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Interpreter perspectives on working with trauma patients: Challenges and recommendations to improve access to care.

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Interpreter Perspectives on Working with Trauma Patients: Challenges and Recommendations to Improve Access to Care

Abstract

Given the growing number of immigrant and limited English proficiency individuals in the U.S., accessing language-congruent services can be a significant barrier for many seeking mental health treatment. The use of spoken language interpreters can help address this barrier; however, the interpretation in the context of trauma therapy can be particularly challenging for interpreters without mental health training. This quality improvement study explores issues identified by interpreters assisting in the provision of trauma-focused treatment for primarily immigrant populations. Ten certified medical interpreters (nine Spanish-language interpreters and one American Sign Language interpreter) participated in a focus group at a specialty trauma clinic in the southeastern U.S. Core findings concerned the challenges of interpreting (i.e., use of mental health terminology, little time to process emotionally-charged sessions, the impact of vicarious trauma, difficulties related to the speed of interpreting and interpreting for multiple patients at once, logistical difficulties, and the availability of interpreters). Interpreters also identified perceived needs and provided recommendations for overcoming challenges (i.e., holding presession meetings with clinicians, ensuring breaks between trauma patients, creating a support group for interpreters, ensuring a direct telephonic line between interpreters and the trauma clinic, providing interpreters with session materials before appointments, and training clinicians on the use of interpreters specifically for trauma treatment). Specific recommendations for agencies and clinicians new to the use of interpreters for trauma-focused services can ultimately enhance service provision for trauma patients in need of language-congruent services.

Key words: Interpreters, trauma, language access, limited English proficiency, mental health

Public Significance Statement

This article underscores the need for trainings and protocols to help interpreters specifically manage experiences of vicarious trauma after psychotherapy sessions. In addition to the potential to improve clinical services for trauma-exposed immigrant populations, mental health providers and service systems should seek the direct input of interpreters for quality improvement purposes.

Interpreter Perspectives on Working with Trauma Patients: Challenges and Recommendations to Improve Access to Care

The continued growth of language-diverse populations in the U.S. presents a challenge to the healthcare system regarding its ability to serve limited-English proficiency (LEP) individuals who require language-assistance services (e.g., telephonic interpreter lines, bilingual staff, staff interpreters, contract interpreters, written language translation). As of 2019, 22% of people speak a language other than English at home, with one in three rating their English-speaking skills as less than proficient (U.S. Census Bureau, 2019a). These statistics exemplify the need to adapt the provision of healthcare services to a population growing more diverse every year. Research has shown professional interpreter use enhances communication during clinical encounters with LEP patients; however, few trainings and support activities have been developed to help interpreters working with trauma patients. The present study reports on findings from a focus group conducted with medical interpreters in a specialty trauma clinic.

Use of Interpreters in Healthcare Settings

Trained interpreters are essential members of healthcare teams as they increase access to services for underserved LEP populations. Systematic reviews suggest utilizing trained medical interpreters for LEP patient's results in increased service utilization, increased comprehension and decreased errors, and increased patient satisfaction with medical appointments (Karliner et al., 2007). In a study of Spanish-speaking Latino patients, consistent use of medical interpreters was associated with higher ratings of satisfaction with care and better communication with providers and staff compared to those who did not always have access to an interpreter (Moreno & Morales, 2010). Furthermore, the use of trained interpreters in-person or using videoconferencing results in half as many interpretation errors for medical encounters in Spanish

compared to the use of ad hoc interpreters (i.e., family, friends, untrained bilingual staff; Nápoles et al., 2015). Overall, trained interpreters increase patient understanding of provider recommendations, which can lead to better treatment adherence and health outcomes for LEP patients.

Since medical interpreters often enhance communication for medical encounters, it is important to consider how they facilitate the disclosure of more sensitive content in mental health settings (Miller et al., 2005). A review of the literature on interpreters use in psychiatric settings found that patients disclosed more information when assessed with a trained versus ad hoc interpreter (Bauer & Alegría, 2010). Qualitative studies on interpretation for psychotherapy have focused on the power dynamic between the therapist and interpreter (Becher & Wieling, 2015), patient perspectives (Patel et al., 2013), differences in therapeutic alliance (Boss-Prieto et al., 2010), and therapist views of working with interpreters (Pugh & Vetere, 2009; Raval & Smith, 2003; Yakushko, 2010). Although the literature on the impact of interpreters on treatment outcomes is lacking, two studies with refugee clients have shown interpreter-mediated trauma treatment was as effective as treatment conducted without the need of an interpreter (Brune et al., 2011; d'Ardenne, Ruaro, et al., 2007). Though these results are promising, clinicians treating refugees have expressed mixed views about working with interpreters and reported that interpreters can serve as cultural brokers who can help facilitate or disrupt the therapeutic alliance between the clinician and patient (Gartley & Due, 2017). Relatedly, Mirdal et al. (2012) identified “curative” and “hindering” factors in psychological therapy from the perspective of refugees, therapists, and interpreters. Curative factors included a good working alliance, while hindering factors related to diverging goals, over- or under-involvement by therapists and interpreters, and stressors external to the therapy (e.g., family problems and fear of deportation).

It is noteworthy, but not surprising that much of the research on interpreter use in mental health takes place with immigrants, asylees, and refugees who have experienced trauma. The majority of immigrants and asylum-seekers in the U.S. are individuals from Spanish-speaking countries (Venezuela, Guatemala, Honduras, El Salvador, and Mexico; U.S. Census Bureau, 2019b; U.S. Department of Homeland Security, 2020). About 30% of Latino immigrant adolescents and 34% of their caregivers have experienced at least one potentially traumatic event in the year prior to their arrival or during their immigration to the U.S. (de Arellano et al., 2018; Perreira & Ornelas, 2013). Unaccompanied and accompanied minors in Germany showed high prevalence rates of clinically significant posttraumatic stress symptoms (64.7% and 36.7%, respectively; Müller et al., 2019). Common migration-related traumas include experiences of political violence, combat situations, loss of family and close ones, and adversities experienced during flight. Also impactful are experiences of discrimination and lack of basic resources post-migration (Müller et al., 2019). Obtaining complete and accurate accounts of a client's history of trauma is of particular importance when evaluating the compounded effect of multiple traumas and determining targets for treatment, but can be difficult to obtain with LEP clients in crisis.

Although numerous evidence-based trauma-focused treatments are available, LEP populations, especially Spanish speakers, experience language barriers that result in the underutilization and delayed use of mental health care services (Bauer & Alegría, 2010; Garcia et al., 2020; Kim et al., 2011). The need to build a bilingual workforce of psychologists is ever present, but only 10.8% of psychologists can provide services in languages other than English (American Psychological Association, 2016). This statistic is likely an overestimation for LEP individuals who require trauma treatment, as not all psychologists have specialized training in

this area. Considering these data, the bilingual mental health workforce is limited in its ability to meet the needs of persons immigrating to the U.S. with histories of trauma.

Thus, interpreters are essential to trauma care with trauma-exposed LEP clients and medical interpreters in particular can help address this need; however, their lack of specialized training in mental health interpreting may pose significant challenges to managing the emotional content of therapy sessions. An additional challenge arises as medical interpreters are now increasingly asked to interpret for patients with behavioral and mental health needs in primary care (Villalobos et al., 2016). In these cases, training in medical interpretation alone may not suffice.

Impact of Trauma on Interpreters

A considerable amount of literature has established that interpreters can experience vicarious trauma, burnout, frustration, and secondary traumatic stress as a result of indirect trauma exposure (Bambarén-Call et al., 2012; Lai et al., 2015; Mehus & Becher, 2016). Quantitative studies indicate these are common experiences among interpreters working with trauma-exposed populations. A needs assessment conducted by Bambarén-Call et al. (2012) in the U.S. reported 73% (N=169) of interpreters said they were emotionally affected by an interpreting session. In Australia, Lai et al. (2015) found 68% (N=271) of certified interpreters reported moderate (i.e., 1 hr a week) to an enormous amount (i.e., 10 hr a week) of exposure to traumatic client material over the previous 6 months. Moreover, one in five (21.4%) interpreters reported that their emotional distress after these sessions reduced the quality of their interpreting, 16.5% lost interest in interpreting, and 37.9% said they would avoid these types of assignments in the future. Mehus and Becher (2016) used a validated screener in their study on 119 certified and uncertified interpreters in the U.S. and identified interpreters at high risk of secondary

traumatic stress (71%) and burnout (14%). Surprisingly, the majority of interpreters also had high levels of compassion satisfaction (61%). Many more qualitative studies have explored the nature of vicarious trauma among interpreters in various treatment settings (for a review of 11 qualitative studies see Darroch & Dempsey, 2016; Gartley & Due, 2017; Lai & Costello, 2021).

The literature on mental health interpretation has resulted in the creation of several best practices and recommendations; however, most of these guidelines are intended to improve the competencies of mental health providers working with interpreters (e.g., O'Hara & Akinsulure-Smith, 2011; Tribe & Raval, 2003; Tribe & Thompson, 2017). Paone and Malott (2008) propose a set of guidelines that recommend pre- and post-session meetings to prepare and debrief with interpreters, modification of speech patterns and pace, use of simplified language, discussion about maintaining confidentiality, and helping interpreters process emotional distress. Some general mental health recommendations appear relevant to managing the vicarious trauma of interpreters. For example, Martin et al. (2020) provide a list of helpful recommendations for psychologists working with interpreters, one of which addresses secondary trauma experienced by interpreters. However, proposed solutions to this challenge only consisted of conducting debriefing sessions to inquire about their reactions to the session and determine whether they should refer an interpreter to seek their own treatment.

There is a general lack of development and implementation of formal initiatives developed to support interpreters providing services specifically to trauma survivors (e.g., Bambarén-Call et al., 2012; d'Ardenne, Farmer, et al., 2007). In the U.K., d’Ardenne, Farmer, et al. (2007) found that none of the 19 specialty trauma clinics they surveyed had developed their own mental health or cognitive behavioral therapy (CBT) interpreting guidelines, and only one clinic provided a mental health training for its interpreters. Unfortunately, this is also the case in

many clinics in the U.S. In addition, our brief search found only two active mental health trainings for interpreters: the National Latino Behavioral Health Association provides a Behavioral Health Interpreter Training (nlhba.org), and the Alabama Department of Mental Health offers Mental Health Interpreter Training and certification for sign-language interpreters (mhit.org). Overall, the lack of national standards and trainings available for mental health interpretation warrants further study of the experiences of interpreters, especially those working in trauma clinics.

Purpose

This quality improvement (QI) project focused on assessing the challenges that medical interpreters face when working within a specialty trauma clinic. In addition, we sought to obtain information that could be useful for mental health professionals and administrators at other mental health settings where interpreters may be working with survivors of trauma. The concepts and themes obtained from focus group conversations with interpreters can provide insight into addressing interpreter vicarious trauma, the role of interpreters in interdisciplinary teams, and improving the quality of services for LEP patients through interpreters. Ultimately, results will serve as lessons learned for other clinics new to interpreter services and that seek guidance before developing and implementing their own clinic protocols and trainings.

Method

Setting

This specialized trauma clinic is a teaching, research, and services clinic within an academic medical institution in the Southeastern U.S. The clinic provides trauma assessment, and evidence-based trauma-focused treatment [e.g., Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), and TF-CBT] to adult and child victims of crime and other

traumatic events, such as domestic violence, physical abuse, sexual assault, serious automobile accidents, natural disasters, and terrorist attacks, among others. Predoctoral psychology graduate students completing their clinical internship year and masters-level clinicians provide these evidence-based trauma-focused treatments via office-based services and community-based programs (home-based, school-based, and via telehealth). Services are provided via grant funding, Medicaid, private insurance, and the State Office of Victim Assistance compensation program. Approximately 35% of referrals received by the clinic are for monolingual Spanish speakers. At the time of this QI project, two options existed for clinic patients requiring the use of language-assistance services: (a) the clinic could call or make an online request for an in-person interpreter (available for American Sign Language [ASL] and Spanish-speakers only), or (b) providers could call a telephonic interpretation line to reach a contracted company which provides over-the-phone interpreting 24 hr a day in over 240 languages.[1] Interpreters are asked to assist patients for intake evaluation appointments, individual therapy sessions, family therapy sessions with caregivers and children, and psychiatric medical assessments and follow-up appointments.

The clinic traditionally assigned Spanish-speaking patients to the limited number of available bilingual clinicians[2]. However, a rise in monolingual Spanish-speaking patient referrals resulted in a need to expand the use of interpreter services. As the demand for interpreter services increased, less interpreters were accepting the requests and reporting that it was challenging and taxing to interpret at our clinic. To improve the quality of services provided to our Spanish-speaking patients, a QI project was developed to better understand the experiences

[1] As of July 2018, providers now can utilize video-conferencing software via a tablet and mobile cart.
[2] Using census estimates (U.S. Census Bureau, 2019a, 2019c) and the APA Center for Workforce Studies online data tool (American Psychological Association [APA], 2020), there are only approximately 17 psychologists per 100,000 people in South Carolina who can serve the population that speaks a language other than English at home.

of the interpreters working with our trauma-exposed population. Prior to this study, clinicians received training on how to request interpreter services, but had minimal training on how to work with them.

Participants

Participants were 10 certified medical interpreters who provide in-person interpretation at the specialized trauma clinic and other inpatient and outpatient clinics within an academic medical center. An interpreter services coordinator was also present in the focus group. Six (60%) of the interpreters completed the demographic questionnaire. The mean age of the six interpreters was 55.8 years (*SD* =14.5) and comprised the following demographic distribution: one female, three Hispanics, and two White-Caucasian. Participants reported an average of 11.16 years (*SD*=2.78) of experience working as interpreters, with 50% providing Spanish interpretation and 10% American Sign Language. At the time of the focus group, 40% of participants had provided interpretation services at the specialized trauma clinic more than 12 times, with each session ranging between 1 and 2 hr.

Measures

In order to better understand the background and experience of interpreters working in this training clinic, the following demographic questionnaire and focus group questions were developed for the purposes of this QI project.

Demographic Questionnaire. Participants were asked demographic questions including gender, age, and race/ethnicity. They were also asked how many months/years of experience they had working as interpreters, length of time interpreting at the current academic medical center, their primary language for interpretation, number of times they provided interpretation services at the specialized trauma clinic, and typical length of trauma-specific appointments.

Participants who had provided prior interpreter services at the trauma clinic were asked to rate how easy or difficult it was to interpret at the clinic. They were then asked to identify barriers to interpreting in a specialty trauma setting from a list of five options: length of appointment, content discussed, terminology utilized, location of the clinic, and how they felt after sessions.

Focus Group Questions. Participants were asked five open-ended questions about their experiences at the trauma clinic: (a) What types of challenges have you faced when interpreting at the clinic? (b) What has been helpful to you while interpreting at the clinic? (c) What resources, tools, and/or trainings would you wish you had in order to provide interpretation at the clinic? (d) What other suggestions do you have for our clinic? (e) If resources/tools/trainings were developed based on your suggestions today, would you be willing to provide us with feedback?

Procedures

The second author contacted the Director of Interpreter Services and explained the aims of the QI project were to better understand the challenges interpreters faced when providing interpretation services to trauma survivors and improve the quality of our services and training. Permission was granted to conduct a focus group during the interpreter monthly team meeting. The focus group was conducted by two bilingual, licensed clinical psychologists (second and last authors) who provide therapy to Spanish-speaking patients and supervise trainees working with underserved people of color. The focus group lasted approximately 1 hr and was conducted in English (per the preference of the interpreters). Participation was voluntary, and participants were encouraged to not respond to questions they did not feel comfortable responding to. Four interpreters participated in the focus group via conference call and six participated in person. Interpreters completed a demographic questionnaire in English and then answered a series of five

open-ended questions. The focus group was audio recorded and transcribed for data analysis purposes. An Institutional Review Board (IRB) application was submitted to the Medical University of South Carolina for the proposed project. After review of the project, it was not considered to be "research" in nature and thus did not require IRB approval. This QI project is reported in accordance with the Standards for Quality Improvement Reporting Excellence guidelines (Davidoff et al., 2008).

Data analysis

This study utilized an embedded mixed-method design, where a short quantitative survey served to enhance focus group data (Hanson et al., 2005). The interpreter focus group audio was transcribed verbatim by the first author. The transcript had inaudible parts lasting a few seconds and that did not affect the understanding of the content of their corresponding paragraph. Inaudible parts in the audio occurred either because of background noise due to the use of speakerphone or because participants could be heard speaking over each other. An inductive approach was utilized to explore general themes in the focus group interview given the lack of existing theories about interpreter experiences of working with trauma survivors. Thematic analysis followed procedures outlined by (Braun & Clarke, 2006). First, the first and third author became familiar with the focus group transcript and audio, reading it initially while listening to its audio. These two authors served as coders, independently generating codes for answers to specific questions asked by the interviewers and responses that provided information beyond the focus group questions. Codes were developed strictly for comments and responses made by interpreters to interviewer questions. Next, the authors independently collated the relevant codes into more general overarching themes. The authors met to discuss general impressions of the focus group and individual codes and themes. Interrater reliability was 86% for the 43 unique

responses made by interpreters. Together, the two coders resolved disagreements on six interpreter statements by reaching a consensus. Ultimately, 12 codes were identified and classified into two major themes discussed below.

Results

Quantitative Survey Responses

Of the six interpreters who completed the demographic survey, five had interpreted for the trauma clinic. When rating how easy or difficult it was to interpret at the specialty trauma clinic, these five interpreters provided a range of responses, from very easy to very difficult. Specifically, two interpreters rated interpreting at a specialty trauma clinic as *somewhat difficult* and another as *very difficult*, while two others reported the task to be *very easy* and *easy*, respectively. Of the five interpreters who responded to the item on the survey, 60% (n = 3) reported that the primary barriers for interpreting in this setting were: the content of session, the length of the appointments, and their feeling after sessions (e.g., affective response, vicarious trauma symptoms). One interpreter wrote about their difficulty sleeping for several nights after interpreting for a rape victim from Central America. Less impactful barriers identified by interpreters were the terminology utilized in session (40%; n = 2) and the location of the specialty trauma clinic as being inconvenient to reach (20%; n = 1).

Focus Group Thematic Analysis

We identified two major themes pertaining to interpreters' experiences providing language-assistance services at the specialty trauma clinic: Challenges and Perceived Needs. We further categorized these themes by their relevance to general mental health and trauma settings (see Table 1). Themes are presented in order of relative frequency of endorsement.

Challenges to interpreting. Interpreters mentioned six-core difficulties that occur before, during, and after they interpret for a patient. Challenges identified appear to affect the efficiency of initiating interpreter services, the quality of interpretation, and the interpreter's own ability to process the content discussed in trauma sessions: (1) logistical problems, (2) vicarious trauma, (3) lack of availability of interpreters, (4) speed of interpretation/interpreting for multiple people, (5) little to no time to process reactions to the session, and (6) use of mental health terminology.

Vicarious trauma. Most evident in the interpreters' descriptions of challenges working with trauma patients was the experience of vicarious trauma after hearing patients' stories:

> *I believe not many people like to admit it, especially interpreters, but we all suffer a certain amount of trauma when we hear those terrible stories of rape.*

This situation appears compounded by the clinician's use of PE, that at times seemed redundant or unnecessary to some interpreters who were not aware of the rationale for patients repeating their descriptions of traumas multiple times. A few interpreters mentioned that the act of repeating what the patient said in first-person language (referring to the PE imaginal exposure procedure) while also conveying important nonverbal, emotional cues was most overwhelming to them.

Logistical problems. Many interpreters highlighted logistical barriers, such as the physical layout of the clinic and the lack of a direct way to communicate with the clinic about patient arrival times and delays. Interpreters reported that requests are often placed before the patient arrives at the clinic. This was problematic given that the standard protocol was for interpreters to wait 10 minutes for patients before leaving due to the demand for interpreters across other departments. In addition, the interpreter services coordinator clarified that the on-

demand system did not allow for requesting interpreters for future appointments. Interpreters noted that when it comes to calling the clinic to verify the arrival of patients, they have difficulty reaching the clinic directly because the phone number provided in the request was the main scheduling line of the psychiatry department instead of the trauma clinic coordinator. Regarding the physical layout of the clinic, an interpreter mentioned difficulties meeting with the provider before the session because they wait alongside patients in the waiting room. Once the providers enter the waiting the room and meet the patients, interpreters stated they must ask the provider to quickly meet with them in a hallway before entering the therapy room.

Lack of availability of interpreters. Some interpreters also commented on the overall demand for interpreters across departments, the length sessions at the clinic being longer compared to medical appointments (especially for intake interviews that can range between 1 and 2 hr), and the inability for others to be available to alleviate you from interpreting at the trauma clinic. For example, one interpreter stated they try to switch interpreters, but their replacement is already on another call resulting in them having to do back-to-back trauma sessions. Another interpreter stated that trauma sessions are much longer than their usual medical appointments, making it a burden for other interpreters who must cover the other calls. Finally, regarding the ability to follow patients for continuity of care, the demand for interpreters makes it difficult to assign interpreters to specific patients even though they agreed it would be helpful.

Speed of interpretation/Interpreting for multiple people. Interpreters commented that the clinician's rate of speech and lack of pauses between sentences was a challenge, highlighting the probable lack of experience or training clinicians had with using interpreter services. Moreover, interpreters described the especially taxing nature of interpreting for family therapy sessions at the clinic when multiple people are present in the room and speak at the same time.

Little to No Time to Process Reactions to the Session. Common across interpreters was the challenge of processing the specific trauma-related content of the sessions. Many noted that they felt exhausted after leaving the clinic but did not have time between appointments to fully allow themselves to decompress after emotionally charged sessions. One interpreter noted the difficulty of interpreting without a break in between trauma sessions. Of note, the interpreter coordinator asked the group how many trauma-related encounters they thought they could interpret for before needing a break. The group of interpreters indicated that one encounter of that type was all they could manage and that a break in between was necessary.

Use of Mental Health Terminology. Some interpreters noted difficulty with transitioning between the terminology used in the medical setting to that used in mental health appointments. Interpreters noted that they needed time to "change gears" mentally when interpreting at the clinic given that they were less familiar with terminology used in mental health sessions and did not use the terms frequently since they did not interpret at the specialty trauma clinic as often as they did at other medical departments (e.g., cardiology). One interpreter referred to the mental health terms used not resonating with patients (i.e., too much psychological jargon). When referring to a specific diagnosis used in a session (adjustment disorder with mixed depressed mood and anxiety), the interpreter found it difficult to interpret this term for the patient in a meaningful way.

Perceived needs

Interpreters identified possible solutions to identified challenges. These needs were specific and detailed recommendations or current practices that they have initiated to improve their experiences and services at the clinic. Perceived needs were as follows: 1) having materials

ahead of time to prepare, 2) pre-session meetings, 3) a support group, 4) establish a direct line to the clinic, 5) breaks between sessions, and 6) trainings for clinicians.

Having Materials Ahead of Time to Prepare. Interpreters noted that it would be helpful to have written materials before sessions. Specifically, they talked about having intake packets and handouts to reference terminology that might be difficult to translate in session. Interpreters expressed this would also make interpreting sessions more efficient, given that they would have some concept of what they were about to interpret as they follow along with the clinician. A couple interpreters noted that it was also challenging to interpret for clinicians conducting intake interviews because they consist of numerous questions and clinicians did not provide enough space for interpretation when obtaining information from clients. When one interpreter recommended that clinicians provide a pre-translated version of the clinic's intake packet, the interpreter services coordinator commented on how this could improve the accuracy of rapid sight interpretation.

Presession meetings. Interpreters explained that they would benefit from pre-sessions with providers. They expressed that this would allow them to prepare for the oftentimes difficult content of sessions. Interpreters also explained that meeting with the provider before sessions, allows them to prepare the provider on how to work with them in the room (e.g., speaking slowly, speaking in short sentences).

Support Group. Interpreters talked about the emotionally taxing nature of working with trauma survivors. Prompted by facilitators, they expressed that a support group would be helpful to process and learn to cope with the impact that this line of work has on them. In addition, one interpreter mentioned that a peer support group or consultation group would help them develop

an action plan for subsequent sessions and clarify questions they had about their interpretation for therapy session.

Establish a Direct Line to Clinic. Interpreters expressed different instances in which it has been challenging to get in direct contact with the clinic. Interpreters expressed that in order to be at appointments for presessions or to check if patients have arrived at the clinic it's important to have a direct line of communication with the clinic.

Breaks Between Sessions. Interpreters also expressed that it is important to get breaks between sessions due to the taxing nature of the content that can arise with trauma patients. Interpreters stated that they often must go from one session in one unit to another session in a different unit without an opportunity to process feelings after sessions. Thus, a mental break to recuperate from interpreting for trauma survivors would be helpful.

Trainings for Clinicians. Interpreters talked about the importance of training clinicians to work with them. Interpreters expressed that the content of trainings should address the needs identified above (i.e., holding presessions, speaking in short sentences, speaking slowly, preparing materials ahead of time, explaining terminology). In addition, they noted refresher trainings would be helpful to remind clinicians about the taxing nature of interpretation.

Discussion

In this QI project, at least half of interpreters in the focus group noted challenges interpreting in our specialty trauma clinic due to experiencing vicarious trauma, logistical difficulties, and a general lack of interpreters available. Although perceived needs were discussed by fewer interpreters, the most common requests were to have clinic documents before therapy sessions, holding presession meetings, and interpreter support groups.

Interpreters who described experiences of vicarious trauma brought to light the difficulty of interpreting for trauma sessions using first-person language and the resulting emotional distress. These challenges underscore the need for mental health training to prepare interpreters for trauma sessions and prevent secondary traumatic stress. Indeed, articles on interpreting recommend interpreters switch to the third person as a strategy to reduce the emotional impact of traumatic content (Miller et al., 2005). An additional recommendation that can help with vicarious trauma is to use in-person simultaneous interpreting for initial imaginal exposures and limit interpretation for subsequent repetitions once clinicians are familiar with the detailed narrative (Woodward et al., 2019).

Giving voice to interpreters who might otherwise not have an outlet for expressing concerns these concerns is key. Interpreters in this study expressed a desire to manage vicarious trauma with the help of therapists at the trauma clinic and with peer support. The literature on vicarious trauma promotes engagement in self-care strategies, including personal therapy, supervision, and peer support, to prevent burnout, but these kinds of standard resources for clinicians are not always available for interpreters (Martin et al., 2020). Anderson (2011) developed the Peer Support and Consultation Project for Interpreters (PSCPI), a model to provide monthly peer support and consultation meetings for a group of certified sign-language interpreters. Results showed that interpreters who attended the peer support and consultation meeting reported a significant reduction of stress and increases in sense of social support, knowledge of vicarious trauma, knowledge of working in the mental health setting, self- and other-awareness, and emotional self-management. Models, such as PSCPI, have the potential to also benefit spoken-language interpreters working in specialty trauma clinics and can be implemented in collaboration with the mental health providers from the clinics they serve.

Clinicians assisting with these types of experiences should also promote the development of vicarious posttraumatic growth made possible through accommodation of new trauma-related information, building resilience (i.e., ability to tolerate change, failure, pressure), and encouraging support-seeking behavior (Kang et al., 2018; Splevins et al., 2010).

Relatedly, clinics should provide trainings that include information on commonly used evidence-based treatment models for trauma (e.g., PE, CPT, and TF-CBT) to prepare interpreters for sessions involving repeated exposure. Just as patients would be provided psychoeducation about treatment and the rationale for exposure-based activities, so should interpreters. Also, helping interpreters become familiar with common analogies and metaphors used by clinicians to describe exposure and avoidance (i.e., the overstuffed linen closet) may help interpreters transmit the rationale using culturally appropriate metaphors. We encourage clinics to develop protocols that consider the interpreter's experience of vicarious trauma in order to help patients remain emotionally engaged in their traumatic memories during interpreter-mediated exposures.

Regarding logistical concerns, our findings parallel existing recommendations to hold presession briefings to prepare for therapy and to consult afterwards to process the traumatic content of sessions (Paone & Malott, 2008; Tribe & Thompson, 2017). Clinics should also consider the layout of physical space available for interpreters to meet with clinicians. We recommend clinicians take the initiative when locating clinic space to hold a brief 5-min presession meeting with interpreters before starting intake evaluations and therapy sessions. As noted in our study, interpreters also reported feeling stretched thin across departments and had difficulty switching between medical and mental health interpretation. Awareness of logistical issues can help clinics determine the adequacy of their current methods of providing interpreter services and consider whether resources exist to hire interpreters housed solely in the clinic.

Indeed, the limited availability of interpreters meant interpreters were rarely able to follow patients throughout their trauma treatment. Advantages included witnessing patients improve over time, providing continuity of care, and that an interpreter's familiarity with cases can facilitate interpretation. Some studies do suggest continuity of care can be advantageous and guidelines recommend clear communication between providers and interpreters about role expectations to safeguard the patient-provider alliance (Bambarén-Call et al., 2012).

Highest on the list of perceived need for interpreters was the desire to have mental health session materials available to them to prepare for the session. Interpreters also asked for pre-translated materials, which could increase the fluency and effectiveness of their interpretation. We agree that the presession meeting is a key opportunity to provide interpreters with copies of registration forms, evaluation questionnaires, and structured interview questions given that many interpreters are not trained in mental health terminology. Based on interpreter feedback, specific terminology and core mental health concepts would also be best explained during the pre-session and having materials in-hand throughout the session would help with accurate sight-translation.

Limitations

Though this preliminary work holds promise in guiding the development of recommendations for improving the provision of trauma-informed interpretation and reducing interpreter risk for vicarious trauma and burnout, the current project has some limitations. First, focus group and survey data were gathered primarily from Spanish-language interpreters in our institution. To continue improving access to care for trauma-exposed populations, future work needs to incorporate data from patients and clinicians about their experiences using interpreters for trauma-focused services. Understanding the challenges faced by patients and clinicians when

working with interpreters would help further guide recommendations and training to enhance the quality of interpretation for trauma therapies.

Second, interpreter concerns identified in this study were specific to the setting in which services were provided—a specialty trauma clinic embedded within a larger academic medical center. These interpreters were trained to provide medically informed services across the broader medical campus. As such, their duties do not include solely working with trauma or psychiatric patients, and they experience exceptionally high demands (e.g., limited time, wide breadth of content knowledge required, limited support for processing challenging visits). It is possible that some of the challenges identified by the interpreters could stem from the nature of this unique setting, having to provide interpretation across a wide range of hospital clinics. As such, interpreters who are either trained in or provide services primarily to psychiatric and trauma patients might not experience the same barriers our interpreters highlighted.

Third, the challenges and recommendations discussed in the current project were gathered from interpreters providing only in-person interpretation. Thus, interpretation provided via telephone or video conferencing (virtual remote interpretation; VRI)—which make up most interpretation contacts in the hospital serviced—could have its own unique challenges. For example, interpreter emotional distress may be attenuated if they are not in the room with the traumatized patient. In addition, logistical challenges reported by interpreters using telehealth may include difficulties related to disrupted internet connectivity, not having enough devices available for remote interpretation, and scheduling online presession meetings with clinicians. It would also be worth investigating how clinics can adapt interpreter peer support groups and consultation for online implementation.

Finally, we did not ask about interpreters about their trauma or treatment history. Indeed, interpreters and patients who share similar backgrounds or have shared trauma experiences may be at increased risk of vicarious trauma (Berthold & Fischman, 2014; Green et al., 2012). On the other hand, it is possible that an interpreter's successful experience with trauma therapy and resilience can serve as a protective factor against the effects of vicarious trauma, while facilitating their understanding of exposure therapy. Future studies should investigate whether personal treatment history of interpreters impacts the experience of vicarious trauma.

Implications and Applications

Of utmost importance is the utility of focus groups as a QI method for clinics seeking to improve patient services through ancillary resources, like interpreters. Had interpreters not been asked about the challenges encountered when providing interpretation services at the clinic, many issues would have gone unnoticed and unaddressed, ultimately affecting patient care. Through the focus group, the interviewers were able to collect important information to resolve phone call issues that occurred simply because interpreters were not provided with the direct line to the clinic. In addition, an agreement was made between interpreters and clinicians regarding the amount of time that interpreters could wait for a patient before being assigned to a new service request. As a result, problem-solving occurred naturally in the focus group and produced recommendations to improve the efficiency and effectiveness of clinical services.

Results of this QI study have been utilized to inform our clinic's service delivery and clinician training using interpreter services. Based on interpreter feedback, our clinic is now conducting trainings with interpreters on trauma-informed approaches. When possible, continuity of care is prioritized so as to assign interpreters to patients for whom they have interpreted for in the past and clinicians now track interpreter service use and identification

numbers in their progress notes. Specific clinic protocols related to best practices when using interpreters were developed. We have instituted a formal training for all clinicians and staff on how best to utilize interpreter services and now conduct this training on a yearly basis. We are also pairing new clinicians with seasoned clinicians and staff who can help model proper use of interpreters and answer questions. Additionally, we are piloting the use of a mobile cart for live interpretation services via videoconferencing software compliant with the Health Insurance Portability and Accountability Act (HIPAA). While in-person interpreting is considered best practice (Price et al., 2012), several logistical barriers prompted our clinic to purchase VRI technology (e.g., limited number of in-person interpreters, interpreter work schedules not coinciding with the same hours as the trauma clinic, and wait times). In the future, we plan to evaluate the impact of VRI on the delivery of trauma-focused therapy and hold additional meetings with interpreters, clinicians, and patients to evaluate satisfaction with the updated clinic procedures. Although measurement of the impact of these changes are currently being developed, anecdotal information from clinicians and interpreters indicates these trainings are generally well received and have improved communication.

In addition to consultation and peer support (i.e., the PSCPI model), mental health trainings for interpreters should include interactive activities with clinicians and standardized patients to simulate trauma therapy sessions. Curriculum for such a training can incorporate in vivo feedback, continuous assessment of vicarious trauma, burnout, and compassion fatigue, and orientation to working with forced migrants. Clinics should also consider the development of a screening tool (e.g., survey or interview) to identify when interpreters are ready for interpreting in trauma therapy sessions. For an interpreter who is still processing their own trauma, this type of screening could help mitigate errors in communication or attempts to minimize discomfort for

the patient and distance themselves from traumatic content. Regarding future directions, an empirical study examining the direct impact of a mental health training on interpreter vicarious trauma is needed. Such a study could be conducted within a single trauma clinic or across multiple sites wherein patients are assigned to interpreters with or without mental health training. Results such as these could help fund initiatives to increase access to trauma-focused services for immigrant populations and develop a special certification for trauma-informed interpreters.

The recent expansion of telehealth after the COVID-19 pandemic can improve access to evidence-based trauma treatment for many individuals seeking services in their preferred language. For example, TF-CBT via telehealth has been found to be both feasible and effective for Spanish-speaking youth and their parents (Stewart et al., 2017, 2020). Although telehealth will expand the reach of bilingual providers, workforce data on the number of mental health professionals suggests interpreters will still be needed to meet the demand for language-congruent mental health services (APA, 2020).

This initial QI project was a crucial first step in the evaluation of the use of interpreter services within a specialty trauma clinic. The results have facilitated the tailoring of clinic procedures to utilize interpreter services in a way that is most beneficial for patients, interpreters, and clinicians. For clinics seeking to improve access to care for LEP patients, we highly recommend the utilization of QI methods to inform best clinical practices. Implementing recommendations provided by interpreters will be essential for improving the communication of trauma experiences and trauma symptoms in sessions, helping interpreters cope with vicarious trauma, and improving collaborative relationships between clinicians and interpreters. Enhancing the support provided to interpreters will likely improve trauma-focused care for monolingual Spanish-speaking patients, while increasing access to trauma services.

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Table 1. Frequency of Focus Group Themes Categorized by Relevance to General Mental Health and Trauma-Focused Settings

Theme	% Interpreters
General mental health	
Challenges to interpreting	
1. Logistical problems	60
2. Lack of availability of interpreters	50
3. Speed of interpretation/Interpreting for multiple people	40
4. Use of mental health terminology	20
Perceived needs	
5. Have materials ahead of time to prepare	40
6. Establish a direct line to the clinic	10
Trauma-focused	
Challenges to interpreting	
7. Vicarious trauma	60
8. Little to no time to process reactions to the session	30
Perceived needs	
9. Pre-session meetings	30
10. Support group	20
11. Breaks between sessions	10
12. Trainings for clinicians	10

Note. n = 10 Interpreters