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Experiences of Interpreters and Deaf Consumers in Mental Health Support Groups

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Contents

Abstract

There is currently a need for further research in the interpreting field for working in support group settings for mental health and addiction recovery. This gap in the research leaves

many unanswered questions of how best to provide services to deaf consumers in these settings. By gathering information on the experiences of both interpreters and deaf consumers who have been in support groups, this research will identify issues that may need to be addressed in order to improve the interpretation process. This research will be the groundwork for future research to identify effective training and skill development that is needed for interpreters to be ready to enter the field of interpreting support groups. The methodology used in this research will be grounded theory which will analyze both questionnaires and interviews to find common themes amongst the study's participants.

Introduction

Currently in the interpreting field there is a lack of research exploring interpreters and deaf consumers in support group settings. In fact, peer support group research is still in its infancy causing there to be a limited amount of research on the topic in any field. The research that has been conducted has mostly focused on self help groups and shows a reduction in symptoms as well as enhanced self empowerment, increased rates of recovery, increased sense of hope and overall enhanced quality of life (Salzer, & Shear, 2002). In the interpreting field, there is research on mental health interpreting and other topics that may overlap with support group interpreting such as medical interpreting, substance abuse interpreting and interpreting for more than two parties at a time, but there seems to be a gap in the study of specific challenges that exist in these settings.

This research study examines the perspectives and challenges that interpreters and deaf clients experience in support group settings for mental health and addiction recovery. Addiction recovery support groups are settings that address any substance use such as alcohol or drug addiction. Mental health support groups address mental health issues that clients face. This includes groups for specific mental health diagnosis such as bipolar disorder, depression, schizophrenia, other mood disorders and personality disorders. Mental health support groups also address other issues related to mental health such as coping skills and symptoms experienced with mental health disorders. Research from social work and mental health fields group addiction recovery and mental health research together due to their overlap. Similarly, this research will look at both mental health and addiction recovery support group consumers.

Rowe, Bellamy, Baranniski, Wieldand (2007) share that the effectiveness of peer support groups has shown that peer mentors are effective due to their ability of the support group leader to relate to clients from their own experiences which provides social support and friendship. These roles lay in between friendship and case manager (Rowe, Bellamy, Baranoski, Wieland,

O'Connell, Benedict, Davidson, Buchanan, Sells, 2007). Peer support provides benefits for the consumer by providing strategies for the management of illness as well as emotional support. The peer support specialists become role models for addiction recovery as well as mental illness by showing the outcomes of treatment adherence (Proudfoot, Parker, Manicavasagar, Hadzi-Pavlovic, Whitton, Nicholas, Smith, Burckhardt, 2012). In a study involving newly diagnosed bipolar patients, it was shown in the interactions between peer support specialists and clients that there was a clear demonstration of experiential knowledge, social support, social comparison and helper therapy (Proudfoot, et al., 2012). These results are based on the connections made and role modeling provided by the peer support specialist. Deaf consumers who use interpreting services as part of their support group experience may face challenges with communication which may result in challenges for connection with their peers. Since these benefits that hearing participants experience are based on bonds through communication, there could be effects on deaf participants due to relying on a third part for communication to take place. In order to minimize the challenges consumers may face, we need to understand the challenges further as well as explore the best practices used to address these challenges.

Salzer & Shear (2002) suggest, "consumer-delivered services are different in many ways from traditional mental health services and require unique approaches to how they are studied" (p. 281). According to this, interpreting in these situations should be looked at from a unique approach as opposed to grouping them with the general mental health field. The key to these services is that the deaf consumer develops a connection with those involved within the support group in order to have the same successful outcomes that hearing consumers experience. The interpreter's presence as well as process of interpreting will affect the dynamics of the group. The effects of this are not yet understood.

This research is needed not only because it is currently lacking in the interpreting and deaf studies field, but because it provides a foundation for further development of education for

interpreters who work in these settings. By identifying the consumer and interpreter experiences, additional research can be done to identify specific skill sets needed in order to be a support group interpreter. These results can be tested through experimentation to find the best approach to working with deaf consumers in support groups. Knowing the consumers' challenges will also provide an understanding for interpreters when working in this specialized field.

Literature Review

Success of support groups as treatment

What causes support groups to be successful

Support groups are a relatively new research field. Peer support groups have only been around since 1991 (Davidson, Bellamy, Guy and Miller, 2012). The research that has been done on this topic has shown that support groups have equal if not more beneficial results than therapeutic intervention alone. When mental health and addiction recovery clients are able to access services from their peers, they are provided unique benefits that therapeutic intervention alone cannot provide.

Davidson, Bellamy, Guy and Miller (2012) argue that there are three unique benefits of support groups. The first of these is the insilling of hope through self disclosure. By connecting with peers, clients are found to be more hopeful in their recovery and treatment process by seeing those like them able to recover. The second benefit is role modeling. Peer support providers are able to share their experiential knowledge to clients on how to navigate society, stigma and day to day routines. Lastly, the relationship between clients and peer support providers is unique in and of itself. The providers are able to have a higher sense of empathy for clients since they have experienced similar hardships. Due to this first hand experience they are also able to hold clients accountable since they are aware of their potential.

When researching a group of forty-four newly diagnosed bipolar patients, Proudfoot, Jayamwant and Whitton (2012) found that there were four components to a successful support

group. The four components were advice grounded in experiential knowledge, social support, social comparison and the helper therapy principle. These findings mostly overlap with Davidson, Bellamy, Guy and Miller's (2012) three unique benefits to support groups. Both articles mention the unique benefit of support groups providing experiential knowledge. The difference between the way experiential knowledge is mentioned in each article is that one says it is shown through role modeling and the other mentions experiential knowledge being demonstrated through social comparison. While different wording is used in each, the concept remains the same that by looking up to the peer support provider that client can feel a sense of connection with someone who has experienced what they have experienced.

Positive Outcomes from Support Groups

Multiple studies on support groups have been done showing the positive effects they have on those who participate. In a study done on patients with severe mental illness it was found that there was a reduced number of hospitalizations, reduced substance use, reduced use in emergency rooms as well as a sense of hope is provided to clients (Davidson, Bellamy, Guy and Miller, 2012). In a review of literature on the topic of support groups used in mental health services that was done by Repper and Carter in 2011, it was found that patients who participate in peer support groups show a reduction in admissions and an improvement on multiple factors that impact patients with mental health problems. Similarly, after three years of research, Schwartz and Sendor (1999) found that in a group of randomized patients who received peer support through the phone, showed decrease in depressive symptoms, increase in self-esteem and self awareness as well as an increase in self functioning.

Proudfoot, Parker, Manicavasagar, Hadzi-Pavlovic, Whitton, Nicholas, Smith, and Burckhardt (2012) did another study on patients involved in support groups who have bipolar disorder. The study looked at two groups of patients, one who received peer support while completing therapeutic intervention and another who only received therapeutic intervention. The

study found that patients who received peer support had a decrease in depression symptoms as well as higher rates of adherence to their treatment plan (2012). Another study facilitated by Pfeiffer, Heisler, Piette, Rogers, and Valenstein (2011) found a decrease in depressive symptoms. In this study they analyzed various randomized control trials related to peer support and depression. Seven randomized control trials were analyzed with a total of 869 participants. The results showed those receiving peer support had a decrease in depressive symptoms.

This study also compared peer support to cognitive behavioral therapy and found no significant difference in outcomes between those two groups. This suggests that peer support is as effective as cognitive behavioral therapy and has value as a treatment option for those struggling with their mental health and addiction recovery. The input of those who have experienced mental illness is being valued more as they are being put into roles of importance to help others (Davidson, Bellamy, Guy and Miller 2012).

Similarly to the study done by Davidson, Bellamy, Guy and Miller (2012) that found a reduction in substance use, a study was done on the effects of peer support groups on those with drug and alcohol related addiction as well as criminal justice charges that yielded comparable results. This study found only a reduction in alcohol use by participants and no significant changes in drug use. Participants in this study were put into two groups, one received therapeutic intervention treatment while the other received peer support on top of the standard treatment (Rowe, Bellamy, Baranoksi, Wieland, O'Connell, Benedict, Davidson, Buchanan and Sells, 2017). Reduction in alcohol use is also shown through positive outcomes in participants who attend Alcoholics Anonymous and have mental illness.

Positive benefits have been shown in peer support providers as well. Both participants in and providers of peer support are found to benefit from this process. Research on support groups have mostly focused on self help groups and have shown reduction in symptoms, increase functioning, a sense of empowerment, increase in recovery, increase of hope, and overall

benefits to the quality of life of participants (Salzer & Shear, 2002). These benefits derive from the helper therapy principle that outlines four benefits to the helper. These four benefits are: an increased sense of interpersonal competence, developing a sense of equality in giving and taking, gaining personally relevant knowledge. By participating in peer support, the providers are found to benefit for their own recovery process. By demonstrating tools the providers use in their recovery they practice their strategies such as how to mitigate boredom and building positive supports. Other benefits found for providers are benefiting from the approval of others, feeling appreciated, boosts in their self confidence and self esteem, benefiting from the relationship with participants and learning from others (Salzer & Shear, 2002).

Barriers for Deaf Clients

The Need for Support Groups for Deaf Individuals

While there is no exact census on the number of deaf individuals in the United States and how many of them use American Sign Language (ASL) as their primary language, it is estimated that there are between 200,000-500,000 individuals that fall into this category (Williams & Abeles, 2004). A report done by the National Institute on Drug Abuse estimated that 206,200 deaf and hard of hearing people have experienced a substance use disorder. This data was broken down to 8,500 heroin users, 14,700 cocaine users, 73,000 alcohol users and 110,000 marijuana users. This report was done in 1980.

Guthmann and Boliz (2001) used the 1992 Department of Justice report of the overall incidence of illicit drug use in the United States to estimate the number of deaf individuals using illicit drugs. The numbers were adjusted considering that deaf individuals represent 0.5% of the population. Guthmann and Boliz found that in the United States, there are currently 138,280 deaf individuals using illicit drugs. This number is broken down into 3,505 heroin users, 31,915 cocaine users, 5,105 crack users, and 97,745 marijuana users. The numbers were adjusted considering that deaf individuals represent 0.5% of the population. The National Council on

Alcoholism reported that there are at least 600,000 individuals that experience alcoholism and some form of hearing loss. While several studies have shown increased rates of alcoholism amongst deaf population, one study reported that 808 participants reported alcohol as their prefered substance out of 1588 patients at the Minnesota Substance Use Disorder Program for Deaf and Hard of Hearing Individuals, this is similar finding to the general hearing population (Kushalnagar , Hoglind, Simons & Guthmann 2019).

Substance abuse amongst individuals with disabilities is reported to be doubled of that of the general population. These rates may be higher due to lack of services or resources for these commnites, isolation, unemployment, and perceived discrimination (Anderson, Chang & Kini 2018). Other factors that may put those at higher risk for substance use that are deaf include limited communication with hearing parents that reduce opportunities for family discussion and learning about substance use. Deaf individuals may also feel isolated from their hearing peers and desire to fit in through substance use and lack resources in their primary language of ASL on substance use education.

Currently there have been no studies done on deaf patients who have completed treatment programs and the long term effects (Guthmann &Boliz, 2001). Lack of research leads to a lack of understanding on the best approaches to treating deaf patients who seek treatment for substance abuse or their mental health wellbeing. While research shows that overall lifetime prevalence of alcohol and drug use has no relation to hearing status, it has also been shown that deaf individuals are more likely to be regular cannabis users and heavy alcohol users when compared to their hearing peers (Anderson, Chang & Kini 2018). In addition to this, when it came to endorsing regular cannabis use, results showed a higher percentage of deaf and hard of hearing respondents than hearing respondents (Anderson, Chang & Kini 2018).

Social factors may also contribute to the high rates of substance use in the deaf community. Many social activities within the deaf community revolve around alcohol and occur

at bars, clubs or at sporting events. Due to the shared language and socialization, when a group of deaf peers gather there may be higher rates of alcohol use. This may also make it more difficult for those in recovery since these events may be triggering but lack of socialization within one's own community can be isolating as well (Kushalnagar , Hoglind, Simons & Guthmann 2019).

Language and Communication Barriers

One of the largest barriers faced by deaf patients is communication. For those who use ASL, there is a barrier between the client and the provider. Without direct communication between providers and their clients, there is a likelihood of incidences that include misdiagnosis, inaccurate case conceptualization, hindrance of therapeutic alliance and a higher likelihood that the client will leave therapy (Williams & Abeles, 2004). Barriers with language use hinder the therapeutic process from the start with diagnosis and can continue throughout treatment. To bridge the communication gap, often professional sign language interpreters are used. National certification is recommended for interpreters working in these settings to ensure interpreter competence. Those interpreters who are certified through the National Registry of Interpreters for the Deaf have shown competency in English and ASL as well as their interpreting abilities, understanding of deaf culture and knowledge of the interpreter's code of ethics. While providing a professional interpreter does bridge the gap of communication in some ways, adding a third party to a therapeutic setting creates its own challenges.

One of these challenges when placing an interpreter into a therapeutic setting is the changes in the transference dynamic and alliance relationship between the provider and patient. This can be caused by either the client seeing the interpreter as an ally which causes the provider to become seen as an outsider or because the client views the interpreter as an intruder on the dynamic. Similarly to how the provider can experience countertransference from the client, the interpreter may receive these reactions as well (Willaims & Abeles, 2004).

Guthmann and Blozis (2001) mention the difficulty of obtaining and financing the provisions of interpretation services for twelve step programs. This challenge may be seen in other support group settings as well especially in less populated areas where there is a lack of qualified interpreters. Communication barriers have led to deaf individuals seeking to maintain sobriety without support groups because of lack of access.

Lack of language access for deaf clients outside of therapeutic settings has led to a lack of access to information. There has been a lack of captioning on public programs as well as curriculum in educational settings that have not been adapted to align with deaf culture and ASL (Guthmann & Blozis, 2001). This limited access to public information has led to the deaf community having more rigid values, stereotypes, social dictates and changes may occur more slowly (Williams & Abeles, 2004). The stigma associated with addiction and mental illness has caused deaf individuals to be hesitant to admit to issues they may be facing (Guthmann & Blozis, 2001).

Due to a history of hearing people talking about and making decisions for deaf people, there is a concern for confidentiality within the deaf community. These issues of oppression can cause distrust throughout therapy. Having an interpreter within therapeutic settings can cause complications within the therapeutic dynamics (Williams & Abeles, 2004). The deaf community is small and there is a tendency for information to be shared. Deaf clients may fear information being passed along to the deaf community if they seek treatment (Guthmann & Blozis, 2001).

Barriers of the Support group

Several barriers may occur because of the support group itself. These barriers may be imposed by the therapist, if one is included in the support group. Most therapists have little to no experience working with deaf clients and may become anxious with this new experience. That anxiety can influence the deaf clients' participation and relationships within the group (Williams & Abeles, 2004). Much like the therapist's anxieties influences the group dynamics, other

participants may experience similar anxieties interacting with a deaf individual. Providers and interpreters may also view each other as adversaries and compete for power within these settings. Much of the benefits of support groups derive from role modeling done by peers. There are few deaf individuals within recovery that are able to be used as peer support providers and be role models to those going through treatment (Gethmann & Blozis, 2001).

To mitigate barriers related to communication and the use of interpreters, it is recommended that the interpreter and provider discuss in advance the roles and expectations of each other. The two should also discuss seating arrangements, other physical arrangements, language use of the client and cultural norms that may impact the group dynamic such as eye contact. Another strategy to mitigate barriers is for a plan to be established for how miscommunications should be clarified if they do occur in order to have the least disruption to the therapeutic process (Williams & Abeles, 2004).

Methodology

A questionnaire, along with the option to participate in a semi-structured interview, was shared with potential participants. The use of the questionnaire aimed to incorporate an increased number of participant viewpoints as well as offer an opportunity for participants to share their thoughts if they are not comfortable participating in an interview. The interviews were video recorded with the participants consent in order to support data analysis. Participants for this study included interpreters who have worked in support group settings in the past five years as well as deaf consumers who have been involved in support groups with the use of an interpreter within the past five years. Including shared experiences from both the interpreter as well as the deaf consumer provided a well rounded analysis of the experiences both parties have as well as pinpoint differences that exist between the hearing consumer and deaf consumer's experience.

Participants were asked if they have been involved in support groups for mental health or addiction recovery including but not limited to support groups for grief, alcoholics anonymous, Self-Management and Recovery Training Recovery (SMART), anger management, specific mental health diagnosis, narcotics anonymous, and domestic violence survivors. The survey gathered information on the length of time that the consumers and interpreters were involved in their support groups. The participants were asked about their experience and what improvements they would like to see in regards to their interpreter experience. Deaf clients were asked what they felt was missing in their experience while interpreters were asked what challenges they face as well as what skills they feel are needed to effectively interpret (see Appendix A).

The goal of this study was to have fifty participants with a fairly even mix of interpreters and deaf consumers. Interpreters were not limited by their years of experience or certifications; however, they must have interpreted in a support group setting in the past five years. The survey was nationwide to include a variety of experiences. Recruitment of interpreting participants was initiated with an email sent out through the Registry of Interpreters for the Deaf for interpreters throughout the country. The survey will also be posted on Facebook groups such as Mental Health Interpreter Training (MHIT), Professional American Sign Language Interpreting and Community for the Deaf and Hard of Hearing. In order to reach the Deaf community, the survey was posted to mental health and deafness related support groups as well as sent to National Deaf Therapy. The survey was also sent to various listservs that included mental health professionals in order to be given to their community members. In alignment with grounded theory, each posting and email included a request for the survey to be forwarded to any individuals the participants may know that would be interested in participating in the study. Through snowballing, the survey was able to reach the maximum number of participants possible.

Barriers to recruitment of participants included lack of participant interest as well as possible hesitance for deaf consumers and interpreters to open up about their experiences.

Because of the sensitive nature of this research, consumers may not have been willing to participate at all or are less likely to have wanted to be interviewed about their experience with mental health treatment. Time constraints for this study posed an additional barrier to reaching a wider audience.

The questionnaires and interviews was analyzed using a qualitative and quantitative methodology since the experiences and quality of services are being analyzed through this research. Transcripts of the interviews were analyzed using grounded theory (Glaser and Strauss, 1965). Grounded theory includes a constant comparison that looks at the data by comparing the words and actions of the participants in order to recognize common responses and themes (Goulding, 2003).

Grounded theory has been used in research in health sciences, sociology and consumer research fields (Goulding,2003). This research overlaps with all of the areas listed, making grounded theory a suitable choice for analyzing the data collected. Using grounded theory, recurring themes were identified through the surveys and interviews. This was an inductive approach in order to not affect the study with preconceived assumptions of what those challenges and gaps may be. Grounded theory is a balance between using prior knowledge and finding new concepts that come from the data. This also ensures a consumer based approach that includes the community we serve in the research.

Since grounded theory states that the researcher should stay in the field until there is saturation of data or no new data emerges, the barriers mentioned above become more concerning with this methodology (Gouling, 2003). Time constraints for this research has been a concern since there should be a large data pool for grounded theory to be used and the limited time has provided a limited pool of participants (Goulding, 2003) . This study has put the participants' experiences at the forefront by entering into the study with no assumptions of the challenges or themes that will be identified. Using the constant comparison method, the

interviews were analyzed for common themes that were used to identify the challenges and gaps deaf consumers and interpreters face.

Data Analysis

The survey was disseminated to various listservs and facebook groups associated with mental health. After one month of data collection the survey returned a total of thirty four participants. Of these participants seven identified as consumers, either deaf or hard of hearing and the remaining twenty seven were hearing interpreters. Of the total number of participants, only four completed the interview process in its entirety, all of which were hearing interpreters.

Demographics of Consumers

Of the deaf participants in the survey, two were male, three were female, and one identified as nonbinary. The ages of participants ranged from 24-64. The deaf participants all identified themselves as white and one identified as hispanic as well as white. Most participants held a minimum of a bachelor's degree and one third of the deaf participants held masters degrees. Fifty percent of the deaf participants work full time. The others were self employed, homemakers or students. The majority of the consumers said they had attended support groups for two years or less. None of the respondents said they were currently attending in person support groups though six said they were currently attending online support groups potentially due to the current COVID-19 pandemic and one was not currently in support groups at all.

Analyzing Themes of the Consumers

The deaf consumers primarily attended substance use disorder related groups. These included Alcoholics Anonymous, Narcotics Anonymous, Self-Management and Recovery Training Recovery, and two respondents said they attended groups that were not listed in the survey. Six respondents said they had attended deaf support groups. All participants indicated they had either always been provided interpreters in their support groups or sometimes were provided with interpreters. When asked what skills they believe interpreters need in order to

successfully interpret support groups, a variety of answers were given (e.g., terminology, empathy, reference to turn-taking).

The participants identified a need for interpreters to be familiar with the program for which they are interpreting as well as knowledge of the specialized vocabulary for these settings such as acronyms, sponsor, recovery and specific substances. Since most respondents attended a substance abuse program that is known to have specialized vocabulary, these responses are to be expected. SMART Recovery, Narcotics Anonymous and Alcoholics Anonymous all contain vocabulary that is unique to the program such as Big Book, twelve steps, sponsor and recovery. Interpreters qualifications also came up in the responses with respondents saying the interpreters should be licensed, skilled, and have attended an interpreter training program. Two respondents indicated their willingness to be interviewed but neither completed the paperwork required before interviewing. Without the ability to interview these respondents it is hard to gauge the reasoning behind these responses and what benefits lie with qualifications besides the assumption of skill.

The deaf consumers responded with a longer list of challenges to attending support groups than they did for skills they would like to see in their interpreters. The main themes found in these answers were coordination issues and problems with communication. Coordination issues that were identified by the respondents included the need for a team of two interpreters when only one was provided, lack of funding for interpreters, scheduling issues, technology issues, inconsistency with interpreters and materials not being provided in a comprehensible manner. While many of these comments do relate to communication, these issues could be resolved with appropriate funding and advance preparation ensuring access will be provided. For communication challenges, deaf consumers pointed out that they struggled with interpreters' skills, lag time, turn taking in the group setting, and overall understanding of the communications that took place.

Hearing Interpreter Demographics

Of the hearing interpreters, twenty two were female and five were male. The ages of interpreters ranged from 24-74. The majority of the interpreters identified as white, although there was one participant who identified as black or African American, one participant identified as hispanic, one identified as American Indian or Alasskan Native, and one who identified as other. There was a range of educational backgrounds identified but most held a minimum of a bachelor's degree. The majority are employed full time, but several work part time or are self-employed. No other types of employment were identified. Of the twenty seven interpreters only five are currently interpreting support groups online and the rest are not currently interpreting support groups of any kind which may be due to the reduced number of support groups being offered during the COVID-19 pandemic. The types of support groups that the interpreters had interpreted varied widely from substance abuse programs to mood and personality disorder support groups (see Figure 1). There was a greater range in types of support groups interpreted in comparison to the deaf respondents.

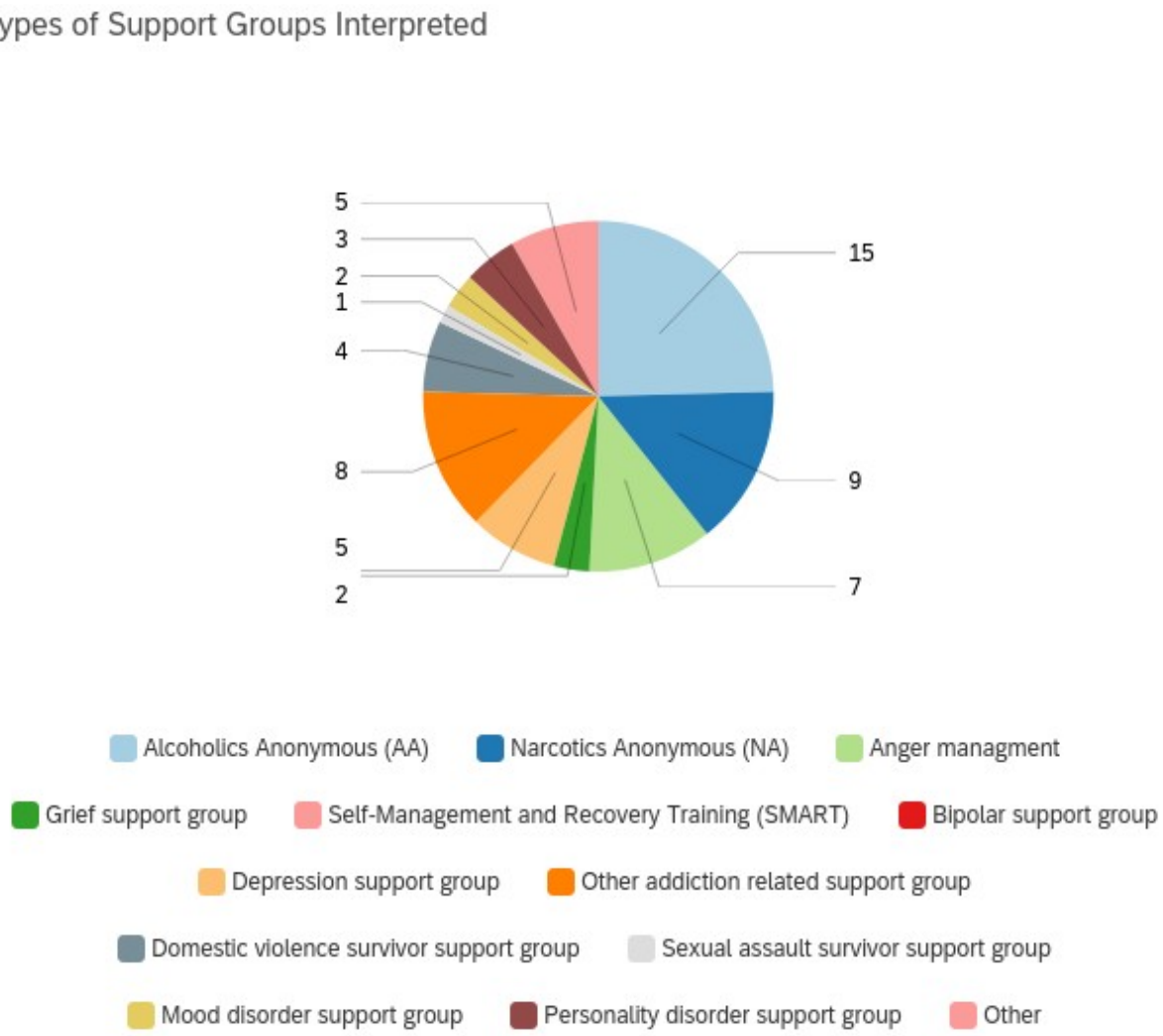

Figure 1

Four of the hearing interpreters completed the interview process and identified as female, white and had at least an Associates degree. One interpreter also identified as American Indian or Alaskan Native. Their ages ranged from 25-64 and were located in various states throughout the United States.

Analyzing themes from Interpreters

There were three identifiable themes that carried through the survey. The participants were asked what skills they felt interpreters needed to interpret in support groups, what challenges they faced and what advice they would give to other interpreters interpreting in these settings. The three

most common themes throughout all three questions were empathy, possessing knowledge of the type of support group, and self care.

Empathy

Four respondents identified a form of empathy or compassion as a needed skill for interpreting support groups. The need for being unbiased and nonjudgmental was also mentioned. While empathy was identified as a skill, there was also a stated need to have thick skin or to not show the emotions one feels while interpreting. When asked what challenges they have faced in support groups, respondents said that they struggled with understanding the behaviors in the group, the emotionally charged content, and with vicarious trauma. Two of the interpreters interviewed mentioned the emotions that are involved in interpreting these settings. While talking about how to deal with these challenges one interpreter mentioned their struggle of "how to walk that fine line of reacting like a human and not detracting from the atmosphere of the group". Another interpreter suggested not internalizing. It was also mentioned that there was a lack of guidance on how to deal with these issues. While there are no set standards for how to handle the emotional content there were various respondents who mentioned debriefing as a form of emotional release.

Knowing the Support Group

The most common answer amongst participants for both skills needed and challenges faced in support groups, were related to knowledge of the content in a support group. Participants brought up the need for knowing terminology, slang, the group's culture, the group's expectations, reasoning for attending the support group, group procedures and frozen text used in the group. The challenges identified strongly lined up with the skill sets that were noted. Challenges that were identified were highly specialized vocabulary, use of frozen text, the use of slang and inside jokes, identifying the goals of the group, understanding the group's culture, and lack of knowledge on the subject matter.

During the interviews with the interpreters, three mentioned the need to learn specialized vocabulary for the settings they work in. Two interpreters also mentioned the need to be aware of vocabulary that can have multiple meanings and how misinterpretation can have serious consequences. For example, when signing alcohol, one interpreter noted that the client was adamant that they do not drink alcohol. It was later revealed that they do drink beer but associated the sign for alcohol exclusively with liquor. Another example that was brought up was what to sign for the word weapon since there are various meanings to weapon and the interpreter did not want to imply inaccurate information. Being aware of the sensitivity of drugs and weapons plays a role in how to choose signs and English words when interpreting. Three of the interviewees mention the Qualified Mental Health Interpreter Training that takes place in Alabama. They felt this training was beneficial to them for working in support group settings.

When asked what advice the interpreters would give to newer interpreters going into these settings, five of the seventeen participants said to attend the meeting in advance to gain understanding of the support group. Three participants responded that interpreters should talk to other seasoned interpreters in order to gain insight into the group. Knowledge of the support group itself is a huge part of the challenges and skills that were identified and lead to about half of the respondents recommending actions that would directly help interpreters familiarize themselves with the group.

Self Care

Issues with self care came up when asked about challenges and skills needed for interpreting in support groups settings. Overall themes from respondents showed a need to have personal boundaries and be aware of the emotional impact interpreting has on the interpreter. Several interpreters recommended having strong self care regimes, which were not specified, and debriefing with teams and facilitators after meetings. All four interviewees mentioned the

importance of debriefing and how it can act as a form of self care. When asked what advice they would give to other interpreters, four respondents mentioned self care and being self aware.

Comparing Interpreters and Consumer Responses

Both consumers and interpreters identified the need for familiarity with the specific support group in order to understand terminology used. Challenges that were identified by deaf consumers largely overlapped with those of the hearing interpreters. Lagtime and turn taking were identified by both groups as concerns but also as important skills.. The deaf consumers had more responses in relation to being provided access to materials and interpreters to begin with while interpreters responses reflected the challenges faced once on site. Interpreters tend not to be a part of the process in setting up interpreters for support group meetings and therefore may not recognize these challenges faced by their clients. One interpreter interviewed did mention the challenges in funding when it came to interpreting in AA settings. This interpreter mentioned how she has had to interpret meetings discussing the unwillingness of the organization to provide interpreters to their deaf members. Empathy and self care were themes noticed in the interpreter respondents that were not mentioned by the consumers. These skills were emphasized by both survey respondents and interpreters interviewed. It seems that not only are interpreters less aware of the challenges faced on the back end of receiving interpreters for clients, but clients are also unaware of the internal challenges that interpreters face.

Recommendations Moving Forward

This research showed a strong need for training on interpreting in support groups. There is a need for interpreters to be educated on specific issues and knowledge of specialized vocabulary used in these settings as well as a need for ongoing support for these interpreters. The taxing work of interpreting in mental health and addiction recovery settings requires self care and support of colleagues. The interpreters in this study pointed to the need for having avenues to debrief as well as maintain self care regimes.

Based on the consumer responses, organizations and interpreters should be aware of the lack of resources currently being provided to the deaf community in these settings. Allocation of funding for interpreters should be established for support groups as well as systems for consistency of interpreters provided. Organizations should also take steps to making their materials more readily available to clients.

Being that this topic has yet to be researched in the interpreting field, further research is needed to examine the needs of interpreters and deaf consumers. Hopefully this research will set the foundation for further research that can identify if deaf consumers receive the same benefits from support groups as their hearing peers. This research can also lead to curriculum development for interpreter training programs and workshops that focus on interpreting in support group settings.

Conclusion

The need for American Sign Language interpreters in support groups is supported by the research on benefits gained for both addiction recovery and its benefits on mental health (Repper and Carter, 2011). With the rate of substance abuse amongst individuals with disabilities being double that of those without a disability, there is a need for accessible addiction recovery and mental health support groups (Anderson, Chang & Kini 2018). Benefits from such support groups include but are not limited to, reduced rate in hospitalizations, reduced substance use, and a reduced use in emergency rooms (Davidson, Bellamy, Guy and Miller, 2012). In order to achieve these outcomes, deaf clients must have access to these services much like their hearing peers.

Barriers to accessing treatment programs range for each client but this study found that there are significant challenges that are unique to interpreting in support group settings. The need for knowledge of support group terminology and culture, self care regimes and understanding of the deaf consumers were the top skill sets recognized by this research. Deaf consumers also face

challenges with obtaining interpreters and the need for interpreters to be familiar with the group settings they are interpreting in. Consistency of services as well as training to provide interpreters skills needed for these unique settings has been identified as the best response moving forward.

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Appendix A

Demographics

What is your gender?

- ○ Male
- ○ Female
- ○ Non Binary
- ○ Other

What is your age?

- ○ Under 18
- ○ 18 - 24
- ○ 25 - 34
- ○ 35 - 44
- ○ 45 - 54
- ○ 55 - 64
- ○ 65 - 74
- ○ 75 - 84
- ○ 85 or older

Are you of Hispanic, Latino, or Spanish origin?

- ○ Yes
- ○ No

How would you describe yourself? Please select all that apply.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Pacific Islander
- ☐ Other

What is the highest degree or level of school you have completed?

- ○ Less than a high school diploma
- ○ High school degree or equivalent (e.g. GED)
- ○ Some college, no degree
- ○ Associate degree (e.g. AA, AS)
- ○ Bachelor's degree (e.g. BA, BS)
- ○ Master's degree (e.g. MA, MS, MEd)
- ○ Doctorate or professional degree (e.g. MD, DDS, PhD)

What is your current employment status?

- ○ Employed full time (40 or more hours per week)
- ○ Employed part time (up to 39 hours per week)
- ○ Unemployed and currently looking for work
- ○ Unemployed not currently looking for work
- ○ Student
- ○ Retired
- ○ Homemaker
- ○ Self-employed
- ○ Unable to work

What do you identify as (select all that apply)

- ☐ Deaf
- ☐ Hard of hearing
- ☐ Hearing
- ☐ Deaf interpreter
- ☐ Hearing interpreter
- ☐ Child of a Deaf Adult (CODA)
- ☐ Deaf-Blind

How long have you attended support groups?

- ○ Less than a year
- ○ 1-2 years
- ○ 3-5 years
- ○ 6-8 years
- ○ 9-10 years
- ○ Over ten years

Are you currently attending a support group?

- ○ Yes in person
- ○ Yes online
- ○ No I am not

When did you most recently attend a support group?

- ○ Less than a year ago
- ○ 1-2 years ago
- ○ 3-4 years ago
- ○ 5 years ago
- ○ Over five years ago

What type of support groups have you attended (select all that apply)

- ☐ Alcoholics Anonymous (AA)
- ☐ Narcotics Anonymous (NA)
- ☐ Anger managment
- ☐ Grief support group
- ☐ Self-Management and Recovery Training (SMART)
- ☐ Bipolar support group
- ☐ Depression support group
- ☐ Other addiction related support group
- ☐ Domestic violence survivor support group
- ☐ Sexual assault survivor support group
- ☐ Mood disorder support group

- [ ] Personality disorder support group
- [ ] Other

In what states have you attended support groups?

Have you ever participated in a deaf support group?

- ○ Yes
- ○ No

Did you have an interpreter in your support group?

- ○ Yes
- ○ Sometimes
- ○ No

What skills do you think an interpreter needs to have in order to do their job effectively?

What challenges did you face while attending support groups in relation to being deaf/hard of hearing/ using interpreters?

What challenges did you face while attending support groups in relation to being deaf/hard of hearing/ using interpreters?

What state do you interpret in?

How long have you Interpreted in support groups?

- ○ Less than a year

- ○ 1-2 years
- ○ 3-5 years
- ○ 6-8 years
- ○ 9-10 years
- ○ Over ten years

Are you currently interpreting a support group?

- ○ Yes in person
- ○ Yes online
- ○ No I am not

When did you most recently attend a support group?

- ○ Less than a year ago
- ○ 1-2 years ago
- ○ 3-4 years ago
- ○ 5 years ago
- ○ Over five years ago

What type of support groups have you interpreted (select all that apply)

- ☐ Alcoholics Anonymous (AA)
- ☐ Narcotics Anonymous (NA)
- ☐ Anger managment
- ☐ Grief support group
- ☐ Self-Management and Recovery Training (SMART)
- ☐ Bipolar support group
- ☐ Depression support group
- ☐ Other addiction related support group
- ☐ Domestic violence survivor support group
- ☐ Sexual assault survivor support group
- ☐ Mood disorder support group
- ☐ Personality disorder support group

☐ Other

What skills do you think are important for an interpreter to possess in order to effectively interpret in these settings?

What were some challenges you faced while interpreting in these settings?

What advice would you give to an interpreter going to work in a support group setting for the first time?

Would you be willing to participate in a one hour video interview about your experiences?

○ Yes
○ No

Please enter the email address that you would like to be contacted at

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