"We need a little help": a qualitative study on distress and coping among pediatric medical interpreters

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Background: Pediatric medical interpreters facilitate communication among patients, families, and clinicians across linguistic and cultural barriers in high acuity, distressing medical encounters. Few studies explore distress among trauma interpreters, and even less research exists on distress and supports for coping among pediatric medical interpreters. Further research is important given the likely risk of secondary traumatic stress and burnout in this population, especially among interpreters working in high-acuity medical settings. This study explores distress among pediatric medical interpreters, available supports and resources for coping with distress, barriers to accessing support, and further resource needs.

Methods: Thirteen Spanish-English interpreters at a midwestern pediatric hospital completed a demographic survey and one-on-one virtual semi-structured interviews. Participants were asked about contributors to distress, experiences accessing resources for coping with distress, coping strategies they employed, and suggestions about resources needed to help manage distress. Interviews were qualitatively coded using inductive thematic analysis.

Results: Interpreters described that encounter type, setting, presence of emotional content, interpreter role, feeling uncertain or unprepared, consecutive consults, and consults related to their own life contribute to distress. Resources used for coping with distress were organizational (e.g., training programs), interpersonal (e.g., manager support), and intrapersonal (e.g., focus on interpreting). Interpreters shared challenges to accessing supports (e.g., employment status, exclusion from medical team debriefings). Interpreters suggested resources such as support groups, team debriefs, and training to facilitate coping with distress.

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Conclusions: Pediatric medical interpreters experience many diverse contributors to distress. Given their unique positions, interpreters are at an increased risk of negative psychological sequelae. Healthcare supervisors, clinicians, and institutions can promote interpreter coping and distress management by viewing interpreters as part of the medical team (e.g., including interpreters in team debriefings), providing coping trainings that are co-created with interpreters, and tailoring supports to interpreters' specific position as language and culture brokers. As this study represented the experiences of Spanish-English interpreters from a single pediatric hospital, further research is warranted to understand more interpreters' experience of distress and the supports and resources needed.

Keywords: Distress; interpreting in pediatrics; medical interpreting; supports and resources; spoken language interpreters

Introduction

Effective communication between families and clinicians is essential for establishing trust, decreasing family stress, and improving quality of care in medical settings (1,2). Families, pediatric patients, and clinicians who cannot communicate in a common language must access trained medical interpreters to communicate with one another. Medical interpretation of voiced languages involves more than being bilingual and repeating words in another language; interpreters must convey the original speaker's tone, emphasis, and emotion in their interpretations (i.e., conveying the "content" and the "spirit" of the message) (3). Interpreters are often asked to serve in high-intensity situations, including medical emergencies and end-of-life care. Given their prominent involvement in these challenging situations, interpreters may experience distress during and after interpreting for intense medical encounters in hospitals.

Secondary traumatic stress is defined as "reactions to indirect traumatic exposure" and has been described as symptoms resembling post-traumatic stress disorder (4). A small body of literature has explored secondary traumatic stress in spoken language interpreters in adult population medical settings, criminal justice and victim services, humanitarian work, and in mental health settings (4-6). Interpreters have described symptoms of secondary traumatic stress, such as avoidance, re-experiencing, and hyper-arousal akin to symptoms of post-traumatic stress disorder (4,7-9). Interpreters also reported feeling distressed when they cannot comfort patients due to expectations of objectivity and neutrality (3,10) or feeling frustrated when

they perceive the clinician as lacking in communication competence (11).

Interpreter burnout as a result of secondary traumatic stress has been documented in a few key qualitative studies, suggesting a positive correlation between interpreter burnout and time spent interpreting for trauma survivors (4,12-14). Some interpreting scholars have suggested that interpreters may be more susceptible to stress and trauma than other clinicians (15), although these assertions have not been systematically evaluated in empirical studies. This suggestion stems from the four-step cognitive process interpreters use to analyze, retain, convert and render content from one language to another, which often includes visualizing and conveying the emotions of the content in their interpretation (6,15,16). Additionally, identification with the client's trauma may increase when interpreters use the first-person perspective when interpreting (8,15) and if the patient and the interpreter are from the same community (17). Other strains on interpreters are a lack of boundaries and changing or confusing role expectations among the parties interpreters serve (18); strict expectations of objectivity and neutrality; that interpreters are viewed as tangential to the treating team, leading to feelings of isolation and frustration; and the perception that other clinicians do not believe interpreters are impacted by the stress of working with clients who have experienced trauma (10,15,19). Therefore, there is a clear need to provide interpreters with supports and resources to effectively manage the distress they may experience during and after high-stress encounters.

Although studies have empirically noted burnout and secondary traumatic stress among interpreters working with

adult medical or mental health populations, few studies have evaluated distress and secondary traumatic stress among medical interpreters working in pediatric settings (20,21). Additionally, few studies have described how interpreters manage the distress they experience during and after stressful encounters. Therefore, the present paper discusses risk factors for pediatric interpreter distress, describes available supports and resources to alleviate the distress interpreters experience during and following intense interpreted medical encounters (IME), and describes barriers to accessing those supports and resources.

Significance of the research

While the numbers of encounters with non-English speaking patients and families and the number of professional interpreters working in pediatric settings are unknown, medical interpreters play a key role in ensuring equitable language access to health information and culturally sensitive health communication for non-English speaking patients and families (22). Studies suggest that using qualified spoken language interpreters improves clinical care, increases patient involvement, and increases patient safety in all medical settings, including pediatrics (22,23). Yet, significant underuse of medical interpreters in US hospitals has been reported (24,25), despite a growing non-English speaking population in the US and increased demand for language services. Indeed, the United States Census Bureau [2018] estimates that 65 million (21.5%) United States residents speak a language other than English at home, with 26 million (8.5%) individuals speaking English "less than very well". By 2060, it is estimated that one in six individuals (69 million) in the United States will be foreign born, most of which are expected to be characterized as speaking limited English (US Census, 2020). At the same time, studies indicate that secondary traumatic stress and burnout among clinicians impact quality of patient care and health outcomes (26), tendencies that may also affect interpreters and the patients and families they work with. This, combined with a lack of qualified interpreters and growing demand for language services, suggests that preventing vicarious traumatization and burnout among professional medical interpreters may prevent interpreters from leaving the field and further risking equitable language access and quality patient care for historically minoritized non-English speaking immigrants, refugees, and migrant workers.

Methods

Positionality statement

Positionality refers to the "*stance or positioning of the researcher in relation to the social and political context of the study—the community, the organization or the participant group*" (27). Positionality influences the assumptions, research design, and methods of a study (28) and is interconnected with the researcher's personal and philosophical views (i.e., worldview). In this sense, researchers are co-creators of meaning with participants, given their lived experiences and the lenses through which they interpret data. The research team included a diversity of voices (e.g., academics from different disciplines including clinical and non-clinical professors, PhD and undergraduate students, and hospital administrators). We acknowledge how our lived experiences (e.g., immigration, navigating hospital systems, minoritized language status) and professional and academic training (e.g., medical interpreting, clinical psychology, hospital administration, human resources) impacted the research process. Therefore, our positionalities were regularly and intentionally interrogated throughout the course of the project to assess for interpretive bias.

Participants

Participants were recruited from a large, free-standing children's hospital in a major metropolitan area. Hospital serves as a level 1 trauma center and contains a level IV neonatal intensive care unit (NICU) and large pediatric intensive care unit (PICU). Thirteen spoken language interpreters participated in the study. All interpreters reported Spanish-English as their interpreting language pair. Most participants were female and identified as Hispanic, Latino/Latina/Latinx. Interpreters who were employees of the children's hospital and those who were hired through a contractor as members of an in-house contract group participated in the study. Professional interpreting experience ranged from 2 to 20 years, with pediatric interpreting experience ranging from 2 to 13 years. Almost all interpreters have worked in "Level 3" clinics, which are high-intensity or acuity clinics (e.g., surgery, transplant, cancer care, end of life, etc.). See Appendix 1 for

a list of clinics per level.

Procedures

The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study was approved by the institutional review board of the University of Wisconsin-Milwaukee (IRB # 20.124) and informed consent was taken from all individual participants. Due to coronavirus disease 2019 (COVID-19) mandates encouraging physical distancing, all recruitment, interviews, and survey completion were conducted virtually via video or phone conferencing (e.g., Microsoft Teams or Zoom). Participants were able to choose which platform to use for the interview.

All voiced language, in-person interpreters within the children's hospital were informed of the study. Criteria for participation included age of at least 18 years old, clinical work at the children's hospital, and experiences in at least one pediatric care setting (e.g., primary care, asthma, PICU, gastroenterology). Additionally, prospective participants were required to have access to a phone or device that could connect to the internet, as the survey and interview were conducted via online survey and virtual interview. Participants were given the option of being interviewed in Spanish or English; most interviews were conducted in English.

Co-principal investigators (Co-PIs) (PSL and AO) and graduate students (KAB and JBT) with experience in qualitative interviewing conducted and audio recorded 1:1 semi-structured interviews with the interpreters (i.e., individual interviews). Interviews and survey completion lasted approximately 90 minutes. Audio recordings were deidentified prior to verbatim transcription by undergraduate research assistants and a transcription agency and were deleted once transcription was complete.

Materials

All participants were asked to complete a demographics survey and a qualitative interview as part of the study.

Qualitative interview

An interdisciplinary team of experts in Translation & Interpreting Studies, Pediatric Psychology, Language Services, and Pediatric Medicine collaboratively developed a demographics survey and semi-structured interview that asked medical interpreters about communication facilitation; identification and communication of patient and family distress to clinicians; the impact of disclosing intense or traumatic information to families; and available resources for coping with distress. The section of the interview related to supports and resources is the primary focus of this paper. Interview questions are presented in Appendix 2.

Statistical analysis

Qualitative coding and analysis

Qualitative coding of data began when initial transcripts were received. All transcripts were coded using a thematic analysis approach, which allows for inductive identification of practices around distress communication (29,30). Transcripts were transferred to QSR NVivo Software (31), a qualitative software package, for thematic analysis. Co-PIs and undergraduate research assistants (research team) read all transcripts in depth and coded them independently using an open coding approach. Co-PIs consulted individuals who conducted interviews and who have research or clinical expertise in medical communication, distress in pediatric clinical care, and/or working with interpreters after initial codes were developed. Initial codes were discussed, and a codebook was created based on the initial codes, which included the code names and their operational definitions. The research team updated the codebook to address coding discrepancies and added new codes identified in the data. A provisional list of codes were provided, but researchers flexibly applied analytic methods during and after coding, depending on the data (29). Coding reliability was achieved by in-depth discussion and unanimous group consensus. Following the coding of all available data, codes were arranged into themes by the research team and clarified using the thematic analysis approach (29,32). Themes were reviewed in-depth by the broad, multidisciplinary study team. Unanimous group consensus was required to finalize themes. To parallel quantitative validity and reliability (33) and ensure qualitative credibility, dependability, and confirmability, team meetings and consensus on themes during coding were documented. Researchers determined data saturation to have been reached when the coding team recognized coding and thematic redundancy across the individual interviews (34,35).

Results

Contributors to interpreter distress

Interpreters described several factors that contributed to

Table 1 Contributors to interpreter distress during interpreted medical encounters

Theme	Code	Operational definition
Type of clinic	Fetal Concerns Center	Clinic for families with a baby that has been diagnosed with a birth defect or other medical condition during pregnancy
	Intensive Care Unit	Intensive care unit or critical care; PICU; NICU
	Oncology	Cancer-related diagnoses
	Psychology	Clinics involving psychological care
Type of encounter	Abuse	Child abuse or neglect
	End of Life	End of life, palliative care
	Care Conferences	Care conferences or family-centered rounds
	New Diagnoses	Involves patient new diagnosis
Emotional content	Emotional content	Content of the encounter is emotionally taxing; interpreter experiences intense emotions during the encounter; involves emotional stamina
	Family is emotional	Family member and/or patient expresses intense emotions or distress during the IME
	Must not express own emotion	Interpreter is unable to express their own emotions during the encounter
Interpreter's role	Repeat bad news	Repetition of bad news to family is distressing
	Interpreter as messenger	Interpreter is the messenger in communicating news or emotions to family
	Interpreter role	Discomfort in doing things outside of interpreter's role (e.g., family asks for interpreter opinion)
Uncertainty	Anticipation	Interpreter anticipates the family's reaction or how to manage family's emotion prior to encounter
	Lack of preparation	Lack of preparation, context or information about the encounter; interpreter unable to prepare for the IME
	Lack of vocabulary	Interpreter did not have vocabulary or terminology necessary for the encounter
	Hard to prepare for emotional encounters	Challenging to prepare mentally or emotionally for encounters
	Consecutive consults	Interpreter goes from one IME to another
	Related to their own life	Encounter reminds interpreter about personal experience with themselves or someone they know

PICU, pediatric intensive care unit; NICU, neonatal intensive care unit; IME, interpreted medical encounters.

distress in pediatric settings, including "types of encounters, types of clinics, emotional content, interpreter role, feeling uncertain or unprepared, consecutive consults, and whether the consult related to their own life". *Table 1* summarizes factors that contributed to interpreter distress during pediatric IME.

Types of encounters

Participants described types of encounters that were more stressful, including interpreting during cases of abuse, end-of-life, new diagnoses or care conferences. One interpreter described their experience interpreting for an encounter related to end-of-life:

"*When you're looking at a mom's face and telling her, 'Your daughter is dead. You need to let go'…*".

Types of clinics

Interpreters also reported heightened stress when interpreting for types of clinics such as the fetal concerns clinic (a prenatal counseling clinic for fetal anomalies), the intensive care unit, oncology, and psychology. Regarding interpreting for oncology, one interpreter shared:

"*I know there's a patient, an oncology patient, who has kind of been through the wringer, and everything came back and it's not going to be happy end [sic]. So, like when I see that name and I know I'm in inpatient and I know that that patient is there,*

depending on my emotional state, I will do whatever I have to do to avoid working with that family because I've already been through so many emotional encounters with that family that I'm not necessarily looking forward to doing it again".

Emotional content
Interpreters also reported that emotional content in IME makes interpreting more difficult because it means interpreters must engage with both the family's emotions, as well as their own, which requires "emotional stamina" during the encounter. For example, one interpreter commented about a case of child abuse: "*It was myself and one of my coworkers that had to deal with this case, and we dealt with the case for a long time… It's something that's been with me*". When discussing emotional stamina through multiple challenging encounters, another interpreter reported:

"*I don't have the stamina to get through that (A) because it's a lot of solid interpreting and (B) the emotional aspect. I've been able to keep it together through a lot of, you know, new diagnoses and end-of-life conversations and care conferences. I've cried while I've interpreted a few times, but if I get to the point where I am crying more than just a few tears… it's the point where it's beyond my emotional ability to complete my job*".

Interpreters also described feeling distressed when the family is emotional, such as times when the family member or patient expressed emotion or distress. One interpreter reported, "*[The mother] was just crying with me and it's like, you know, it's like what do you do? You know, you just cry with them*". Finally, interpreters noted they must not express own emotion during the medical encounter by virtue of their training. They described experiencing strong emotions which they are not able to express during IME as further contributing to their distress. One interpreter shared about interpreter training:

"*One of the things they taught us was, as an interpreter, to try and keep your emotions out of your interpreting encounter. And in some cases, if you're interpreting in a trauma type of situation or in a psychologist setting where the patient may be talking about a very painful experience in his or her life, a lot of times in those encounters, there's a lot of tears involved. I've even seen some of the providers tear up in some of these situations. So, when you see everybody crying in a room, if it's a situation that besides that touches your own personal life as the interpreter, it's really hard to try not to cry*".

Interpreter role
Interpreters also expressed that repeating bad news to families and taking on the role of interpreter as messenger contributed to their distress. Specifically, even though the information did not originate with the interpreter, they described a certain 'weight' of being the one to deliver difficult news or messages. An interpreter shared:

"*I've had to say it to a mom because mom kept saying that her daughter was going to wake up and she was going to stay right there because she was gonna wait and she would talk to her; and the other daughters didn't know what else to do and so the psychologist came over and we pulled mom into a room and you sat like front—face to face, really close, and I had to tell mom in several ways and several phrases with different explanations until the mom broke into crying*".

Feeling uncertain or unprepared
Many interpreters reported feeling distressed because they anticipated giving bad news to families. One interpreter stated, "*So that's the part that I guess will make me a little nervous, [to] not know what, once that doctor uses those words and they come out of me in Spanish, what the reaction is going to be*". Other interpreters reported that feeling uncertain or unprepared for the encounter contributed to their distress. Particularly, interpreters expressed that it is hard to prepare for emotional encounters because they could not know how the family might react to the information being interpreted. An interpreter said, "*If they tell you you're going into this kind of situation, you know maybe brush up on your terms and whatnot, but I mean emotionally, I don't think there is anything you can do*". Interpreters also reported that, oftentimes, they are not briefed on the type of encounter they are about to walk into, resulting in feeling a lack of preparation about the context of the encounter or a potential lack of vocabulary particular to the topic of the IME (i.e., not having the terminology to accurately interpret for an encounter).

Consecutive consults
These consults were defined as instances when an interpreter interpreted an intense encounter and then immediately moved on to the next consult, which contributed to distress. One interpreter said, "*After, you know, a two-hour care conference, they put another consult in for say the psychologist and it's just like, 'Nope, I can't do that one'*".

Related to their own life
Finally, many interpreters expressed that it is particularly distressing when an encounter related to their own life, especially when it reminded them of family members who have experienced similar medical problems, or when they
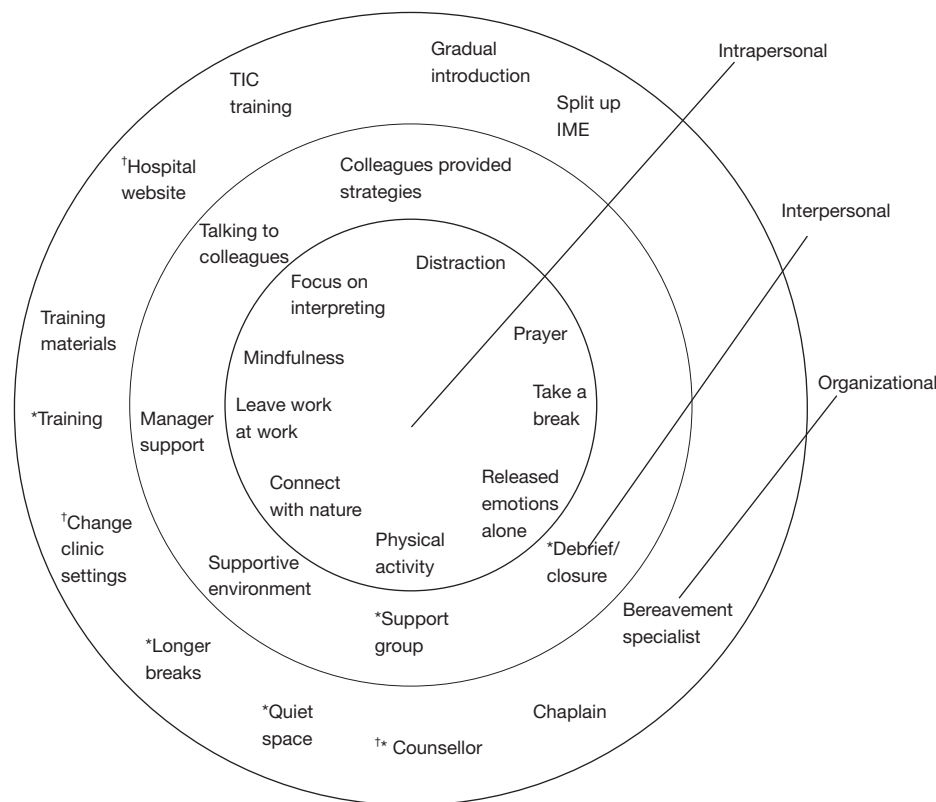
Figure 1 Supports and resources identified by interpreters (hospital employees and in-house contract interpreters). Themes presented in this figure are meant to be considered as inter-related. *, denotes resources that interpreters requested be made available; †, denotes resources that are accessible by some (not all) interpreters. TIC, Trauma Informed Care; IME, interpreted medical encounters.

saw patients that reminded them of their own children due to age or personality characteristics. For example, one interpreter expressed, "*I think the most difficult ones… is any encounter that reminds me of one of my kids*".

Coping strategies and available resources

Coping strategies and resources were conceptualized as organizational (i.e., access provided by the hospital), interpersonal (i.e., emotional or instrumental support from another individual), and intrapersonal (i.e., implemented by and for oneself). *Figure 1* illustrates coping strategies and resources that interpreters either have found helpful and/or would like made available to them. Appendix 3 is a complete list of supports and resources identified as available to participants by language services program management.

Organizational resources were described as resources that are accessible through the hospital system and included access to individuals with expertise in coping (e.g., bereavement specialist, a chaplain, and a counselor or

mental health provider through the Employee Assistance Program). One interpreter described their experience with the bereavement specialist:

"*She's licensed in trauma and stress and… has this little ritual that she'll teach us and things like that that help us… cope with things. So even if I don't need her services or those services, I know they are here. All it takes is an email to say, 'we need a little help' or 'we'd like to meet with you'*".

Additionally, almost all interpreters attended a hospital system Trauma Informed Care (TIC) training and had access to training materials via physical copies or the hospital website. An interpreter shared that TIC training "*provided [interpreters with] some different tools on how to deal with… the stress that [they] go through when [they] are in situations when [they are] giving care to families*".

Interpreters also shared that it was helpful when they were able to split up IME "*by planning to have somebody switch with [the interpreter]*" during long care conferences or change clinic settings (i.e., interpreters provided with an option to interpret in less intense departments) because it

allowed interpreters to take a break from intense IME. One interpreter shared:

"*I did ask the scheduler, 'Please just give me a few—give me a month. Give me a few weeks. Don't schedule me in psychology right now. Not right now', and yeah, it was maybe for a month, then I'm back again… I think I'm better, and that was the only time*".

Finally, the language services program developed a system of gradual introduction where new interpreters were eased into more challenging encounters (see Appendix 2 for a list of clinics per level). One interpreter described it as:

"*New interpreters that are coming in, they'll go into group 1… they're doing dental clinic, eye clinic, nothing traumatic… And then after a few months, you know they go onto group 2, where they're doing… surgery clinic, neurology, urology, you know a step up. And then they're doing group 3 after a few months and that's when they're going to be working with everything and everyone*".

Interpersonal coping strategies involved the instrumental or emotional support of fellow interpreters and supervisors or managers. Unanimously, interpreters expressed that talking to colleagues was a huge support. One interpreter shared, "*…I think the best tool ever is just talking to your coworkers. Just talking to someone who's been in the same situation… and having someone to listen to you*". Interpreters also reported that it was helpful when colleagues provided strategies by giving a "*different point of view of the situation and even sometimes just a better understanding of what happened*" and receiving manager support. One interpreter stated, "*We have a pretty good manager and so when we go through something tough, we can talk to her…*". Overall, interpreters said that a supportive environment in the workplace made a large difference in the way they coped. An interpreted reported:

"*My interpreter team I'd say is my biggest resource. Just being able to rely on them to relate emotionally and to support me and to help cover those appointments that I am too tapped out to do. We definitely coordinate ourselves as a team to do that and we try to look out for each other and send more experienced interpreters to more emotional situations*".

Intrapersonal coping strategies are self-implemented tools that helped interpreters cope with distressing content both during and after encounters. During an encounter, interpreters focused on interpreting and not on the emotional content or family's emotions. One interpreter reported: "*I focus a lot on my language, and I think that's when my better language comes out [because] I'm concentrating so much on it and trying to leave the emotional part out*". Another way interpreters managed their distress during encounters was

to distract themselves. One interpreter described, "*Obviously [the] family is in distress and they're crying for the loved one but [I] just think of what groceries I need at home…I'm there but I'm not there at the same time*". Other interpreters practiced *mindfulness* by focusing on different parts of their bodies (i.e., toes and fingers) to cope with the distressing encounter. An interpreter described their strategy: "*Sticking my nails through the palm of my hands, clenching my fist kind of a thing while I have my hands behind me… wiggling your toes… It's like drawing attention to your body versus what's going on outside of your body*".

After the encounter, interpreters often released emotions alone and experienced emotions after the IME. For example, an interpreter said, "*It's like I have to be professional in front of my encounter even though I go out and cry afterwards*". Interpreters also coped by using distractions, such as listening to music, watching movies, or reading books. They also engaged in physical activity, connected with nature, took a break, and prayed to cope with distressing encounters. Interpreters found it healthy to leave work at work at the end of the day and not take it home with them. One interpreter shared "*You have to find a way to leave it at the door. The walk from the hospital to the parking structure sometimes is very therapeutic to just kind of put some space… before entering my new part of life, home*".

Barriers to accessing supports and resources

Interpreters shared challenges they experienced in accessing the resources described above. Lack of access for contract interpreters included difficulty accessing mental health professionals for individuals who were not employed by the children's hospital. One interpreter noted: "*We're from a contract group so we don't really have the benefits of the full-time employees of like counseling or anything like that*". For interpreters who had access to counseling through the hospital, they expressed that schedule/time was a barrier. One interpreter stated: "*I work a P.M. shift and usually everyone is gone by the time I get there*". There were also challenges associated with the location of the resource (e.g., outside of the main hospital campus), being inconvenient since the interpreter had to complete multiple steps to access the resource, or lack of helpfulness of the counselor in instances when significant time has passed since the activating event. An interpreter shared:

"*I believe they take your information and then somebody calls you back and then you have to make an appointment and then you have to get PPL [personal paid leave] to go for the appointment*

Table 2 Barriers to accessing supports and resources

Code	Operational definition
Hesitant to ask for time off	Interpreters expressed being hesitant to ask for time off, a break, or schedule change
Inconvenient	Calling a counselor is inconvenient; challenging to access counseling because it's confusing, hard to schedule, etc.
Lack of access for contract interpreters	Interpreters contracted by the hospital have less access to resources compared to hospital employees
Lack of helpfulness	Interpreter's emotions have de-escalated, reducing the counselor's helpfulness in coping with distress
Location	Interpreter mentions location of the resource as a barrier to access
No access to computer	Not having computer/internet access in their home is a barrier
Not part of team	Interpreters described lack of inclusion in team debriefs and support as members of the medical treating team
Respect patient privacy	Difficult to disclose to colleague to respect patient's privacy; HIPAA
Schedule/time	Interpreter mentions schedule and time as a barrier to accessing resources

HIPAA, Hospital Insurance Portability and Accountability Act.

and I'm guessing that, by the time you get there, it's gone. You've moved on. Yeah, maybe it's hidden somewhere but do I have the energy to go through that? No".

Some interpreters might not have access to a work computer at home and thus could not access the hospital's intranet after work hours. For example, one interpreter shared:

"*The [hospital intranet homepage]… maybe you don't have access from home to the page so that can be a barrier… if you needed to use those resources while you were home… You may have to use other resources within the community*".

Many interpreters also felt hesitant to ask for time off to access the resource. An interpreter noted, "*I don't [ask for time off] because I know that we're busy and I need to keep going, but I know of an interpreter or two who have done it and actually one of them got in trouble*".

Interpreters expressed they were not part of the team and felt excluded from treating team debriefs with clinicians and nurses. One interpreter stated: "*In between nurses and doctors, they have a group after an end of life… It's just that we're not involved in the conversation afterwards*". As a result, interpreters often felt left out of such conversations, resulting in difficulty obtaining closure/debrief and moving on from difficult encounters. Interpreters also noted that having to respect patient privacy could be a barrier when talking to colleagues. One interpreter described, "*…We [have to] be really careful with that [because] if [my colleague] is not working with that family, I really can't be sharing anything with anybody*". *Table 2* summarizes barriers interpreters have

identified to accessing supports and resources.

Supports and resources that interpreters would like to be made available

Interpreters expressed that the ability to change clinic settings based on their emotional needs and taking longer breaks should be made available. One interpreter said: "*It would be nice to be able to just call the office and say, 'I need half an hour. I need 20 minutes', that would be nice*". Interpreters also requested a counselor, especially after intense or distressing encounters, as a potentially beneficial resource. One interpreter stated that it would be helpful to "*have like a counselor in campus that we could go to and have the ability to get a one-hour block or 40 minutes to just run and vent*". Interpreters also requested support groups where they could talk with their team and receive necessary support and advice. Finally, interpreters requested a debrief with the larger treating team after an intense IME. An interpreter stated, "*I think we should be offered to attend a debrief… when a patient passes, I think that us as interpreters should [be included] because we were there*".

Interpreters also *requested training* (e.g., "end of life", "trauma", "coping") that is in-depth and occurs more frequently. They also *requested a quiet space* away from other employees to process challenging encounters. One interpreter noted, "*Maybe if they had a smaller place where an interpreter can go where they wouldn't get in trouble for just sitting a little bit in silence*". Resources that interpreters would

like to be made available are presented in *Figure 1*.

Discussion

The purpose of this paper was to describe risk factors for interpreter distress during pediatric IME, available supports and resources that interpreters used to manage distress, barriers to accessing supports and resources, and resources that interpreters would like to be made available in the hospital. The analysis signals that spoken language medical interpreters in pediatric IME experience distress, and potentially secondary traumatic stress, related to their work, and that diverse risk factors contribute to interpreter distress during pediatric IME. While studies suggest that interpreters may be at higher risk for adverse emotional symptoms (e.g., secondary traumatic stress, burnout, compassion fatigue) given the nature of the interpreting process and their use of first-person language (3,8,15), interpreters in this study noted many additional factors that contributed to their distress.

An important category of stressors they identified relate to the specific context of individual IME: the IME's topic of discussion (e.g., abuse, end of life, care conference, new diagnosis), the clinic or department where these encounters take place (e.g., fetal concerns clinic, intensive care unit, oncology, psychology) and the presence of emotional content within those encounters (e.g., families emotional responses, families expressing distress), including whether aspects of the encounters related to their own lives. Within these distressing IME contexts, factors related to interpreters' roles also appear to be sources of interpreter distress. The National Council on Interpreting in Health Care's (NCIHC) Code of Ethics for Interpreters in Health Care signals that interpreting "*requires that interpreters have the ability to detach themselves from the content of the message*", in order to accurately convey the interlocutors' intended meaning (3). Consistent with NCIHC guidelines, interpreters in this study acknowledged that they experience emotions and distress; they attributed reluctance to expressing their emotion to their roles and training; and described how "detachment" (not getting personally involved) or inability to express their emotions further impacts their own experience of distress. Interpreters noted that acting as impartial messengers, repeating bad news, not being able to comfort families are additional role-related factors that contribute to their distress. The role-related distress spoken language interpreters in pediatric IME disclosed in this study are consistent with role-related

distress identified in studies of sign language interpreters and in non-pediatric interpreting settings (10,18,20).

Interpreters also highlighted systemic factors, or factors related to the health care system that, when combined with their role boundaries, heighten their distress. Studies suggest that interpreters in clinical settings are not viewed as members of the medical treating team in part because they are viewed as "invisible language facilitators" (36,37). Clinician notions of interpreting work as invisible, derivative, or external to patient care may factor into interpreters' reports that they are not included in clinician debriefing processes, nor are they privy to information clinicians have regarding distressed patients and families. Interpreters in this study emphasized that they do not feel like they are viewed as part of the treating team, and that they are often not provided information related to highly emotional IME before or after their interaction. These factors increased their sense of uncertainty, unpreparedness, and anticipation when going into encounters, which in turn impacted their distress before, during, and after encounters. Lack of inclusion in team debriefs and support as members of the medical treating team, especially after stressful and emotional encounters, in addition to difficulty related to preparing for emotional encounters, are factors interpreters have identified as contributing to their distress.

In sum, this study identifies three major concerns regarding the above-mentioned factors: (I) because unpredictability and lack of situational control have been demonstrated as factors that intensify stress (38), interpreters are at an increased risk for being adversely impacted by anticipatory anxiety, due to feeling emotionally and/or cognitively uncertain about or unprepared for distressing encounters; (II) interpreters are at risk of experiencing the deleterious effects of having to "detach", suppress, or hide emotions given their role restraints, which could make it more challenging to recognize, process, and cope with heightened emotions during pediatric IME; and (III) the combination of the above cited factors, and particularly the interpreters' invisibility and exclusion as members of treating teams, could amplify risk factors for secondary traumatic stress, burnout and compassion fatigue (4,12,14).

Despite multiple intersecting factors that contribute to interpreter distress before, during, and after emotional and stressful IME, the interpreters in the current study demonstrated remarkable strength, resilience, and creativity in effectively managing their distress. It is likely that engagement in intrapersonal coping strategies coupled with significant emotional and instrumental support from

fellow interpreters have reduced the impacts of traumatic material during their interpreting work. Indeed, interpreters alluded to using a combination of seeking peer support and mentorship, debriefing with other interpreters, and sharing emotions following intense and stressful encounters, all of which have been considered adaptive coping strategies that mitigate distress (8,15,39). These strategies were also consistent with available online resources to prevent and reduce secondary traumatic stress, such as the Children's Hospital of Philadelphia Health Care Toolbox for Medical Interpreters (40) and MasterWord Tools for Interpreters (41).

In addition to having a diverse list of adaptive intrapersonal and interpersonal coping strategies, interpreters also noted that systems level support (e.g., gradual introduction to more challenging encounters, access to counselors) minimized the frequency and/or intensity of distress reactions. Notably, stress and coping should be addressed both individually and as an organization "*because secondary traumatic stress is a hazard for all who work in the healthcare setting. Managers, supervisors, and institutions at large must partner with staff to develop ways to regularly combat the potential for secondary traumatic stress, to promote staff health and well-being*" (40). Since interpreters are instructed not to "reveal personal feelings" in assignments and to "limit personal involvement with all parties during the interpreting encounter" (3), in addition to having "the ability to detach themselves from the content of the message" (3), it is essential that they have ample opportunity to unload and process their own emotional burden. Therefore, it is imperative that hospital systems offer a variety of supports and resources and ensure that these resources can be equitably accessed by all interpreters who are part of the system, regardless of employment status. Hiring more full-time interpreters could increase interpreters' access to supports and resources at the systems level. In addition, increasing access for interpreters systematically may require shifting the perspective that interpreters are "technicians" and "auxiliary" (37) to the medical team, and adopting the perspective that interpreters are professionals and integral to the medical team. Shifting the perspective might result in inclusion of interpreters in research and discussions related to secondary traumatic stress and increased access to resources (e.g., team debrief, trainings, counseling) that historically have been granted to medical health care clinicians. Specific emphasis should be put on ensuring that interpreters are adequately prepared for pediatric IME whenever possible, since lack of preparation was repeatedly identified as a source of distress.

Finally, while some supports and resources have been made available at children's hospitals at the request of interpreters, studies indicate that medical interpreters struggle to make their voices heard when requesting supports and resources, such as training associated with TIC, stress, and coping strategies (42). It would be beneficial to collaborate with interpreters and develop workshops to enhance, amplify, and support their mental and emotional well-being throughout their interpreting work. Interpreters might be interested in learning and practicing mindfulness, relaxation (e.g., deep breathing, guided imagery), labeling and addressing emotions to manage distress related to anticipatory anxiety specific to their roles as interpreters. We highlight the necessity to partner and collaborate with interpreters in developing support strategies which are parsimonious with their diverse lived experiences, preferences for stress management, and employment status (e.g., employed versus contract interpreters). Mental health care professionals can play a role in collaborating and creating multi-modal interventions that offer diverse ways for individuals to access materials according to the different ways they learn, process, and retain information (e.g., online, in-person, video, audio, written text, and in the language of user's choice, etc.). Finally, it is imperative to also partner with training agencies, contracting agencies, and other language services programs to determine the feasibility of providing these resources, especially since medical systems, language services programs, and agencies have different ways of supporting and managing interpreters.

Limitations

Although we recruited all language pairs to participate in this study, the interpreters who were interviewed for this study were all Spanish-English interpreters. External agency interpreters (distinct from in-house contractors, who were included), who are called to interpret when hospital employees and in-house contractors are not available, and virtual/phone-based interpreters, were also not included in the participant pool. These factors may limit the degree to which this study's findings generalize to non-Spanish-English interpreters, or to interpreters from different environments, such as external agencies or phone/virtual interpreters. These factors warrant further exploration.

Additionally, interpreters in this study were recruited from a single, pediatric hospital. Since one hospital does not reflect how all hospitals operate, it is likely that each

hospital and language services program will offer supports and resources unique to the needs of their interpreting team. Interviewing interpreters from different centers would help elucidate which stressors, supports, and resources are common across centers, and which are unique to specific centers. This knowledge could enrich our collective knowledge, help inform policies and procedures, and perhaps ultimately lead to the development of "best practices" with respect to supporting voiced language interpreters.

It is also plausible that interpreting in pediatrics may pose unique stressors to interpreters and could be very different from interpreting in other populations (e.g., adult, victim services, legal), since pediatric interpreting may be tetradic (i.e., involving four parties: the clinician, interpreter, parent/caregiver, and child who may be bilingual). It would be beneficial to determine which resources and coping strategies could be generalizable for all interpreters, and which resources and coping strategies are more beneficial for interpreters working in pediatric medical settings.

Lastly, as a qualitative study, data are collected, analyzed, and presented by a group of researchers who necessarily have their own beliefs, experiences, and perspectives: positionality. Thus, qualitative data are never fully free of bias. We intentionally and systematically revisited our own positionalities and assumptions throughout the research process to ensure that data interpretation reflected the voices and perspectives of the participants as closely as possible. Further, data collection and direct analysis were performed by team members who were remote from participants (no supervisory relationship, efforts made to decrease patient care overlap) to create a safe space for participants to share their honest perspectives.

Practical applications and future directions

Interpreters shared diverse strategies and resources that would be helpful in supporting their wellbeing before, during, and after IME. It may be beneficial to further study the acceptability, feasibility, and efficacy of these supports and to develop training materials based on collaborations among interpreters, training agencies, mental health professionals, and hospital systems. Determining which elements of the training material interpreters find most useful may be an effective way to balance time commitment to and cost of attending the training, while also maximizing the utility of the training. Any such training should be consistent with trauma-informed care principles. Additionally, surveying other language services

programs from diverse pediatric hospitals about how they support their interpreting team and asking clinicians how they support interpreters are potential avenues for further understanding how systems can better support interpreters. It could also be revealing to learn about individual-level factors (e.g., demographics, work experience), which may be associated with interpreter well-being. While the current study is not powered to answer these questions, this could represent an interesting future direction.

The present study also brought to light concerns related to anticipatory anxiety and uncertainty before going into an encounter, which greatly contributed to interpreters' distress. Further research on (I) how hospitals could create systems to better inform interpreters about the encounter they are about to enter; and (II) how interpreters could better manage anticipatory anxiety and feelings of uncertainty, may be beneficial for improving the mental and physical health of interpreters everywhere. Potential interventions which warrant further exploration might include training of healthcare professionals in "best practices" for working with medical interpreters, the use of "team huddles" prior to IME, checklists to facilitate conversations prior to pediatric IME, and perhaps leveraging technology such as the electronic medical record to give interpreters a warning for encounters which the care team believes to be more intense or distressing. These interventions may help increase interpreters' sense of belonging and team cohesion while decreasing anticipatory anxiety and distress following intense IME.

The study also reveals interpreters' perceptions of sustaining trauma through their work. The lack of consistent and equitable access to mental health resources based on the nature of employment poses a significant problem and opportunity for improvement for healthcare institutions. These institutions should ensure equitable access to mental health resources for interpreters working at their facilities regardless of the nature of employment.

Finally, interpreters expressed that they managed their distress during an encounter by drawing their attention to something outside of the encounter (e.g., fidgeted with their hands or feet, allowed their minds to wander to something like a grocery list, or focused on a window or wall to avoid the emotional content of the IME). Once outside the encounter, many had difficulty suppressing these emotions and either shared it with a team member or released it on their own. Further work should investigate diverse ways interpreters regulate their emotions during the encounter, which strategies are most effective, and the

role of emotional self-regulation on interpreter wellbeing. Developing emotional regulation strategies in collaboration with interpreters and interpreting teams would result in the most effective and affirming strategies for interpreters regarding distress management.

Acknowledgments

Footnote

Data Sharing Statement: Available at https://jhmhp.amegroups.com/article/view/10.21037/jhmhp-22-23/dss

Conflicts of Interest: All authors have completed the ICMJE uniform disclosure form (available at https://jhmhp.amegroups.com/article/view/10.21037/jhmhp-22-23/coif). PSL has received financial support for this manuscript through the Center for Latin American & Caribbean Studies (CLACS) at the University of Wisconsin-Milwaukee. Amy Olen has received financial support for this manuscript from Center for Latin American & Caribbean Studies (CLACS) and Translation & Interpreting Studies at the University of Wisconsin-Milwaukee. The other authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. The study was conducted in accordance with the Declaration of Helsinki (as revised in 2013). The study was approved by the institutional review board of the University of Wisconsin-Milwaukee (IRB # 20.124) and informed consent was taken from all individual participants.

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Appendix 1

Interview questions related to supports and resources

Training

1. As an interpreter, have you ever received information or education on working with patient trauma and stress? Briefly describe the training you have received.
2. As an interpreter, have you received information or education on coping strategies for managing your own stress and emotions? Briefly describe the training you have received.

Impact of disclosing intense/traumatic information to families and/or providers

3. Can you tell us about the kinds of interpreting encounters in which you feel personally distressed because of the information being discussed?
   a. What about the information being discussed is personally distressing?
   b. Outside of interpreting difficult content, are there other things at home, work, or elsewhere that make you feel more distressed when interpreting?
4. Have you ever left an interpreting encounter because it was too stressful or distressing?
   a. Have you ever wanted to leave an interpreting encounter because it was too stressful or distressing?
   b. What about the assignment was challenging or distressing?

Resources and support for interpreters

5. What resources do you know of that you can use to minimize feeling distressed after interpreting for families?
   a. Which of those do you use?
   b. What are the barriers to accessing those resources?
6. What coping strategies do you use when actively interpreting for a distressed family encounter at work?
   a. What about when recovering from a distressing family encounter at work or at home?
7. When you are dealing with traumatic information, have you ever disclosed these situations to a colleague because you felt distressed?
   a. What happened after disclosing to a colleague?
8. What resources and supports for interpreters do you think should be made available in the hospital to decrease feeling distressed in this line of work?

Appendix 2

Types of clinics by level

Level 1

- Audiology
- Dental
- Dermatology
- Eye
- Eyes, Nose, and Throat
- Imaging
- Lab
- Occupational Therapy
- Orthopedics
- Physical Therapy
- Speech Language Therapy

Level 2

- Adolescent Medicine
- Asthma Allergy
- Child Development Center
- Child Protection Center
- Diabetes
- Endocrinology
- Gastroenterology
- Neurology
- Psychiatry
- Pulmonary
- Renal Clinic
- Rheumatology
- Surgery Clinic
- Urology

Level 3

- Bone Marrow and Transplant
- Day Surgery
- Emergency Department Trauma Center
- Fetal Concerns Clinic
- Genetics
- Hematology and Oncology
- Herma Heart Institute
- Hospitalized Patients
- Pain Clinic
- Palliative Care
- Special Needs
- SurgiCenter

Supports and resources identified as available to participants by language services program management

Resource	Who can access this resource?	How would interpreters know about this resource?	How could interpreters access this resource?
	Hospital employee interpreters, on-site contract interpreters, and external agency interpreters (called to provide coverage when the first two groups are unavailable).		
Healing Wreath	All interpreter groups	Located in Language Services program office.	When visiting Language Services office, interpreters see it, read about it and use it in office space. (External agency interpreters may access it when they visit the Language Services office to receive PPE.)
Employee Assistance Program	Hospital Employees (On-site contract interpreters may access this resource in special circumstances with the appropriate permission.)	Shared by HR at hire, info is on system-based intranet, in the system-based newsletter, and is shared via the Language Services communication tool. Language services manager provides resource information in one-on-one meetings with interpreters.	Available 24/7 via phone or online.
Computer/online access during work	Staff interpreters and on-site contractors	Interpreters sign a document for access.	During downtime at work.
Request time off (for emotional wellness)	All interpreter groups	Staff may request paid time off (PTO) or may ask the office manager for brief breaks during work hours. In–house contractors and external agency interpreters may take a break from accepting new appointments.	Via emailing their interpreting lead/manager. A phone call or email.
Treating team debrief	All interpreter groups	If Language Services management is informed of a debrief, management will inform involved interpreters. If interpreters want to attend, management will create availability in their schedules for the debrief.	Planned in advance.
Trauma informed care (TIC) training	All staff interpreters and select in-house contractors	Leader schedules interpreters for initial training. "TIC Champions" share information regularly with staff and in-house contract team.	Planned/scheduled in-person training. TIC champion training is available as a resource in the office.
Training on death and dying	Staff interpreters and on-site contractors only	Language Services training hosted in the past. This content is available on the Language Services shared drive.	Training hosted in the past and is stored online for access.
Lunch and Learn seminars	Staff interpreters and on-site contractors only	Lunch and Learn content is available in meetings and on the shared drive.	During work hours or online.
Healing Garden	All interpreter groups	Access in the main campus hospital.	During downtime and only when open (seasonal).
Access to patient medical records	Staff interpreters and on-site contractors only	Interpreters learn about access during orientation.	While at work.
Hospital Intranet (e.g., benefits page)	Staff interpreters and on-site contractors only	Interpreters learn about access during orientation.	While at work.
Language Services program shared directory	Staff interpreters and on-site contractors only	Interpreters learn about access during orientation.	While at work.
Language Services program Newsletter	Staff interpreters and on-site contractors only	Interpreters learn about access during orientation. Emailed biweekly.	While at work.
Chaplain	All interpreter groups	Request services through the on-call system. Language Services office manager can call for interpreter.	While at work.
Bereavement specialist	All interpreter groups	Request services through the on-call system. Language Services office manager can call for interpreter. Bereavement specialist has given talks to interpreter teams in the past.	While at work.
Critical Incident Stress Management (CISM) team	All interpreter groups	Request services through the on-call system. Language Services office manager can call for interpreter.	While at work.