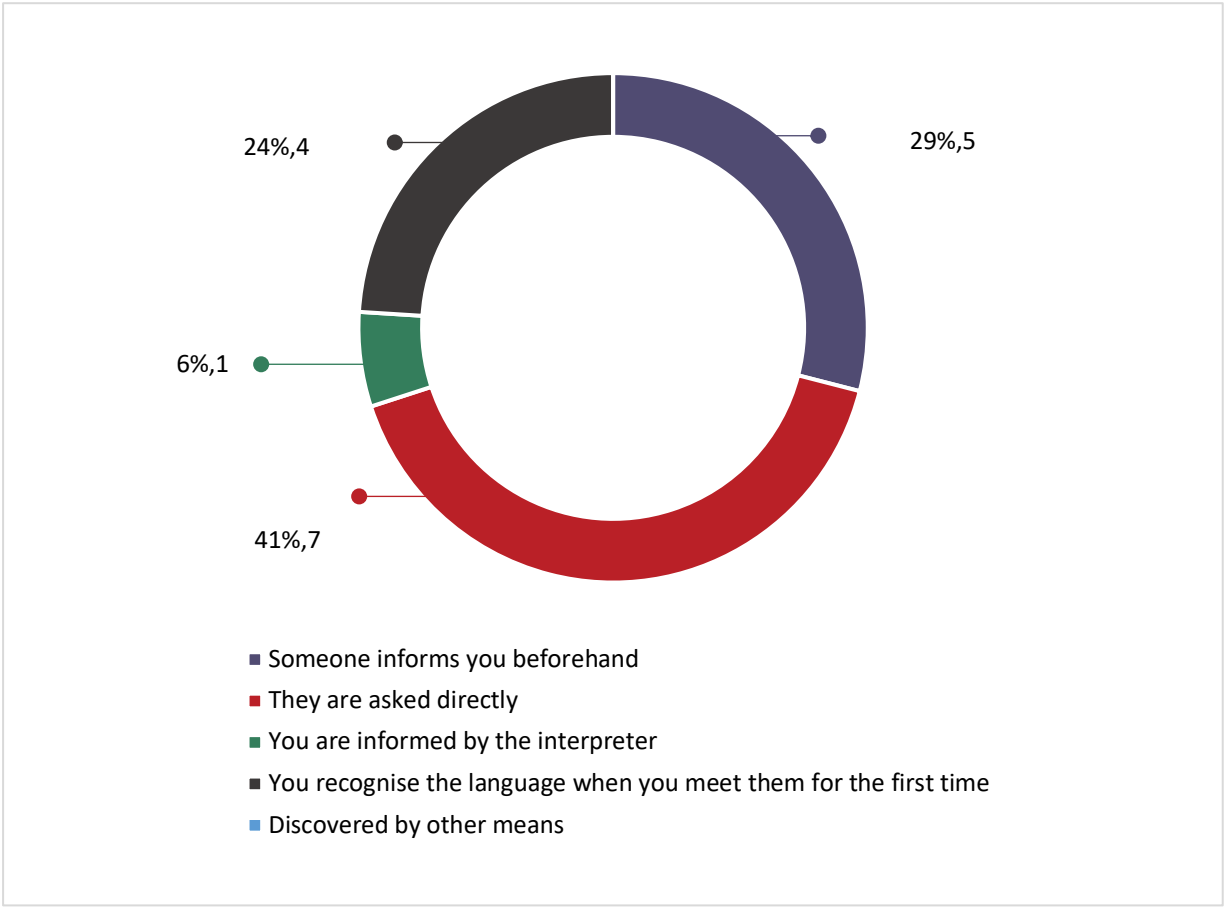
Regarding the Spanish data, the most challenging items were problems due to illegal status (28%), drug abuse (including alcohol) (25%), presence of linguistic barriers (25%). The spectrum of items marked as quite challenging is wider: victim's circumstances make it difficult to provide support (34%), victims are unaware of available services (32%), again linguistic barriers (31%), illegal status (30%), cultural barriers (29%), lack of training in trauma attention (28%), victim seems suspicious or uncooperative (27%), insufficient staff support/supervision (26%), and, again, drug abuse (inc. alcohol) (25%).

Irish respondents also indicated that most of the items listed are not particularly challenging. However, 25% reported that the presence of linguistic barriers was 'very challenging' - the most frequently cited 'very challenging' response for this cohort. 38% of Irish respondents said it was quite challenging when a victim's circumstances make it difficult to provide support. 47% of respondents report that they find it challenging when victims are unaware of available services. Other issues identified as 'challenging' include presence of cultural barriers (36%); difficulty of understanding between service providers and interpreters (36%); lack of prior information about the case (35%). Insufficient staff support/supervision was an item that 28% reported as 'challenging' while 19% of respondents noted that this was 'very challenging'.

4.1.6. Communicating with GBV victims

Given that this project focuses on best practices for support services providers and interpreters working together to provide access to GBV support, it was important for us to ascertain how support service workers report communicating with their clients who are either deaf or are refugees or migrants from languages of lesser diffusion communities. When asked how they usually ascertain the clients' language, the UK respondents' experiences were varied, as seen in Figure 3.1.

■ **Figure 3.1: Respondents' identification of client language preference - UK**

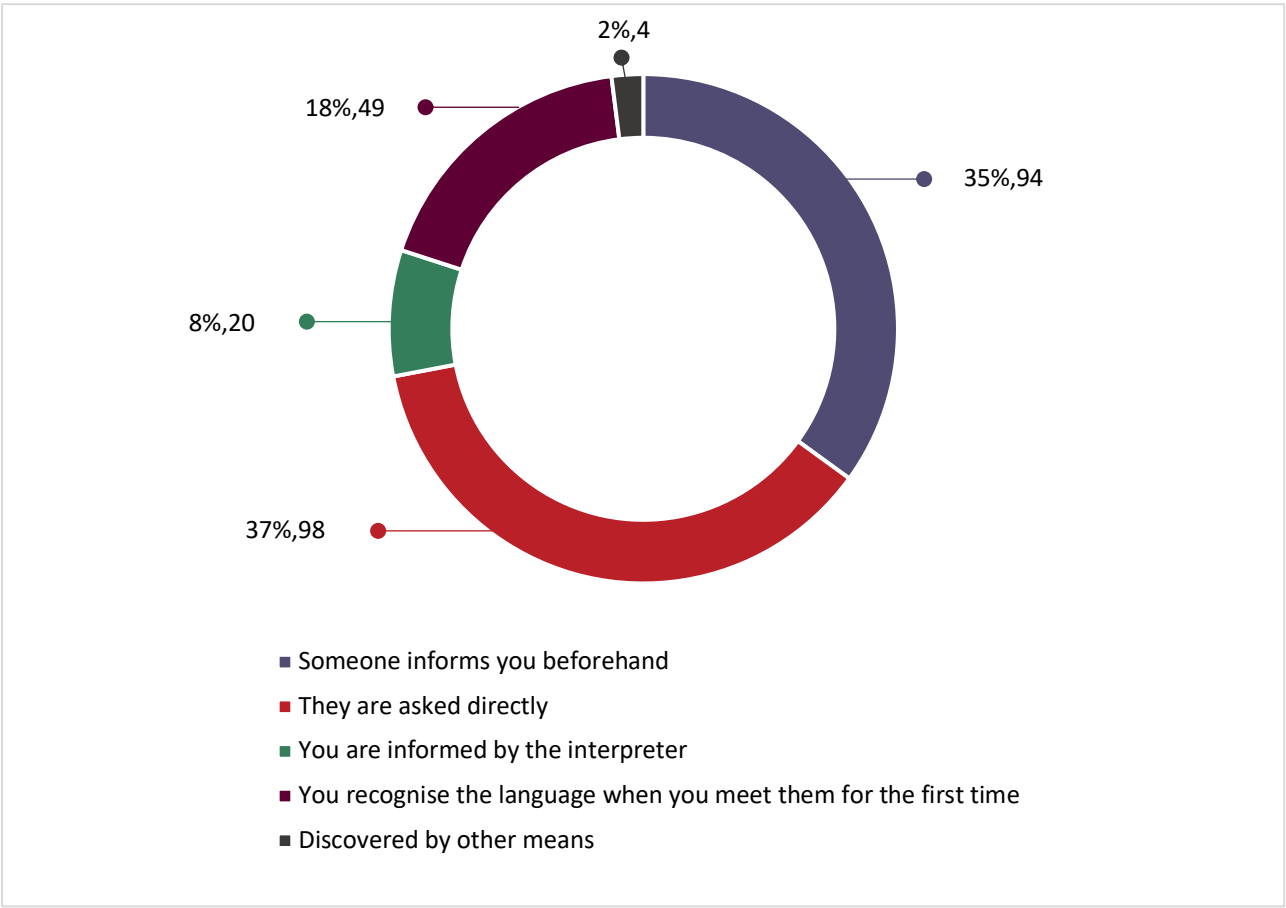


Following from this, 55% of UK respondents noted that when interacting with the client/victim, they typically communicate in the language the woman states is her first language. Twenty seven percent reported that they use the language of the host country, while 18% stated that they use another language that the victim says she understands/speaks/sign. As one respondent shared:

"Whichever language victim is happiest with, English if deemed the victim is fully understanding the process, an interpreter would always be considered if required."

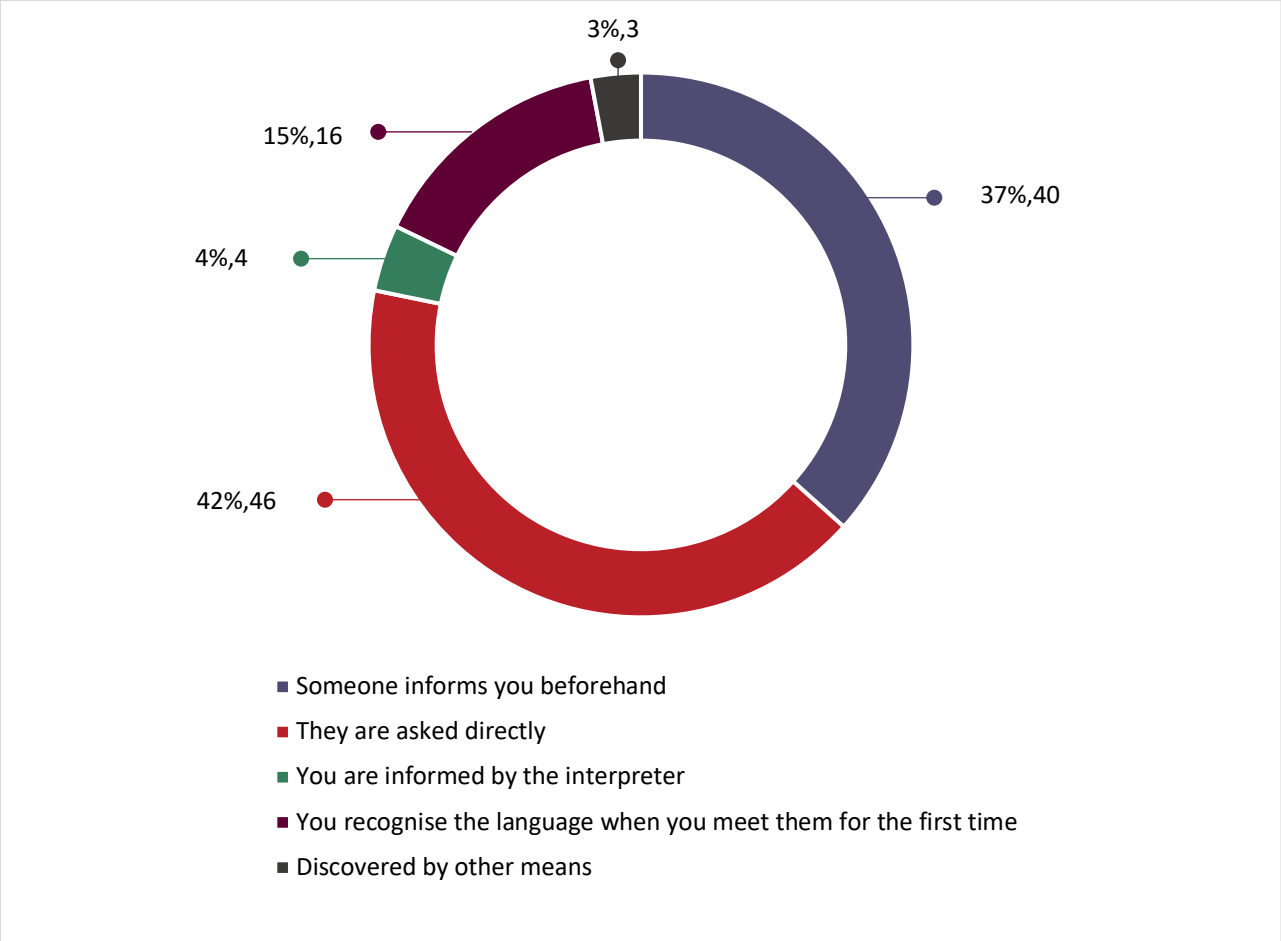
Spanish is the first choice (53%) as the language of communication in Spain. Twenty-eight per cent of the interactions take place in a language the woman identifies as her own, and 17% in another language that they say that they understand. The language of the person is identified in several ways, directly and indirectly (see Figure 3.2).

Figure 3.2: Respondents' identification of client language preference - SPAIN



In Ireland, the majority of respondents said that the language that the woman states is her first language will be used (47%), with the language of the host country (here, English), identified as the language typically used for communicative purposes by 37% of respondents. A further 10% reported that a language that the client/victim says she understands/speaks or signs would be selected, while 6% selected 'other'. The language of the person in question is identified in a range of ways, as indicated in Figure 3.3.

■ **Figure 3.3: Respondents' identification of client language preference - IRELAND**



Overwhelmingly, 83% of UK respondents agreed that there is a clear procedure to request assistance from an interpreter, but 20% noted that the procedure is not always applied at all times. In the same way, 72% of Spanish respondents say there is a protocol to request assistance from an interpreter but, as in the UK, 20% say it is not always applied. 93% of Irish respondents stated that there is a procedure in place to request an interpreter, and 65% say this process is applied consistently.

When asked if it is helpful to have an interpreter in this work, 82% of UK respondents confirmed that it was helpful. In both Ireland and Spain, 91% considered it very helpful or quite helpful. We also asked respondents what they do if an interpreter is not present: we asked them to consider how often they seek to resolve communication issues through other means, such as: (i) through gestures/ pointing; (ii) through drawing/ writing; (iii) getting help from a colleague who understands the language of the victim; (iv) getting someone who can communicate with her: (v) asking the victim to bring someone who can help; or (vi) using a multilingual software for spoken languages (for example an automatic translation programme like Google Translate).

For UK respondents, 71% used a multilingual translation software; 56% stated that they occasionally used gestures/pointing; 50% sought help from colleagues who understood the language being used, while 44% said that they occasionally used drawing/writing. Spanish responses also indicate that no single approach is always used.

Respondents report that they get someone who can communicate with her (almost always 36%) or get help from a colleague who understands the language of the victim (almost always 35%). A sizeable number seek to communicate through drawing/writing (occasionally 33%) or use gestures/pointing (almost always 32%). Some ask the victim to bring someone who can help (almost always 28%) or use a multilingual software for spoken languages ('almost always' in 24% of cases, although 28% of respondents say they never do this).

For Irish respondents, there were very low rates of reference to any of these items as 'always' used. The highest response for an item 'almost always' selected is getting someone who can communicate with the victim (29%) - this option was used 'occasionally' by 51% of respondents. Fifty eight percent of Irish respondents report that they occasionally ask the victim to bring someone who can help. Worryingly, 22% say that they always or almost always ask the victim to bring someone who can help. Irish respondents also note that they occasionally use gestures/pointing (51%) or seek help from a colleague who understands the language of the victim (51%).

Seven of the 13 UK service provider respondents had not worked with a spoken language interpreter in the 24 months previous to completing the survey. For those who had, engagement ranged from once to up to 100 times. These service providers reported working with Lithuanian, Polish, Romanian and Spanish-speaking interpreters. When asked about their experiences of working with sign language interpreters, the majority (n=8) had not worked with a sign language interpreter; the 4 that had ranged from once to 20 times and all in British Sign Language.

In Spain, 68 respondents (n=161) had not worked with interpreters in the 24 months prior to completing our survey. 20 people report working with an interpreter on one occasion across this timeline, while 11 say they have worked with interpreters 20 or more times. The languages most frequently encountered by the Spanish service providers are Arabic (65), Romanian (13), Russian (8), English (9), French (6), Spanish Sign Language (5) and others. In Spain, 128 respondents say they have never worked with a sign language interpreter. Of those who have, most report only one experience (11), while 6 respondents say they have had 10 or more engagements with interpreters.

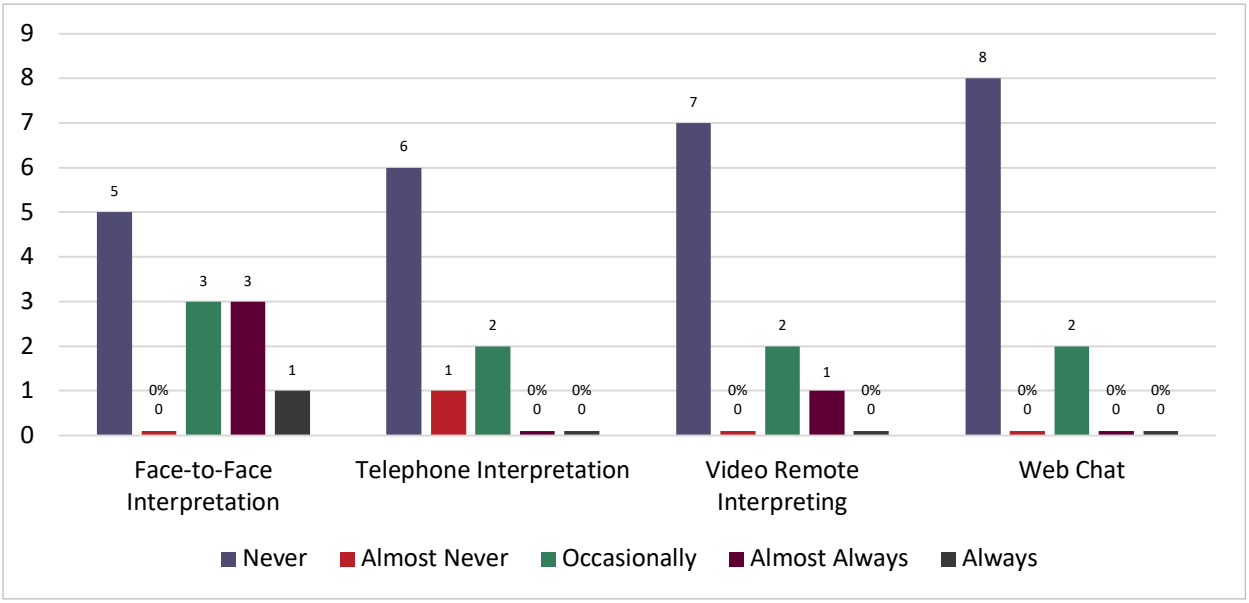
Nineteen of the Irish service providers report that they have never used an interpreter in a GBV related case. For those who have worked with interpreters, 3 report working with interpreters on 20 occasions in the past 24 months; 11 had worked on 10 occasions. Thirty-seven had worked with interpreters on 1-10 occasions and of these 37, 10 had worked with interpreters just once. For Irish respondents, the spoken languages encountered in interpreting contexts were Polish (3), Arabic (2), Lithuanian (2), Romanian (1), Syrian (1), and Spanish (1). The majority of Irish respondents (63) report that they had not worked with a sign language interpreter in the past 24 months. Of those who have done so, one has worked with interpreters on 30 occasions; 1 on 10 occasions, 1 on 8 occasions, and a further 11 have worked with sign language interpreters on 1-3 occasions. The sign languages encountered included Irish Sign Language, with reference also made to multiple sign languages (Irish Sign Language, Russian and Lithuanian) being used in a particular setting.

Building on experiences of working with deaf women, we were interested to know how often service providers had worked with a deaf interpreter as an intermediary to relay information between a hearing sign language interpreter and the deaf woman who had experienced GBV. Half the respondents had never had this experience, but at least one respondent always worked with a deaf interpreter in these contexts. The majority of Irish respondents had no experience in working with a deaf interpreter (65%).

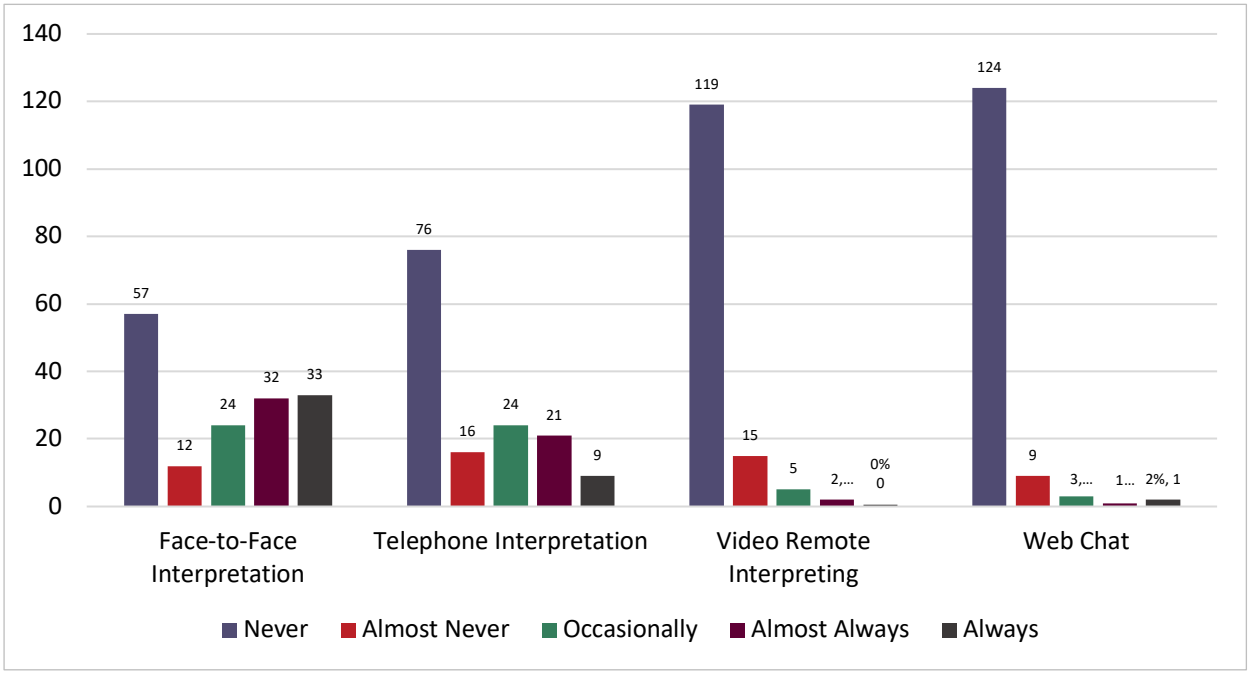
4.1.7. Working with interpreters

To build a picture of the way in which support service providers work with interpreters, we asked them to indicate how often they have used different interpretation services in the 24 months leading up to the survey including face to face interpreting, video-remote interpreting, telephone interpreting, and web chat models of interpreting. As Figures 4.1-4.3. reveal, UK, Spanish and Irish respondents mostly never have had experience of working with interpreters.

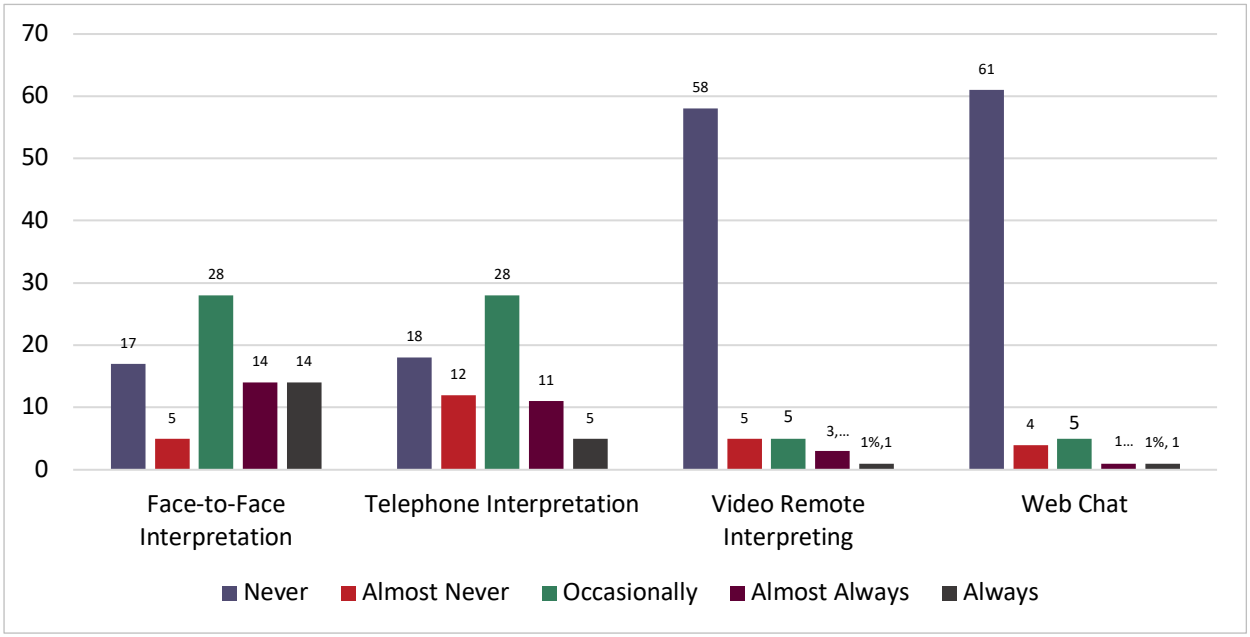
■ **Figure 4.1: Types of interpretation service used by respondents - UK**



■ **Figure 4.2: Types of interpretation service used by respondents - SPAIN**



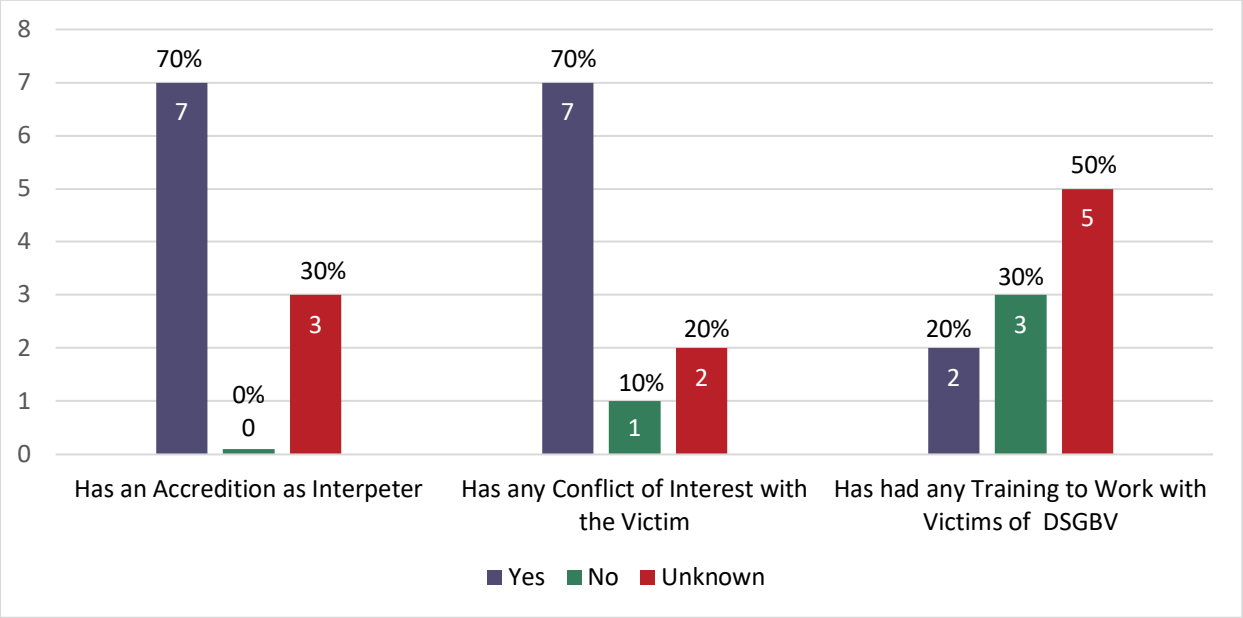
■ **Figure 4.3: Types of interpretation service used by respondents - IRELAND**



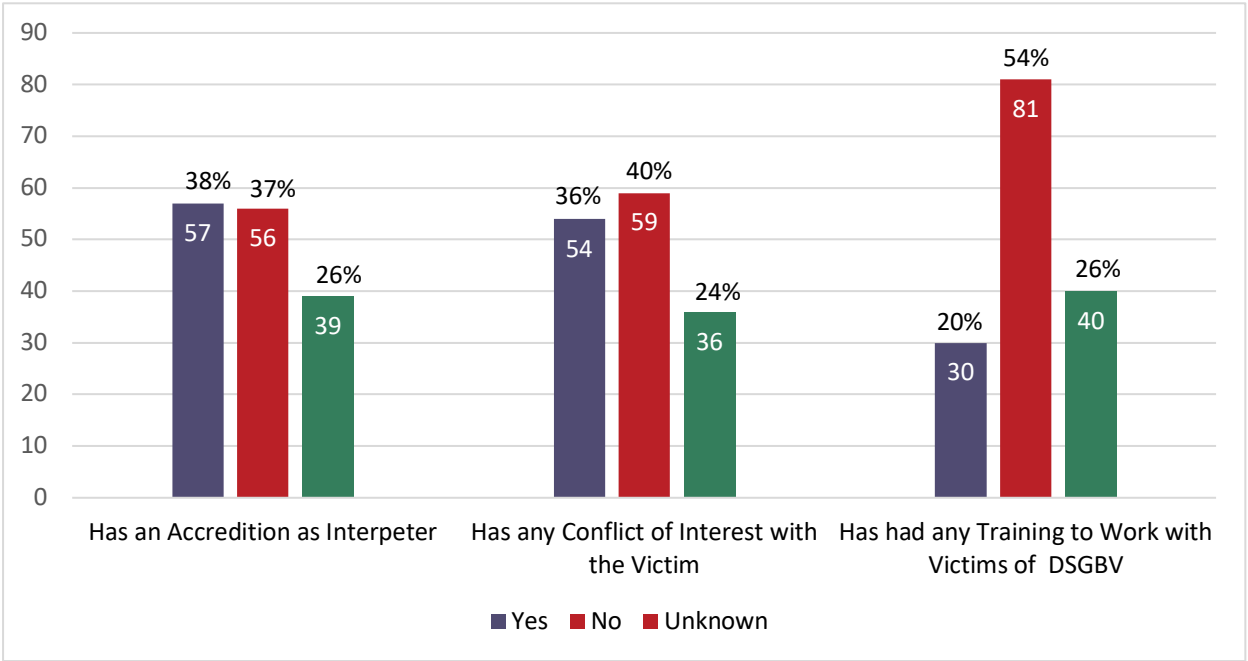
A wide body of literature in Interpreting Studies confirms the importance of working with professional interpreters who are suitably trained or accredited to do the work, especially in high-stakes settings where people are vulnerable such as adult and child refugees or asylum seekers (Todarova, 2020; Gallai 2023; Sultaníc, 2023). Professional interpreters are also expected to abide by ethical codes of conduct requiring them to remain impartial (Kalina, 2016; Baixauli-Olmos, 2020). As such, we asked if support service providers check if interpreters are accredited, if they have

had training to work in GBV contexts, or whether they have a conflict of interest with the client (which can often happen in small language communities). Figures 5.1-5.3 illustrate that for UK, Spanish and Irish respondents, they do check if the interpreter has accreditation or a conflict of interest, but do not tend to check if they have had any relevant training.

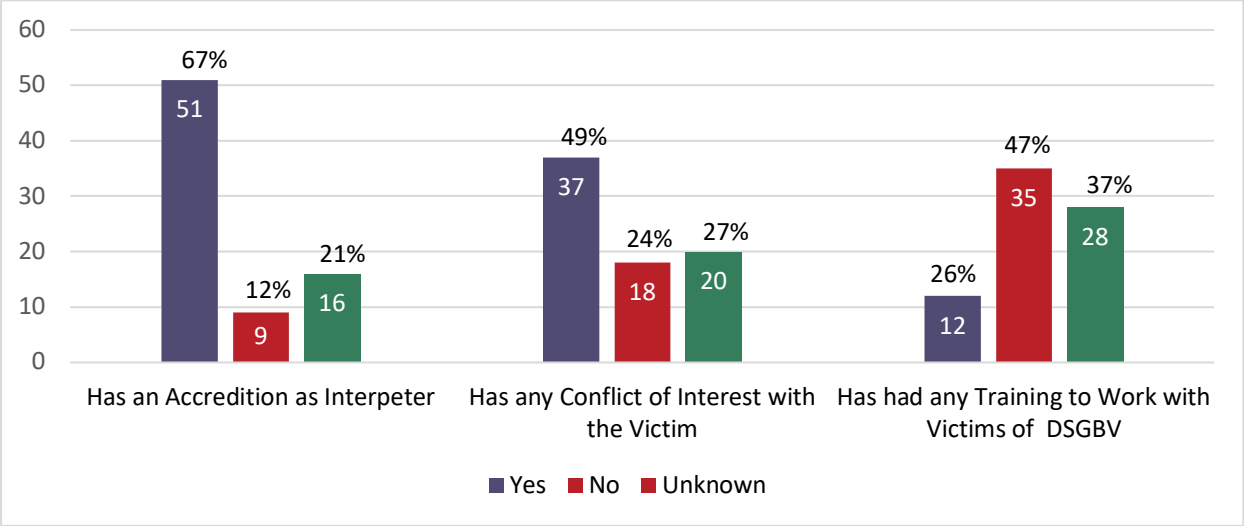
- **Figure 5.1: What respondents check with interpreters - UK**



- **Figure 5.2: What respondents check with interpreters – SPAIN**



■ **Figure 5.3: What respondents check with interpreters - IRELAND**



The Interpreting Studies literature also points to the need for interpreters to be given the opportunity to prepare in advance of assignments, in order to better understand the linguistic, cultural and power dynamics in any given context (Hale, 2007; Kalina, 2007; Knox, 2008; Nicodemus, Swabey & Taylor, 2014, Borja Albi & Del-Pozo- Triviño 2018). Thus, we asked respondents to indicate if, when they are working with an interpreter, the interpreter is given prior information about the nature, content or format of the meeting, the purpose of the questions that may be asked during the meeting and any potential emotional load that the interpreter might experience, along with any other information. The majority of UK respondents (80%) confirmed that they provide information to interpreters about the nature of the meeting, but 20-30% stated that they did not give any of the other types of information. Information provided to interpreters in Spain stands out in a positive way: 67% say they tell interpreters about the nature of the meeting, 58% explain the format and 57% outline the content to be covered. Forty-eight percent outline the the purpose of the questions to be asked while 44% say they address the potential emotional load. Seventy-one percent of Irish respondents say that they provide information about the nature of the meeting but only 49% say they outline the content of the meeting. Some 70% say they describe the format of the meeting, while the purpose of the meeting is addressed by 56% and 51% say they discuss the possible emotional load.

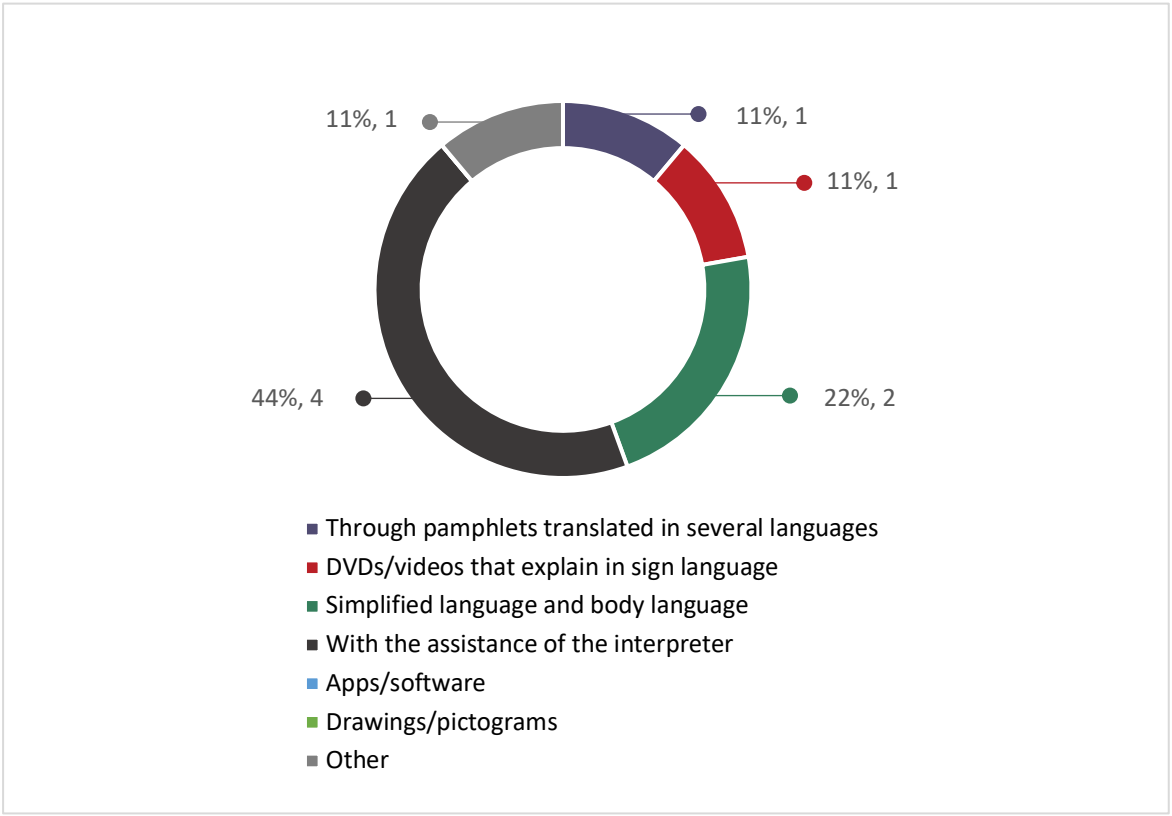
Working conditions for interpreters are well established in terms of the logistics of carrying out the assignment (e.g., where to sit, the length of time that an interpreter should work for before experiencing cognitive load and fatigue, and safety etc). (Biagini, Boyd & Monacelli, 2017). Despite this, working conditions often need to be negotiated and agreed in order to ensure the best communicative conditions for all interlocutors. So, when asked if interpreters' working conditions are agreed prior to a meeting, it was disappointing to see that only 44% of UK respondents said that this issue is always addressed. Forty-five percent of Spanish respondents say no or almost no information on working conditions is provided, although which contrasts with the 34% who say that the conditions of the meeting are always or almost always agreed. For Irish respondents, 51% said this information was always (26%) or almost always (25%) agreed prior to a meeting. A further 26% said it was sometimes agreed while 23% said the interpreter's working conditions were never or almost never agreed prior to a meeting.

Likewise, the role of the interpreter is also well understood, on the basis of research that has identified interpreters as co-participants and co-constructors of meaning in interaction (Baraldi & Gavioli, 2012; Roy, 2000; Wadensjö,

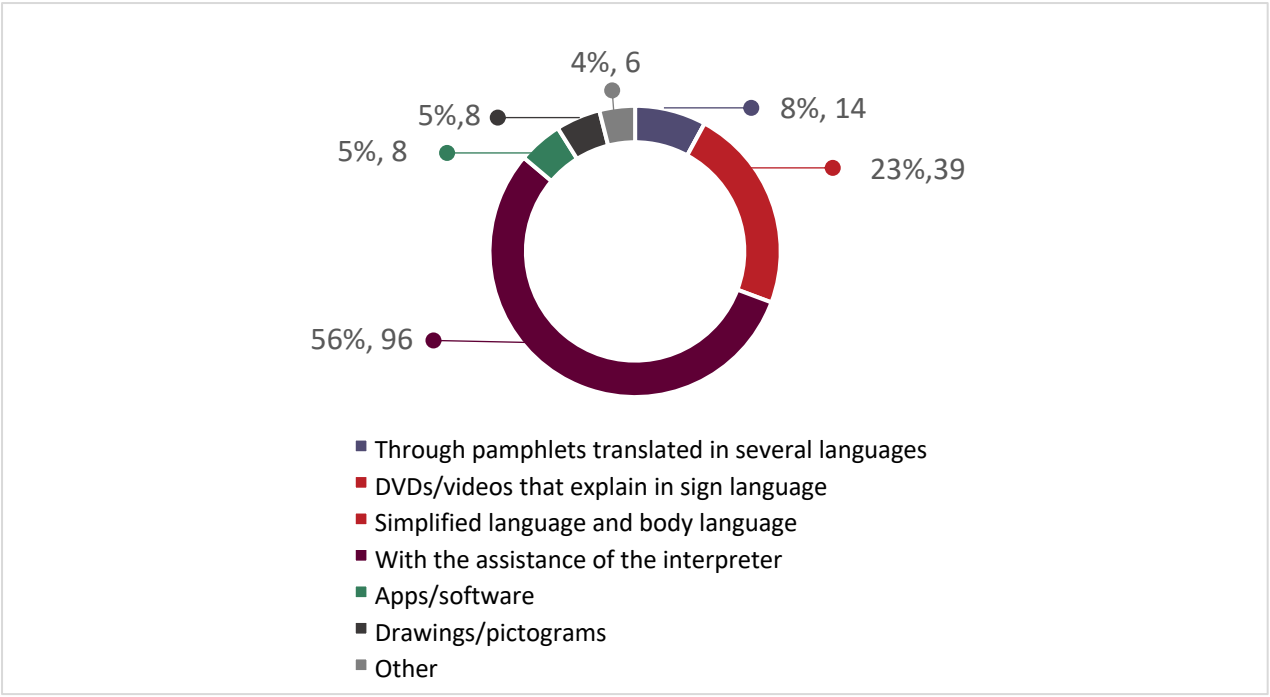
1998), with the responsibility to mediate utterances between people who do not use the same language without imposing their own opinion and declaring any conflicts of interest (Berk-Seligson, 2009). We asked support service providers whether the expectations of the interpreter's role are agreed with the interpreter before the meeting begins (e.g., who to direct speech to, how to clarify, interrupt, etc.). Fifty percent of UK respondents stated that they always discuss and agree the interpreter's role while the remaining 50% report doing this some of the time. Ninteen percent of Spanish respondents say this information is always offered, while 26% say they never address this issue in advance of a meeting. For Irish respondents, 40% say that they always discuss and agree the interpreter's role, with a further 24% saying they almost always discuss this. Worryingly, 18% report that they never or nearly never discuss the interpreter's role ahead of a meeting commencing.

Furthermore, we enquired whether the person who has experienced GBV is informed of the role of the interpreter before the meeting begins, and if so, how they are informed. Fixty-six percent of UK respondents confirmed that they are informed, through various means, as seen in Figure 6.1. In Spain, this figure reaches 77% (Figure 6.2), although 12% that did not indicate a response, which is comparable to those who do not inform a victim of GBV about the role of an interpreter ahead of an interaction (11%). A significant majority of Irish respondents (89%) confirm that they inform victims of the role of interpreter ahead of time with 8% reporting that they do not (Figure 6.3).

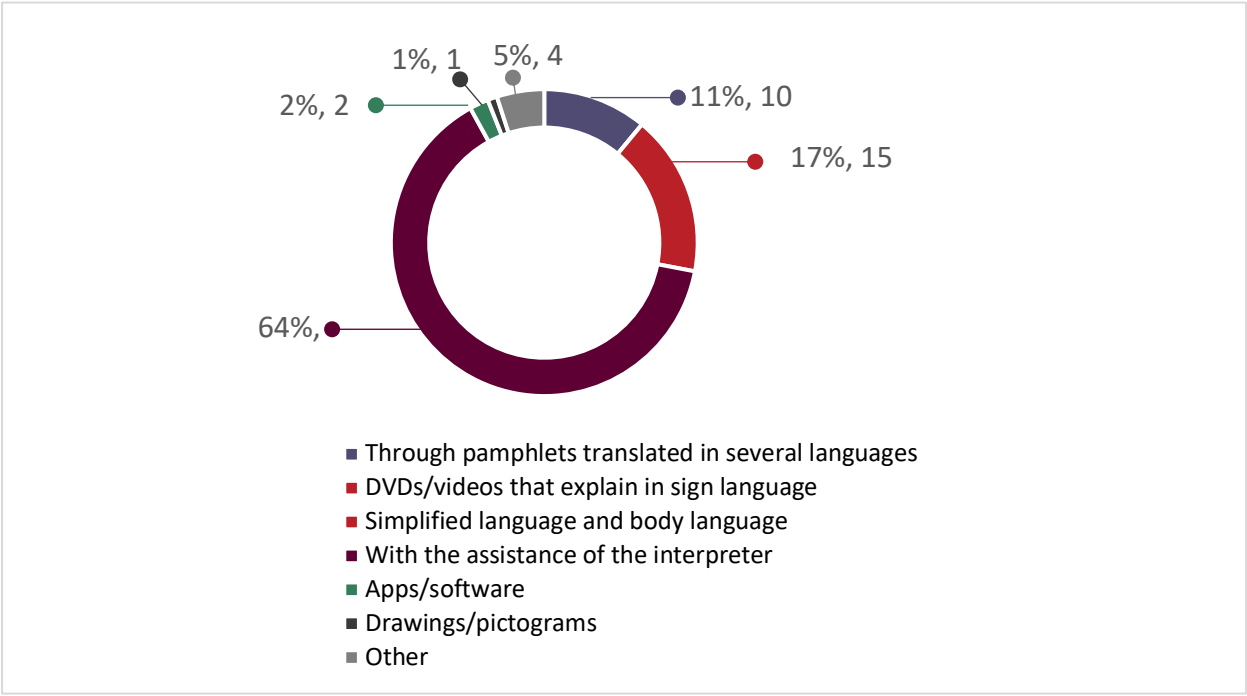
■ **Figure 6.1: Means to inform about the role of the interpreter - UK**



■ **Figure 6.2: Means to inform about the role of the interpreter - SPAIN**



■ **Figure 6.3: Means to inform about the role of the interpreter - IRELAND**



One of the recommendations for interpreters who work in sensitive settings is to have the opportunity to debrief, in order to discuss any issues with the interpreter, including any problems or possibility of vicarious trauma (Darroch & Dempsey, 2016; Lai & Costello, 2021; Knodel, 2018). When asked if they ever hold a subsequent meeting with an interpreter to give them the opportunity to debrief, only 2 UK respondents say that they always offer this option. In Spain, 16 of 134 respondents say they do this but most do not (51). Seven percent (n=5) of Irish respondents say they always hold a meeting with the interpreter for debriefing purposes. The overwhelming majority, however, never (41%) or rarely ever (28%) do.

On a Likert scale of 0 = not satisfied, to 4 = very satisfied, support service providers were asked to rate their general level of satisfaction with respect to interpreters they have worked with. UK respondents were overwhelmingly satisfied, with 86% of service providers rating 4 or 5. The distribution is, even with a high degree of satisfaction, less positive in Spain, where 29% rate their satisfaction with interpreters very positively, 39% say their experience is quite positive, but 28% are lukewarm. The situation is similar in Ireland where 26% say they are very satisfied with the interpreters they have worked with; 49% say they are quite satisfied; and 25% report being fairly unsatisfied or neutral.

4.1.8. Interpreters' Training, Competencies and Skills as Perceived by Support Service Providers

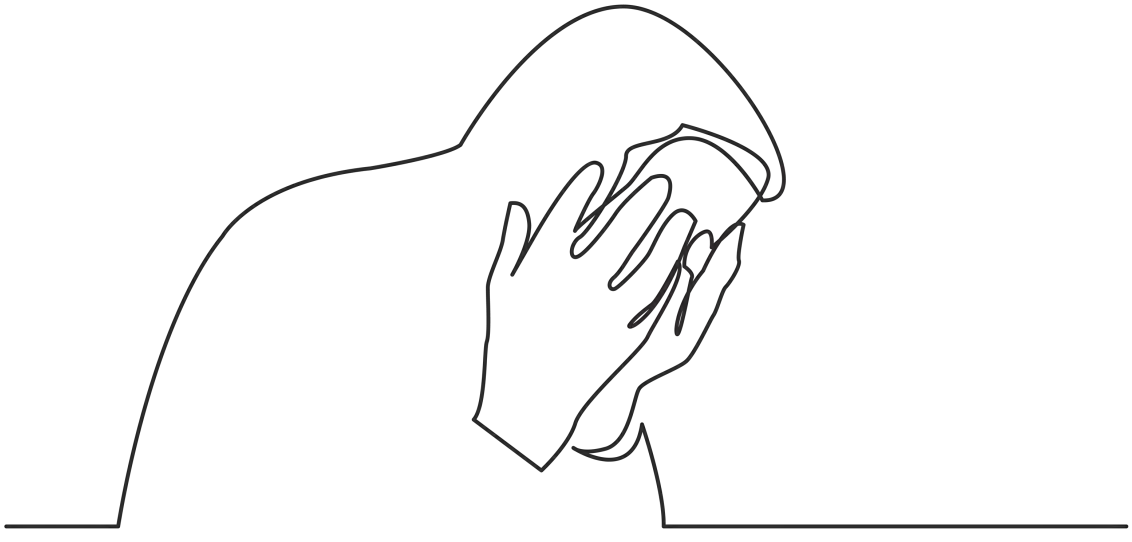
Given that interpreters typically work across a wide range of settings, we were interested to know how important support service providers feel it is for interpreters to have specific training in topics related to working in GBV settings. We asked respondents to rate certain topics as not important, a little important, important, quite important, or very important. Very few UK respondents found any of the topics unimportant, with the majority stating that most topics were important. Spanish respondents scored quite differently in most cases.

Respondents were then asked to list the three most important knowledge areas that interpreters working with people who have experienced GBV should know, as seen in Table 8.

■ **Table 8: Support service provider perceptions of important knowledge areas for interpreters**

UK	Spain	Ireland
➲ Language ➲ Legal issues ➲ Trauma ➲ Training in GBV ➲ Awareness of occurrence & legal issues ➲ Language skills ➲ Culture ➲ Specific terminology ➲ Communication skills ➲ Conduct ➲ Nature of abuse ➲ Knowledge of the cultural context of the client	➲ Language skills ➲ Intercultural communication ➲ Legal issues/rights ➲ Communication skills ➲ Emotional management ➲ Psychological aspects of GBV ➲ Training in GBV ➲ Ethical codes ➲ Specific training	➲ GDPR ➲ Services ➲ Emotional management ➲ Accuracy in communication with victims ➲ Terminology ➲ Procedures, including how long it takes to take a statement in a complex case ➲ Language ➲ How to distance oneself personally from the subject matter ➲ Cultural needs ➲ Supports ➲ Communication Skills ➲ Discretion - and 'not to interfere'

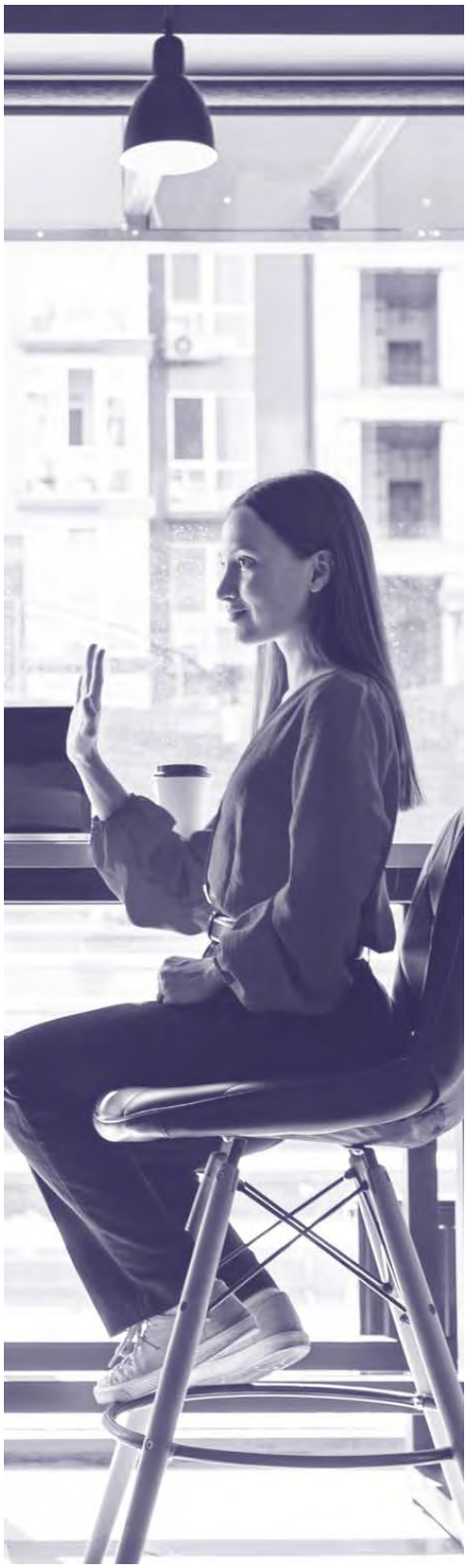
Finally, respondents were asked to suggest the three basic skills/ competencies that interpreters should have, and these can be seen in Table 9.



■ **Table 9: Support service provider perceptions of important skills/competencies for interpreters**

UK	Spain	Ireland
➲ Professionalism ➲ Ability to communicate effectively ➲ Discretion ➲ Listening skills ➲ Specific terminology ➲ Understanding meaning of GBV terms ➲ Languages ➲ Intercultural communication ➲ Interpreting accuracy ➲ Empathy ➲ Communication skills ➲ Signs for GBV	➲ Empathy ➲ Emotional management ➲ Professionalism ➲ Listening skills ➲ Interpreting accuracy ➲ Intercultural communication ➲ Patience ➲ Communication skills ➲ Neutrality ➲ Cultural awareness	➲ Language Skills (3), including pronunciation ➲ Be conscientious ➲ Effective communication skills ➲ Translation (interpreting) skills ➲ Be able to take direction ➲ Be well presented ➲ Listening skills ➲ Be non-judgmental ➲ Be resilient ➲ Empathy ➲ Patience ➲ Be Understanding ➲ Be polite ➲ Professionalism

4.2. Interpreters



The call for survey responses from spoken and sign language community interpreters in the UK, Ireland and Spain followed the same process as with support service providers. Information about the project and our survey was circulated through the networks of the research team (e.g., to interpreter e-mail lists), via social media (Facebook and Twitter) with tagging of the relevant professional interpreter organisations, as well as direct contact with professional interpreter organisations with requests for them to distribute the call to their members/registrants. Responses were received from 45 interpreters in the UK, 11 in Ireland and 57 in Spain. It is difficult to confirm what the potential sample population may have been as interpreting is not a regulated profession in any of these countries. Additionally, not all interpreters working in 'public service' domains work with people who have experienced GBV.

In the UK, there are two registers of interpreters: the National Register of Public Service Interpreters (NRPSI) for public service (community) interpreters (across 100 different spoken languages), and the National Register for Communication Professionals with Deaf signers (NRCPD) for BSL/English interpreters. These registers report that there are 1800 and 1600 registered interpreters respectively, giving an overall potential sample total of 3,400 community-based interpreters, which means that responses were received from 1.32% (n=45) of the potential UK interpreter population. There are other professional membership organisations, but it is possible for interpreters to be members of more than one, so we used the memberships of NRPSI and NRCPD as a baseline. However, as interpreting is not a regulated profession, registration is not mandatory, so it is highly likely that there are many more interpreters working who are not registered.

In Ireland, the Register of Irish Sign Language Interpreters (RISLI) was established in December 2020, a requirement of the Irish Sign Language Act (2017). There are currently 113 Irish Sign Language interpreters registered, 16 of whom are deaf interpreters, although more are eligible to register (Leeson & Venturi 2017, Sheridan, Lynch & Leeson, in press). Of these, 79 are members of the Council of Irish Sign Language Interpreters. Under the Act, all public services are required to work with sign language interpreters who are members of RISLI. However, there is no parallel register of spoken language interpreters in the Republic of Ireland, and very few are registered members of the Irish Translators and Interpreters Association (Mary Phelan, personal communication). It is therefore impossible to point to any centralised estimation of the number of community interpreters working between spoken languages in Ireland. Thus, the context that spoken language interpreters operate within is radically different in terms of regulation and oversight in the Irish context. Against this backdrop, responses were received from 11 interpreters, 5 of whom self-identified as sign language interpreters.

Spain presents a different context. There is an official registry of foreign languages interpreters and translators recognized by the Ministry of Foreign Affairs and

Cooperation that includes those professionals who have passed a sworn interpreter/translator testing process. A sworn interpreter/translator must pass a state recognition examination that gives legal validity to her/his interpretations and/or translations. Sign language interpreters must be accredited by the CNSE (Spanish Confederation of the Deaf) and/or hold a higher degree of Professional Training in Sign Language Interpretation. According to the most recent data, the number of foreign languages sworn interpreters/translators is 6604, but there is no official registry for sign language interpreters. To these numbers must be added people with language knowledge and no regulated training who also carry out translation and interpretation tasks in both the legal and non-legal context (health, police, NGO, etc.). There is no data available that indicates number nor qualification, reflecting the volatile and informal nature of provision in this space. Membership of associations of interpreters and translators is only available to professionals, leaving an undetermined number of people who carry out translation and interpreting tasks without a verified qualification. For this survey, professionals have been contacted through the official listings, via professional associations, and through organizations that use interpretation and translation services.

Nevertheless, the pooled survey results from interpreters in the UK, Ireland and Spain provide us with a window into their experiences and training needs in working with women who use languages of lesser diffusion who have experienced GBV.

4.2.1. Profile of Interpreter Respondents

The majority of UK respondents were BSL/English interpreters and were female (84%), with 57% aged between 36-55 years. A high proportion of UK interpreters had completed higher education to undergraduate or postgraduate level (76%). This data corresponds with the demographic picture of BSL/English interpreters confirmed recently through a census survey (Napier, et al, 2021). The data in Spain also show a large majority of women compared to men (82% vs. 18%) across a wide age spectrum with a predominance those aged 36-45 years (39%). Fifty-three percent of the Spanish interpreter respondents hold postgraduate qualifications and 79% state they have specific training in interpreting (mostly professional training (34%) and specialized courses (24%). For Ireland, there were 11 respondents, 5 of whom self-identified as sign language interpreters. Sixty-seven percent of the Irish interpreters were aged 46-55 years and the majority were female (78% of those who documented gender). All of the Irish interpreters had completed higher education - 50% hold a Bachelor degree while the remainder hold a postgraduate qualification. All respondents had received specific training in interpreting.

The majority of the UK interpreters report that their first language is English (n=27) with 1 each stating BSL, Arabic, Polish, Turkey, and 3 indicating they have two balanced first languages (2 = BSL/ English, 1 = Ukrainian/English). When asked to report their working languages as interpreters, the majority state BSL and English, with two reporting Portuguese and French. In Spain, none of the respondents stated Spanish Sign Language (LSE) as their first language, Spanish is the reported by the majority (36), along with other co-official languages (Galician= 4, Catalan= 2, Basque= 1). Others reported Arabic (9), while 4 or fewer reported Russian, Romanian, French or German as their first language. Irish interpreters reported English as their first language (n=8), with all of them reporting Irish Sign Language as a working language. International Sign was also listed (1).

4.2.2. Work Experience of Interpreters

The survey participants were asked about how long they had worked as interpreters. UK interpreters reported a range of experience from 7-30 years of working as interpreters, with expertise working across a range of settings, including: social services (19%), health (21%), education (15%), charity/third sector (13%) or legal (12%); and 20% in other areas such as: business or work-based, training courses, arts and performance, community care, and mental health. The experience of interpreters in Spain ranges from 2 to 6 years (13), 7-13 years (13), with 23 respondents reporting that they had between 14- and 30-years' experience. The settings they work across are relatively homogeneous: judicial (17%), NGO (16%), police (14%), social assistance (12%) and health (11%), and 29% in various professional fields (from audio-visual to financial). Irish interpreters report having between 6 and 28-years' experience, and report having worked across a range of settings on a pretty even basis: social services (16%), the charity/NGO sector (16%), in educational settings (14%), in health settings (14%), and legal (14%). The highest number of responses received was 'other' (28%) such as conference interpreting, media interpreting, mental health, the arts, politics/government, etc.

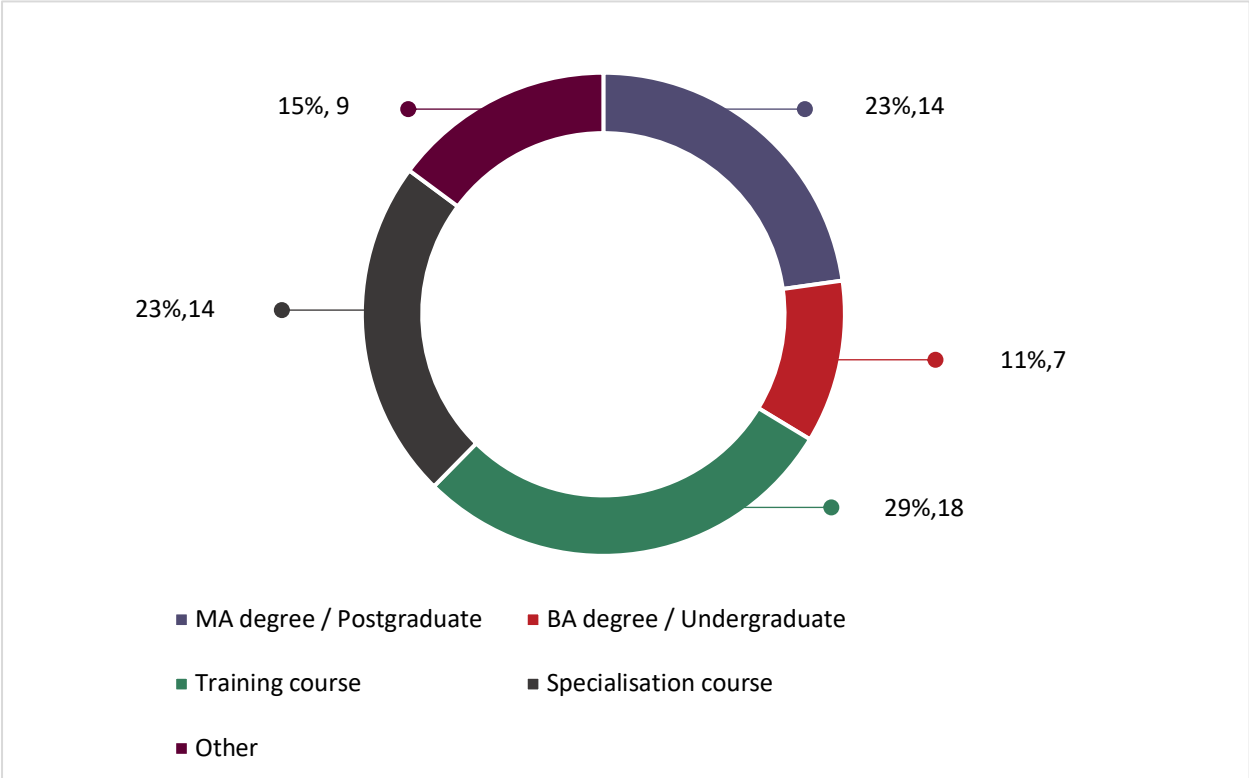
To provide a more complete picture, we asked the interpreter respondents to confirm which languages they had interpreted in over the 24 months preceding the survey. Almost half of the 33 UK respondents reported that they had worked between English and BSL, followed by Polish, Portuguese, French and Ukrainian. The most translated languages reported by the Spanish respondents are Spanish (25) and LSE (18), English (11), French (9), Arabic (8) and

Russian (5). For Irish interpreters, all respondents who completed this question said they had interpreted between Irish Sign Language and English (7).

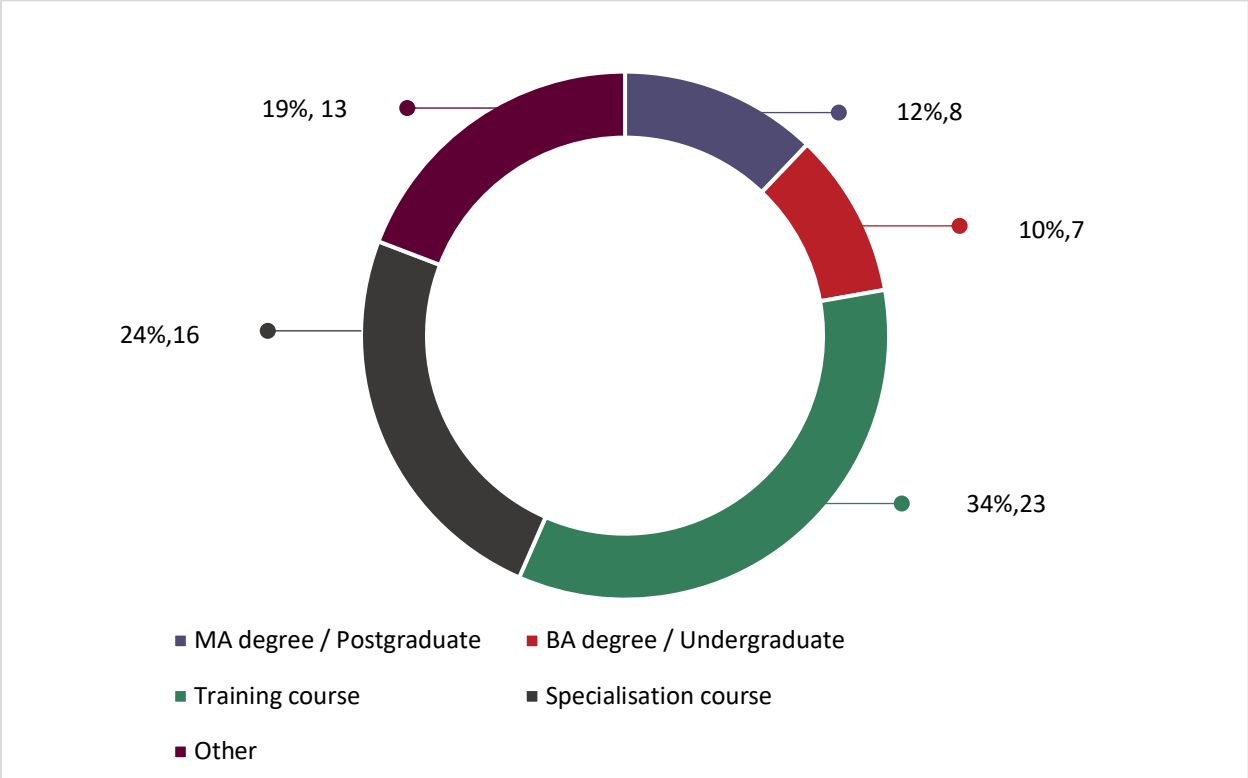
4.2.3. Interpreters' Training Experience

Of the UK interpreter respondents, 95% had completed specific training in interpreting across a range of different types of training. The 'other' category was typically a diploma qualification in interpreting. Spanish respondents indicated that they had completed training courses (34%) and specialisation courses (24%), while others completed courses in Bachelor degrees (10%) and Masters degrees (13%). Others (19%) range from specific minor courses or experience working with NGOs. A majority of Irish interpreters report completion of a Bachelor's degree (50%), with 17% reporting completion of a specialisation course or another training course. A further 8% report completion of an MA/postgraduate qualification. A further 8% reported they had completed 'other' training such as a Diploma programme (see Figures 7.1-7.3).

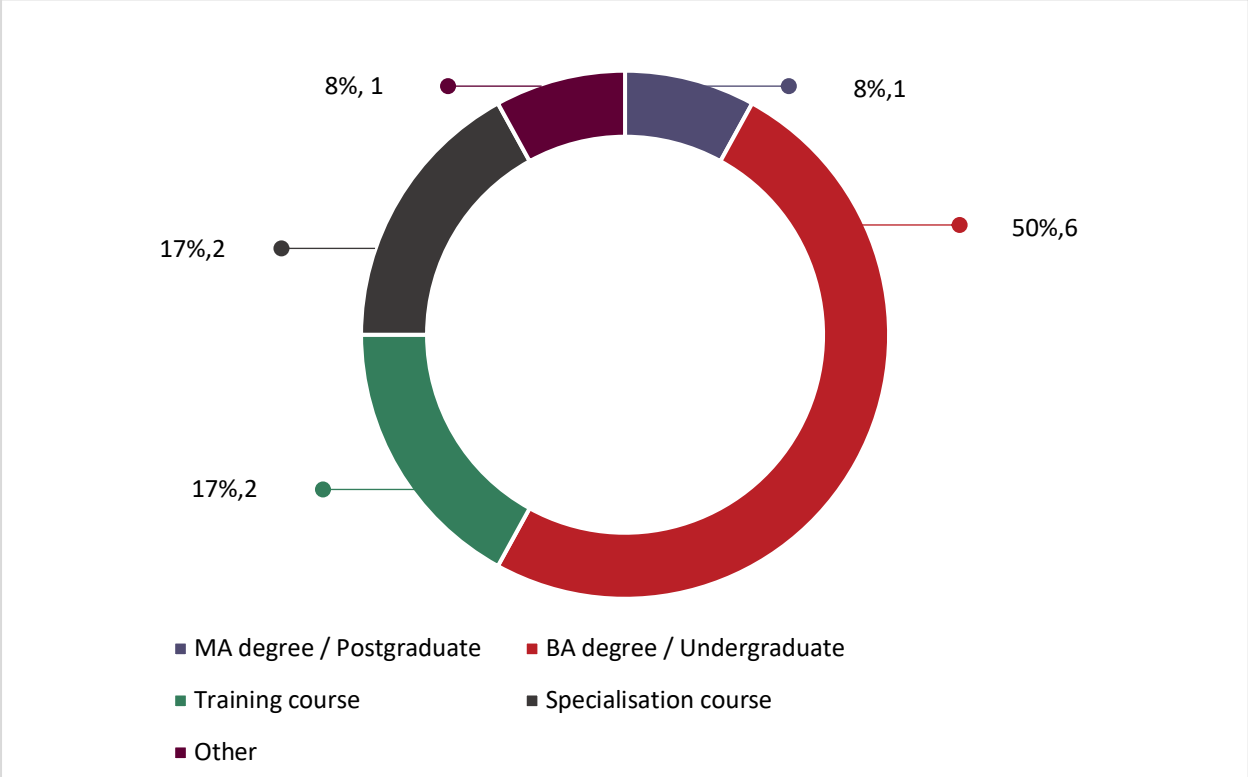
■ **Figure 7.1: Training experience of interpreters - UK**



■ **Figure 7.2: Training experience of interpreters - SPAIN**



■ **Figure 7.3: Training experience of interpreters – IRELAND**



With regards to specialised training relevant to GBV, the UK interpreters reported that they had received training in: GBV (33%), diversity (deafness, immigration) (33%), humans rights and protective legislation (18%) and intercultural communication (15%), typically through professional development workshops (63%), with some attending conferences/ talks (28%) or partaking in official formal studies (10%).

For Spanish respondents, the situation is a little different. GBV is the most reported topic covered in training (32%), followed by intercultural communication (30%), diversity (20%), and human rights (18%). This training has been received mainly through small units (conferences, talks, etc.) (48%), while 37% have completed specific courses and 15% report completing a programme of formal study. Irish respondents reported completion of subsequent training around GBV (39%), diversity (deafness, immigration) (28%), human rights and protective legislation (17%), and intercultural communication (17%). They accessed this training primarily via professional development workshops (54%), conferences/talks (31%), or, in a smaller number of cases, via official formal study paths (15%).

As with support service providers, interpreters were asked to indicate the approximate total number of hours training that they had completed. UK respondents reported a range from 6-300 hours, with the majority estimating between 6-30 hours. The majority of UK interpreters (94%) found the specialised training useful, very useful or extremely useful. Although in Spain the average of training completed is reported at more than 200 hours, the distribution is uneven, with 6 interpreters reporting that they completed between 15-30 hours, 12 between 40-100, 9 between 110-300 while three report more than 1000 hours. The usefulness of training is evaluated as very positive with 47% saying they find it extremely useful and 33% reporting training as very useful. Irish interpreters reported spending between 6 and 200 hours in training, recording their sense that training accessed was extremely useful (38%) or very useful (63%).

Interpreters were also asked to share which three topics covered during their specific training sessions they felt were most important. The suggestions interpreters put forward can be seen in Table 10.

■ **Table 10: Most important topics covered during training for interpreters**

UK	Spain	Ireland
➲ Honour-based violence ➲ Interpreting for victims of domestic abuse ➲ Dynamics/ reflective practice ➲ Ethics ➲ Cultural differences ➲ Legislation ➲ Domestic violence ➲ Cultural awareness around domestic violence ➲ Coercive control ➲ Sexual assault ➲ GBV cycles ➲ Police Interpreting ➲ Identity ➲ Types of GBV ➲ Modern slavery ➲ Cultural aspect in different settings ➲ Forms of abuse ➲ Human trafficking ➲ Coercion and control ➲ Court Interpreting ➲ Cultural implications ➲ Wheel of power ➲ Police interviews	➲ Gender based violence ➲ Migration ➲ Interculturality ➲ code of ethics ➲ GBV mediation ➲ Diversity ➲ Legislation ➲ Human rights ➲ Intercultural mediation ➲ Emotional management ➲ Interpreting techniques ➲ Mediation	➲ Domestic Violence ➲ Vicarious Trauma ➲ Matching tone and language in the Target Language ➲ Autonomy ➲ Working with Experts in the Field ➲ Protective Legislation ➲ Sexual Abuse ➲ Trauma Informed Approaches ➲ Hierarchy of Victimhood ➲ Intercultural Communication ➲ The lived experience of clients ➲ Legal Processes ➲ Definition of GBV ➲ Window of Tolerance ➲ Intercultural Approaches ➲ Maintaining Boundaries

When asked if they felt specific training would be useful to their interpreting work, 100% of UK respondents felt that specialised training would be useful, very useful or extremely useful. In the Spanish context, 89% said that such training would be extremely useful or very useful. Eighty percent of Irish interpreters responding to the survey said

they felt training would be extremely useful in helping them fulfil their role, with a further 20% saying it would be very helpful. Suggestions made for topics that could be covered can be seen in Table 11.

■ **Table 11: Suggested Training Topics for Interpreters**

Ireland, UK, Spain	DSGBV; Legislation; Cultural, Linguistic/Social Aspects (e.g., DA doesn't always entail physical violence; victim/survivor behaviours & experiences, coercive control); Procedures & possible scenarios (e.g., what to expect at a police station as an interpreter; taking a victim statement; working with a deaf/hearing interpreting team – protocols for interrupting/clarifying).
Ireland, UK	Scope of role of interpreter (e.g., co-working, maintaining boundaries); ethical considerations.
Ireland, Spain	Intercultural communication, mediation.
Spain	Migration, migration law, diversity, minors.
UK	Vocabulary, specific terminology, medical, characteristics of perpetrators, interpreting skills (e.g., focus on accuracy, matching tone, and language in target language).
Ireland	Autonomy of victim/survivor; vicarious trauma and self-care; Window of Tolerance; Hierarchy of Victimhood; Trauma and trauma-informed approaches.

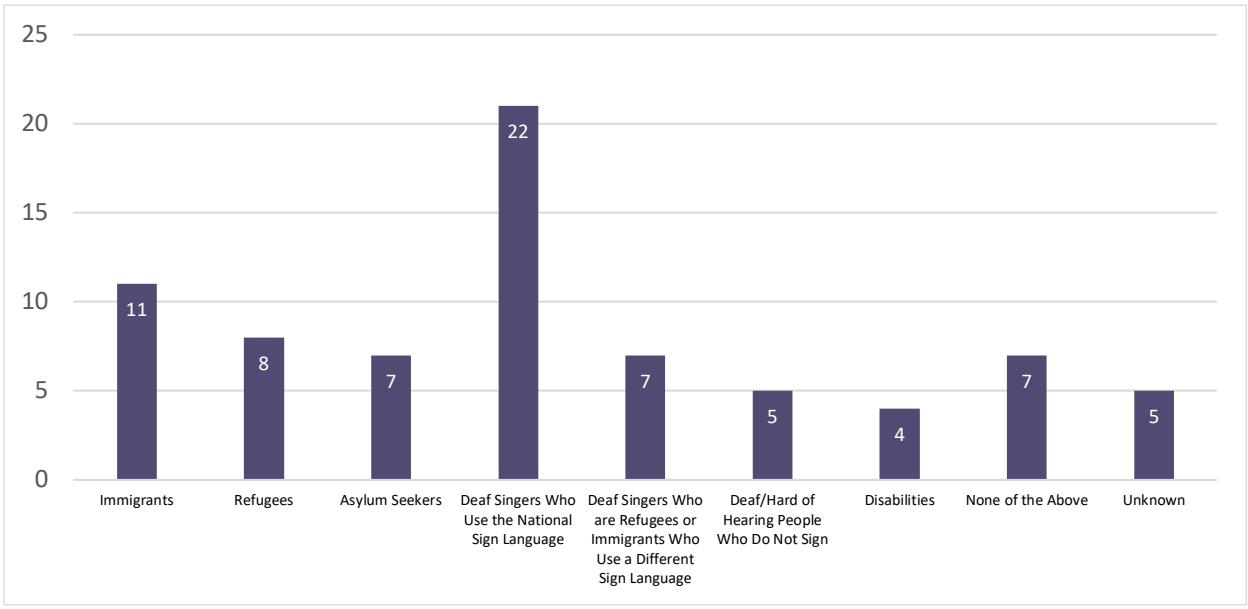
4.2.4. Characteristics of interpreting end users

Interpreters were asked to note the number of GBV cases they had interpreted in the preceding 24 months and the nationality of the end users that they worked with; most of the UK respondents noted that the women they had worked with were British Nationals (approx. 30 times in last 24 months), others noted that they were foreign (approx. 20 times in last 24 months). They reported that there were approximately 17 occasions in the preceding 24 months where they did not know the nationality of the client they'd worked with. These figures could have been confounded if they responded to more than one category as they could have worked with some people who were deaf migrants/refugees who do use BSL but may have moved to the UK from another country, for example. Spanish respondents report that the women they worked with were mostly non-national: 463 cases compared to 55 naturalised Spanish cases. The country of origin of the women worked with was unknown in 19 cases. Only 7 of the 11 Irish respondents completed the question about what languages they had interpreted over the preceding 24 months, with all reporting that they work with Irish Sign Language. All interpreters reported that they had interpreted in GBV settings with women who were Irish; a further 5 interpreters reported working with foreign nationals. One instance was reported where the nationality of the victim was unknown.

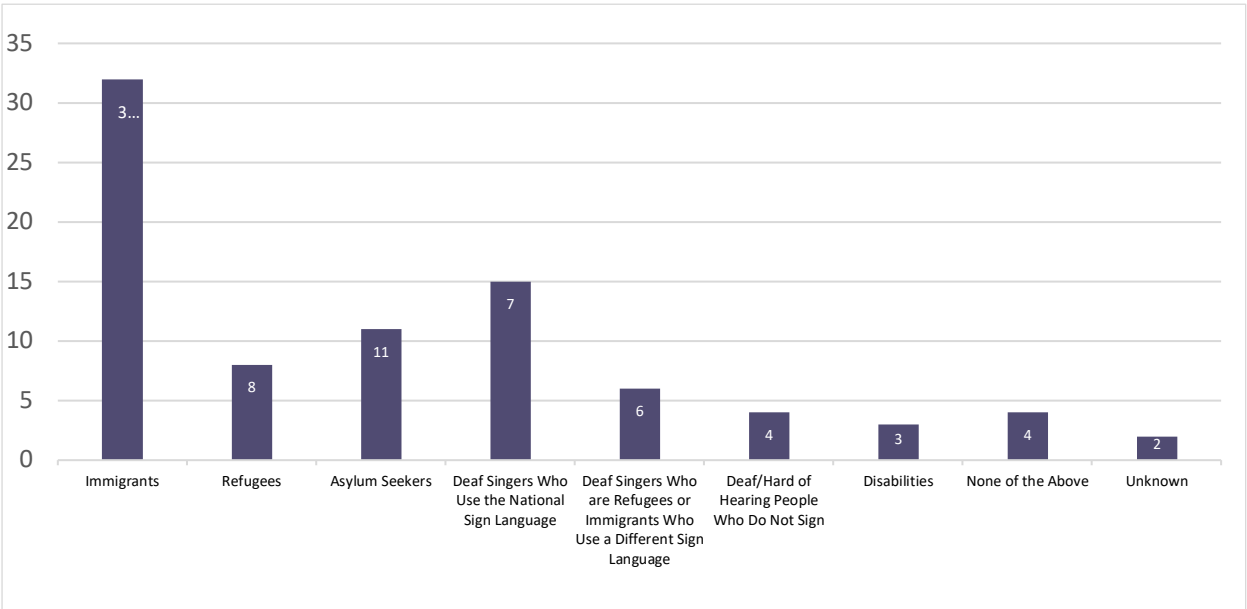
Respondents reported working with women across a range of ages from less than 18 years old to over 66 years old, but the majority were aged 18-45 years. Respondents were also asked to identify other characteristics (see Figures

8.1-8.3). Spanish interpreters report working mostly with women aged 18-35 years old (209) and 36-45 years old (211). 152 report having worked with women aged 46-55 years while those who have worked with under 18s and over 55s are in the minority (4 and 12 cases respectively).

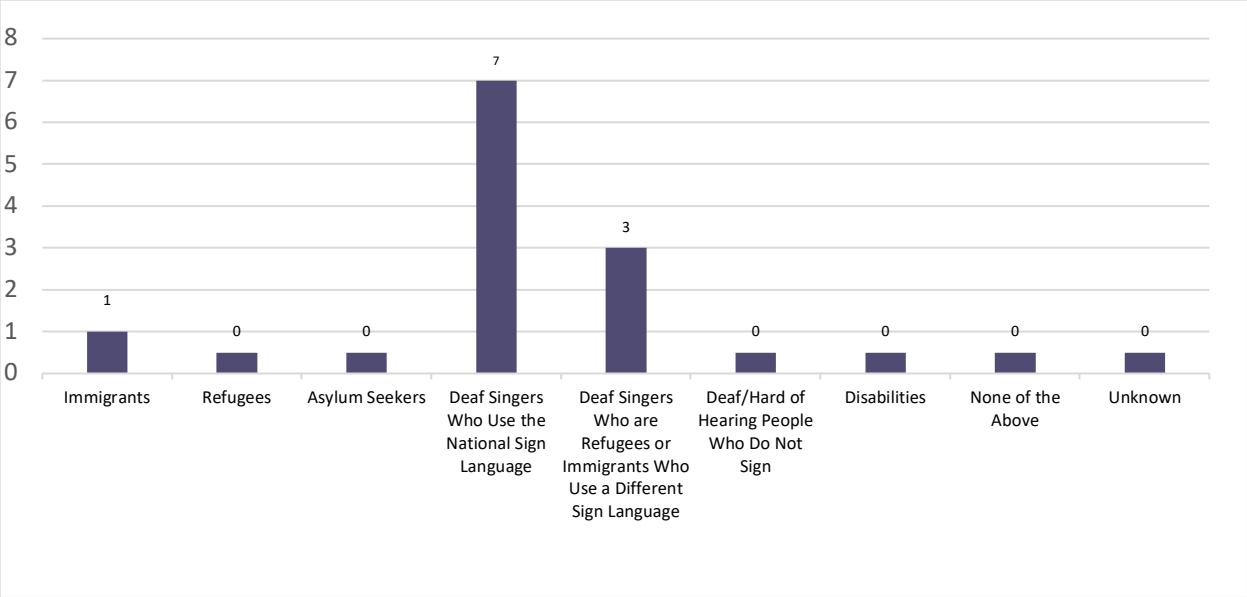
■ **Figure 8.1: Other characteristics of interpreting end users - UK**



■ **Figure 8.2: Other characteristics of interpreting end users - SPAIN**



■ **Figure 8.3: Other characteristics of interpreting end users - IRELAND**



4.2.5. Working with women who have experienced GBV

Although the role of the interpreter is not to give support to women who have experienced GBV, we sought to elicit information from interpreters about any challenges that they perceived in giving support through ensuring effective interpreting services. The options offered included:

- Presence of cultural barriers
- Presence of linguistic barriers
- Difficulty of understanding between service providers and interpreters
- Difficulty finding appropriately qualified interpreters in certain language combinations
- Presence of religious barriers
- End users unaware of available services
- End users seem suspicious or uncooperative
- End users' circumstances make it difficult to provide support
- Presence of problems due to illegal migration status
- Substance abuse
- Not enough training to work with people who have experienced GBV
- Inadequate workspace

- Lack of prior information about the case
- Poor working conditions and/ or lack of resources
- Insufficient staff support/ supervision
- Lack of trauma informed care

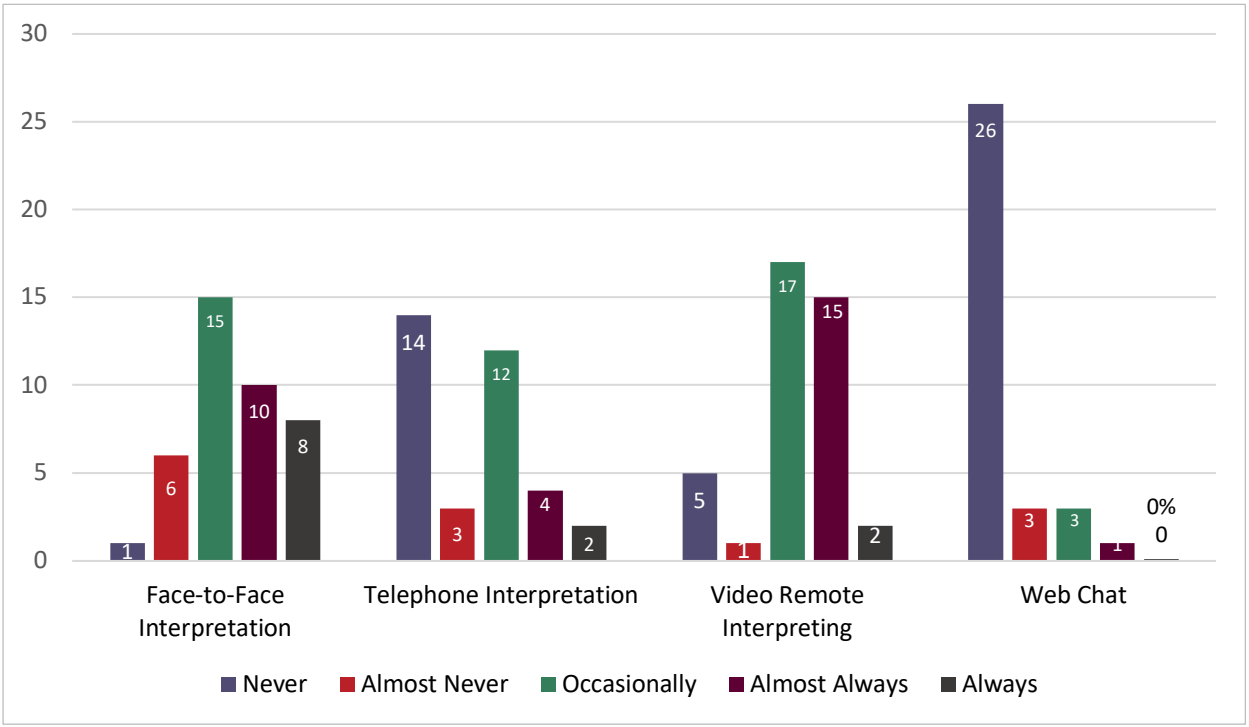
Respondents were asked to rank the issues they found most challenging from the list above, using a five-part Likert scale ranging from not challenging, to a little challenging, challenging, quite challenging and very challenging. For UK respondents, the most challenging issues (marked as 'very challenging') were the difficulty finding appropriately qualified interpreters in certain language combinations, end users being unaware of available services, and lack of prior information about the case. In the Spanish context, the most challenging items listed were: difficulty finding appropriately qualified interpreters in certain language combinations, victims unaware of available services, lack of prior information about the case and lack of trauma informed care. Irish respondents ranked the presence of linguistic barriers as very challenging (50%) while difficulty finding appropriately qualified interpreters in certain language combinations was identified as a challenging issue by 63% of interpreters. Thirty eight percent of Irish interpreters say that they find it quite challenging when users circumstances make it difficult to provide support.

4.2.6. Interpreters working in GBV contexts

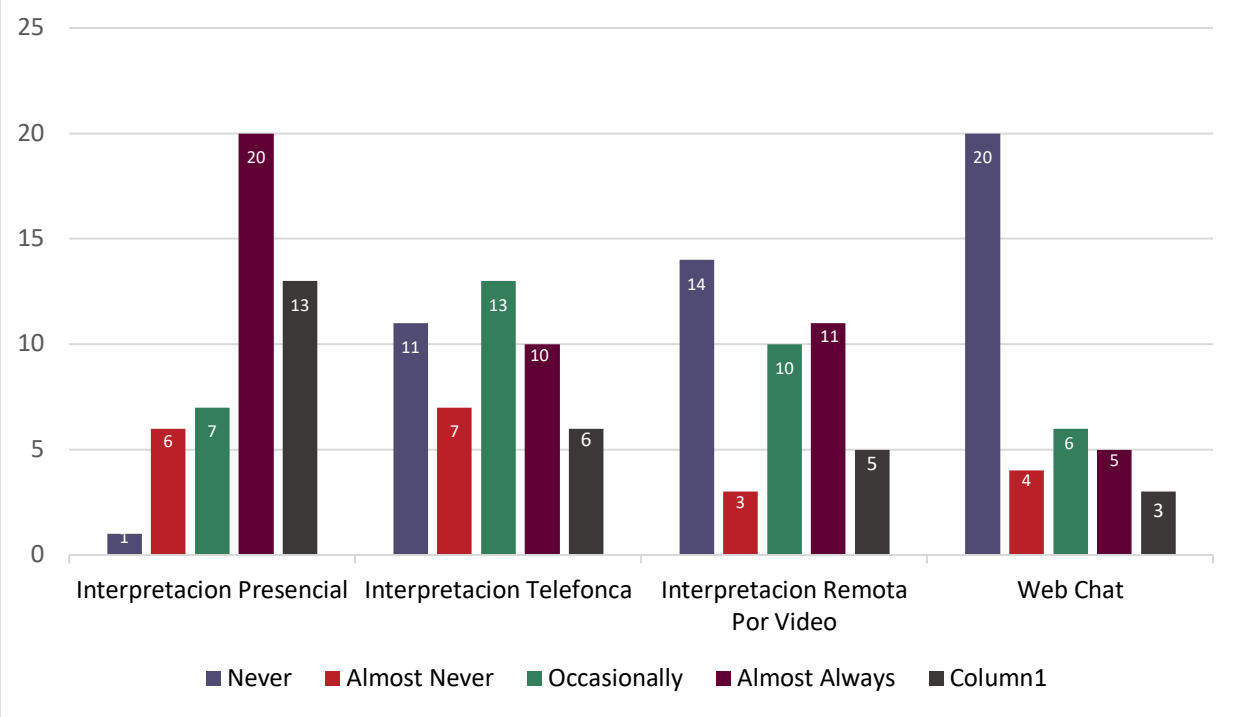
In this section, we explored a range of factors for interpreters in working with GBV clients. In the majority of cases reported in the UK data (74%), the encounter with the woman who had experienced GBV took place in the language the person identified as their own language, with the women rarely not using the language for which the interpretation was required. For those respondents who were sign language interpreters and worked with deaf clients, 48% of UK respondents had never worked with a deaf interpreter as a relay or intermediary. Spanish respondents report that the language the woman identified as her own is used in 67% of cases, while in 27% of situations, the language used is one that the woman says she understands. Seventy-eight percent of respondents say that no deaf interpreter (or, in Spanish usage, deaf mediators) were provided. Irish interpreters indicate that the language in which the encounter with the victim takes place is the woman's own language (88%), while another language is reported as used by 13% of respondents.

Interpreters were asked to indicate how often they had provided different types of interpretation services in the 24 months preceding the survey. All interpreter respondents primarily worked face-to-face or by video, as seen in Figures 9.1-9.3, with Irish interpreters also reporting occasional use of telephone interpreting (63%), which is surprising.

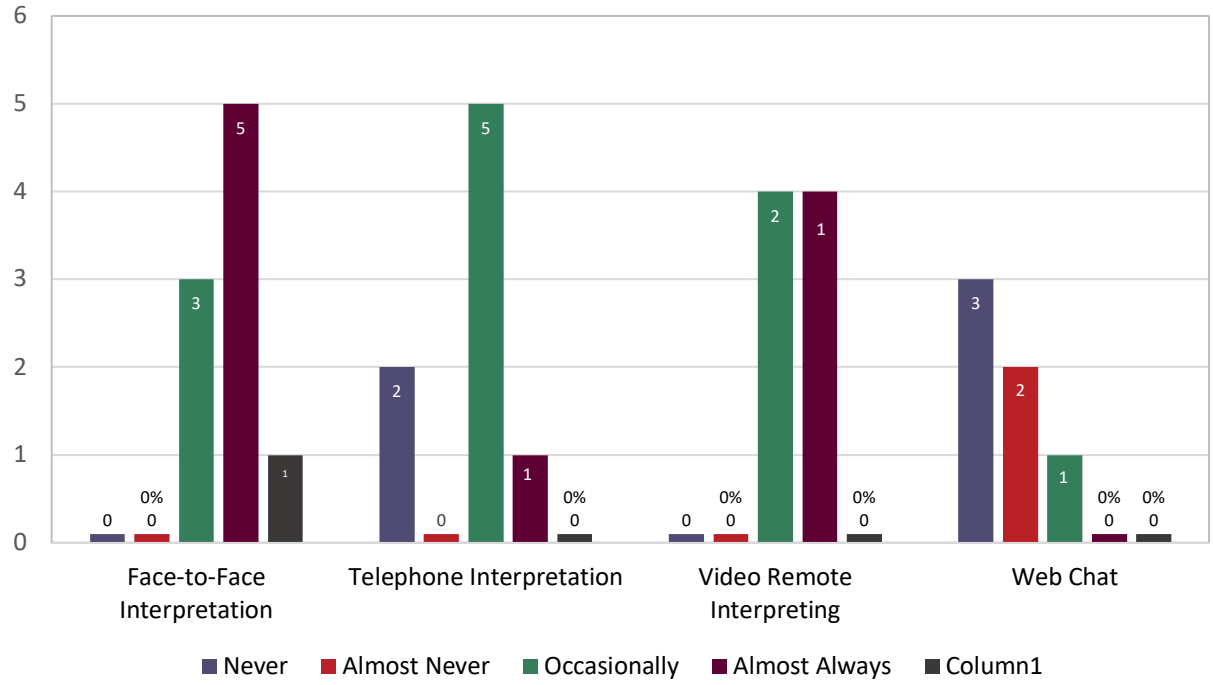
■ **Figure 9.1: Types of interpretation service provided by interpreters - UK**



■ **Figure 9.2: Types of interpretation service provided by interpreters - SPAIN**



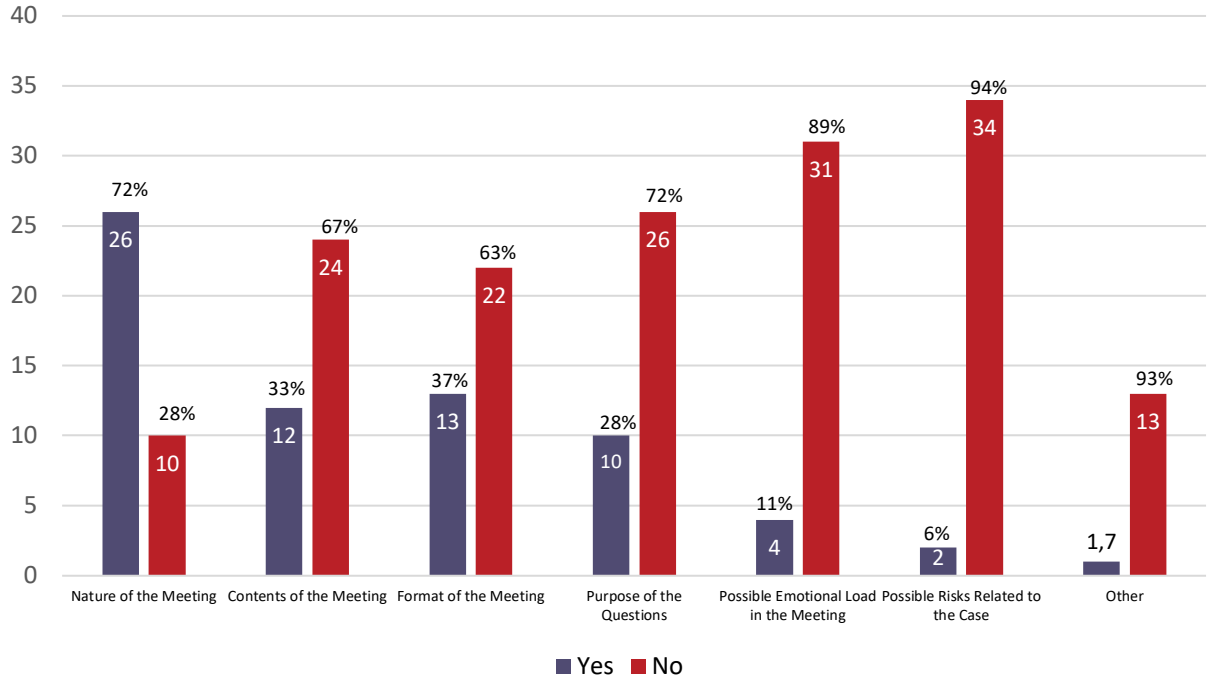
■ **Figure 9.3: Types of interpretation service provided by interpreters - IRELAND**



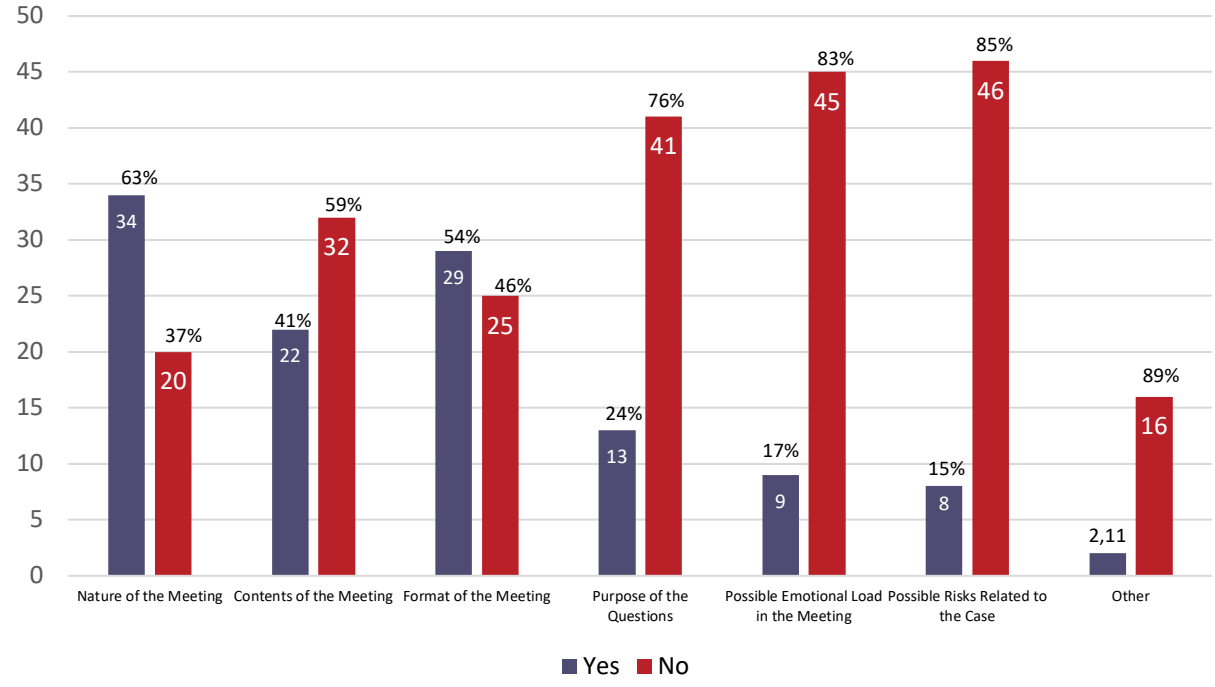
To contrast with the support service provider perspectives, we also enquired if the interpreters are ever asked whether they are accredited, have had training to work in GBV contexts, or whether they have a conflict of interest with the client/victim. Results revealed that for all interpreter respondents, the majority are rarely asked if they have a conflict of interest or have completed relevant training but are more likely to be asked if they have accreditation.

Interpreters were also asked whether they are usually given any information about the assignment prior to the encounter in relation to the nature, content or format of the meeting, the purpose of the questions that may be asked during the meeting and any potential emotional load that the interpreter might experience, along with any other information. Alarmingly, as can be seen in Figures 10.1-10.3, the majority of UK respondents reported that they are not given most of this information. The information that they tend to receive the most is the nature of the meeting. In a similar way, in Spain, information on the nature of the meeting is usually provided (although not in all cases) and, to a lesser extent, on the format of the meeting. The same pattern follows through for Irish respondents. While most report receiving information about the nature of the meeting, most report that they do not receive any other information.

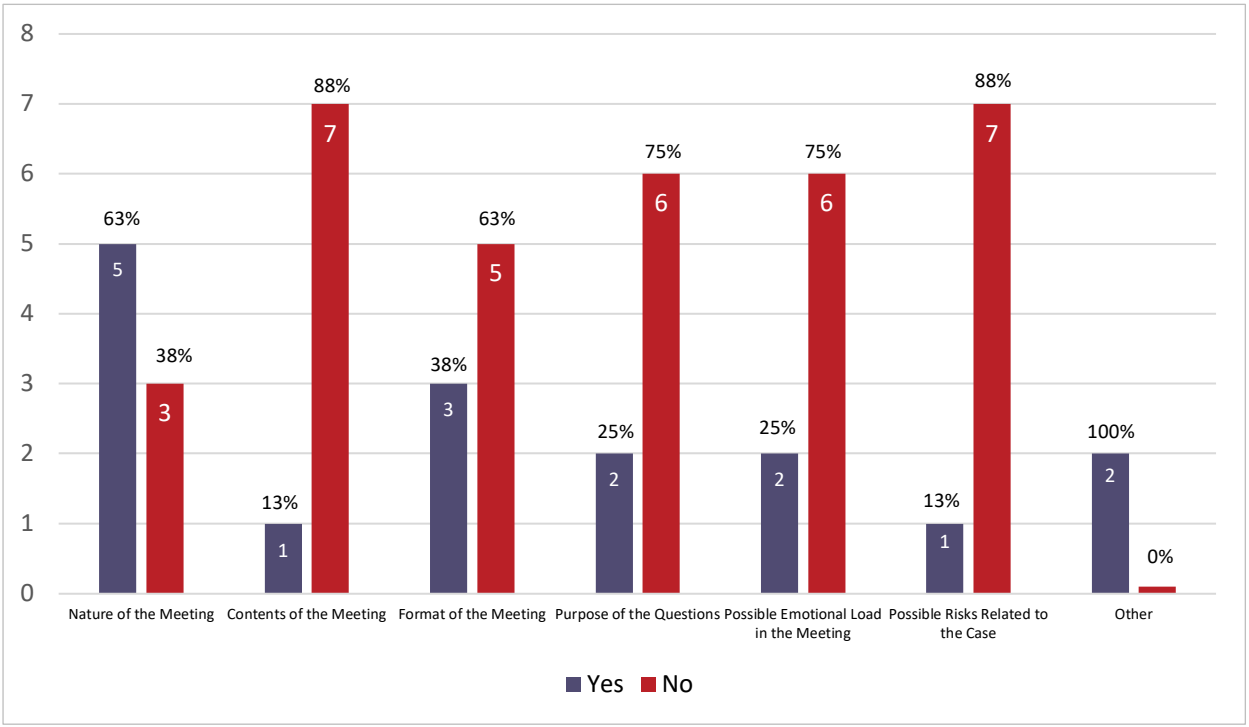
■ **Figure 10.1: What information interpreters receive - UK**



■ **Figure 10.2: What information interpreters receive - SPAIN**



■ **Figure 10.3: What information interpreters receive - IRELAND**



Likewise, UK interpreters conveyed that they rarely experience any agreement about their role or working conditions prior to a meeting and that they mostly do not know if the client is informed about their role beforehand. If they are informed, it is through the interpreter mediating the information. Sixty-three percent of UK interpreters also confirmed that they are never offered the opportunity to have a subsequent meeting with the support service provider, in order to debrief. Despite this response, 75% of UK interpreters said that they were reasonably satisfied with the support service providers with whom they have worked. Sixty percent of Spanish respondents indicated that they never have a debriefing session after an interpreting assignment, with just 16% saying that they always/almost always have access to one. As with UK respondents, Spanish interpreters report a high or very high level of satisfaction with support service providers. Irish interpreters report that their role or working conditions are sometimes discussed before a meeting (63%), with 25% saying that this rarely happens. Fifty percent of Irish interpreters responding say they never have a follow-on/debriefing meeting with the service provider to discuss interpreting related issues. A further 50% say this occurs very rarely or occasionally. Despite this, Irish respondents are satisfied with respect to the service providers they have worked with (71%), with 29% report being fairly satisfied in this regard. Clearly, this is an areas where more can be done to bridge the gap between best practice expectations and their operationalization.

4.2.7. Interpreters' Perceptions of Training, Competencies and Skills Needed to Work in GBV Contexts

As noted earlier, interpreters tend to work across a range of different contexts, so we were interested to know which topics they felt it was important to have specific training on, in order to work in GBV settings. As with the support service providers, we asked interpreters to rate the topics as not important, a little important, important, quite important, or very important. Interestingly, interpreters felt that almost all topics were very important. The most popular topics across all three countries are as follows:

➲ Specific terminology	➲ Trauma in victims/ Understanding of psychology in people who have experienced GBV
➲ Specific training in GBV	➲ Communication skills
➲ Emotion management	➲ Vicarious trauma/personal implications

When interpreter respondents were requested to list the three most important knowledge areas that interpreters working with people who have experienced GBV should have, outlined in Table 12.

■ **Table 12: Interpreter perceptions of important knowledge areas**

UK	Spain	Ireland
➲ Understanding bias ➲ Effects of trauma ➲ Specific training in GBV ➲ Any sensitive issues ➲ Confidence ➲ Risks ➲ How to intervene appropriately ➲ Specific language/ terminology/ signs ➲ Intercultural communication ➲ Special instructions ➲ Professionalism ➲ Coercive control ➲ Emotion management ➲ Knowledge of the cultural context of the victim ➲ Empathy ➲ Competency ➲ Ethics in relation to GBV ➲ Signs to spot GBV [indicators of GBV]	➲ Emotional management ➲ Cultural context of the victims ➲ Specific training in GBV ➲ Language proficiency ➲ Legal issues ➲ Trauma ➲ Communication skills ➲ Human Rights ➲ Ethical code ➲ Psychological aspects of GBV ➲ Intercultural communication ➲ Intercultural mediation	➲ Trauma and retraumatization ➲ Training in GBV ➲ Vicarious Trauma (managing this as an interpreter) ➲ Self-care ➲ Ethics (confidentiality) ➲ Knowledge of legal issues ➲ Psychology (of GBV contexts) ➲ Communication Skills ➲ Understanding the processes ➲ Managing emotions ➲ Legal Rights ➲ Specific Terminology (medical, psychological, legal) ➲ Service provider's goals in a given interaction ➲ How an interpreted event will impact on subsequent parts of the process (e.g. examinations, police interviews, court case, etc.) ➲ Working with a Deaf Interpreter

Following from this, interpreters were asked to suggest the three basic skills/ competencies that interpreters should have, and their suggestions are listed in Table 13.

■ **Table 13: Interpreter perceptions of important skills/competencies – UK**

UK	Spain	Ireland
➲ Emotional intelligence ➲ Language/ communication skills ➲ Management of own emotions ➲ Impartiality ➲ Independence ➲ Knowledge of interventions/services ➲ Specific Terminology ➲ Competence in subject matter and culture and legal systems ➲ Professionalism ➲ Intercultural communication ➲ Knowledge of how to secure a deaf interpreter ➲ Empathy & trust ➲ Accuracy ➲ Knowledge of GBV	➲ Empathy ➲ Cultural codes ➲ Neutrality ➲ Emotional intelligence ➲ Advanced language training ➲ Active listening ➲ Communication skills ➲ Professional conduct ➲ Patience	➲ Legal Issues ➲ Self-reflection skills ➲ Trauma-informed approach to interpreting ➲ Communication skills (3) including reading body language of participants ➲ Boundary setting ➲ Trauma ➲ Empathy ➲ Understanding the legal-medical context where GBV work occurs ➲ Cultural understanding ➲ Ability to clearly communicate when the interpreting process is not meeting the intended aims and ability to flag alternative solutions ➲ Emotional Management ➲ Fluency in working languages ➲ Understanding key concepts and terminology ➲ Understanding the consequences of the interpreting assignment ➲ Managing own presence (making it 'small')

4.3 Women's Experiences

Although this report focuses on the results of the survey questionnaires with support service providers and interpreters, we include brief information from the perspective of women who have experienced GBV to contrast with the questionnaire findings. Here we give a snapshot of the perspectives of deaf women (n=8) in the UK who were interviewed as part of the Justisigns 2 project. It is important to say that we focused only on their experiences when reporting GBV and their access to information and on-going support. Four of the women were from different minority ethnic backgrounds. More detail of the UK interview results are forthcoming (Napier & Clark, in prep), but we provide a breakdown of the key themes here, and offer some illustrative quotes to support our recommendations (see Chapter 5).

Deaf women have reported that feelings of general safety in the workplace as women are compounded by being deaf (Napier, submitted). It is clear from the interviews that in the GBV context, deaf women feel that they experience a 'double discrimination' because they are deaf. A thematic analysis of the interview data revealed 8 key themes that capture comments repeatedly made by the deaf interviewees, where there were 9 or more tokens mentioning these themes:

Lack of communication 9 tokens	**Information in BSL** 13 tokens
Training/education 9 tokens	**Deaf cultural awareness** 15 tokens
Diversity 9 tokens	**On-going support** 13 tokens
Deaf-specific services 12 tokens	**Interpreting** 41 tokens

4.3.1. Lack of Communication

The theme of lack of communication refers to the participants lack of contextual knowledge of what could be considered as GBV and the lack of information provided about procedures, but was also closely linked to whether information was available in BSL and understanding of key terms and legal definitions associated with GBV. For example:

> *[I] would like to have, you know, they have the CPS website with various different resources, for example, lots of information about rape, drug use, stealing, and so on, but we need BSL translations as well. They need to have visual information for the deaf community to help us to understand what exactly that means, what the person has been charged with, and what the process is. I've learned a lot about the voyeurism charges, but I've had to do my own research on what it is.*

4.3.2. Training/Education

Several of the deaf women talked about how resources in BSL could be complemented by providing more training/ education for deaf women in BSL so they can better understand what GBV is:

> *The deaf community needs more training, most are not aware of domestic abuse is more than just physical abuse, there are so many other facets to it that many are shocked to find out. I'm lucky that I can read English, but some others can't. I feel we need to make sure that they have an understanding of what a healthy relationship is, I don't think there's a lot of clear information available in BSL.*

Training was another theme raised in relation to interpreters and the fact that they ideally need to have training to understand the complexities of working in GBV contexts:

> *I do wonder whether they can improve the [registration body] website, at the moment they allow interpreters to include the domains that they have worked in, for example, police, healthcare, community, and so on. There is no option to list that they have undertaken training in domestic abuse, if they did it means that when a hearing service provider goes on to [website] they can see instantly that person has been trained to work in domestic abuse situations and they can book them. They should definitely do that.*

> *Really the interpreter didn't really have an in-depth knowledge of domestic violence, they had a basic understanding of what domestic violence entails but did not have expertise in that area.*

4.3.3. Interpreting

As can be seen from the above list of thematic tokens, the most common theme discussed was that related to interpreting. Participants presented divergent views on the merits and challenges of working with interpreters when disclosing their experience of GBV or when trying to access on-going support. One of the key issues was whether they could trust the interpreter and concerns about confidentiality:

> *The process of informing the police was really hard, it wasn't easy at all. Also, it is difficult to trust an interpreter with my personal business. Luckily, I have a close friend who is an interpreter so she was able to ask to volunteer her time to support me with bringing this to the police.*

> *I know most deaf signers have their suspicions when working with interpreters due to the risks of confidentiality being broken. That's why I was cautious about working with interpreters as I know some of them have broken confidentiality before, not all of them, but some have in the past. Confidentiality is so important; it is crucial that we have the right to privacy and can trust the interpreter.*

Several of the deaf women also talked about wanting to have the same interpreter throughout their journey of reporting incidence(s) of GBV and through the police/court system, so that they can build rapport and so that the interpreter is familiar with the case:

> *I wanted to have the same interpreter so that I didn't have to keep repeating what happened and they would have that contextual knowledge. I also wanted to keep the number of people that knew about the incident to a minimum and just have one interpreter that I can trust.*

> *I really preferred having the one reliable, consistent interpreter. They knew exactly what's been going on and she had all the background information. I didn't have to repeat myself explaining traumatic things to different interpreters again and again. So, they knew everything that had gone on from the start right through the whole process.*

The deaf women also commented on the stress that can be created by lack of interpreter availability and how this can exacerbate an already stressful situation:

> *Once the police arrived, I was waiting for the interpreter to come, but they kept trying to talk to me, I had to keep saying to them to wait until the interpreter arrives. They asked me a lot of questions about where he could be then 20 minutes later, my ex texted me to say he needed help.*

> *Access to interpreters. I was never let down in that regard in [city], but since I have moved to [city], they have let me down with booking interpreters which has been very stressful.*

Interpreters not understanding the deaf women or the use of GBV- related terms by support service providers also provides another layer of stress:

> *I felt like I couldn't express myself fully because it [the assessment] was being conducted by a hearing person and then translated through an interpreter. The way the assessment was set up is not for deaf signer[s];, the hearing professional did not have any deaf awareness and the interpreter was not able to understand everything I was explaining so the interaction just got progressively worse.*

> *They [the interpreter] did not have the appropriate knowledge to interpret in this setting. Or, they would ask the hearing person "what do you mean by that?" and then relaying over to me but you can see that they didn't understand how to actually accurately translate that information. This has an effect on me because I'm looking at the two of them having the discussion and I can see the interpreter is not competent which stops me from feeling like I can trust them and build a rapport. It just seems when I've been using these services, there's a lot of back and forth and clarification that's involved leading me to feel a little bit uncertain about what's going on.*

In some cases, qualified interpreters were not provided, but rather hearing people who had basic sign language skills, which impacted on the quality of communication:

> *Before I met with the housing officer, I requested a BSL interpreter, but instead they brought in a 'deaf advisor' who worked for the council who was not qualified to interpret as they only have Level 3 BSL. I could communicate with the advisor, but I explained to the housing officer that it has to be a fully qualified interpreter. The housing advisor just could not understand what the difference was between an interpreter and an advisor and the difference in cost between the two.*

Although interpreters are only there to mediate the interaction between support service providers and women who have experienced GBV, several of the deaf women mentioned the support they had received by interpreters who were familiar with what support the deaf women could access and where and signposted them to it:

> *I really do want to thank my interpreter for giving me the heads up about what's other people already knew. And also for putting me on touch with [name of deaf-specific service] as well as warning me about going down a route where potentially I would have my child taken away. So yeah, she (the interpreter) was really good. And I wasn't aware of things like that. I was very ignorant about those things.*

This calls into question the role of the interpreter in these settings, but if deaf women are already experiencing a double disadvantage in being able to report their experience or accessing support, if the interpreter is the only person who has the deaf cultural and community awareness of what they need, perhaps it is not surprising that the interpreters themselves may offer support.

4.3.4. Deaf Cultural Awareness

The issue of lack of deaf cultural awareness among support service providers was mentioned repeatedly by the deaf interviewees:

> *I think the police should be that aware if I deaf person files a report they should be prioritised, for instance, making sure that they have access to interpreters and social services. They need to also ensure they give support and information as well.*

> *I'd say it is worse for me because we're both deaf, so we have no way of communicating with support providers and they are not deaf-aware. They seem to be ignoring us. So, it seems that it's worse than if you have a couple where one of them is hearing and one is deaf. Obviously, the risk is still the same, of course, but I feel like the process is a little bit quicker because the communication is there for one of the parties involved. It feels like they look at us and think "what do we do with you?" This attitude and lack of knowledge delays the process for us.*

4.3.5. Deaf-Specific Services

The lack of deaf awareness among hearing support service providers highlights the benefits of having deaf-specific services to provide support directly in sign language to deaf women who report GBV, which mitigates for the lack of communication, lack of information in BSL and also issues with sourcing interpreters or finding appropriately qualified interpreters:

> *I had previously considered going to a deaf counsellor but I was just so uncertain about whether it would be right for me. I decided to try it and see how it went because even after 1 year the incident was still affecting me significantly. When I made contact with the deaf organisation it was really overwhelming because I finally got to be able to talk to someone in my language who understood me. Straight away they offered support, information, workshops and explained what explained I needed to do which was so empowering. I started to suddenly feel like I could see a light at the end of the tunnel. I had finally gotten the support I needed and they understood exactly what it was I was needed without me even having to say it. It was so much easier dealing with someone directly in BSL and not having to use text or email. Looking back on my experience I should actually gone to a deaf organisation in the first place. I really wish I did, but unfortunately, I didn't.*

> *The hearing services didn't really support me at all - they told me that I had to phone to get a counsellor, and also advised me to go to legal services or something like that. But it was very expensive. That route was very expensive. They gave me some information that wasn't really very useful at all. What was much better for me was going to the Deaf services, because they gave me a much faster service, so I got a restriction order and I wasn't charged at all.*

Although deaf-specific services might be preferred by some because of the ease of communication, others highlighted the fact that it is not always preferable due to the close networks in the deaf community (e.g., deaf support service providers may have gone to school with deaf perpetrators):

> *The problem is with the deaf community being small, there's a concern about confidentiality… if you were to disclose domestic abuse everyone in the deaf community would know, it would spread so quickly. [Name of country] is a big country and then when you move to somewhere like the UK it's even smaller yet again, so that's why deaf signers are so cautious.*

4.3.6. On-Going Support

The deaf women mostly were referred to mainstream 'hearing' services for on-going support and had variable experiences:

> *[Regarding] the police on domestic abuse cases, they informed me of any updates and gave me a lot of great advice throughout the process. I worked with the same woman at Assist for two years, she was fantastic, I was very lucky as she had such a nice attitude. I was able to communicate with her through the interpreters provided.*

> *They explained what the process would be and the support available for victims of domestic abuse. The officer sent me an email link with information on what support is available, but I felt like the information was not accessible to the deaf community. The service seemed to be for hearing people, I asked him, would the service have interpreters available but they didn't know which was disappointing.*

> *I moved to [cityA] to build myself back up again and work on improving my mental well-being and my son's life. I moved to be close to my family, so their support keeps me going, but last year was horrible when I decided to end my relationship. I have now realised that [cityA]'s services are poor, especially for what I need… finally, I found [name of deaf Independent Domestic Violence Advisor] to support me through the process at the moment. I have found that [cityA] does not have any accessible services for deaf signers who have experienced domestic violence. When I compare [cityA] to [cityB],*

it is clear that [cityA] needs to improve their services big time as the support available in [cityB] is fantastic.

4.3.7. Diversity

As noted in section 2.1, deaf women who are also migrants, refugees or asylum seekers may experience greater impact on their experiences of GBV and accessing services because of their intersectional characteristics (Admire and Ramirez, 2021). Several of the women interviewed who were from different minority ethnic backgrounds mentioned this specifically:

With [name of organisation] they did not have a full understanding of my ethnicity and background, they had more of a superficial understanding. I had to take on the burden of explaining my experiences, my background, and my culture to enable them to gain a better understanding, they didn't already have that knowledge… Obviously, they need to be more deaf aware and improve accessibility, without this it becomes very frustrating and can led to me feeling even more trapped. They need to ensure the process is as smooth as possible by having a greater awareness of the influence ethnic backgrounds can have to enable them to tailor their support to these sensitive issues. I was having to educate them on that, on top of the already stressful situation and having to deal with barriers as well as can be challenging.

After the initial meeting and assessment, they decided it would be best to not use an interpreter and communicate with me through email. The issue is that English is not my first language. I immigrated here and I really struggle with English, especially with the jargon. I was so lost trying to work out what each email said, if they are going to use email, they should consider who is going to pay for that information to be translated… There are not many foreign sign language interpreters available for medical appointments or anything… it is disappointing that they do not have the opportunity to study and gain exposure to BSL. There is a lot of support and help with benefits, debt, employment, and I'm disappointed that domestic abuse is not offered because of the impact that it can have on your mental health. They do have resources to do with mental health, so why not add in domestic abuse?

CHAPTER

05

CONCLUSION

In summary, it can be seen that both the support service providers and interpreters who responded to the survey admit to not having much experience in working together in GBV contexts, and also lack of familiarity with how to best work together. There are also some contradictions in the different perspectives, for example, support service providers suggest that they mostly check interpreter credentials, but interpreters state that they are rarely asked to confirm their credentials. Furthermore, with respect to briefing of interpreters, support service providers seem to think they are doing that but interpreters do not feel like they are briefed. Support service providers have worked with women across a range of characteristics and ages, as have interpreters.

The survey results reveal that support service providers and interpreters have had minimal training on how best to work together in GBV contexts, and any training received has mostly been through professional development workshops. There is a juxtaposition between priorities for support service providers and interpreters and where there are mismatches concerning the ranking of language skills, people skills, and level of specialist information needed; with a lot of attention on both sides given to interpersonal skills.

Both support service providers and interpreters confirmed the need for specialist skills and competencies to work with women in GBV contexts and the requirement for specialised training. Although support service providers and interpreters are expected to undertake general professional development, as the work with women who have experienced GBV is such a specialised and sensitive area both groups commented on the need to be trained on how to deal with emotional boundaries, managing emotional responses, empathy, and specific terminology, the nature of GBV, and legislative processes.

It is clear from the results that there are many things that are imperative to include in training that may need to be localised. For example, support service providers in Ireland referred to their desire for more information on GDPR specifically. This then impacts on understanding of ethical guidelines and unanticipated consequences of other things in the system, e.g., citing GDPR as a reason for not giving information to interpreters. So, guidance needs to be provided that not only is it appropriate to give this information to interpreters for preparation purposes but that it is actually best practice to do so to protect human rights.

Likewise, police in Spain have to inform a suspect of all the evidence they have against them before going to court. This is a fairly recently new directive (4 years old), which is problematic when the victim is endangered as police do not want to hand over all information, including to interpreters, which creates a tension then between protecting victim rights (by ensuring that interpreters understand what has happened so they can interpret as effectively as possible) and protecting suspect rights.

From the survey data it seems that existing training is repetitive, focussing primarily on terminology/ legislation, although these topics were noted by interpreters as being particularly important to know. As such, a new lens is needed to provide more in-depth training across a range of issues that are particularly pertinent to support service providers and interpreters working together in GBV contexts e.g. in relation to cultural issues and emotional issues that are more than just general explanations of GBV.

The issue of cultural awareness, understanding of GBV related issues and the need for training for support service providers and interpreters was also mentioned by the deaf women interviewed, alongside their needs for specific on-going support, clear communication and information available in their own language, and recognition of the needs of women from diverse minority ethnic backgrounds. Interestingly, one of the issues highlighted from the perspective of deaf women concerns confidentiality and the fact that deaf communities are small and highly networked. As such, rather than assuming that deaf women would automatically prefer deaf-specific, language concordant (e.g., BSL) services, there may be times when they

would prefer to access mainstream services via interpreters so that they can preserve some anonymity. It is also evident, however, that some deaf women felt better able to express themselves when receiving support from a deaf-specific service. This highlights two things: the need to fund deaf-specific services and the need to train more interpreters for work in GBV settings in order to provide deaf women with the choice of which service to approach. This same principle applies to the provision of support services for women who are migrants, asylum seekers or refugees as they may also experience similar issues concerning small, networked communities and feelings of safety.

5.1. Recommendations

Based on the findings from the survey of support service providers and interpreters, and interviews with deaf women about their experiences in GBV settings, we make the following recommendations to translate the findings into policy, practice and pedagogy, followed by suggestions for further research.

5.1.1. Policy

- Submissions are needed to government, public service and charity consultations concerning legislation or strategies related to GBV against women who are migrants, asylum seekers, refugees or deaf signers to articulate the need for funding for specific services tailored to meet the needs of different linguistic and cultural minorities, particularly for deaf women where there is a particular dearth of direct service provision;
- Development of multilingual toolkits/best practice guidelines for support service providers and interpreters to work together to be shared with professional stakeholder organisations;
- Development of multilingual factsheets for police officers, social workers, healthcare professionals, and other GBV support service providers with tips on working with women who are migrants, asylum seekers, refugees or deaf signers;
- Development of multilingual factsheets for interpreters with key issues to consider when working with women who are migrants, asylum seekers, refugees or deaf signers who have experienced GBV.

5.1.2. Practice

- Development of multilingual resources for deaf and linguistic minority communities providing information in various languages about GBV, e.g., glossaries of GBV terms in different languages, website information, information videos, all of which could also be used as resources by interpreters.

5.1.3. Pedagogy

- Development of a training handbook for support service providers and interpreters including a range of information about working with women who are migrants, asylum seekers, refugees or deaf signers, which can be made available as a free resource;
- Delivery of educational workshops for deaf and linguistic minority communities in their own languages about how to recognise and report GBV and women's rights;
- Delivery of masterclasses for support service providers, interpreters and women from linguistic minority communities together on best practices for working together, with combined and tailored breakout sessions for each group;
- Training of more women as Independent Domestic Violence Advisors (in the UK) or equivalent GBV support workers in other countries, who are deaf or themselves migrants, asylum seekers, refugees or deaf signers in order to be able to provide language concordant support;
- Training of more deaf interpreters to work specifically with deaf women in GBV contexts.

5.2. Further Research

As evidenced by the literature review, there has been a dearth of research on the experiences of women who are migrants, asylum seekers, refugees of deaf signers in reporting incidences of GBV and accessing GBV support services either directly or through interpreters. As noted by Mastrocinque et al. (2020) there are still many gaps in understanding the prevalence of GBV particularly in deaf communities. This study has contributed new knowledge through eliciting perspectives from support service providers and interpreters, and a small number of deaf women.

There is a clear need for more direct co-designed participatory research with migrants, refugees, asylum seekers and deaf signers who are survivors of GBV with a focus on their lived experiences of interpreting in GBV contexts. There is also a need for further research on interpreter preparedness towards enhanced understanding of its impact on disclosures by victims and survivors of GBV. The issue of vicarious trauma for interpreters and the gaps in understanding on the parts of law enforcement and support agencies about what constitutes positive interpreting experiences for all parties, are among the areas most urgently requiring further research.

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