Coping with Vicarious Trauma in Mental Health Interpreting

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ABSTRACT

This research explores coping strategies used by American Sign Language (ASL) interpreters who work in mental health settings. Due to the highly emotional nature of such assignments, interpreters are at an increased risk for experiencing vicarious trauma. This study also investigates the available training regarding vicarious trauma in current interpreter education. Previous research has typically recognized the need for self-care and focused on general suggestions for coping; the present work uses firsthand accounts from practicing interpreters. To uncover interpreters' personal experiences, the researcher created an online survey that resulted in 222 qualifying responses. Of the total number of respondents, 83% expressed that they have experienced vicarious trauma as the result of interpreting in mental health settings. However, 58% reported that they have not received any training related to managing the emotional impact of such interpreting assignments. Debriefing was chosen as the most utilized strategy (80%), but was also identified by some interpreters as a potential breach of confidentiality. While some interpreters have refined their own self-care routines, there is still a significant gap in educating interpreters about managing the adverse effects of vicarious trauma.

INTRODUCTION

Historically, research about sign language interpretation has focused primarily on the product of the target text, such as interpreting strategies (Finton & Smith, 2005; Baker, 2011), working memory (Baddeley, 2003), controlling the interaction (Wadensjö, 1998, 2004), and the co-construction of meaning (Davidson, 2002; Janzen & Shaffer, 2008). A topic less studied is the emotional impact that certain assignments may have on interpreters. Previous studies indicate that interpreters, especially those who work frequently in mental health settings, should have strategies to cope when working in emotionally-charged situations (see RID, 2007; Walker & Shaw 2011). However, despite these suggestions, there is little evidence regarding the effectiveness of the methods from interpreters themselves (for an exception, see Wessling and Shaw, 2014). The purpose of this study is to explore available resources for ASL-English interpreters who work in mental health settings, and, specifically, to examine interpreters' preferred coping mechanisms for highly emotional assignments. This study also highlights areas for improvement regarding how to approach the critical practice of self-care in interpreter education programs. The findings may be significant to the profession as they document firsthand accounts of interpreters' experiences in dealing with vicarious trauma in mental health settings, while also providing potential guidelines for future generations of interpreters.

BACKGROUND

Interpreting is often viewed as a technical profession related solely to linguistics, both from outside as well as inside the field. Interpreters themselves may feel that they function purely as linguistic conduits, despite experiencing "the complexity of their role and the responsibility they take to ensure effective communication" in their work (Hetherington, 2012, p. 47). Further, interpreting is unique as individuals in the profession each undergo "various career choices, professional identities, and work experiences" (Schwenke, 2012, p. 35). This versatility can cause further confusion for those outside the field. One participant in Hetherington's (2012) study expressed that other professionals "think I'm a magician's assistant, I wave my hands and the Deaf person understands and they have no cognition around how I get from A to B or how things are being conveyed, or the amount of work that I need to do to enable this dialogue to happen" (p. 49). This lack of comprehension regarding the interpreter's role can also lead to a lack of respect for the profession, which is a further source of stress for the interpreter (p. 49).

Dean and Pollard (2001) are well known for their adaptation of the demand-control schema, as first presented by Karasek (1979), and its application to signed language interpreting. Rather than focus solely on the linguistic aspect of interpreting, they explored the cognitive and psychological demands as well. Demands on an interpreter, as described by Dean and Pollard (2001), are "numerous, dynamic, and interactive and arise from complex linguistic, environmental, interpersonal and intrapersonal factors" (p. 12). They have suggested that interpreters face linguistic demands related to language translation, environmental demands based on assignment settings, interpersonal demands from all participants in the communication process, and intrapersonal demands regarding physical and psychological factors of the interpreter (p. 4). These demands can shift, sometimes multiple times during one assignment. To exacerbate the situation, interpreting has also been referred to as a profession that has low decision latitude, meaning interpreters have few options for how to manage the multiple demands in their work. This low decision latitude puts the interpreters at risk for stress-related burnout (p. 12). Dean and Pollard (2001) also explained, "positive or negative outcomes of a given occupational situation are not dictated by job demands, but by the relation between demands and control" (p. 6).

One demand-control relationship that is often discussed in the interpreting field is that interpreters are held to a standard of neutrality; they are typically taught that they should not interject their thoughts, commentary, or feelings into an interaction (Dean and Pollard, 2001, p. 8). Despite Roy's (2000) work, which showed that interpreters are active participants in their interactions, many interpreters and consumers still assume the interpreter should be "invisible." Dickinson and Darby (2011) described that this concept of invisibility remains the "most commonly held understanding of the interpreter's role, both from within and outside the profession" (p. 110). For example, in Heller, Stansfield, Stark and Langholtz's (1986) study, interpreters reported that having any sort of emotional reaction to their work was seen as unprofessional; some went so far as to say such reactions would be considered a violation of their professional code of ethics. In fact, this guideline is found in the Code of Professional Conduct (CPC) created by the Registry of Interpreters for the Deaf (RID). Under the CPC Tenet 2: *Professionalism*, sub-tenet 2.5 reads, "Interpreters…refrain from providing counsel, advice, or

personal opinions" (RID, 2005, p. 3). Hale (2007) asserted the following regarding this code of conduct:

> Much more than the mere existence of a code of ethics is needed in order to ensure quality of interpreting services. There is large contradiction between the high standards expected of interpreters, as outlined in the code of ethics on the one hand, and the total absence of any compulsory pre-service training, low institutional support and poor working conditions to allow interpreters to meet those standards on the other. (p. 105)

As Hetherington (2012) described, interpreters may think that by acting impartially, they are expected to *feel* impartial as well (p. 49). ASL-English interpreters who were interviewed by Harvey (2003) explained that this concept of impartiality is "psychologically unfeasible on an emotional level" (p. 207). The expectation of interpreters to be invisible as well as the confusion regarding professional confidentiality standards can cause a lack of clarity regarding how much of an emotional reaction they are 'allowed' to experience.

Interpreters' work can have a significant impact on them, both emotionally and psychologically. This effect is intensified when working with those that are considered "vulnerable client groups" (Hetherington, 2012, p. 47). For example, Potterveld (2012) investigated interpreters in legal settings and observed that ASL-English interpreters are often faced with information that is "emotionally difficult to process"; this can impact their ability to continue working (p. 160). In addition to legal work, medical interpreting also puts interpreters at risk for emotional distress. Bontempo and Malcolm (2012) explored the unique challenges faced in the healthcare environment for both spoken and signed language interpreters. Their work suggests that there is a difference between typical work-related stress and occupational stress that can be physically and/or psychologically damaging. They described that coping with this is, in large part, dependent on personality (p. 114). A participant in Hetherington's (2012) study supported this by saying, "You are the interpreter but you are also a person and sometimes your own personality can affect your practice" (p. 51). Walker and Shaw (2011) surveyed novice interpreters to uncover their feelings of preparedness for working in specialized settings. One participating interpreter reinforced the role of personality in the effects of trauma, suggesting to interpreters, "build your emotional defenses before trying mental health. If you empathize too much, this might not be the best setting for you" (p. 103).

The present study focuses on mental health interpreting and its distinctive encounters. Hsieh (2014) emphasized how specialized mental health is, stating that mental health is the "only medical specialty in which researchers and practitioners have presented systematic discussions on how medical interpreting imposes unique challenges to and expectations for interpreters" (p. 92). This is possibly due to a lack of familiarity with mental health settings. Interpreters are likely to have experienced a variety of medical encounters in their lives, e,g., doctor's appointments, dentist appointments, emergency room visits, etc. However, the exposure to mental health interactions is not as common. Interpreters in Dean, Pollard and English's (2004) work verified this, describing that they had a lack of understanding of "psychiatric patients, staff, and environments" (p. 67). Further, a participating interpreter in Zamanyi's (2010) study explained that as an interpreter, "I'm not going to have to have the background in…psychology" (p. 6). Interpreters are not required to

have this specialized expertise; this, combined with the frequent absence of firsthand knowledge, supports Searight and Searight's (2009) finding that errors are more common in mental health than medical interactions.

Anecdotally, interpreters report that when they become stressed due to the high demands of their work, namely when interpreting emotional content, they may bring this stress with them into a mental health situation. Brunson and Lawrence (2002) investigated the impact interpreter mood had on both clients and therapists in an interpreted mental health situation by examining therapists and interpreters who spoke or interpreted, respectively, with differing moods (despondent, neutral/slightly cheerful). They video-recorded two teams of two, each consisting of one licensed healthcare professional and one nationally certified ASL-English interpreter; the team of professionals read or signed dialogue from scripts using an assigned mood. The Deaf participants then watched the recorded videos without sound, and completed questionnaires. The researchers found that the client may withdraw from the interaction or feel depressed if the interpreter is perceived as being exhausted (p. 577). This suggests that the mood of the interpreter has an impact on the entire interaction.

Therapy settings already involve more emotional subject matter than most interactions. Brunson and Lawrence (2002) further showed that in these scenarios, the interpreter is an active member of a triadic therapeutic process. The authors suggested that when interpreters are unsure of how to handle or process "emotionally charged clinical material," they may experience vicarious distress, or become fatigued (p. 579). Green, Hawkins, Malcolm, and Stewart (2001) cited this as well in their document written for The Deaf, Hard of Hearing, Deaf-Blind Well-Being Program (WBP). The authors explored the unique relationship between therapist and sign language interpreter. Using their own experiences as a guide, they identified issues in such relationships, what was learned from encountering these issues, and how they have worked to resolve these matters. They stated that, "While working in mental health settings, [sign language] interpreters will sometimes be exposed to traumatic material that may evoke emotional reactions in them" (p. 26). Taken together, these studies suggest the importance of preparation for interpreters who work in tense settings. The next section examines one potential side effect of this work: vicarious trauma.

VICARIOUS TRAUMA

The term *vicarious trauma* is used to describe the "emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured" (American Counseling Association, 2011). In his article directed towards psychotherapists, Figley (2002) called this *compassion fatigue*, and defined it as a state of "tension and preoccupation with the traumatized patients by re-experiencing the traumatic events…associated with the patient" (p. 1435). Figley also cited an Australian study that found that 27% of professionals who work with traumatized individuals also experienced extreme distress (p. 1435). Aside from vicarious trauma and compassion fatigue, *burnout* is another term that is frequently used in everyday discourse to describe feelings of being worn down or exhausted. However, Harvey (2001) emphasized that vicarious trauma and burnout are not synonymous; burnout is typically a "gradual process of emotional exhaustion" while vicarious trauma can surface abruptly and without warning (p. 89).

Bontempo and Malcolm (2012) explicitly stated that sign language interpreters are "not immune to the effects of trauma exposure" (p. 127), while Harvey (2003) asserted that signed language interpreters in particular are at risk for "empathetically drowning" (p. 211). Searight and Searight (2009) investigated clinicians who work with foreign language interpreters. They recommended that if a client is using an interpreter and is discussing a traumatic experience in therapy, the clinician should pay attention to the reaction of the interpreter. As they described, "psychologists must be alert to the possibility of secondary traumatization to the interpreter," as interpreters may have their own traumatic memories resurfaced (p. 445). Even if the interpreter does not relate their personal experiences to that of the client, they can still internalize the suffering that they are exposed to. McCann and Pearlman (1999) further supported this notion by explaining that anyone who works with a victim of trauma experiences the client's memories and eventually can include these into their own memory systems; they compared this process to that of post-traumatic stress disorder (PTSD) (p. 144). Dean, Pollard and Samar (2010) noted, "sign language interpreters on the whole reported significantly more psychological distress, depression and physical exertion than either the practice profession or the technical profession norms" (p. 41). It is evident that this issue needs to be taken seriously and addressed in interpreter education.

TRAINING

Mental health professionals typically receive some training regarding their own emotional reactions and feelings as part of their education. As of 2007, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards contain eight main topics, three of which include information about crisis counseling and counselor self-care (Sommer, 2008, p. 66). Furthermore, as Munroe (1999) explained, the American Psychiatric Association (APA) has guidelines for training their professionals stating: "Not only should we be concerned about warning candidates of the potential harm of being exposed to trauma, but we should also train them how to cope with this exposure" (p. 125). While this is an area of focus for mental health professionals, Green et al. (2001) described that interpreters' training "may not have included developing awareness of the needs for emotional self-care that is usually part of a therapist's training" (p. 6).

Granger and Baker (2003) discussed how the emotional demands of interpreters' work often goes unacknowledged, and that they are "rarely provided with any training or support systems to help deal with these demands" (p. 113). Anderson (2011) supported this as well, stating that interpreters have "equal vulnerability to occupational stress [as mental health professionals] but lack adequate training in order to recognize it or take necessary steps to offset negative impacts" (p. 1). Anderson did more than just acknowledge this need; she developed an intervention model titled the Peer Support and Consultation Project for Interpreters (PSCPI). After receiving direct feedback from 16 interpreters who attended various PSCPI meetings, the findings showed that there is a "strong positive relationship…between attendance at a PSCPI group meeting and increased positive perception of being part of a productive and supportive professional network." Moreover, attending such meetings helped these interpreters feel that they had "a variety of strategies for self-care and self-management" (p. 17). Crezee et al. (2015) recommended that interpreter educators consider teaching their students to be aware of their individual potential stressors, so they can develop self-care regimens early in their careers (p. 75).

It has been suggested that interpreting in mental health settings would be improved with supplementary training. Searight and Searight (2009) report that only about 20% of interpreters who have been involved with psychotherapy for an extended period of time have had any sort of formal preparation regarding mental health. Walker and Shaw (2011) highlighted that the lack of training or familiarity with the therapeutic process can cause additional stress, as the demands of the interaction "begin to outstrip the resources available" (p. 98). One participant in their study also reflected on the education received, stating that, "Even though the program trained us for the setting, the actual work was much more intense" (p. 103). Zimanyi (2010) interviewed spoken language interpreters in Ireland to gain an understanding of their prerequisites for mental health interpreting. The participants in this study expressed that training should be ongoing, as it is for other professions, such as doctors and lawyers. Further, one participating interpreter emphasized that vocabulary in both languages is not sufficient, as there must be some familiarity with the medical terminology as well (p. 6). The lack of proper training for interpreters could be dangerous, as it could possibly lead to misdiagnosis of the patient (p. 8). Searight and Searight (2009) supported this as well, stressing, "interpreter error is a form of medical negligence" (p. 445).

Dean and Pollard (2001) included firsthand reports from interpreters who claimed that there is a lack of preparation in regards to "the realities of the working world and frustration with the lack of professional support available after graduation," and that most of their work is learned "on the job" (p. 3). Other practice professions require "newly qualified practitioners to work under the guidance of senior colleagues" and are "rarely the only individuals in the work environment with the specialized knowledge needed to conduct the work…they rarely perform their duties unsupervised" (p.10). In the interpreting world, new interpreters and even those still in training typically work alone. Hetherington (2012) explained that interpreters often work as sole or freelance practitioners, so poor service can easily go unnoticed (p. 52). Without the supervision of a more tenured colleague, these interpreters may be working "beyond their personal and professional limits" (p. 49). The idea of learning through experience rather than being guided with further support after graduation appears to be insufficient for interpreters beginning work in mental health.

SUPERVISION

Dean and Pollard (2001) explained that professionals within mental health, medical, legal, and other specialized settings typically receive additional supervised learning outside of the classroom (p. 10). One type of training that could be implemented for sign language interpreters is that of observation-supervision, as suggested by Dean and Pollard (2004). It is important to first note that the mental health profession defines *supervision* as "discussion between practicing professionals" rather than "oversight by one's boss." In contrast to the codes of ethics in the interpreting field, ethical standards in mental health professions "mandate that such supervision be obtained whenever needed" (p. 66). This observation-supervision method of teaching provides a more complete overview of interpreting in specialized settings. In the first component, observation, the interpreters attend specific service settings with no interpreter involved. For example, an interpreting student could observe a hearing psychologist with a hearing patient. This allows the student to focus on the setting as a whole, rather than solely on observing another interpreter and their language choices. The supervision component, then, is a group learning experience, "led by

a teacher or mentor who is well-versed in the *teaching* application of the [Demand-Control] schema" who has experience in a particular setting, such as mental health (p. 57). The groups of students discuss their observation experiences and consider the demands in what they observed, while simultaneously devising potential controls as a group. Controls are defined as skills, decisions, abilities, or other resources that an interpreter may use in response to demands that are encountered during an assignment (p. 67). This process allows the trainees to brainstorm their own controls, while also learning new ideas from others (p. 68). The results of this study show that this observation-supervision approach to learning improved critical thinking, analytical skills, and interpreter confidence. In the observation phase alone, the participants reported that they felt they were gaining controls, i.e., increasing their knowledge of disorders, treatment approaches, dynamics, and more (p. 67). One participant reported that this type of training was effective due to the first-hand experiences that created a "much better learning environment than hearing about something in a classroom." Others conveyed that this model allowed them to have more open dialogue with their colleagues, be more analytical of their work, and be able to contemplate the consequences of their decisions (p. 71).

Hetherington (2012) further explored the effects of supervision in the interpreting profession, after noticing a significant gap in "professional frameworks of support and accountability for signed language interpreters" in the U.K. (p. 47). She proclaimed that the interpreting profession should be recognized as more than linguistic-related work. She also expressed that supervision should be implemented consistently so that interpreters can receive ongoing "support, guidance, and feedback on their work," while also acknowledging "the impact interactions and interpersonal dynamics may have on interpreters" (p. 54). This impact can lead to vicarious trauma or compassion fatigue, as discussed in the previous section. It is encouraging to note, though, that Figley (2002) considers this trauma to be "highly treatable" via the incorporation of a systematic self-care routine (p. 1438).

SUGGESTIONS FOR COPING MECHANISMS

A number of researchers in the sign language interpreting field have explicitly stated that interpreters need to be prepared with strategies for dealing with highly emotional situations. Potterveld (2012) explained that sign language interpreters may be faced with such scenarios, and recommended that interpreters have a therapeutic outlet to express their reactions to potentially traumatic material (p. 160). The Registry of Interpreters for the Deaf (RID) developed a series of Standard Practice Papers (SPPs) that outline best practices for various interpreting specializations. The SPP dedicated to mental health interpreting states that interpreters should "incorporate a routine of self-care and develop an intellectual appreciation of the field of mental health in order to offset the negative impact of repeated exposure to the psychological and emotional pain of others" (RID, 2007, p. 3). Thus, RID affirms that emotional management is necessary for interpreters, although no explicit recommendations are made regarding how to cope with these reactions. Bontempo and Malcolm (2012) emphasized that self-care "should be a priority rather than a luxury that is squeezed into a busy schedule" (p. 119). They go on to explain that the foundations of a self-care plan include the consideration of physical and emotional health, as well as social, spiritual and financial needs (p. 119). It is important to note that interpreters who do not have coping strategies at their disposal are described as being "at increased risk for developing

symptoms of emotional exhaustion" (Schwenke, 2012, p. 49). The use of such resources can help address or reduce negative outcomes in interactions (p. 74).

Scholars who have studied the effects of vicarious trauma within therapy or counseling fields offer a myriad of suggestions for those professionals. McCann and Pearlman (1999) conducted research that is related to therapists and their experience with vicarious trauma, and present a list of potential coping mechanisms. They first proposed contacting other professionals who work with victims, attending support groups, and having "feelings" time with coworkers (p. 145). The authors also offered a multitude of other options:

> The coping strategies that have emerged from our weekly discussions include: striving for balance between our personal and professional lives; balancing a clinical caseload with other professional involvements such as research and teaching that can replenish us; balancing victim with nonvictim [*sic*] cases; being aware of and respecting our own personal boundaries, such as limiting evening or weekend work; developing realistic expectations of ourselves in doing this type of work; giving ourselves permission to experience fully any emotional reactions of which we are aware; finding ways to nurture and support ourselves; engaging in political work for social change; and seeking out non-victim-related activities that provide hope and optimism. (p. 146)

As mentioned previously, Figley (2002) also recommended that psychotherapists develop self-care routines. His suggestions included disengagement, desensitization, taking regular vacation time, and increasing social support (p. 1438). Figley further advocated for talking openly with other professionals and self-soothing techniques, and his article included a link to a Self-Test for Psychotherapists to determine how at risk they are for compassion fatigue (p. 1440). Regehr, Zhou, and Bober (2006) encouraged similar self-care practices for therapists, including physical activity, healthy diet and rest, outside activities not related to work, and "professional support networks" (p. 73). Sommer (2008) discussed trauma-sensitive supervision for counselors, suggesting they talk about the impact of the work on their personal emotions, address vicarious trauma directly, and use a "collaborative, strength-based approach" (p. 64). Other recommended self-care strategies include living a healthy lifestyle and continuing to become educated about trauma, as well as breathing techniques, guided imagery, and readings related to self-reflection (p. 68).

Some scholars in the interpreting field do offer examples of specific, potentially effective approaches. Dean and Pollard (2001) showed that previous research proposed strategies such as "self-exploration or self-assessment, constructive thinking, reflection, venting, prayer, guided imagery, and meditation." However, they pointed out that these skills are short-term solutions and are focused solely on the interpreter, instead of the "interaction between interpreters and the demands of their work" (p. 5). Crezee, Atkinson, Pask, Au, and Wong (2015) created a document regarding the practice of teaching self-care to interpreters. They provide a list of self-care options, including time and workload management, rest and diet considerations, exercise, mindfulness, counseling or debriefing, and third-person interpreting. Bot (2005) presented a more in-depth look at this use of third person interpreting, via interviews with three spoken language interpreters. The participants explain that utilizing this strategy allows them to "assign themselves a place of their

own," and distance themselves from the words they are speaking. This is often done to emphasize that "they are not the authors of the words they speak" (p. 245).

A thread of responses named *debriefing* as a coping strategy, loosely defined as having a discussion with the others involved in an interpreted situation. Brunson and Lawrence (2002) briefly mentioned that sign language interpreters may want to utilize "short breaks and debriefings" to alleviate emotional fatigue. Green et al. (2001) also suggested debriefing after a therapeutic session (p. 8) or having some sort of safe space to work through any trauma the interpreter may be experiencing (p. 27). Additionally, they stated that it can be beneficial for the interpreter to personally experience therapy not only to understand the process, but also for "identifying and resolving personal issues" (p. 20). McCann and Pearlman (1999) challenged the idea of debriefing, though, by pointing out that "we struggle with two competing needs: the need to verbalize the traumatic imagery we are attempting to work through and the need to protect our colleagues from the stress of assimilating new traumatic material" (p. 145). Additionally, Green et al. (2001) highlighted that issues should not be worked out via the therapist with whom the interpreter is working. When it comes to finding a mental health professional outside of the interpreted interaction, Dean and Pollard (2001) observed that interpreters do not always feel they can debrief due to concerns about violating their confidentiality oath, as examined previously (p. 7).

Wessling and Shaw (2014) are the only researchers studied in this literature review who have included interpreters' personal, firsthand accounts for how they have dealt with these situations. The coping mechanisms they compiled were provided directly by interpreters involved in Video Relay Service (VRS) settings. In their survey, the authors asked open-ended questions regarding coping strategies. They received a range of responses, debriefing being the most frequent. Other solutions included taking a break, going for a walk, praying, exercising, crying, eating, meditating, and even reducing hours in VRS work (p. 12). The authors also mentioned that these methods are based on experience and interpreters develop them over time, through trial and error (p. 17).

Based on the studies discussed above, there is a clear need for research related to vicarious trauma and related coping strategies in mental health interpreting. In addition to determining such mechanisms from interpreters' firsthand accounts, the training related to trauma and self-care is worth exploring further. This research attempts to uncover both topics, and consider how the profession can improve in these areas.

METHOD

To collect data, this study utilized an online survey of ASL interpreters. The survey was developed using REDCap software and consisted of closed and open-ended questions about interpreting in mental health settings. The survey collected demographic information, including the education and certifications of the respondents. The closed questions were analyzed in a quantitative fashion with an emphasis on percentages to demonstrate the trends found in the results. Open-ended questions allowed participants to expand on their experiences related to their work in the mental health field

and their relevant training. The data from the open-ended questions was examined by assessing themes that were prevalent throughout participants' responses.

PARTICIPANTS

Interpreters who work in mental health settings are often not required to have any specialized certifications. Therefore, any interpreter in the field could, in theory, have relevant experience working in mental health. Initially, the researcher contacted the regional interpreter education centers in the U.S. that are under the National Consortium of Interpreter Education Centers (NCIEC), as well as the Registry of Interpreters for the Deaf (RID). NCIEC shared the research information along with the survey link on their social media sites, while RID included it in the "Research Corner" section of one of their monthly newsletters. These preliminary efforts resulted in 18 total responses. In an effort to increase the sample size, the researcher then directly recruited individuals for their participation in the study. The participants were recruited via emailing the addresses listed on the RID's 'Find a Member' online database. The same recruitment email with the survey link was sent to 3,480 members listed as having either the National Interpreter Certification (NIC) or Certified Deaf Interpreter (CDI) credentials in the U.S. and Canada. Although being certified was not a requirement for participation, using these filters helped to create a much larger participant pool. The reasoning used for selecting the NIC over other certifications was due to its more recent inception in 2005 (RID, 2015). Since the present study also strives to focus on training, or lack thereof, for mental health interpreters, interpreters newer to the field provide a current overview of interpreter training programs. However, many participants held earlier certifications such as the Certificate of Interpretation (CI), Certificate of Transliteration (CT), and Comprehensive Skills Certificate (CSC) (see Table 2).

To protect confidentiality of the participants, all of the email addresses were blind copied, so no potential participant had access to who else was receiving the email. It is worth noting that over 300 of these emails were not successfully delivered, perhaps due to outdated email addresses or incorrect information on the database. Further, many interpreters responded to the email to explain that they did not have experience interpreting in mental health settings and would not be good candidates for the study. The combined recruitment efforts resulted in a total of 232 survey responses. Two participants responded 'No' to ever having worked in mental health settings. Additionally, eight of the responses were duplicates of an identical response, indicating that a participant unintentionally filled out the form multiple times. After removing these responses, a total of 222 unique, qualifying responses were analyzed.

MATERIALS

Those who opted to participate completed a 41-question survey created using REDCap survey software. The survey first provided an informed consent statement, explaining the purpose, risks, benefits, and other details of the research. Demographic information was collected, including gender, race, hearing status, education, and interpreting credentials. No identifiable information was collected about the participants or their worksites. Specific questions regarding the mental health field included how long participants had worked in such settings and for how many hours on average, whether or not they had experienced vicarious trauma due to mental health

assignments, any training related to this trauma, and their personal coping mechanisms for dealing with these emotional responses.

RESULTS

DEMOGRAPHICS

The breakdown of the demographics of the 222 participants in this study can be seen in Table 1. Respondents tended to be college educated with at least an Associate's degree (88.8%), with the distribution of each education level depicted in Figure 1. However, only 55.9% stated that their degree was in an interpreting discipline. Of the 222 responses, 217 (97.7%) hold NAD-RID certification. The majority of respondents have been certified for 5-10 years (45.9%) (see Figure 2). While these participants are much newer to the field, it again helps provide us with a relevant picture of what training looks like currently. Figure 2 shows the main certification types, including those outside of NAD and RID, as identified by the participants.

Table 1: *Demographic Characteristics of Survey Participants*

Characteristic	*n*
Gender	
Female	188
Male	33
Prefer not to answer	1
Hearing Status	
Hearing	205
Deaf	12
Hard of hearing	4
Prefer not to answer	1
First Language	
English	204
ASL	41
Spanish	2
Other: Korean	1
Race	
White/Caucasian	193
Black/African American	7
Hispanic or Latino	6
American Indian or Alaska Native	2
Asian	2
Native Hawaiian or other Pacific Islander	0
Other	5
Prefer not to answer	7

Note. n = number of responses.

Participants were also asked to list any additional certifications or credentials they hold related to interpreting. As shown in Table 2, 41 participants listed state licenses or certifications, while six listed court certifications. Figure 2 shows that nearly 78% of participants (*n*=173) hold NAD-RID's National Interpreter Certification (NIC) in some capacity. Again, this is due in part to the recruitment strategy of the researcher.
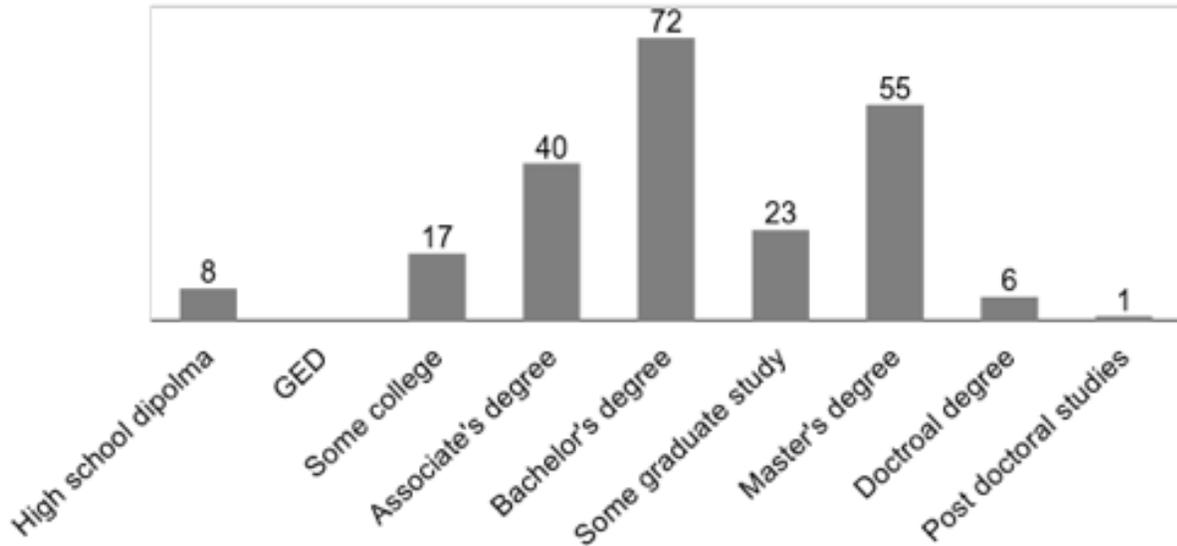

Figure 1. Highest education achieved by survey participants, in number of responses.

Table 2: *Certifications Held by Survey Participants*

| Certification Type	*n*
CDI	12
CI/CT	33
CI only	1
CT only	4
CSC	4
ED K-12	14
EIPA	27
NAD III	5
NAD IV	8
NAD V	2
NIC	166
NIC-Advanced	4
NIC-Master	3
RID (Certification not specified)	11
SC:L	6
State Licensure/Certificate	41
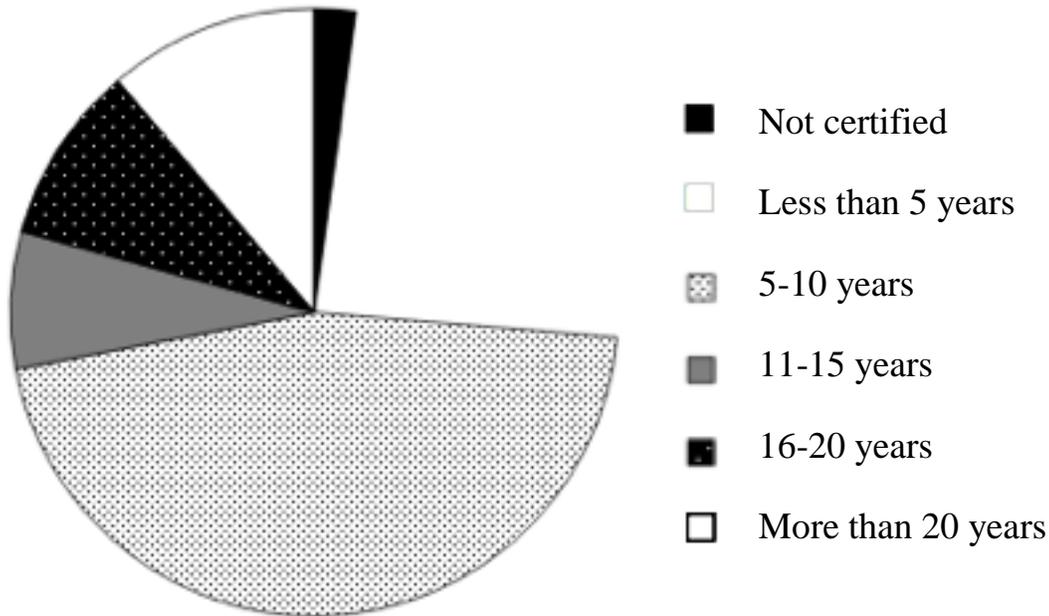
Figure 2. Length of certification of survey respondents.

MENTAL HEALTH SETTINGS

The questionnaire listed the following options for types of mental health settings: one-on-one-therapy, group therapy, family therapy, K-12 school counseling, college counseling, psychological evaluations, and substance abuse sessions. 'Other' was also an option, and if selected participants were provided space to input other mental health interpreting situations they had experienced. Of these participant-identified settings, the most commonly listed included in-patient treatment in psychiatric wards, prison interpreting, medication checks, home visits, and sex offender treatment.

Regarding the length of time worked in the mental health field, 68% of participants had less than 10 years of experience. The participants were asked if they had decreased their hours of mental health-related work in the past twelve months, to which 51% responded 'Yes.' Of these, 36% reported that this decrease was due to other work commitments, and 26% reported a decrease in available hours in mental health settings. Other factors included home commitments (11%), intrapersonal stress from working conditions (8.5%), school commitments (4.5%), interpersonal stress (with coworkers and/or management) (1.3%), physical injury (<1%), or a mental health issue terminating their employment (<1%).

VICARIOUS TRAUMA

The following question was asked in the survey:

> "For the purposes of this study, vicarious trauma will be described as feeling emotional demands or impact due to the nature or topic of discussion in a therapeutic (or other mental health) setting. Have you experienced vicarious trauma as a result of mental health interpreting?"

An 83% majority responded in the affirmative. However, 70% of those participants said they experienced this trauma in less than a quarter of mental health assignments.

Subsequently, participants were asked, "Have you ever sought professional help (such as a therapist or counselor) due to this emotional impact?" A striking 71.6% of participants selected 'No,' and were then given the option to provide a specific reason. Of these respondents, 27% did not provide a reason. The majority of those that did expand on their response (28%) said they deemed it unnecessary, or they did not feel the trauma was severe enough to warrant professional help. Another 17% explained that they had self-care strategies in place instead of seeking professional help. The remaining 28%, however, listed their reasons as lack of time, affordability, and/or lack of resources.

Not surprisingly, 80% of participants responded that they have requested feedback from a fellow interpreter due to the emotional impact they felt during an assignment. Conversely, the responses were essentially an even divide when participants were asked if they had pursued feedback from a friend *outside* of the interpreting field.

COPING MECHANISMS

The participants were provided with a list of examples of coping mechanisms and were prompted to select as many as they felt applied to them. The distribution of responses can be seen in Figure 3. Additionally, the option to select 'Other' was given, with a text box that allowed for responses to be typed in. Only 24 participants (10.8%) wrote in supplementary strategies. These additional coping mechanisms are presented in Figure 4.
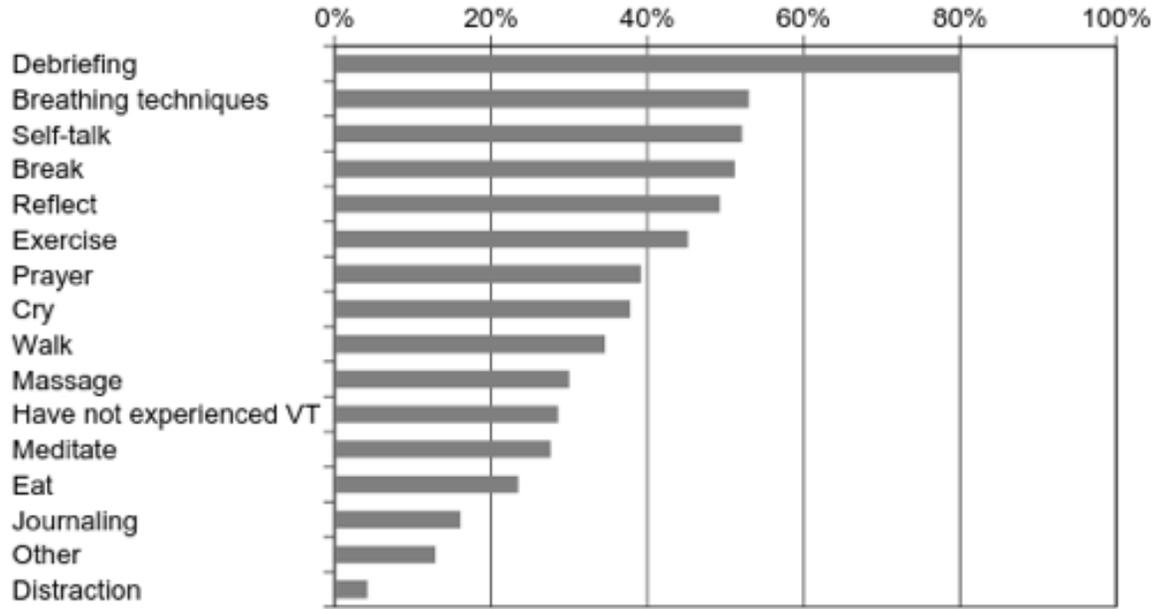
Note. VT = Vicarious Trauma.

Figure 3. Coping mechanisms utilized by participants.
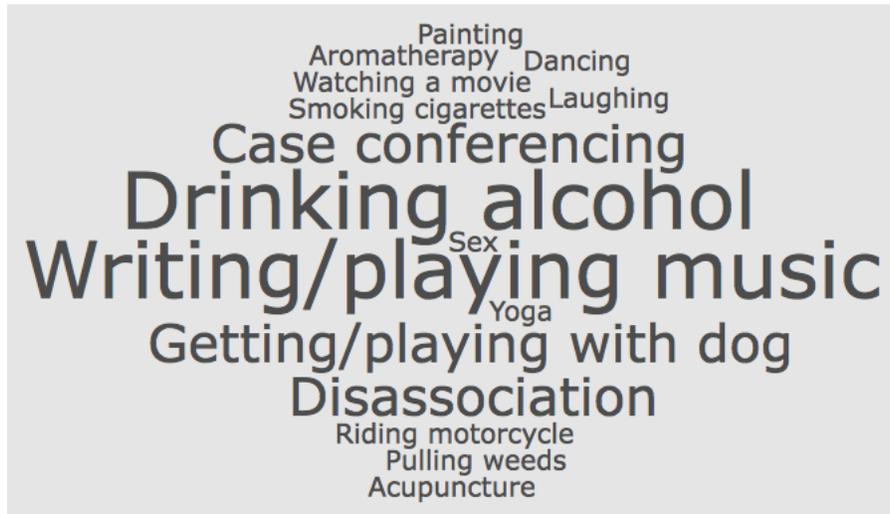
Figure 4. 'Other' personal coping mechanisms identified by interpreters.

While "debriefing" was by far the most frequently selected coping mechanism (80%), some participants reported feeling conflicted with this method. As mentioned previously, Dean and Pollard (2001) stated that interpreters often feel that discussing their work could breach their oath of confidentiality (p. 7). Two examples of participants expressing this concern are here:

> "Many professionals don't understand our code of ethics and how debriefing can be equally stressful because we're concerned about protecting the information of the Deaf client. It's almost more stressful trying to talk about the work then [*sic*] the work itself."

> "I feel guilty debriefing with someone about mental health assignments for breaking confidentiality and I often don't tell anyone about the difficult situations I interpret."

In contrast, another respondent wrote the following comment at the conclusion of the survey:

> "Seek help! We are humans. Don't allow 'confidentiality' to keep you from talking to a therapist, fellow interpreter, or friend about your experiences."

When performing a search of all of the open-ended responses, 13 different participants included the term "confidentiality" in some capacity. As discussed in the aforementioned literature, this suggests that there may not be a standard definition for confidentiality in the field, which causes interpreters additional stress about violating it.

TRAINING

In order to understand the status of mental health interpreter training, the following question was asked:

> In your educational history related to interpreting, did you receive any sort of training related to dealing with the emotional impacts of interpreting in mental health settings?

A staggering 58% of participants in this survey responded with 'No.' This means that more than half of the participating interpreters have not received any formal, specialized training for the work they do in the mental health field. There was the option to comment on this question as well. Many participants took advantage of this, and their comments are below:

- "We might have discussed it in class but if we did it was so brief I don't remember."
- "Wasn't made aware of it at all."
- "Very minimal...Deep breathing."
- "The only thing I was told was that it may help to talk with another interpreter that you could trust. Other suggestion was to take a bath."
- "Some of the suggestions were to find an outlet. Not anything extensive."
- "One Workshop. [I was also] told to debrief with the counselor (which never can happen due to their time) or find [your] own counselor."
- "No training until much later when I took a workshop to earn CEU's. I then learned of a continuing support group of interpreters that I could join."

- "No 'training,' but trauma was mentioned in ITP. It was not a focus."
- "I took one Continuing Education workshop which focused on vicarious trauma for general interpreting purposes. I do not remember much of what was taught at the training."
- "I only learned what vicarious trauma is, but not how to protect myself or to deal with it when it happened."

The training that participants described consisted primarily of workshops that were attended after completing an interpreter-training program and entering the field. Several participants noted that the topic of vicarious trauma was touched upon in their interpreter education courses, but, as one participant phrased it, "It was not extensive as it should have been." This is consistent with the literature regarding a lack of in-depth training related to self-care for interpreters.

A succeeding question inquired whether the respondents' workplaces (interpreting agency or mental health worksite) have made resources available for dealing with this stress. Only a slight majority of 52% responded 'Yes,' while 48% said resources were not available to them. Of the affirmative responses, these resources include in order of frequency, debriefing, referrals to mental health professionals or employee assistance programs (EAPs), a hotline provided by a VRS company, and trainings or workshops. While these can be helpful, they do not excuse a lack of formal training and focus on vicarious trauma and self-care for this field.

DISCUSSION

Mental health interpreters work in a specialized field that frequently involves highly emotional interactions which can lead to vicarious trauma. However, this introductory study shows that interpreters may not be as prepared as necessary for these experiences. While some interpreters have learned what coping strategies are effective for them personally, this was often learned 'on the job' rather than being taught how to develop a self-care routine in their training. The common themes discussed by participants of this study support previous research regarding conflicting feelings around debriefing and confidentiality. Supervision, as examined previously, may have a significant impact on helping novice interpreters feel comfortable entering into specialized settings. Further, in the observation-supervision model proposed by Dean and Pollard (2004), the students learn about the setting itself first, before focusing their attention and energy on interpreting. This is beneficial for interpreters entering the field to have an understanding of the different session and meeting types, the dynamics, and the language used. The students from Dean and Pollard's study who engaged in this type of training also seemed to become more comfortable withdiscussing their findings and feelings, which is one way to help dispel the conflicts interpreters feel regarding debriefing and confidentiality early in their careers.

Education regarding self-care and coping with vicarious trauma should be emphasized for sign language interpreters. Bontempo and Malcolm (2012) suggest the following:

It is time for the interpreting profession to recognize the vulnerability of interpreters when working in traumatic settings or with emotionally challenging material and to respond appropriately…. Interpreter educators can introduce teaching tools that make traumatic realities accessible in a safe learning environment. Authentic, controlled activities in the

classroom will help students develop coping skills and strategies for dealing with occupational stress and cumulative trauma experiences, better equipping them for future interpreting work in healthcare settings as a result. (p. 127)

There is clearly a gap in this field that needs to be filled in order to reduce the effects of vicarious trauma and burnout on interpreters, especially those who work in mental health.

LIMITATIONS

There were several limitations of this study that may prevent the generalization of this data to the entire field. Primarily, the research was limited due to time restrictions. This research was completed for a graduate degree, and was limited to two semesters to complete the data collection as well as the analysis; this time limit directly affects the depth of the work. A relatively small pool of participants was studied, as the time dedicated to recruitment had to be confined. Additionally, most of the direct solicitation was towards participants with NIC or CDI certifications, whereas interpreters with previously offered credentials are likely to have more experience in the field as well as in specialized settings. By excluding these tenured professionals and focusing instead on a population where only half had interpreter-specific training, the data is potentially flawed, and may not be able to be applied to the profession as a whole. As mentioned previously, the focus on the newer certification was to understand the most current training being provided. However, more seasoned interpreters may have more refined self-care regimens. Follow-up interviews could have also provided more in-depth discussion. Although not implemented, this method was clearly of interest, as over 100 respondents were willing to participate. Had time allowed, at least some of these interviews could have been conducted to get a clearer picture of the work of mental health interpreters.

FUTURE RESEARCH

Future research could begin by including more tenured interpreters with previously offered certifications. Since these interpreters would have more experience overall and therefore in mental health settings, it would be beneficial to see their coping strategies as well as the specific training they've received. Additionally, subsequent studies could delve more deeply into self-care courses and workshops to discover how they might improve interpreting practice. There is also a need for discussion about supervision, perhaps by interviewing interpreters who have experienced such training firsthand, and then investigating ways it can be implemented in interpreter education curriculums. The concept of observation-supervision as described by Dean and Pollard (2004) could have a multitude of benefits for interpreters in specialized settings such as mental health. Finally, there is an opportunity to explore the varying perceptions of confidentiality in the interpreting field. The implementation of supervision in the mental health arena could possibly help interpreters have a better understanding of confidentiality and how it relates to debriefing and discussing emotional trauma. It is imperative that this field works to further acknowledge vicarious trauma and self-care to maintain the well-being of current and future interpreters.

CONCLUSION

Vicarious trauma can affect all participants in mental health interactions, including sign language interpreters. In order for members of this profession to successfully overcome this trauma, they must be educated about what it may look like and what outlets can be used to manage its adverse effects. Having a comprehensive understanding of vicarious trauma, coping mechanisms, and self-care is crucial to a successful future for our field. Interpreter education programs need to ensure this is a focus in training, rather than a subject that is briefly or superficially mentioned. Full courses dedicated to the consequences of compassion fatigue and how to overcome these challenges are essential for future interpreters. Supervision should also be implemented more often, where tenured interpreters can mentor novice interpreters in this field. Having specialized certification for mental health interpreters (as for legal interpreters) could help to fully prepare interpreters who enter these highly emotional settings. As Harvey (2001) described, "When we do not nurture ourselves, we become physically and psychologically impaired" (p. 89). We as a profession need to be more vocal about incorporating self-care into training and ensure we are taking care of one another and ourselves.

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