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Ad hoc Intervention Programs to Foster the Emotional Management of a Group of Public Service Interpreters, a Group of Telephone Interpreters and a Group of Social Workers

Introduction

Social work requires a high level of emotional management due to the uncertainty of many of its daily situations, usually generating symptoms of an anxious-depressive nature such as stress, compassion fatigue, burnout, depression, anxiety, etc., (Lázaro, 2004; Valero Garcés, 2006; Morrison, 2006; Bontempo & Malcom 2012; Esteban Ramiro, 2014; Delgado, Faza, Calvo, Gil, & Gómez, 2020). These studies have highlighted that the more socio-emotional skills and competencies healthcare professionals possess, the less likely they are to suffer from psychophysiological disorders (burnout, in particular), as they are able to face the daily problems related to their profession with more emotional agility and greater efficiency.

Other studies show that people with a high index of emotional intelligence tend to have more professional success (Jamali, Sidani, & Abu-Zaki, 2008), are more satisfied and feel better at work (Grandey, 2000), have strong leadership skills (Goleman, 2004; Turner, 2004), show positive attitudes in the development of their work and greater adaptability (Gorroño, 2008; Ingram & Cangemi, 2012; García, 2011), better manage situations of stress and change (Nikolaou & Tsaousis, 2002) and better face adversities using different emotional regulation strategies (Bar-On, Brown, Kirkcaldy, & Thome, 2000). Even though there are many studies that demonstrate the importance of having high levels of emotional management skills in order to carry out jobs of social interest, it seemed necessary to implement a study focused on

the design and development of *ad hoc* intervention programs, by way of emotional management courses to help professionals in the development of their work and in their personal lives.

The current Study

Our study focused on three specific groups, public service interpreters, telephone interpreters and social workers. Public service interpreters carry out their work on a daily basis in complex environments such as hospitals or courts and in direct contact with foreign people who do not know the language of the country, they have arrived in. These individuals have faced difficult and/or tragic situations that make them vulnerable, weak, or even desperate, such as refugees, asylum seekers, victims of abuse (Jiménez Ivar, 2002; Vargas-Urpi, 2009; Corsellis, 2010).

These professionals usually establish an emotionally intense relationship with their clients, not only because they are the only ones that understand them, but often because they also share the same ethnicity or come from the same country, in addition to sometimes having certain things in common such as age, gender, and the same immigrant experience (Valero Garcés, 2006).

Due to the situations and contexts in which they carry out their work, public service interpreters often suffer professional and personal consequences (Baistow, 1999; Loutan, Farinelli, & Pampallona, 1999; Parrilla Gómez, 2020).

Within the category of public service interpreters, there are telephone interpreters, who carry out their work not in person, but rather through a telephone that allows them to communicate simultaneously with two interlocutors who need their linguistic and cultural mediation to understand each other. Generally, telephone interpreters are required to be available twenty-four hours a day and are able to deal with different situations quickly and efficiently, without the additional aid of nonverbal communication. In addition to possessing certain linguistic and cultural skills, they must also be versatile and mentally agile, to adjust their tone of voice depending on the situation they are facing. They should know how to manage time, distinguish between their own private and professional lives, as they telecommute and often face difficulty in keeping these spheres of their lives separate from one another. According to a study carried out in Spain (Jiménez Castaño, 2015), 51% of the interpreters at one of the two most recognized telephone interpretation companies in the country, admitted suffering from problems relating to stress and anxiety due to the conditions of their work.

Social workers, on the other hand, usually carry out their work within organizations that distinguish themselves by their decentralization and delegation

of power among professionals. These professionals usually occupy low positions in the organizational hierarchical structure, although sometimes they can assume intermediate positions such as coordinators, team leaders or directors of management tasks (Lázaro, 2004). Generally, social work is characterized by its versatility, ranging from attending to and providing assistance to vulnerable, defenseless or conflicted individuals or families to developing administrative functions and coordinating services (Morrison, 2006). When carrying out their work, it is essential for them to be empathetic, calm, available and open (Lázaro, 2004). However, in most cases social workers lack these interpersonal skills because of the professional burnout they suffer (Siebert, 2008) and the high levels of stress to which they are subjected (Sequeira, 1995).

Our study arose from the need to empirically verify whether it is possible to improve emotional resources and management for specific professional groups through intervention programs whose designs are based not only on models of emotional intelligence, but on the needs of each collective. There are hardly psychological intervention programs that target the specific needs of social workers, despite all the problems and difficulties that both public service interpreters and social workers experience daily.

For this reason, we aimed to achieve the following objectives:

1. Design courses in emotional management accommodating the different needs of each group participating in our study.
2. Assess the quantitative effects of each intervention program.

Our starting hypotheses were as follows:

1. Public service interpreters and social workers who participate in the intervention improve their scores in emotional intelligence and empathy indicators, while simultaneously decreasing their scores on the burnout indicators.
2. The control group, which do not receive any form of intervention, have either lower scores or the same scores in the indicators of emotional intelligence and empathy in the second measurement time, in comparison with the first one.

Method

Participants

The sample for our study was made up of forty-five participants belonging to four different groups of professionals. The first group was constituted of eleven

public service interpreters, who work at two social interpretation organizations. These organizations carry out their work in the health sector and offer their translation and interpretation services in various public hospitals in the Community of Madrid. The interpreters, who volunteered to be a part of the study, were of different nationalities such as Morroccan, Algerian, Romanian, Spanish and Russian. Of the initial 14 participants, three were later excluded from the study, as they did not attend 80% of the sessions that made up their intervention program. The average age of these participants was 29 years old.

In addition, there was another group of nine telephone interpreters. Their company provides linguistic mediation services, through telephone interpretation, in professional, social and cultural environments where providers of certain services encounter linguistic barriers. These interpreters, who voluntarily joined the study, are from Spain and Morocco. The average age of these participants was 37 years old.

A third group of sixteen social workers, from a rural region in Spain. These individuals attend to disadvantaged families or vulnerable members of the community as well as immigrants who arrive in this region. The participants are all Spanish, have an average age of 44 years old, and are also voluntary participants in the study.

Finally, we included a control group of nine telephone interpreters made up of 8 females and one male, whose average age was 34 years old, and voluntarily joined the study.

For each group there was just one male, and the rest were female participants. This could be probably justified by the fact that in these kinds of professions, there is generally more prensence of women than men, but things are fortunately changing in society. We can't give evidence of what mentioned since the professionals with whom we worked are performing relatively quite new kind of jobs in Spain and most of them are freelances, so it was very hard to get information about the population from a database, a list or a book.

For this reason, we had to recognize the research terrain and, as we tried to cover as many aspects of the phenomena as it could be possible, hence we finally opted for a typological representativeness instead of a statistical sampling. No gender-related factors were found.

Instruments

For the quantitative analysis of our study, we used the following questionnaires:

BarOn ICE (*EQI BarOn Emotional Quotient Inventory*)

To calculate the emotional intelligence coefficient and the variation of each factor included in it at the pre-test and post-test moments, we used the Spanish adaptation of the BarOn Ice questionnaire, EQI BarOn (Ugarizza & Pajares, 2005).

The BarOn questionnaire allows for the measurement of "a set of non-cognitive abilities, competences and skills that influence our ability to succeed in adjusting to the demands and pressures of the environment" (BarOn, 1997, p. 14). It is made up of 133 items, grouped into the following categories:

1. Intrapersonal subcategories: Self-Regard, Emotional Self-Awareness, Assertiveness, Independence, and Self-Actualization
2. Interpersonal subcategories: Empathy, Social Responsibility, and Interpersonal Relationships
3. Stress Management subcategories: Stress Tolerance and Impulse Control
4. Adaptability subcategories: Reality Testing, Flexibility and Problem Solving
5. General Mood Scale subcategories: Optimism and Happiness

The questionnaire has passed both reliability and predictive validity tests. The internal consistency (Cronbach's alpha measure) for the total inventory is 0.93 and for all factors. This instrument uses a Likert scale, with response intervals that range from 1 ("Rarely or almost never") to 5 ("Very often or always").

BCSQ-36 (*Burnout Clinical Subtypes Questionnaire*)

We used the Spanish-adapted version of the *Burnout Clinical Subtypes Questionnaire*, (Farber, 1983) the version validated by Montero-Marín, García-Campayo, Fajó-Pascual, Carrasco, Gascón, and Mayoral-Cleries (2011), to evaluate the subtypes of the burnout syndrome in the workplace. The subtypes in question are: frenetic, underchallenged, and worn-out. The "frenetic" subtype is typical of people who are heavily involved in their work, have a strong ambition, and often become overloaded. The subtype "underchallenged" is characteristic of those who do not have adequate personal development at work, showing indifference and boredom towards their work. The "worn-out" subtype, on the other hand, is typical of those people who feel undervalued at work and who, not seeing their efforts and results recognized, feel that they are not in control of their situation, eventually deciding to abandon their responsibilities.

The questionnaire has a total of 36 items organized around nine first-order and three second-order factors. It uses a Likert scale with a response interval that ranges from 1 ("Totally disagree") to 7 ("Totally agree"). Internal consistency, calculated using Cronbach's alpha (1951), showing values of 0,8 in all variables.

(IRI) *Interpersonal Reactivity Index*

To measure the dispositional empathy of the participants in our study, we used the Spanish-adapted version of the *Interpersonal Reactivity Index Questionnaire* (IRI, Davis, 1980). The Spanish version of the questionnaire (Pérez et al., 2003), has psychometric characteristics similar to those of the original version. In fact, in the original work the coefficients ranged from .70 to .78. (IRI, Davis, 1980). The resulting coefficients in the validation version (for more information on these coefficients, see Pérez et al., 2003, p.269), although somewhat lower in general, were adequate and similar to those presented by the author in the construction of the instrument (Davis, 1980). The questionnaire itself is made up of four independent dimensions of 7 items each, whose internal consistency, calculated using Cronbach's alpha, is similar to the original version (Pérez et al., 2003). In total, the instrument consists of 28 items. The dimensions mentioned above are as follows: fantasy, perspective taking, empathic concern, and personal distress. The "fantasy" dimension measures the propensity of people to be identified with fictional characters from novels or movies, the "perspective taking" dimension indicates the ability of the subjects to adopt the point of view of others, the "empathic concern" shows the tendency of individuals to have compassion or concern for other people, while the "personal distress" evaluates if subjects experience a certain level of discomfort when witnessing unpleasant experiences lived by others.

This instrument uses a Likert scale, with a response interval that ranges from 1 ("Does not describe me at all") to 5 ("Describes me very well").

Design

This study was carried out using a quasi-experimental, pre-test–post-test design with a control group. Baseline data were collected on the first day of each intervention program. Each intervention program was made up of 3-h class sessions distributed across three months. Finally, post-test data were collected on the last session of each intervention program.

It should be noted that before administering the questionnaires to the four groups of participants, they were informed about the objectives of the instruments employed and how the results would be used, and they provided their

signed informed consent. Participants were also assured that data collected would be kept confidential and would only be used for research purposes.

Procedure

Ad hoc Intervention programs

Three *ad hoc* intervention programs were created based on the needs of each group we worked with. These intervention programs were designed to verify whether their implementation would lead to an increase in emotional intelligence and empathy scores, as well as a decrease in burnout levels, for both public service interpreters and social workers.

The three intervention programs that were carried out were based on a process-experiential approach (McWhirter, 2011; Nogueiras, Kunnen & Iborra, 2017). We created procedures that allowed us to focus our intervention programs on the specific characteristics of each group and subject we worked with, instead of creating conventional emotional management courses based on content and techniques.

Regarding the models of emotional intelligence that underlie our intervention programs, we focused on the '*Conceptual Act Theory*' (Barrett, 2016; Lindquist, 2013). According to this model the brain constantly builds emotional events through a conscious process in which it tries to make sense of uncertainty or ambiguity using a known emotional category and the context in which the sensation occurs. Language and concepts, tools which the brain uses to transform sensations into emotions in many situations, are key elements in the construction of emotions, understood as categories or labels, through which we can communicate what we feel and try to understand others when we refer to subjective emotional experiences (Barrett, 2014).

Intervention program locations, participants and the initial needs of each group

FIRST INTERVENTION PROGRAM:

The first intervention program was carried out with the group of face-to-face public service interpreters This group presented the following picture of their initial circumstances:

- self-esteem issues due to the lack of recognition of their work by the health and medical workers with whom they collaborate to provide health services to foreigners,
- high levels of empathetic concerns due to the close, direct relationships they have with clients, which often become ambiguous, as clients are

prone to confuse the role of the interpreter with that of a lawyer or friend, as they share the same culture and native language,
- anxiety and stress issues due to a combination of heavy involvement and overload at work, as well as a sense of a lack of recognition of their work by other professionals.

We adapted our procedure with this group to match its state at the start of the course, basing our approach throughout the process on practical examples from group members' lived experiences, in matters relating to self-esteem, self-concept, connecting and accepting their emotions, perspective-taking, assertive communication, roles and status in interpersonal relationships and stress management.

Second Intervention program:
The second group we worked with was the group of nine telephone interpreters. This group presented the following picture of their initial circumstances:

- Problems related to stress management, due to their work schedule and the lack of a clear distinction between their personal and professional lives, as they must be on call 24 hours a day and guarantee their services at any time and any place; if they are unable to do so, it is very likely that they will not be called on following occasions or that they will be called less frequently due to the strong competition that exists in their line of work.
- Low levels of empathy towards their clients and towards the rest of the professionals with whom they usually work with over the phone, as they feel depersonalized and burned out.
- Problems with communication and interpersonal relationships due to the aforementioned issues.

This group was used to working in front of a screen or with a telephone in hand, without having direct, in person contact with the users of their services. These individuals had learned to protect themselves from difficult situations by both depersonalizing themselves and their clients, focusing only on their clients' words without paying attention to their broader meaning. We worked cautiously with topics related to transitions, roles, changes and the creation of contexts so that they could learn to improve their time and stress management and distinguish their private lives from their professional ones.

Third Intervention program:
The third group we worked with was that of sixteen social workers who work in a region in a rural area of northeast Spain. We adapted our work approaches to the problems and characteristics of the group, whose issues at the start of the course were the following:

- Problems of confidence and connection within the work team, despite the fact that most of the participants had been working at the same organization and within the same team for more than 20 years.
- Scarce communication between colleagues and with supervisors, which led to uncomfortable situations and misunderstandings on more than one occasion.
- High levels of involvement and work overload, which made it difficult to distinguish the professional from the personal and led to burn-out.
- Resignation in the face of their initial situation as a team, but at the same time a small hope of a change that could lead to improved professional and personal well-being.

Hence, we proceeded by rewarding moments in which each person could embrace their emotions, learn to accept them or build emotional experiences that were more appropriate, and by promoting a dialogic and collaborative approach through which to generate a climate of trust, tolerance and openness towards diversity of opinions, ways of life, etc.

Data analysis

As we were in this specific study interested in the effects of the intervention considering two moments (pretest and post-test) we just present the within-subjects differences, after using Student t-test with paired samples. We performed all statistical analysis with SPSS 25 software.

It should be mentioned that, for the purposes of this study, we took into account the fact that each intervention was an independent one, involving a population of professionals dedicated to social assistance, but whose needs were very different from one another. The intent of these analyses was to verify the changes in each group, which were primarily attributed to the type of intervention carried out. In other publications we do present data on the interaction between the groups, but this is not what we want to focus on in the current study.

Results

The study of simple effects between groups confirmed the homogeneity between all groups before the intervention in all dimensions, with one exception only. A significant difference appeared in Time 1 between the Control and the Third Intervention Group in the variable of Interpersonal Emotional Intelligence, according to post hoc analysis using Scheffé statistic (mean difference: -0.69, SE: 0.163, t = -4.26, p. = 0.018). It should be mentioned that we employed Scheffé post-hoc tests because we wanted to have sureness about the statistical hipotesis about the real difference when comparing groups.

Similarly, there were no differences between groups either in any dimension in Time 2 after the intervention had taken place. Once again, there is only one exception concerning the emotional intelligence variable of General Mood. After the intervention there were statistically significant differences just between the intervention group 3 (mean = 4,36) compared with the control group (mean = 3.47) (mean difference: -0.89, SE: 0.23 t = -3.91, p. = 0.044).

We focus in a within group pre-post intervention analysis using a Student t-test with paired samples. Instead of focusing on variables we present the results focusing on the different groups in order to show a better description of those changes comparing the outcomes in the dependent variables before and after the intervention.

Table 1. Mean scores and standard deviations of the emotional intelligence and empathy variables at both times. DT: standard deviation, r: Pearson's correlation coefficient r[1]

Public service interpreters group. SeC	Variables	PRETEST (N = 11)		POST-TEST (N = 11)		*t*	r
		M	DT	M	DT		
EQ-I Bar-On Factors	Intrapersonal	3.44	0.50	3.77	0.49	-2.3*	0.59
	Self Awareness	3.10	0.91	3.64	0.61	-3.1**	0.70
	Assertiveness	2.83	0.81	3.32	0.88	-2.64*	0.64
	Problem Solving	3.53	0.58	3.97	0.56	-3.1**	0.70
	Flexibility	3.32	0.74	3.83	0.57	-3.9*	0.78
	Stress Management	3.5	0.8	3.76	0.77	-2.25*	0.57
IRI Factors (Interpersonal Reactivity Index)	Perspective Taking	3.83	0.48	4.40	0.65	-2.9**	0.68
	Empathic Concern	3.45	0.68	3.02	0.41	2.4*	0.61

*p. .05; **p. .01

1 DT: standard deviation, Pearson's correlation coefficient r. These abbreviations will be presentin all the following tables. The effect size for the t-test for independent samples was calculated using Cohen's d.

Table 2 summarizes the mean scores and the standard deviations at each time point (pre-test and post-test) for the first intervention group of public service interpreters.

The data indicated that there were significant differences between the scores at pre-test and post-test for two second order factors (Intrapersonal, Stress Management) and three first order factors (self-awareness and assertiveness belonging to Intrapersonal and problem Solving and Flexibility belonging to Adaptability) regarding emotional intelligence. The data also showed significant differences between the scores at pre-test and post-test for the variables Perspective Taking and Empathic Concern regarding the interpersonal reactivity index. No significant differences were found in relation to the subtypes of Burnout Syndrome.

All scores in the dimensions which presented significant differences increased their scores in the post-test, presenting also large size effects (above 0.5). The variable flexibility showed the highest size effect (0.78) and stress management the lowest (0.57). The only dimension which decreased was empathetic concern which presented a large size effect (0.61).

Below there are the intragroup results for the second group of telephone interpreters.

Table 2. Mean scores and standard deviations of the emotional intelligence and empathy variables at both times

Telephone Interpreters	Variables	PRETEST (N = 9)		POST-TEST (N = 9)		*t*	r
		M	DT	M	T		
EQ-I Bar-On Factors	Intrapersonal	3.68	0.44	3.91	0.33	-2.40*	0.64
	Problem Solving	3.71	0.41	3.93	0.39	-4.36**	0.83
	Stress Tolerance	3.35	0.47	3.82	0.49	-4.36**	0.84
	Stress Management	3.32	0.47	3.80	0.40	-4.03**	0.81
	Optimism	3.68	0.41	4.05	0.46	-3.83**	0.80
	General Mood Scale	3.71	0.36	4.08	0.55	-3.80**	0.80
IRI Factors	Happiness	3.75	0.37	4.12	0.69	-2.43*	0.65
	Empathic Concern	2.65	0.23	3.50	0.43	-4.11*	0.82

*p. .05; **p. .01

As in the previous group there were significant differences between the scores at pre-test and post-test for almost all of the factors concerning emotional intelligence and empathy. No significant differences were found in relation to the subtypes of Burnout Syndrome. All scores in the dimensions increased

their scores in the post-test, presenting this time larger size effects (six variables present effects above 0.8).

The variable stress tolerance showed the highest size effect (0.84) and intrapersonal skills and happiness the lowest (0.64 and 0.65 respectively). In contrast to the previous results the difference in the variable empathetic concern was higher in the post-test presenting a larger size effect (0.82).

Below there are the intragroup results for the third group of the social workers.

Table 3. Mean scores and standard deviations of the emotional intelligence and empathy variables at both times

Social Workers	Variables	PRETEST (N = 16)		POST-TEST (N = 16)		*t*	r
		M	DT	M	DT		
BCSQ-36 Factors	Lack of Control	4.64	0.88	4.15	1.11	2.511*	0.54
	Burn-out	3.40	0.64	3.13	0.71	2.511*	0.47
FACTORES EQ-I Bar-On	Self Regard	3.40	0.64	3.13	0.71	2.078*	0.47
	Assertiveness	3.27	0.70	3.67	0.41	-4.073**	0.72
	Independence	3.37	0.55	3.53	0.47	-2.058*	0.46
	Intrapersonal	3.65	0.42	3.87	0.29	-3.724**	0.69
	Empathy	4.39	0.35	4.07	0.14	3.062**	0.62
	Social Responsibility	4.31	0.37	4.05	0.15	3.318**	0.65
	Reality Testing	3.69	0.39	3.87	0.29	-2.926**	0.60
	Problem Solving	3.97	0.38	4.24	0.23	-3.810**	0.70
	Adaptability	3.68	0.27	3.86	0.18	-3.256**	0.64
	Stress Tolerance	3.52	0.56	3.75	0.41	-2.221*	0.49
	Impulse Control	3.63	0.64	3.92	0.59	-2.21***	0.78
	Stress Management	3.58	0.47	3.84	0.41	-3.98***	0.71
	Happiness	4.09	0.46	4.34	0.33	-3.706**	0.69
	Optimism	3.86	0.45	4.39	0.33	-5.09***	0.79
	General Mood Scale	3.97	0.38	4.36	0.27	-4.90***	0.78

*p. .05; **p. .01.; p***<0.001

There were significant differences between the scores at pre-test and post-test for almost all of the factors concerning emotional intelligence and on this occasion in one burnout subtype. There were no significant differences in the variables from the Interpersonal Reactivity Index. Most variables increased their scores in the post-test, presenting a higher variability in the size effects: two variables (independence and stress tolerance) presented size effects below 0.5; five variables presented high size effect above 0.70 (impulse control, optimism, general mood, assertiveness and problem solving) presenting the

rest five variables moderate size effects between 0.6 and 0.69. Five variables decreased their scores in the post-test: lack of control, burn out, self-regard, empathy and social responsibility. First two variables presented low size effects (below 0.5) while the rest presented medium size effects between 0.6 and 0.69.

The variables optimism, impulse control and general mood showed the highest size effect (above 0.75).

Finally, below are the quantitative results of the control group, which did not receive any form of intervention.

Table 4. Mean scores and standard deviations of the emotional intelligence and empathy variables at both times

Group Control	Variables	PRETEST (N= 9)		POST-TEST (N= 9)		*t*	r
		M	DT	M	DT		
BCSQ-36 Factors	Neglect	1.83	0.66	2.19	0.64	-2.87*	0.71
	Lack of Control	3.69	0.85	4.08	0.83	-1.53*	0.02*
	Indifference	1.86	0.97	2.08	0.99	-2.53*	0.66
EQ-I Bar-On Factors	Assertiveness	3.03	0.52	3.28	0.52	-3.1**	0.73*

*p. .05; **p. .01

As it is shown in the table the control group presented significant differences comparing post-test and pre-test. Three variables of the Burnout Inventory Questionnaire increased their grades in the second measurement moment, indicating a deterioration of his previous emotional state. Only one variable belonging (assertiveness) to the emotional intelligence improved in the second moment of measurement.

Discussion

Few to no studies have been conducted with the purpose of demonstrating that it is important for healthcare professionals to have high levels of emotional intelligence, socio-emotional skills and empathy, as well as low levels of burnout for an adequate development in their profession. Likewise, very few studies have offered intervention programs to improve the situations of these groups. In fact, generally, most of the studies about emotional management intervention programs focus almost exclusively on the educational field. Furthermore, their main aim is usually to demonstrate the validity of certain techniques or theoretical approaches to foster emotional management

(Graczyk, Weissberg, Payton, Elias, Greenberg, & Zins, 2000; Miller, Nickerson, & Jimerson, 2009; Oliver & Reschly, 2010; Webster-Stratton, Gaspar., & Seabra-Santos, 2012; Gregersen, MacIntyre, Finegan, Talbot, & Claman, 2014; Korpershoek, Harms, de Boer, van Kuijk, & Doolaard, 2016; Domitrovich, Bradshaw, Berg, et al., 2016, Li, & Xu,2019).

At the same time, since it has been proven that high levels of EI could generate in people's personal, academic or professional lives, (as mentioned in the introduction part of this study), fostering individuals' social-emotional competencies through EI intervention programs has been shown to be effective (Daus, & Cage, 2008). Nevertheless, recent systematic reviews (Kotsou et al., 2018; Hodzic et al., 2018) on the effects of EI training show that most intervention programs do not take into account cultural and contextual factors, omit specifying what sort of interventions are carried out, summarizing what these interventions are like and what they consist of as well as in most cases, as well as lack of a control group or active control groups.

That is why the current study on one hand aimed to raise awareness of the problems of the professionals participating in it, and on the other hand especially insististed in the importance of designing specific *ad hoc* interventions constantly adapted to the needs and characteristics of each group and to the context generated.

We corroborated the starting hypothesis of the investigation.

The results obtained, which are described in the following paragraphs, can be attributed mainly to the *ad hoc* design and methodology used in the intervention programs. Through this type of programs, we have been able to facilitate in the participants a new creation of value in their lives, not only by promoting a better emotional regulation, but also by facilitating a transformational change in the way they conceive themselves, how they interact in the world and how they behave with others. This type of intervention also demonstrates a new and more up-to-date approach to fostering social-emotional competencies. By employing an experiential process-oriented methodology (McWhirter, 2001) with collaborative and dialogic distinctions (Iborra et al., 2010), this type of approach has allowed participants in each group to explore their experiences in detail, having new distinctions that allowed them to create new meaning to their emotional episodes, experiences, and concerns, from challenging situations. Furthermore, this focus, based on a constructivist and sociocultural paradigm of education (Tascón, 2003), has encouraged at all times an active construction of knowledge by the participants themselves, instead of encouraging a passive teaching-learning process where participants are mere receivers of contents and not active architects of their lives.

The analysis of the quantitative results showed more relevant and statistically significant differences between the pretest and the postest, for the groups which received the *ad hoc* intervention program, in almost all the variables of emotional intelligence, empathy and burnout subtypes.

The control group showed less statistically significant differences between the pretest and the posttest. When these differences appeared, they referred to higher punctuations in the burnout subtypes: neglect, lack of control and indifference.

These results could be taken as an evidence of the need of developing intervention programs which could benefit these distinct groups of professionals.

Although there are some differences between the results of each group that received the intervention program, they can be justified by contextualizing the initial problems of each group and the effects obtained by each intervention program on the participants. For example, for the first group that participated in the study there were significant improvements in most of the emotional indicators. The variable empathetic concern, instead, had a lower value in the post-test. This contradicts our initial hypothesis. However, it is an understandable result taking into account the specific needs of this group of participants in the research. Having a high empathic concern allows us to feel compassion for others, to care for less fortunate people, leading us to be more altruistic, to get involved in volunteer activities or to give selfless help to those who need it most (Konrath, Ho, & Zarins, 2015). But for our participants, having a high empathetic concern towards the users they usually attend led them to experience anxiety-depressive symptoms because they were not able to look at clients' problems with some detachment.

The variable taking perspective, the ability to imagine the point of view of others, and empathetic concern, feeling compassion for others, usually present a positive correlation (Chopik, O'Brien, & Konrath, 2017). As we saw, in our case it is the other way around. The subjects increased their values in perspective taking while those of empathetic concern decreased. The group with whom the intervention was carried out, previously presented self-esteem problems due to the undervaluation they felt by the rest of the professionals with whom they worked together, taking usually to home their problems, living the other's pain as if it were his own. Through the intervention, the interpreters were helped to be aware of themselves and their own emotional experience, to differentiate their own experience from that of others. This process of differentiation between one's own emotions and those of others is a basic emotional process in research on empathy and hence could explain

the results obtained regarding a lower punctuation in empathic concern (Woltin, Corneille, Yzerbyt, & Förster, 2011).

The second group, the telephone interpreters, initially reported issues with low stress tolerance, frustration and general distress due to work conditions that required them to guarantee their availability 24 hours a day. These participants learned to manage their emotions more adequately through the intervention program, due to a better understanding and connection to themselves, improving their stress management and tolerance, which were some of the key abilities that this group lacked. This group seemed to have adopted more effective problem-solving strategies, and, as a result, improved their general mood, as seen in the higher levels of optimism and happiness in the posttest.

It should also be noted that these participants significantly improved in their levels of empathetic concern, which they initially lacked greatly, both towards their clients and the rest of the professionals with whom they worked as communicative mediators. In the case of this group the higher punctuations in the postest of the variable empathetic concern as compared to the prestest it's not surprising, on the contrary, it is what we expected considering their needs and starting conditions.

The social workers also connected more deeply with their emotions, established better interpersonal relationships and had less personal discomfort. Thus, they felt less worn-out compared to the initial situation of the team. It should also be mentioned, that, the following variables, that is, self-regard, empathy and social responsibility had a lower value after the intervention. These quantitative results seem to contradict our initial hypothesis. However, that's not the case if we also consider the process of the intervention program itself and the particular context and dynamic of this group. Immediately after the intervention program, in which, we worked especially on the reconstruction of their implicit conceptions and beliefs about the labels "empathy", "self-awareness", "team", they were in a certain status of personal and group crisis which would lead them to a restoration as members of a group.

Conclusions

The intervention programs for emotional management, designed based on the needs and characteristics of each professional group targeted, were effective and beneficial.

The control group did not improve its scores, demonstrating not only the need for adequate emotional management in these professionals, but also the

need for specifically designed *ad hoc* intervention programs for each group in question.

We defend the importance of designing specifically tailored programs. Processes such as the management of uncertain transitions coming from formal to informal contexts and the objectification of perspective-taking processes emerge as illustrations of specific problems belonging to these professional groups that are not usually covered in general emotional interventions. Thus, designing the intervention from current needs of the participants could then make a deeper difference. It should also be stated that it is not possible to interpret accurately what does it mean the increase or decrease of the variables measured in these studies to test the impact of the interventions, as most studies implement general interventions. Thus, we defend to consider the context of the interventions in order to lessen the uncertainty in the interpretation of results.

Limitation of the study

One limitation of the study, among others such as the quasi-experimental design, was the lack of randomization in our sample and the size of the groups.

It should be stressed that at the beginning of our research, we sought to have a statistical representativeness, but we faced various difficulties to achieve the units because we worked with a new and original population. For example, in the case of Public Service Interpreters and Telephone Interpreters, their professions are quite new in the job field, so most of them are freelances and it is very difficult to get information about the population from a list or a book.

For this reason, we had to recognize the research terrain and, as we wanted to cover as many aspects of the phenomena as it could be possible, we finally opted for a typological representativeness instead of a statistical sampling.

The size of the groups is justifiable by the fact that all our participants worked on a daily basis in care, social and health contexts, requiring their presence for many compelling reasons (emergency situations involving vulnerable population groups) at different times of the day. Hence, it was very hard to organize intervention programs which could cover the schedule and the geographic availability of all the professionals involved, and even to find participants who could attend them.

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SUMMARY

Generally, public service interpreters and social workers experience symptoms of an anxious depressive nature, due to their works. For this reason, we aimed to design three *ad hoc* emotional management intervention programs to evaluate their impact, combining quantitative and qualitative information.

The study developed a quasi-experimental pre-test-post-test design, performing T-tests on related samples for each group.

Three *ad hoc* intervention programs were developed for a group of public service interpreters, a group of telephone interpreters and a group of social workers. The study also included a control group that did not receive any intervention. The *Bar-On ICE*, the *Interpersonal Reactivity Index (IRI)* and the *BCSQ-36* were used to evaluate the Emotional Intelligence factors, the Burnout syndrome and the Empathy processes.

Most of the emotional intelligence and empathy factors showed statistically significant differences between the pre-test and the post-test, in favor of the latter for each of the groups. The control group's T2 results worsened, as they had not received any form of intervention.

This paper will discuss how these participants have incorporated the key takeaways of the intervention programs in their emotional management at work.

KEY WORDS: *ad hoc* intervention programs, public service interpreters, telephone interpreters, social workers, emotional management