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The Presence of Coping Education in American Sign Language Interpreter Education Programs as Perceived by Graduates

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By

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"Anything that's human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary. The people we trust with that important talk can help us know that we are not alone." – Fred Rogers

Abstract

This study investigated whether coping strategies were part of the curriculum in various American Sign Language interpreter education programs (ASL IEPs). The researcher conducted a national survey and ten interviews with participants to assess their current coping strategies, where they had been learned, and whether their IEPs had prepared them to cope with the possibility of secondary traumatic stress (STS) and vicarious trauma (VT). The researcher utilized literature regarding risks of STS and VT in several settings for interpreters to position the gap of literature regarding coping strategies interpreters use. This study focused on graduates of IEPs because IEPs provide an appropriate environment in which to learn coping strategies. The study has found that interpreters are not being prepared with the skills to cope with STS or VT, and that graduates' perceptions of the demand-control schema as a coping strategy do not align with its emphasis in interpreter education.

Keywords: secondary traumatic stress, STS, vicarious trauma, VT, demand-control schema, DCS, coping, coping education, coping strategies, coping mechanisms, interpreter, ASL interpreter, interpreter education, ASL interpreter education

Chapter 1: Introduction

Throughout the COVID-19 pandemic, numerous American Sign Language interpreter colleagues have been experiencing early signs of burnout. Of course, a pandemic can cause anyone in any field to experience symptoms of burnout, but for these interpreter colleagues of mine, it was more than just the pandemic that was causing it. As communication facilitators, American Sign Language (ASL) interpreters are exposed to intimate details of the lives of deaf and hard-of-hearing people. As the pandemic began and escalated, interpreters were privy to the nuances of what mask mandates and stay-at-home orders meant for the deaf community. Over and over, deaf people shared their stories of being refused service because the waitress wouldn't write, and masks made it impossible to lipread. There are stories of deaf people being denied their one guest at a doctor's appointment because the interpreter counted as their guest instead of a spouse or family member. Countless other examples of oppressive behavior occurred as the pandemic heightened, and ASL interpreters not only observed it, but sometimes interpreted it. Interpreters were responsible for communicating the changes and challenges – that a spouse had to wait in the car or that they had misunderstood instructions because someone wearing a mask refused to communicate in an accessible way. It was and still is traumatic for deaf consumers, but it was traumatic for the interpreter(s) too.

The increase in instances of traumatic or oppressive interpreting scenarios was a recipe for exhaustion. Coworkers and friends in the field were all tired, miserable, and completely burnt out. Their burnout made the researcher wonder what they could do to support their colleagues through these feelings. When starting to research coping strategies and ways to repair burnout casually, the researcher noticed that, to date, there was no research about what coping strategies ASL interpreters were using. The more research reviewed, the more noticeable the gap in

literature regarding what tools interpreter education programs (IEPs) provided their graduates with for coping. There was an abundance of research regarding the risks of secondary and vicarious trauma, especially related to mental health and legal interpreting, but nothing discussed how ASL interpreters were managing feelings in relation to experiencing trauma. It was then that the researcher decided to fill in that gap with this research.

Because the COVID-19 pandemic is an anomaly from the average career of an ASL interpreter and is still ongoing, the author elected to research more broadly whether IEPs included content about coping strategies in their curriculums. While the motivation for this research was born from the COVID-19 pandemic, there will be no further discussion of it in this publication, and none of the survey or interview questions are related to the pandemic. The COVID-19 pandemic caused an uptick in ASL interpreter burnout; however, it is not the sole cause of ASL interpreter burnout. Burnout frequently occurs due to secondary or vicarious trauma experienced by the ASL interpreter. To prevent or reduce burnout in the field, it is crucial to mitigate secondary or vicarious trauma of ASL interpreters, so they do not reach a point of burning out. At the conclusion of this publication, recommendations will be provided for IEPs regarding coping education based on the findings.

Secondary and Vicarious Trauma

ASL interpreters are exposed to intimate details of the lives of the people they serve, including the deaf or hard of hearing consumer and the hearing consumer. Sometimes, those details include experiences and retellings of trauma or oppression. When the ASL interpreter is responsible for communicating stories of trauma or must interpret an act of oppression, typically in first-person language, they may begin feeling as though they experienced the trauma(s) or oppression themselves. Feeling as though they experienced the trauma or oppression can cause

the ASL interpreter to become distressed and impact their ability to successfully complete job tasks due to distraction. To combat distress and allow ASL interpreters to remain successful while avoiding secondary trauma, they should utilize coping strategies. This study aims to investigate the perceived presence of education related to coping strategies, coping skills, and secondary traumatic stress and vicarious trauma during interpreter education programs through three research questions. The researcher aims to answer: 1) what percentage of participants were informed of the possibility of secondary traumatic stress and in how much detail? 2) how are interpreters' experiences of secondary traumatic stress mitigated, lessened, or prevented by the coping mechanisms provided by their interpreter education programs? And finally, 3) what coping mechanisms are interpreter education program graduates currently using to prevent or mitigate secondary traumatic stress, and where did they learn them? The researcher has conducted a national survey and several interviews with graduates of ASL IEPs throughout the United States to investigate this phenomenon.

The Role of the Interpreter

According to the National Deaf Center on Postsecondary Outcomes (2019), ASL interpreters are responsible for facilitating communication "between a visual communicator and an auditory communicator" using a high level of fluency in multiple languages, satisfying the mutual needs of both communicators in an interaction (p. 2). An interpreter may use several modalities, including ASL interpreting, transliteration, tactile interpreting, oral transliteration, or cued speech transliteration. The ASL interpreter chooses a modality that matches the preferences and modality used by the visual communicator. Given the range of modalities an ASL interpreter can use, learning the language alone is not enough. ASL interpreters must also understand, manage, and utilize the competencies of at least one modality to be qualified. Sometimes hearing

children of deaf adults (CODAs) naturally learn these skills through interactions between their parent or guardian (a visual communicator) and the public, such as store clerks and office receptionists (usually auditory communicators). Not all interpreters are CODAs, meaning other interpreters likely learned ASL as a second or additional language. IEPs provide a rich environment for non-heritage signers to learn the language and the interpreting theory or skills necessary to become successful interpreters. Heritage users of sign languages are referred to as heritage signers. Heritage signers have used sign language since birth or an early age, typically due to having a deaf family member. Non-heritage signers are non-native language learners of sign language and thus are more likely to attend an IEP to learn the language, culture, and theory necessary.

Deaf Community

Throughout this publication, there will be references to deaf people and the Deaf community. It is commonly accepted among the interpreting, IEP, and hearing loss communities that a capital D on Deaf refers to members of the Deaf culture (Padden and Humphries, 1988). To be a fully entrenched member of the Deaf culture, one must satisfy specific criteria, including having a degree of hearing loss, using ASL as a primary method of communication, viewing deafness not as a disability but as a benefit (referred to as Deaf gain (Bauman & Murray, 2014)), and having relationships with other members of Deaf culture. People who have a certain level of hearing loss but do not identify with the other facets of Deaf culture are referred to as deaf using a lowercase d. Depending on the degree of hearing loss, those who identify as hard of hearing may also satisfy the same criteria as the lowercase d deaf community. Because anyone can utilize the services of an interpreter (see the various modalities above), this study will be using lowercase d deaf throughout the paper. Using lowercase d deaf encompasses those people who

have a hearing loss that identify with Deaf culture, those that do not identify with Deaf culture, those who are hard of hearing, and those who rely primarily on assistive listening devices (such as hearing aids and cochlear implants) to hear instead of relying mainly on ASL. The phrase visual communicator will also be used to reference anyone who uses ASL, regardless of their cultural identity.

Auditory communicators, who not only speak but can hear to listen, will be referred to as hearing people or members of the hearing community. Please note that some deaf and hard-of-hearing people prefer to speak when communicating with other hearing people. Thus, auditory communicators and hearing people must satisfy both criteria (speaking and listening). The phrase nondeaf is not a commonly accepted term and therefore will not be used. Note that hearing people does not exclusively refer to those who speak English, as there are ASL interpreters who work between more than just English and ASL. Thus, the auditory communicator in an interaction may use another language, including but not limited to Spanish, French, Portuguese, Creoles, or Russian. As hearing people, hearing interpreters will never be fully assimilated into the Deaf culture due to a lack of hearing loss. The Deaf community is uniquely theirs, and hearing people, including interpreters and CODAs, may toe the line but not become fully immersed members.

Due to the differences between Deaf culture and the hearing world, interpreters must learn about the Deaf community and Deaf culture. Part of the role of a communication facilitator is cultural mediation between the two communicators. CODAs and heritage signers learn the cultural mores and values through their lived experience. Non-heritage language learners should be exposed to Deaf culture education during their IEPs.

Challenges of Learning the Language and Skills Simultaneously

Throughout the coursework, IEPs teach their students the language at the same time they are learning about interpreting skills. This presents a challenge, as it is difficult to practice interpreting theory and skills before becoming fully fluent in another language. IEPs can be found at several higher education institutions and can range in completion time from two-year programs resulting in an associate degree to four-year programs resulting in a bachelor's degree. It is accepted that becoming fully fluent in a language requires approximately 700 hours of practice (with an additional two years required for interpreter-level fluency) (Lapiak, n. d.). Considering that IEPs extend a maximum of four years and students are learning interpreting skills simultaneously, students' language development may suffer. The opposite may also be true: students' interpreting skills may suffer when focusing on language acquisition. However, interpreting theory, skills, and the language are not the only things IEPs need to include in their curriculum.

IEPs are also responsible for educating their students about ethical decision-making, the code of professional conduct, and about Deaf culture. Many IEPs utilize the Demand-Control Schema (DCS) when teaching their students about ethical decision-making. One aspect of the DCS is that interpreters, or during IEPs, students, determine what controls (mitigating factors) they have to resolve or prevent various demands (requirements) before, during, and after assignments. According to several interview participants, IEPs focus heavily on the before and after assignment controls, more so than the during assignment controls. To summarize, IEP curriculum must contain several concepts to create successful interpreters, but one aspect of interpreter education is lacking – during-assignment controls.

Chapter 2: Literature Review

American Sign Language interpreters are frequently exposed to a variety of settings in which a deaf consumer may be actively experiencing or relaying an experience of trauma. When deaf people are discussing their trauma, the interpreter is responsible for relaying the message, typically speaking in the first person. In some cases, witnessing a traumatic event, an experience or relaying the message regarding the trauma in first-person language causes interpreters to feel as though they experienced the trauma(s) themselves. When the interpreter begins to feel they have been distressed by their work situations, they may start to experience secondary traumatic stress, vicarious trauma, or compassion fatigue. Secondary traumatic stress (STS) is defined as "trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experiences, rather than from exposure directly to a traumatic event. Secondary trauma can occur…among all professionals who provide services to those who have experienced trauma" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. xviii). Vicarious trauma is an adverse change in one's perception of the self or self-worth that results from indirect exposure to the trauma of a client (Lai et al., 2015). Compassion fatigue is the projection of clients' trauma onto oneself in response to empathetic engagement and exposure to clients' trauma, causing symptoms such as distress, hopelessness, apathy, and withdrawal (Zafirah et al., 2020). These three terms are often used interchangeably, but the term secondary traumatic stress will be used to encompass them all for this research.

STS is frequently associated with mental and behavioral health clinicians, potentially leading to the belief that interpreters working in such settings are the most at risk. However, the experience of STS is not limited to mental health interpreting, as trauma can occur or be discussed in any setting, such as medical and educational environments. Trauma experienced

directly and indirectly has many impacts on one's mind and body. In many instances, a traumatized person will react initially and then recover quickly with adequate social and psychological support. However, if one does not have sufficient support, they may feel emotional dysregulation or numbing, sleep disturbances, intrusive thoughts or flashbacks, hallucinations or delusions, an inclination to self-harm, or gastrointestinal, dermatological, urological, or substance abuse disorders (SAMHSA, 2014).

Reasons for Current Review

Many researchers have investigated the impact of consumers' trauma on ASL interpreters in mental health settings (see Daly & Chovaz, 2020; Knodel, 2018; Zafirah et al., 2020). These investigations have not begun to explore other areas in which interpreters can be exposed to clients' trauma. In addition to a lack of exploration into different settings where ASL interpreters can be exposed to their clients' trauma, there is a dearth of discussion about the coping mechanisms ASL interpreters use to manage the exposure and the feelings induced as a result of the exposure. Knodel (2018) discussed how ASL interpreters cope focusing exclusively on mental health interpreters, thus limiting the discussion of coping to a single subfield of interpreting. Because there has been little to no research on this topic thus far, it is impossible to know whether ASL interpreters are successfully coping with trauma exposure in other environments and what tools they are using to address this challenge.

To continuously meet the deaf consumers' needs most effectively, ASL interpreters should be aware of their risk for STS. They should develop techniques to cope with STS feelings before accepting assignments in case they arise. This study will investigate whether ASL interpreters have the means to cope, how they obtained them, what they are, and if they can recall the means to cope when needed. Thus, this study aims to gauge the preparedness of

interpreter education program (IEP) graduates to address STS resulting from interpreting work and assess their preparedness to address STS using coping strategies taught during IEPs, if any.

Variety of Environments in Which STS Can Occur

There are various environments in which an interpreter can be indirectly exposed to the traumatic experiences of deaf people. The most common perception is that ASL interpreters working in mental health settings have a higher risk of STS because they are more likely to interpret stories of trauma (Knodel, 2018). The risk increases when the interpreter works with children in mental health settings (Zafirah et al., 2020) as many interpreters feel a higher degree of empathy for children than they do for adults. STS may also occur when an interpreter relays a deaf person's negative self-talk or descriptions of their emotional state due to the use of first-person language such as "I" and "me." Take an interpreter who has an alcohol or substance abuse disorder as an example. If this interpreter accepts an assignment that involves interpreting a deaf person's experience with the same condition, the risk of STS is higher due to triggers associated with their own experiences. If the deaf person's substance use problem is due to childhood trauma and the interpreter suffered the same condition for the same reason, that increases the risk for STS. Mental health settings are not the only setting with increased risk of STS for ASL interpreters. One possible cause of STS is witnessing oppressive behavior or acts of violence against a deaf person, which can happen in any setting at any time. Deaf people are a marginalized community; therefore, these acts of oppression or violence are unfortunately common. The use of a language other than English and their collectivist values are factors that set deaf individuals apart which can lead to their marginalization. To illustrate a situation where a deaf person experiences oppression or acts of violence, the interpreter working with a deaf student in a mainstream-educational environment witnesses firsthand when a teacher declines to

provide captions for a video in which spoken English is being used, or requests that the deaf person speaks instead of signing to the interpreter. In such cases, these are traumatic experiences for the deaf person, and as a result, the interpreter may suffer STS. Additionally, mental health influences all aspects of one's life, which can create tense or traumatic situations when the deaf person is triggered in the presence of the interpreter. ASL interpreters are acutely aware of the nuances of the deaf world, meaning they feel strong empathy when they see someone oppress a deaf person due to their perceptions of the ethics and boundaries in the Deaf culture. When humans feel too much empathy, we may experience emotional contagion (Moody, 2021), leading to STS.

Definitions

Secondary Traumatic Stress

Recalling the definition of STS from above (SAMHSA, 2014), it is also important to note additional definitions used in the literature reviewed. Thompson et al.'s (2014) research regarding predictors for mental health clinicians to experience STS led Daly and Chovaz (2020) to define STS as "the prolonged anxiety experienced by an individual witnessing or listening to trauma experienced by others" (p. 354). When examining both definitions, it is clear that the stress reactions and symptoms discussed by SAMHSA (2014) may present in the form of anxiety (Daly & Chovaz, 2020). Anxiety is expressed in several ways, including racing heartbeat, irritability, restlessness, edginess, fatigue, muscle tension, and difficulty sleeping or concentrating (The National Institute on Mental Health, 2018). From Cordes and Dougherty (1993) and Maslach and Jackson (1981), Darroch and Dempsey (2016, pp. 167-168) conclude that further symptoms or stress reactions that may occur as a result of STS, include "emotional exhaustion, cynicism, diminished perceived personal accomplishment, and depersonalization;" to

complement Pearlman and Saakvitne's (1995) "disturbance of the individual's cognitive frame of reference/identity, as well as their psychological needs, beliefs about self, internal imagery, and interpersonal relationships." When all these symptoms are considered in the context of working as an interpreter, they may be disruptive and intrusive to the work environment as the interpreter struggles to remain focused on the task at hand, doubts themselves, or struggles to establish interpersonal relationships with clients. For example, when a connection cannot be established with a client, the interpretation will suffer because there will be a lack of trust. When an assignment lacks trust, there is an increase in mistakes in the interpretation, negatively influencing the outcome of the interpreted event. Similarly, if the interpreter cannot maintain their focus, they may miss vital information, and if they doubt themselves, the interpreted message may not have the same emotional impact as the source message due to hedging or miscues.

Coping Strategies

Assuming that interpreters will not be exposed to or experience trauma, including STS, during their careers creates a gap in the education of interpreters about coping. Comparatively, throughout literature, authors investigating the coping skills used by interpreters have noted that prior to beginning their professional careers, mental health practitioners are trained to prepare them for any consequences they may experience as a result of their profession (Daly & Chovaz, 2020, Knodel, 2018). Training includes teaching coping skills that can be used to mitigate or prevent negative consequences of the work. The American Psychological Association (n.d.) defines coping strategies as "an action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation or in modifying one's reaction to such a situation…typically involve[ing] a conscious and direct approach to problems" (para. 1). Coping strategies have been

proven to aid in the prevention and management of STS and other mental health issues, which lends them to being beneficial for ASL interpreters as well. In fact, when ASL interpreters do not have coping strategies as a means of mitigation, they are "'at increased risk for developing symptoms of emotional exhaustion'" (Schwenke, 2012, p. 49; as cited by Knodel, 2018, pp. 7-8). Like anxiety, emotional exhaustion may look like changes in mood, irritability, difficulty sleeping or concentrating, forgetfulness, racing heartbeat, or changes in appetite. Emotional exhaustion, however, may increase pessimism or cynicism, a lack of motivation, headaches, weight changes, and impacts on work such as increased absences, missed deadlines, and lack of enthusiasm or commitment to the organization (Leonard, 2018).

Demand-Control Schema

The demand-control schema (DCS) is described as "a job analysis method useful in studies of occupational stress and reduction of stress-related illness, injury, and burnout" (Dean & Pollard, 2001, p. 1). Karasek and Theorell (1990) initially described the demand-control schema. Dean and Pollard (2001) applied it to the work of ASL interpreters. Daly and Chovaz (2020) use the demand-control schema to describe the process that ASL interpreters may go through when faced with traumatic interpreting assignments, witnessing the oppression of deaf people, or becoming overwhelmed with the requirements of an assignment. The DCS utilizes the concepts of "demands" and "controls" to describe influences on an interaction such as lighting, location temperature, jargon, relationships with others involved, and mental distractions, and things that mitigate those influences such as layering clothing, looking terminology up in advance, or meditating to clear the mind. In the context of the DCS with sign language interpreters, demands are job requirements that influence the interpreter, such as the job environment and the precise task needing to be performed. There are four categories of demands

for interpreters: environmental, paralinguistic, interpersonal, and intrapersonal demands (Dean and Pollard, 2013). Environmental demands are things influencing an interpreted interaction that are part of the surroundings or the specific interpreting context, including scents in the room, distracting background noise, the location of the assignment, jargon, sign choice, and grammatical structure used. Paralinguistic demands are influences that change an interpreter's approach to an interpreted event such as the positioning of the signer, positioning of the speaker, issues with amplification, and accents (signed or verbal). Interpersonal demands come from relationships between the interlocutors in an interpreted event (both deaf and hearing). These relationships include that between the interpreter and consumers, and that between consumers such as boss to employee, teacher to student, and other power structures. Relationships may include hostility, trust issues, or weak boundaries. Intrapersonal demands come from within the interpreter, including hunger, headaches, or distractions that carry over from home life.

Control, then, is used to describe the degree of power an interpreter has in accommodating the demands. Controls can include decision-making skills, resources for various job tasks, and changes to the environment of the assignment (Dean & Pollard, 2001). The assessment of a job's demands and controls creates a framework frequently used in IEPs to discuss which assignments an emerging interpreter should or should not accept. The DCS is also used to evaluate ethical scenarios in IEPs, a heavy focus in the curriculum due to their inclusion on the certification examination. While the primary job task for interpreting is facilitating communication between parties who do not use the same language, the approach an interpreter uses may change based on an assignment's environmental and linguistic demands, thus requiring the interpreter to access multiple controls.

The Importance of Coping

Coping using the Demand-Control Schema

One of the pillars of the demand-control schema (DCS) is that not all assignments that have high levels of demands are inherently stressful or negative; instead, the stressfulness of an appointment with high demands is determined by the controls available to the person experiencing demands – in this case, the interpreter (Karosek & Theorell, 1990). There are many assignments that an interpreter could perceive as having high levels of demands without knowing the details, such as court interpreting, medical interpreting in the emergency room or oncology unit, and interpreting for the signing of legal documents such as wills and power of attorney forms. How stressful they are is determined by the interpreter's controls. If, for example an interpreter has considerable experience with the terminology used in court, wills, or power of attorney forms, they have more linguistic controls making the assignment less stressful than it would be for an interpreter unfamiliar with that terminology. The interpreter's experience with the jargon provides them with more controls, reducing the stress of the environment.

ASL interpreters are often taught controls for environmental and linguistic demands simultaneously while learning the language, culture, and processes associated with being a sign language interpreter. Some interpersonal controls are introduced when learning about the cultural differences and barriers that may require mediation during the interpreting process. However, intrapersonal controls are often something ASL interpreters learn on their own, as they are difficult to naturally incorporate into the language learning, cultural exposure, or processes of interpreter education. Intrapersonal controls such as eating before an assignment, having headache medicine on hand, or compartmentalizing, would be relied upon most in the prevention and mitigation of STS, as they are the controls intended to manage the demands occurring inside the interpreter's mind or body. Intrapersonal demands appear frequently enough to be included in

the DCS framework related to ASL interpreters, which means that their subsequent controls are also critical to the development of interpreters. Given that the American Psychological Association (n.d.) includes thought processes as a reaction to stressful situations in their definition of coping strategy, it follows that coping strategies can be intrapersonal controls.

Self-Care

If a lack of coping strategies can increase one's risk of emotional exhaustion (a symptom of STS; Darroch & Dempsey, 2016), then coping skills are paramount in preventing and managing STS. The definition of coping strategies from the American Psychological Association lends itself to Owens-King's (2019) definition of self-care, "behaviors and activities that may guard against…STS" (p. 40). The author emphasizes that some self-care activities can worsen the effects of STS, such as taking time alone to meditate or reflect, which becomes a time of ruminating on the traumatic content. For the current study's focus, self-care activities that may help prevent STS will be discussed. According to Crezee et al. (2015), "an interpreter who is aware of potential stressors has already taken a step toward needed self-care" (p. 75).

According to research conducted by Owens-King (2019), mental health professionals who regularly participate in self-care are more likely to be satisfied with their job and thus are less likely to experience STS. They suggest that, based on chronic stress theory, several factors may contribute to the stress that causes STS. These factors increasing stress include one's workplace environment and duties, the magnitude of work with traumatized populations, and job satisfaction, while self-care is one method of remedying those contributors. Crezee et al. (2015) describes various techniques of self-care that can be used as coping strategies for ASL interpreters. These include time and workload management, rest, healthy diet, exercise, mindfulness, and meditation, interpreting in the third person instead of using first-person

language, and counseling or debriefing. These self-care techniques are proven useful based on the literature synthesized by Crezee et al. (2015); however, the methods require practice and education to use them for maximum benefit. One recommendation is for interpreter educators to introduce self-care coping strategies to students throughout their IEPs. "Educators should emphasize the importance of engaging in preventative self-care…Students must be guided to make use of their own support systems and provisions" (Crezee et al., 2015, pp. 79-80). Some institutions are taking steps to become trauma-informed organizations, indicating that awareness of risks for STS and coping skills is an essential aspect of managing and preventing STS.

Organizational Aids

Sprang, Lei, and Bush (2021) investigated institutional awareness of STS's effects on employees' experiences of STS. They noted a heavy focus on individual steps or actions to reduce STS symptoms and stressors, though a gap regarding how an organization may be worsening or aiding in that symptom and stress escalation instead of how an organization could support its employees. Sprang et al. (2021) identified that institutions operating as trauma-informed organizations tend to have fewer employees experiencing STS or burnout. They completed research that involved training selected members of the organization in trauma-informed practices, which the members then returned to their companies and implemented. These organizations' STS levels were reassessed after a few weeks of implementation. The authors learned that the practices implemented reduce employee burnout and STS. Drawing upon the conclusion that the more trauma-informed an organization is, the less STS and burnout their employees will experience (Sprang et al., 2021). The trauma-informed practice approach can be applied to the interpreting field as well.

When students attend IEPs, they anticipate learning everything necessary to be prepared for a professional career. If we were to apply the same trauma-informed practice approach to IEPs, they may provide the means to aid graduates in preventing STS. The trauma-informed approach could be applied not only to IEPs but also to national organizations supporting interpreter education such as the Conference of Interpreter Trainers (CIT), the Registry of Interpreters for the Deaf (RID), the National Association of Black Interpreters (NAOBI), Mano a Mano (a trilingual interpreter association), and the Commission on Collegiate Interpreter Education (CCIE).

Commission on Collegiate Interpreter Education (CCIE)

The Commission on Collegiate Interpreter Education (CCIE) is a board made up of deaf people, interpreter educators, interpreter researchers, professional associations, and IEP administrators who work together to elevate and advance the field of interpreters by standardizing the education programs. As a group, they collect and review applications from college IEPs, conduct site visits, and determine if the IEP satisfies the required standards. The board is also responsible for determining and maintaining the criteria for the curriculum and operations of IEPs wishing to obtain accreditation. They determine several standards that institutions must meet before being awarded accreditation. These standards include (1) program quality: missions, goals, philosophy, and governance, (2) institutional commitment and resources, (3) providing students with current, accurate information and academic advisement, (4) qualified and culturally appropriate faculty members, (5) program quality: curriculum and teaching-learning practices, (6) curriculum: knowledge competencies, (7) curriculum: skills competencies, (8) curriculum: interpreting field experience, (9) assessment of outcomes, assessments, and evaluation, and (10) a commitment to improvement, planning, and

sustainability (CCIE, 2019). In standards number five through eight, CCIE outlines the elements that IEP curricula must include to achieve accreditation.

Currently, the standards outline elements such as ASL and English proficiency, interpretation and translation theory, a specific number of hours of field experience – observing, discussing, and actively interpreting, and lessons regarding cultural competence and diversity that must be included in the curriculum. To date, these standards have not mentioned STS, vicarious trauma, burnout, stress, coping, or emotion regulation as aspects of the curriculum. The gaps in CCIE's standards indicate a lack of trauma-informed practice, which may inadvertently harm the graduates of accredited programs

Current Lack of Research

Limited Study of Sign Language Interpreters

In collecting literature to review in support of this research study, there was a limited amount of published writing on coping strategies for ASL interpreters. The research includes interpreters' experiences of STS. Studies (Lai & Costello, 2021; Lai et al., 2015) do not discuss in any depth what coping skills ASL interpreters utilize when experiencing STS. The flagship study of STS in ASL interpreters is also outdated, discussing the risks of over-empathizing with the deaf consumer (Harvey, 2003). The few articles that graze coping skills for interpreters focus on spoken language interpreters or mental health clinicians (Bercier & Maynard, 2015; Mehus & Becher, 2016) or a specific subfield of sign language interpreting (Harvey, 2003; Bontempo & Malcolm, 2012; Knodel, 2018; Daly & Chovaz, 2020; Zafirah et al., 2020). The aforementioned article discusses spoken language interpreters who work with populations seeking refuge or asylum in a non-native country. Articles written about sign language interpreters (Bontempo &

Malcolm, 2012; Knodel, 2018; Daly & Chovaz, 2020; Zafirah et al., 2020) focus on subfields of interpreting including mental health, physical health, educational, or settings working with children among others.

To illustrate the focus on subfields of interpreting research, take Knodel (2018) and Zafirah et al. (2020), who discuss coping mechanisms used by ASL interpreters in the mental health setting. Knodel's (2018) work focuses strictly on the coping strategies used by ASL interpreters when working with adults in the mental health environment. Zafirah et al. (2020) focus on the experiences of ASL interpreters working with children in mental health settings who are experiencing STS as a result of that work. They broach coping mechanisms used by ASL interpreters in that environment that may be unique to working with children, but it is not a focus of the study. Bontempo and Malcolm (2012) focus on preventing STS for ASL interpreters working in healthcare settings and describe several coping mechanisms, a few of which are specific to healthcare interpreting work. Mehus and Becher (2016) studied the impact of STS on spoken language interpreters but failed to mention coping strategies used by these interpreters. Most research discussing coping with STS or any of its related concepts (vicarious trauma, compassion fatigue, burnout) focuses on the field of mental health professionals leaving a gap in research regarding the phenomenon in other areas.

Bercier and Maynard (2015) investigated the interventions – which, based on the examples provided, also qualify as coping strategies – used by mental health professionals to prevent STS into individual and organizational interventions. Their listed interventions included therapy, debriefing, supervision, workshops, supportive organizational culture, and programs or services designed explicitly for STS. Likewise, Crezee et al. (2015) and Knodel (2018) mention counseling, debriefing, and supervision as possible self-care strategies for ASL interpreters to

use. Sprang et al. (2021) discuss the importance of organizational culture in trauma-informed organizations. Darroch and Dempsey (2016) discuss further education as essential tools for ASL interpreters, such as workshops and niche training programs.

Coping in Interpreter Education

While publications such as Darroch and Dempsey (2016), Knodel (2018), Crezee et al. (2015) and Bercier and Maynard (2015) list some coping strategies, there is a noted a scarcity of research regarding the inclusion of coping curriculum in interpreter education, specifically in IEP programs. Furthermore, the literature returns to the example of mental health professionals who have received training to combat STS as part of their education, a requirement of the accreditation body for counseling and related programs. Daly and Chovaz (2020) note, "past research on STS has largely overlooked its effects on SLIs [sign language interpreters]" (p. 354). Additionally, there seems to be a lack of awareness and education in IEPs. In their study, Knodel (2018) found that

> several participants noted that the topic of vicarious trauma was touched upon in their interpreter education courses, but, as one participant phrased it, "It was not extensive as it should have been." This is consistent with the literature regarding a lack of in-depth training related to self-care for interpreters (p. 17)

As evidenced by these studies and analyses, there is currently minimal research regarding coping skills within the education of ASL interpreters. There is also a trend that coping skills in interpreting have thus far been referred to as self-care in the literature, a misleading term, which may prevent a complete understanding of the depth of the issue. Several publications (Daly & Chovaz, 2020; Darroch & Dempsey, 2016; Knodel, 2018; Mehus & Becher, 2016; Zafirah et al., 2020) also mention Dean and Pollard's (2001) demand-control schema as a form of coping strategy but fail to expand on other coping mechanisms that can be used as controls in the

demand-control schema. This study aims to draw conclusions that can best advise recommendations for additions to the curriculum of IEPs referencing STS and coping strategies.

Need for Reports of Coping Education

Crezee et al. (2015) notes that "the field lacks – but needs – reports of actual self-care programs in interpreter education" (p. 77). Based on the literature reviewed, this sentiment can be taken further to show that reports of coping education programs, not just self-care programs, in interpreter education are needed. IEPs are a pipeline into the interpreting field, as many hearing ASL interpreters are not heritage language users and thus likely attend IEPs, offering an environment to learn coping strategies for the mitigation or prevention of STS.

The National Registry of Interpreters for the Deaf (RID) is the organization in charge of the only national certification available for ASL interpreters, indicating it has the largest membership of ASL interpreters in the country. Of the 10,557 hearing interpreter members, only 1,361 identified themselves as having deaf parent(s) (RID, 2019). While RID does not provide data on the number of ASL interpreters who have deaf siblings or other family members that are not parents, it can still be inferred that most hearing ASL interpreters are second language learners. Thus, the role IEPs have is increasing, making graduates of that environment appropriate candidates to evaluate coping education in IEPs.

It is important to note, based on the searches for literature included here, there is limited data regarding the education of diverse interpreter populations concerning education about coping and STS. Global majority populations such as Black, Indigenous, and People of Color (BIPOC) communities are understudied in this context in America. There is a correlation between racial minorities and higher rates of STS, as a history of personal trauma increases one's

risk of STS (SAMHSA, 2014). Global majority populations in America often have traumatic experiences of their own, increasing their risk of developing STS due to witnessing or retelling a deaf consumer's trauma.

Conclusion

STS presents a valid and genuine risk to ASL interpreters, regardless of the environments in which they work. In most interpreting settings, the risk for STS has not been investigated to its full breadth. The limitations of the current literature on STS in ASL interpreters have potentially influenced the perceptions of the severity of STS in ASL interpreters. The misconceptions associated with STS and ASL interpreters have led to a dearth of research on the coping skills ASL interpreters are taught during their formalized interpreter education. This study aims to investigate the presence of coping education in interpreter education as perceived by graduates of IEPs to provide insight to fill the gap created by the current literature and identify the coping skills that IEP graduates may have learned and their perceptions of those skills. As the literature has described, these skills may include the DCS and self-care. Finally, the data collected will advise recommendations for IEPs regarding coping education and its inclusion in the curriculum.

Chapter 3: Methodology

This research study was conducted using a mixed methods approach that included both a survey and a series of interviews. The survey (appendix A) contained both open and closed ended questions that asked for measured responses and personal experience or opinion responses. The interviews consisted of a Zoom video meeting during which the interviewees were asked twelve questions. Some interviewees were not asked all twelve questions as their previous responses dictated whether they were asked some questions. The mixed methods approach was used due to the phenomenological nature of the subject of the study. It was important to collect a combination of statistical data and empirical data to identify patterns and themes derived from a variety of experiences.

Participants

Participants consisted of currently working ASL interpreters in the United States who had graduated from an IEP between 2017 and 2021 – five graduating classes from the year of this publication. The limit of five years served to increase the likelihood of participants recalling accurately the coping education received during their IEPs. The requirement that they be currently working as an ASL interpreter served to standardize, to the extent possible, participants' work experience. All participants were required to be eighteen years of age or older. The study was not limited to participants who have completed bachelor's degree programs and thus included a mix of associate degree holders, bachelor's degree holders, and even some master's degree holders. Recruitment was conducted online nationally in the United States. Participants were required to be working as an ASL interpreter but were not limited to a specific setting or modality, targeting a range of settings where participants work including K-12 education, post-secondary education, video relay service (VRS), medical, and community.

Eighty-one people began the survey and forty-eight completed all fifty-two questions. The survey respondents targeted were of various ages, gender identities, races, or ethnicities. Exactly ten people were interviewed. An additional six people responded as willing to be interviewed, but one was disqualified from the interview portion and the other five failed to respond to attempts for contact to schedule the interview. Due to the author's personal experience with the IEP at Bloomsburg University of Pennsylvania, they did not feel they could adequately report unbiased facts from interviews with other graduates of the same program. The lone participant to be disqualified from the interviews was a fellow Bloomsburg graduate. Of the interviewees, nine identified as female, using she/her pronouns, and one identified as male, using he/him pronouns. While the exact ages of interviewees were not collected, they all completed the survey and therefore are within the same range as the survey participants.

Recruitment

Participants were all recruited virtually. There are several Facebook groups for ASL interpreters that are used by many members of the profession. The researcher utilized these groups to recruit participants. The national Registry of Interpreters for the Deaf (RID) also emails their members a monthly newsletter of which the author applied to be featured in. A message (appendix B) in the *Discover Interpreting!, BLeGIT* Queer Member Section of RID Interpreters, Sign language Community of Maryland & DC, and Best Practices in Educational Interpreting* Facebook groups. These groups were chosen for their broad range of connections and the exposure to a national network as well as a more local to the author network. There is a high concentration of interpreters in Washington D.C. due to the large deaf community there because of Gallaudet University. The postings were each accompanied by an image (appendix C). Recruitment materials were posted to each Facebook group three times over the course of six

weeks from January 9th, 2022, to February 21st, 2022. Given that the recruitment material was posted on Facebook, it is possible that the survey link was shared beyond the scope of the above listed groups.

Participants for the interviews were recruited directly from those who completed the survey. The last question of the survey asked if the taker was willing to participate in the interview portion. If the respondent selected yes, they were rerouted from the end of the anonymous survey to a separate survey asking for personal contact information to set up an interview. The personal contact information form contained three questions (shown in appendix A): what is your name and your pronouns, what is your contact information (with subpoints for phone number, email address, and whether it was acceptable to text them), and which exact IEP did you attend? This information was requested to accurately refer to participants in future communications using correct pronouns and to contact them using more than one method if necessary. The author did not intend to text any interviewee unless absolutely necessary which only occurred once.

Questions were asked as to what IEP each potential interviewee attended to eliminate potential participants who attended the same IEP that the author graduated from. When planning and preparing this research, the author did not feel as though they could analyze data from a fellow graduate of the same program without bias. In the survey it did not apply because the survey was anonymous and did not ask questions that alluded to the precise school a respondent attended. In the interviews it was more likely that the interviewee would mention their specific school, so the author needed to separate themself from the data by not interviewing anyone that also graduated from Bloomsburg. The author applied to be featured in the newsletter from RID

in January 2022, but to date, the recruitment material was not chosen to appear in their publication materials. The survey was closed in the last week of February to begin data analysis.

Survey Development

The survey (appendix A) contained a total of fifty-two questions and contained both open and closed response type questions. Question one was a notation that the participant had read, understood, and agreed to participate in the study. Questions two, three, and four related to demographic information such as age, gender identity, and ethnic identity. Questions five through eight gathered demographic information about the participants' IEP (where it was located, how many years of coursework) and completed the eligibility requirements, verifying participants completed an IEP and had graduated no more than five years prior to 2022. Questions nine through twenty-one delved into the participants experience with secondary traumatic stress, vicarious trauma, and coping skills in their IEPs. The questions aimed to gather data related to the frequency with which coping skills were discussed, whether their IEP had discussed the demand-control schema as a coping strategy, whether participants understood the meaning of STS and VT, whether they were coping and if so, how, and finally what settings they worked in most frequently.

Questions twenty-two through thirty-two contained a selection of questions from the reflective coping scale, the instrumental support seeking scale, and the avoidance coping scale subsections of the Proactive Coping Inventory. These subsections of the Proactive Coping Inventory (PCI) were included because they covered aspects of coping that were not discussed in the Brief COPE Inventory (BCOPE) from the Science of Behavior Change which made up questions thirty-three through fifty-one of the survey. These coping skill inventories were included to measure the success interpreters were having in coping with negative feelings or

feelings of STS or VT that arose from their work. Both the PCI (Greenglass et al., 1999) and the BCOPEI (Carver, 1997) have been tested and validated by their creators and several other researchers, so the author felt comfortable using these assessments. Both the PCI and BCOPE are available open resources on the internet, thus allowing the author permission to utilize them in this research.

Question fifty-two of the survey asked whether respondents were willing to participate in the interview portion of the study. If a respondent selected yes, they were taken to a different survey to collect personal contact information. The personal contact information survey was separate so that responses to the first fifty-one questions of the survey would remain anonymous. Both surveys were distributed through Qualtrics XM experience management software.

Interview Procedure

Upon receiving notice that someone was willing to participate in the interview portion, the researcher sent an email explaining that they were the primary investigator of the study, asking if the respondent was still interested in participating, and if so, what availability of theirs matched the author's which was included in the message. If a message was sent and an undeliverable error message was received, a text message was sent to the person instead (if they said texting was acceptable). There was only one potential interviewee whose email address was mistyped and thus bounced back undelivered. For that one potential interviewee, a text was sent (as they had indicated was acceptable) and the corrected email address was obtained. The other potential participants either responded to the email or did not respond at all. If an email was sent, did not receive an undeliverable error message, but did not get a response, another email was not sent nor was a text. Delivered but unanswered emails were interpreted as respondents who were no longer interested. Once the interviewee and the researcher had confirmed a date and time for

the interview the researcher sent the interview informed consent document (appendix D) to be signed and returned at or before the interview. A Zoom meeting was then scheduled for each interviewee as well as an email containing the invitation scheduled to be sent the day before the interview.

The interviews were conducted via Zoom video conferencing platform. Most lasted approximately twenty minutes, with a few extending to thirty to forty minutes. No interview reached the anticipated length of one hour. The interviewees were asked twelve questions developed to answer the research questions (appendix E). Some of the questions were contingent upon the interviewee's previous responses, thus, not every interviewee was asked all twelve questions. The interviews were intended to expand upon the responses in the surveys and contained questions about the interviewees' experiences with learning coping strategies, using coping strategies, being exposed to trauma in the workplace, and what they wish had been done differently in their respective IEPs. Notes were made about each interview as well as a recording to refer to later for data analysis. Also noted were what settings each interviewee worked in most often to see what could be concluded from that coupled with their experiences of interpreting traumatic material.

Data Analysis

To analyze the survey data, the researcher utilized Qualtrics's internal data analysis tools and Microsoft Excel. In Qualtrics, graphics that represented the data were created, the automatic average calculator was used, and percentages were determined to represent portions of the survey pool's responses to closed-ended survey items. Any quantitative data that was contained in an open-ended response type question was downloaded to Microsoft Excel for ease of calculations. This included averaging the ages of participants, the year they graduated, and how many years of

coursework their IEPs required. For open-ended qualitative survey items, the responses were exported to a Qualtrics Report in Microsoft Word, where the researcher was able to order the responses A-Z. This allowed the researcher to see common themes among responses that started with the same letter or mentioned the same words or phrases. To analyze the interview data, the author first needed to verify and edit the transcripts. While reviewing the transcripts, themes in the responses were identified. For further analysis the author printed the deidentified notes on each interview, highlighted and color-coded evidence of the themes on the sheet, cut each piece of evidence into its own slip and then gathered all the evidence for each theme from all the interviewees. Once all the evidence for each theme had been gathered, the researcher glued all of the slips onto a common sheet for easier reference along with notation of which participant made the comment(s) used as evidence.

Data Storage

All documents and data containing identifiable information relating to this study were stored in the online software Box Document Storage and were marked "locked" in that software. Locking the documents and data in Box allowed only the researcher to access the information contained. Each participant had a deidentified folder that contained their interview recording, transcript, notes, and informed consent documents. Box Document Storage was only accessed from the primary investigator's private, password protected, laptop computer in their home using their protected home wireless network. Any documentation (that was not printed) of the analysis of the data was also kept there. The key containing the names and locations detailing which participant was associated with which number was password encrypted and stored on the same private, password protected, personal laptop. All printed material used for interview data analysis was deidentified before being printed, thus there was no risk of identities being revealed.

There was no identifiable information contained in the anonymous survey data. The data was stored in Qualtrics until it was downloaded to Microsoft Excel or Word for analysis. Upon downloading the data to the Microsoft software, the researcher password protected the spreadsheet and documents so that they were only accessible to the researcher in an abundance of caution[1]. The personal contact information collected by the second survey was stored in Qualtrics as well, protected by their safety and security measures as well as the security measures of the Google Chrome browser the author used to access the Qualtrics site.

[1] It is an abundance of caution because the responses to the survey were already anonymous, thus there was no risk of identifiable information leaking, but the researcher opted to password protect the documents anyway.

Chapter 4: Results

This study produced results from two separate approaches to data collection. The survey results will be discussed first, followed by the results of the interviews with selected participants. The survey portion included questions from the Proactive Coping Inventory's Reflective Coping Scale, Instrumental Support Seeking Scale, and Avoidance Coping Scale (Greenglass et al., 1999), and Carver's (1997) Brief COPE Inventory (derived from the original Coping Orientation to Problems Experienced Inventory [COPE], Carver et al., 1989). The discussion will follow.

Survey

Eighty-three people began the survey, but only 75% met all participation requirements, and only 49 participants completed the entire survey (N=49). Of the 83 that started the survey, one is a transgender man, one is a transgender woman, five identified as non-binary, one identified as genderfluid, one identified as genderqueer, five are men, and 69 are women. These quantities reflect the field as the author knows it, with a majority being female and there being a few queer or male interpreters. Participants varied in ethnicity as well, including one African American (self-identified from Black, African, and African American options), two Latinx/Hispanic/Spanish, one Mexican American, one Puerto Rican, two American Indian or Alaskan Natives (specifically one Navajo), one Black and Caucasian mixed person, and 75 Caucasian people. For the age of participants, the youngest was 22, and the eldest was 69, with an average age of 28, though most of the upper age range could not completely participate because they graduated more than five years ago from 2022. All the participants lived in the United States. However, there was a high concentration of participants from the East Coast, likely because residents of the East Coast were more likely to see the recruitment posts because the author lives on the East Coast, thus sharing a time zone.

As mentioned above, all participants must have graduated from an IEP in the United States. Of 76 participants who responded to the question asking where their program was (after affirming they had attended and completed one), 28 attended programs on the East Coast, 27 attended programs in the Midwest, seven on the West Coast, six in the South, four in the Pacific Northwest, and four in the Central United States. Each program has a different coursework requirement; 42.11% of participants completed four years of specialized IEP coursework, 25% completed two years of IEP coursework and two years of general education, 21.05% completed two years, and 6.58% completed three years. The remaining 5.26% included two and a half years, three years at community college and five years at a four-year institution, the passing of the Educational Interpreter Performance Assessment (EIPA) as a graduation determinant, and one participant who completed four years for a bachelor's degree and two years for a master's degree. Participants worked in a variety of settings, including 30.16% in K-12 education, 16.67% in post-secondary education, 13.49% in medical, 13.49% in business/workforce settings, 7.14% as a designated interpreter, 0.79% in legal settings, and 18.25% in other locations such as video-relay service (VRS), religious scenes, performance, mental health, human services, non-profits, and other community settings.

Secondary Traumatic Stress and Vicarious Trauma Education

Following the demographic information, participants were asked a series of questions regarding secondary traumatic stress, vicarious trauma, the demand-control schema, and their IEPs. When asked to provide a quantifier for what their IEPs taught about vicarious trauma, 50.91% of respondents selected "it was mentioned in a few courses but not often" (N=55; n=28[2])

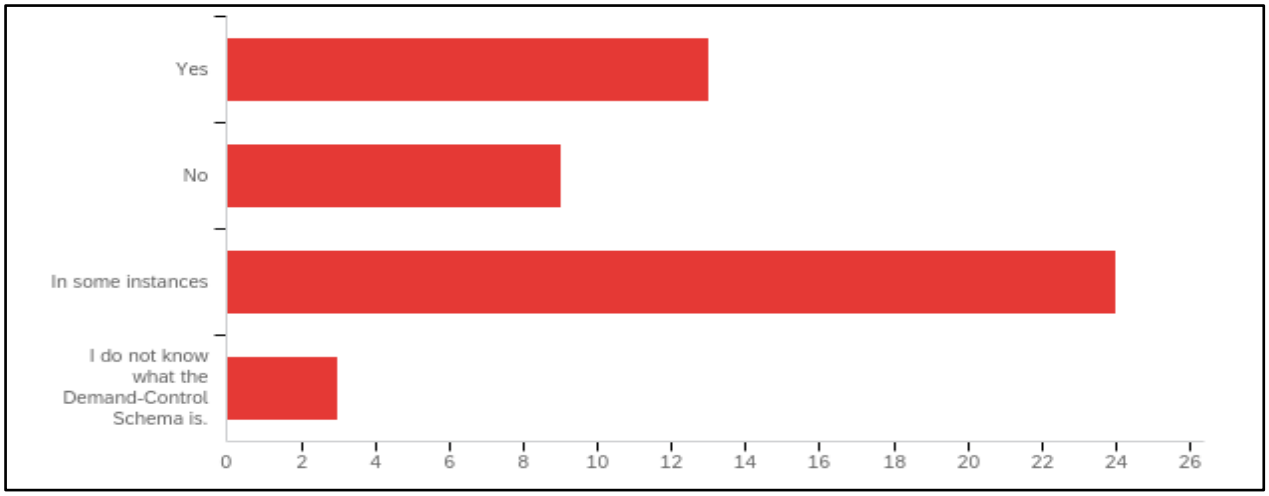
[2] Where N is the total number of respondents and n is the number of respondents who select each response.

and 12.73% selected “it was not part of the curriculum” (n=7). When the verbiage was changed, however, and participants were asked to do the same for secondary traumatic stress, 75.47% of respondents selected “it was not part of the curriculum” (N= 53; n=40) while 13.21% selected “it was mentioned in a few courses but not often” (n=7). Only six participants selected “it was discussed theoretically” or “it was discussed in-depth, and we were taught how to handle it” for secondary traumatic stress. In comparison, twenty participants selected those responses for vicarious trauma.

When asked if their IEPs taught them how to manage feelings of secondary traumatic stress or vicarious trauma, 35.19% selected “no” (N=54; n=19), 31.48% selected “they may have, but I don’t recall” (n=17), 24.07% selected “yes” (n=13), and 9.26% selected “they did, but I have not found the skills useful” (n=5). Respondents were then asked if the demand-control schema (DCS) was taught during their IEP and whether they viewed it as a coping mechanism. Of the 49 respondents who shared their familiarity with the DCS, 83.67% were taught it (n=41), 10.2% selected “mentioned but not elaborated on” (n=5) and 4.08% were not taught it (n=2). 48.98% of respondents stated the DCS is perceived as a coping mechanism “in some instances” (n=24) while 18.37% said they do not perceive it as a coping mechanism (n=9), and 26.53% stated that they perceive DCS as a coping mechanism (n=13) (see Figure 1).

Figure 1

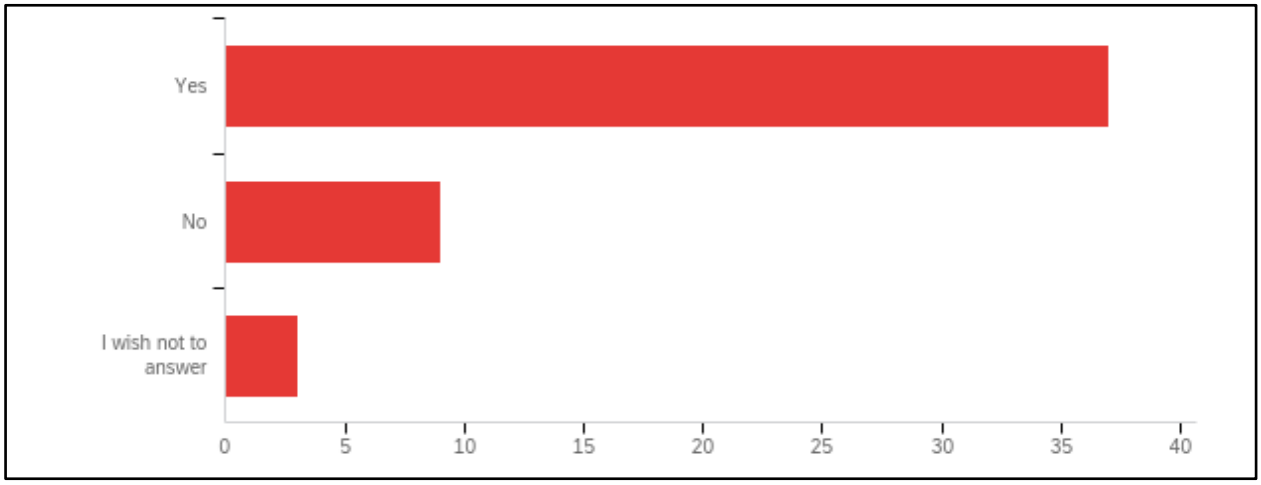
Responses to the question: Do you perceive the Demand-Control Schema as a coping mechanism?



When asked if they had experienced feelings of secondary traumatic stress or vicarious trauma related to work since becoming an interpreter, 75.51% of respondents selected "yes" (N=49; n=37) while 24.49% selected "no" (n=9) or "I wish not to answer" (n=3) (Figure 2).

Figure 2

Responses to the question: Have you experienced these feelings of secondary traumatic stress or vicarious trauma in relation to an interaction you interpreted since becoming an interpreter?



Participants were asked to share the coping strategies they use to manage negative feelings that arise from their work. Only 5.21% of respondents selected "I have not had negative

feelings arise from my work" (n=5) while the other 94.79% used various coping methods such as therapy (29.17%, n=28), medication (13.54%, n=13), alcohol (16.67%, n=16), drugs (4.17%, n=4), consulting or debriefing with peers, colleagues, or friends, exercise, journaling, meditation, yoga, and time away from work (all of these made up the "other" selection, accounting for 31.25%, n=30)[3].

The Proactive Coping Inventory

The researcher opted to include select questions from some subscales of The Proactive Coping Inventory developed by Greenglass et al. (1999). While the use of only some questions from the subscales eliminates their psychometric value, the phrasal pattern and response options were beneficial to this study and thus still used. The subscales the author opted to choose from are the Reflective Coping Scale (RCS), the Instrumental Support Seeking Scale (ISSS), and the Avoidance Coping Scale (ACS).

From the RCS, the author selected the following: "I tackle a problem by thinking about realistic alternatives," "I imagine myself solving a difficult problem before I actually have to face it," and "I address a problem from various angles until I find the appropriate action." Forty-nine respondents answered those three questions. When responding to the first RCS question, most respondents selected "somewhat true" (n=28, 57.14%) closely followed by "completely true" with 38.78% (n=19) of responses. No one selected "not at all true," and only 4.08% (n=2) selected "barely true." When responding to the second RCS question, most respondents again selected "somewhat true" (n=26, 53.06%), followed by "completely true" with 28.57% (n=14), and "barely true" with 14.29% (n=7) of respondents. Two respondents (4.08%) reported not ever

[3] For this question, respondents were asked to select all that applied. Thus, N=96.

imagining themselves solving a problem before facing it by selecting “not at all true” as their response. The final RCS question elicited no “not at all true” responses. It again had “somewhat true” as the most common response (n=27, 55.1%), followed by “completely true” (n=15, 30.61%) and “barely true” (n=7, 14.29%).

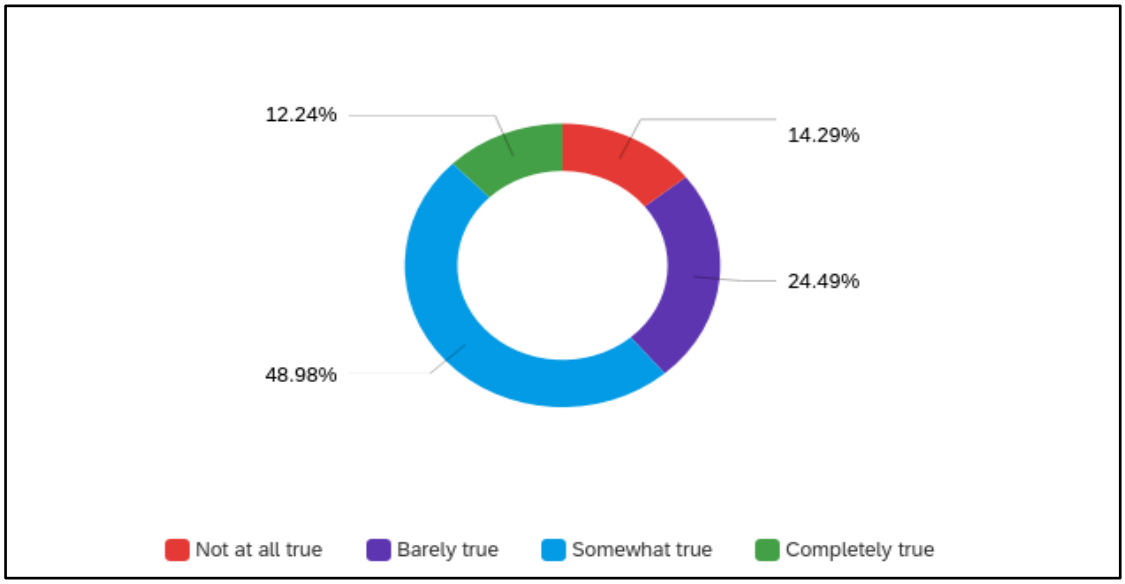
From the ISSS, the author selected: “I try to talk and explain my stress in order to get feedback from my friends” (ISSS 1), “I ask others what they would do in my situation” (ISSS 2), “Talking to others can be really useful because it provides another perspective on the problem” (ISSS 3), “When I am in trouble I can usually work out something with the help of others” (ISSS 4), and “Information I get from others has often helped me deal with my problems” (ISSS 5). From participants’ responses to these five questions, it is clear seeking support from others is a frequently used coping strategy for interpreters. Three of the five questions (ISSS 1, 2, and 3) had “completely true” as the most common answer (48.98% [n=24], 44.9% [n=22], and 75.51% [n=37], respectively). The same three had “somewhat true” as a close second, representing 42.86% (n=21), 40.82% (n=20), and 24.49% (n=12) of respondents, respectively. For question ISSS 3, no respondents selected “not at all true” or “barely true” as their answers. For ISSS 4 and ISSS 5, “somewhat true” was the most common answer representing 53.06% (n=26) and 63.27% (n=31) of respondents, respectively. For both four and five, no one selected “not at all true,” though there was a higher percentage of “barely true” responses (10.2% [n=5] and 2.04% [n=1], respectively). Respondents who selected “completely true” made up 36.73% (n=18) of ISSS 4 responses and 34.69% (n=17) of ISSS 5 responses.

The ACS is only made up of three questions, so the author did select all three for this study. The three ACS questions were: “When I have a problem, I like to sleep on it” (ACS 1), “If I find a problem too difficult sometimes, I put it aside until I’m ready to deal with it” (ACS 2),

“When I have a problem, I usually let it simmer on the back burner for a while” (ACS 3). For ACS 1, most respondents selected "somewhat true" (48.98%, n=24), followed by "barely true" (24.49%, n=12), "not at all true" (14.29%, n=7), and "completely true" (12.24%, n=6).

Figure 3

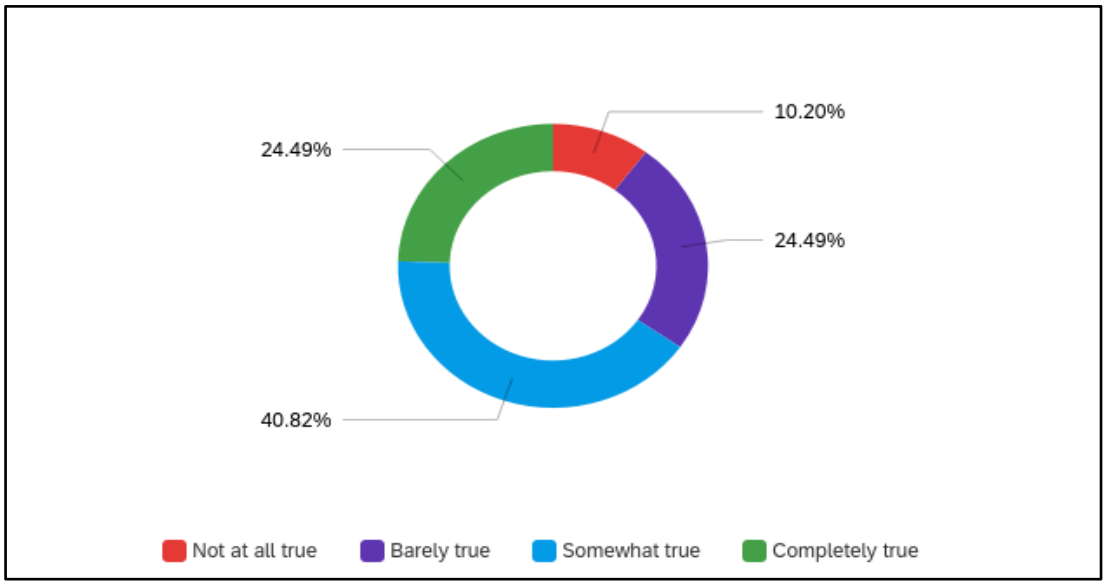
Responses to ACS 1.



ACS 2 had a similar response pattern, with 40.82% of respondents choosing “somewhat true” (n=20), followed by “barely true” and “completely true,” each with 24.49% (n=12) and concluding with “not at all true” (10.2%, n=5).

Figure 4

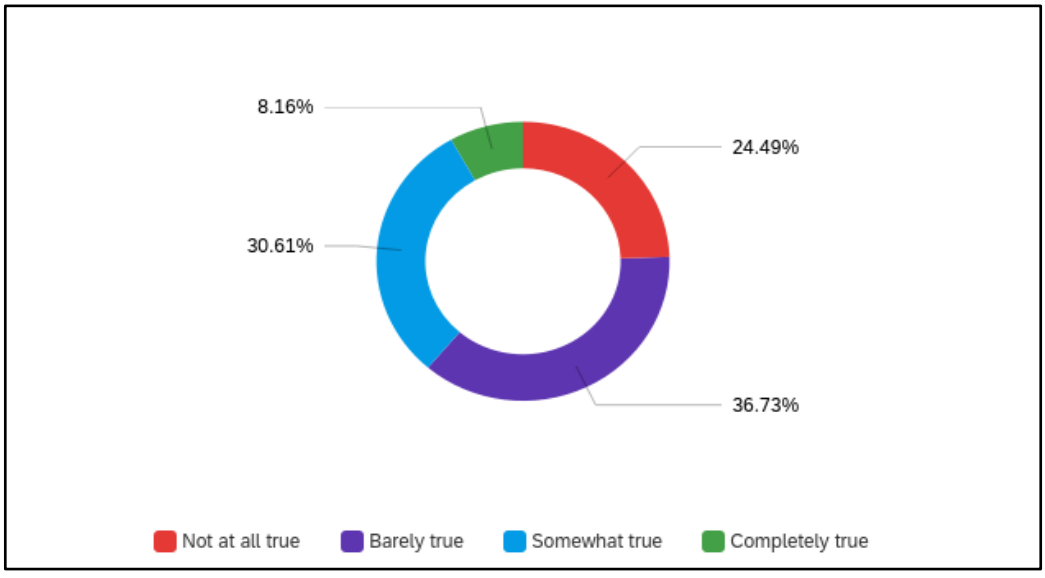
Responses to ACS 2.



ACS 3 had a different response pattern, however, with 36.73% (n=18) of respondents selecting "barely true" followed by "somewhat true" with 30.61% (n=15), "not at all true" with 24.49% (n=12) and concluding with "completely true" at 8.16% (n=4).

Figure 5

Responses to ACS 3.



Given these responses, it does not seem that avoidance is as common a coping strategy for interpreters as seeking support is.

The Brief COPE Inventory

Upon data analysis, the author noted that eight questions from the Brief COPE Inventory (Carver, 1997) had been omitted in error. Thus, while the instrument could not be scored in its traditional way, the author proceeded with a qualitative analysis of the data. The labels for various groups of questions will also be used when applicable to describe the behavior or concept described in the respective questions. Overall, the responses contained a combination of positive and maladaptive coping strategies. Most participants sought support – both emotional and instrumental – and distraction. Simultaneously, however, they blamed themselves for things that had gone poorly during assignments. According to SAMHSA (2014), cognitive shifts such as a "heightened sense of vulnerability" and an "extreme sense of helplessness or exaggerated sense of control over others or situations" are common signs of secondary traumatic stress (p. 199). When an interpreter starts blaming themselves for the consumers' or their own trauma it can create a sense of vulnerability or an exaggerated sense of control over the consumers' lives. Thus, self-blame and its implications are a sign of STS.

For questions 34 (number four on the Brief COPE) and 39 (number eleven on the Brief COPE), which both fall under the *substance use* category, approximately 86% of respondents selected "I haven't been doing this at all" or "I've been doing this a little bit" as their response. Comparatively, roughly 64% of respondents selected "I've been doing this a lot" or "I've been doing this a medium amount" for questions 35 and 42 (numbers five and fifteen on the Brief COPE), constituting the *use of emotional support* category and 62% selected the same choices for questions 38 and 48 (ten and twenty-three on the Brief COPE) for the *use of instrumental*

support category. The most common coping strategies outside of these categories included distraction with 64.58% doing it a medium amount or a lot, self-blame with 95.83% doing it at all, positive reframing with 50% doing it a medium amount or a lot, and acceptance with 91.67% of respondents doing it at all (nineteen, thirteen, twelve, and twenty-four on the Brief COPE respectively). The uncommon coping strategies included categories of *religion, humor, venting,* and *behavioral disengagement.*

From these results, most participants seek support and distraction while blaming themselves for negative or traumatic events that occur while working. The support is emotional and instrumental, meaning they seek help and advice from others such as peers, colleagues, friends, and family members. The distraction is often self-distraction, including retail therapy, sleeping, reading, daydreaming, or watching television or movies. The combination of support-seeking behaviors, distractions, and self-blame indicates a mixture of both positive and maladaptive coping strategies. The results also suggest that few interpreters engage in substance use or behavioral disengagement to cope. Only some seek religious support, reframe positively, vent, or use humor to cope with STS or VT.

Interviews

Throughout the interviews, the researcher identified several themes that answered or related to the research questions posed at the start of the study. The themes drawn from the evidence in the interviews and the research questions were: how STS is mitigated or lessened by coping strategies learned in the IEPs; how coping strategies learned in IEPs prevent or fail to prevent STS; coping strategies IEP graduates are currently using; and where graduates learned current coping strategies. The themes drawn exclusively from the data provided by the interviewees included: what maladaptive coping strategies are presently being used by IEP

graduates, why they believe the skills are maladaptive, how those maladaptive strategies are impacting their lives; and what recommendations can be made for IEPs and interpreter educators to aid future and emerging interpreters in mitigating, lessening, or preventing STS. Outlined in this section are the most common responses as well as less common responses the researcher felt necessitated mentioning.

How STS is Mitigated, Lessened, or Prevented

The first theme was a deductive theme based on the research question: How are interpreters' experiences of secondary traumatic stress mitigated, lessened, or prevented by the coping mechanisms provided by their interpreter education programs? Several participants provided a list of coping strategies they learned during their IEPs (N=10). Most often, those coping strategies were talking or debriefing with another interpreter (within the bounds of confidentiality), counseling or therapy, self-care, stretching or yoga, and the demand control schema (DCS). Other, less commonly mentioned strategies included baths, mentoring, meditation, and time with family, friends, peers, or pets. Participant 3 noted that a professor in their IEP emphasized the concept of the interpreter's humanity outside of their work, frequently epitomized in the phrase "your work is not your worth." Interestingly, only one participant stated that most of their coping strategies came from their IEP program. That participant is also the most recent graduate, thus potentially limiting their experience and time removed from the IEP to learn other coping strategies elsewhere.

The second theme identified in the data was deductive, based on the same research question as the first, but focused solely on the prevention aspect of coping strategies learned during a graduate's IEP. It was found that coping strategies taught during an IEP could prevent STS but sometimes failed to do so. Participants shared several ways coping strategies prevented

them from experiencing STS. Two participants shared that working in an educational setting limits their exposure to client trauma in the workplace, thus preventing them from experiencing STS (N=10, n=2). Contrarily, another participant shared that working in education was especially traumatizing due to the injustices they witnessed daily (n=1). Witnessing the unfairness toward the deaf students in the school impacted this participant in such a way that their perception of their role and duty was shifted as a result.

Other preventative coping strategies participants mentioned were not interpreting someone else's trauma from ASL to English - meaning they did not have to interpret trauma verbally in the first person (Participant 1) - and lacking empathy for consumers, both deaf and hearing (Participant 5). The absence of interpreting traumatic material from ASL to English for Participant 1 is not an adequate preventative coping strategy, as they may be faced with similar situations at any time in the future. That a situation requiring Participant 1 to interpret trauma into English has not arisen thus far can be attributed to chance (of the ten participants, Participant 1 is the only one to have said this). Participant 5, who mentioned they were able to resist empathetic feelings toward consumers, stated that not expressing empathy is a learned behavior that has become a personality trait. The participant indicated that while their IEP recommended boundaries, the participant's ability to turn off their empathetic response to consumers' trauma is not a learned coping strategy. Participant 3 reported the opposite; they reported having frequent empathetic responses toward consumers, allowing them to develop relationships with their consumers, increasing their risk for STS. Participant 3 is likely to cry when others cry or become upset when others are upset. Given the variety of viewpoints related to IEP-taught coping strategies preventing STS, more research is necessary to determine if preventative coping

strategies are being taught in IEPs or if they are being learned outside of the IEP, including the presence of empathy or lack thereof as a preventative measure.

Current Coping Strategies Used

The third theme identified by the researcher was deductive, based on the research question: What coping mechanisms are interpreter education program graduates currently using to prevent or mitigate secondary traumatic stress, and where did they learn them? The ten participants (N=10) identified approximately 28 different coping strategies they currently use. The most common included talking to other interpreters, talking to family, friends, spouses, or pets, exercise, therapy or counseling, redirecting the self with sensory input, and reading for pleasure. Of the half of the participants (n=5) who stated they used therapy or counseling as a current coping strategy, 30% were currently attending or believed it was an effective tool for coping (n=3). In comparison, 20% thought it was ineffective or had stopped going (n=2). Other less common strategies such as baths, social media, boundaries, games (video or board), journaling, food, hobbies outside of interpreting, preventative self-care, and doing things they know work for them were also reported amongst the participants. Interestingly, two participants reported not believing they have any current coping strategies for themselves, only coping strategies to address the consumers in a situation such as redirecting the offender or bystanders and making sure the deaf consumer feels seen and heard.

Participant 8 mentioned that their favorite current coping strategy was to create their own resolution to a situation. To avoid obsessing and spiraling into a rut over traumatic situations, they create scenarios in their mind that close at the end of their interaction with the consumers, even if their leaving is not the end of the real-life scenario. They reported using this strategy at the conclusion of VRS calls, as the interpreter only sees a blip in the grand situation they may

have interpreted. Additionally, as someone who frequently works in environments related to respite care for deaf consumers, participant 8 does not always see a situation to its conclusion. The participant reported creating happy endings where the situation requiring respite care is resolved or a positive outcome results from a difficult VRS call. By creating their own conclusion, participant 8 is practicing radical acceptance – the idea that they have done all they can in a situation and their best is satisfactory.

It was essential to the research that participants share where most of the current coping strategies were learned. Knowing where coping strategies are being learned could provide conclusions and inferences regarding coping education and IEPs. Most participants (n=7) stated they were unsure if things were learned from their IEP or elsewhere but were able to report where they have learned coping strategies. The themes that surfaced regarding where coping strategies were learned included life experiences as an adult (n=3), experiences or training from previous employment (n=3), therapists of their own (n=2), Facebook groups or other social media (n=3), friends both in and outside the field (n=4), and workshops (n=2). Two unique responses were reported once each; however, they are important to note, nonetheless. Participant 1 reported learning their coping strategies via research on their own, born of a need or desire to model healthy coping for their children, including being a dry family, meaning no alcohol is consumed or kept by those living in the home. The participant and their spouse ask that any visitors who bring alcohol to the house either finish it or take it with them, thus not leaving any leftover alcohol in their family's home.

The second unique response regarding where coping strategies were learned was reported by participant 9. They reported that while working with an intern, they have become attuned to the revelation of how hardened they have become to semi-traumatic situations. Participant 9

reported being unphased by semi-traumatic conditions that have caused a visceral reaction in their intern, indicating that participant 9 has developed an avoidance or coldness toward some semi-traumatic situations. It can be inferred that participant 9's indifference toward semi-traumatic events potentially has been developed due to life and work experience the intern has not yet had, conceivably validating the benefit of life experience as a coping strategy.

Maladaptive Coping and Interpreters

The researcher identified approximately ten maladaptive coping strategies listed by the participants. According to the participants, these coping strategies are maladaptive; there was no influence from the researcher when identifying what qualified as maladaptive during the interviews. More than one participant mentioned four of the ten maladaptive strategies; however, all ten will be listed here. Additionally, there are caveats to some participants' responses which will be noted. Several participants (n=4) also mentioned their reasoning for turning to maladaptive coping strategies and the results or impact of these maladaptive coping strategies on their lives.

Supporting the survey data, substance use was not a common coping strategy among interview participants. Out of ten, only three participants mentioned alcohol consumption as a maladaptive coping strategy (n=3). All three emphasized that it was not to the extent of binge drinking, one identified that it was primarily unrelated to work stress. Still, there are occasions when their inclination is to drink after a shift. Another mentioned that alcohol is abundant in their home yet reported they do not partake themselves even though it is an option. Two participants[4] mentioned drugs (not including alcohol) as maladaptive coping strategies, but both

[4] The two participants who mentioned caveats for their alcohol use are the participants who mentioned drugs. In an abundance of caution, they will not be identified for these responses in this publication.

came with caveats. One participant noted that they **would**[5] use drugs as a coping strategy, but it is too expensive for them, and thus they do not use them. Another participant reported that marijuana is legal in their state, and therefore their use is for recreational purposes and not primarily as a coping strategy for work stress. Participant 8 and participant 10 both said that they are unsure if their coping strategies are maladaptive, indicating a gap in awareness and education for graduates of IEPs. The most mentioned maladaptive coping strategy was food (n=4). Participants 6, 8, 9, and 10 all said treating oneself to food was a maladaptive coping strategy due to its ability to ruin budgets, weight management, and disruption to family mealtime.

The maladaptive coping strategies mentioned once by various participants included dissociation, avoidance, compartmentalizing, accepting one's limited control in a situation, not using coping strategies at all, and the binging of useless things other than alcohol and food. Participant 6 described unproductive strategies such as Netflix, Tik Tok, video games, board games, and reading in excess. In moderation, these things can be appropriate ways to disconnect from a workday; however, when one becomes lost in them and spends hours on them, participants are prevented from accomplishing necessary tasks (e.g., chores), therefore becoming a maladaptive coping strategy. The same could be applied to reports related to avoidance, compartmentalizing, and accepting limited control. If one avoids processing a traumatic interpreting scenario forever, the potential resulting STS cannot be appropriately handled. This is also true if one compartmentalizes and does not revisit the compartmentalized thoughts or feelings. The lack of follow-up or reconciliation is when avoidance and compartmentalizing become maladaptive. Accepting one's limited control in a situation can lead to instances of acceptance where it is inappropriate. Tolerating a situation for an extended period may create an

[5] All bolded terms in this piece are bolded for emphasis.

inability to acknowledge healthy opportunities to challenge or express resistance to an environment where they have limited control. Finally, not using any coping strategies is maladaptive for self-explanatory reasons. Not having coping strategies is one thing, but not using them is a different form of avoidance, as it allows the affected person to remain in the STS state. Though some responses were only mentioned once, the researcher opted to include all responses to demonstrate the wide range of maladaptive coping strategies available. The participants felt it was important enough to mention unprompted during their interviews, thus making it valuable data for the research.

Participants 8 and 9 both reported that having better access to healthy coping strategies would make it easier to avoid maladaptive coping strategies. Participant 9 indicated that they felt their lack of access to healthy coping strategies was due to limited general knowledge of them. This results in their opting for maladaptive coping strategies more frequently. Those same two participants reported easily falling into maladaptive coping habits when one falters in the continuous effort and steps required to maintain positive, healthy coping strategies. Participant 8 emphasized the importance of a support system, having people around you that can support you when necessary and can be leaned on when needed. They also mention that maladaptive coping becomes cyclical and can be very difficult to escape once maladaptive strategies have become ingrained.

Maladaptive coping strategies have adverse effects on the lives of those who use them and their loved ones. Participants 4 and 9 mention feeling overwhelmed or irritable when using maladaptive coping strategies. Both reported mental exhaustion and a lack of a sense of being rested when awaking. Participant 9 reported feeling more stressed and increased headaches when opting for maladaptive coping strategies. Finally, participant 6 reported feeling a separation of

self. According to participant 9, the higher self is the ideal self, the goal one is working toward. When experiencing STS, it is harder to attain the ideal self; therefore, one falls into their lower self, resulting in gravitation toward maladaptive coping strategies.

Recommendations for Interpreter Education

During each interview, the researcher asked participants to share what they wished they had learned during their IEPs. The results were varied, with some responses being repeated and others being unique to the sole participant who shared them. There were no repeated IEPs; all ten interview participants listed different colleges as hosts for their IEPs. The researcher identified the most common and relevant reported recommendations for interpreter educators. Ideally, these responses would be incorporated into the curriculum of IEPs; however, the author recognizes that may not be possible and instead hopes that individual interpreter educators begin including these points.

The most shared recommendations included four requests for IEP curriculums. Participants expressed a desire for more discussion of STS and coping strategies (n=4) in general as one of their chief wants. These participants felt that they were unprepared for the possibility of STS due to a lack of discussion and awareness of the concept. Five participants shared a desire that IEPs educate students that any setting has a chance of STS because it is dependent on the interpreter and their mind or body more than the situation they're interpreting. Several of the five participants (n=3) worked in the k-12 education setting and reported feeling unprepared for exposure to trauma in the educational environment. One of the five reported an expectation that all the trauma they would be exposed to would be deafness or sign language related, such as language deprivation and the oppression of the deaf community. When that was not the case, they reported feeling taken aback and struggling to reconcile their feelings.

Participants 1, 2, 4, and 7 reported that when using the DCS, they find a need for more during assignment controls as there was a heavy focus on pre- and post-assignment controls during their IEPs (n=4). They reported feeling content with the amount of pre- and post-assignment controls their IEPs provided them with but struggling to identify during assignment controls in the moment. Finally, participants 2, 3, and 4 reported they wish their IEPs had included more of the instances STS may come up, especially the more subtle examples (n=3). They reported noticing feelings related to STS during or after instances of subtle trauma exposure, such as subtle acts of exclusion or passing mentions of traumatic experiences. Other important recommendations included: warning students that having **too** strict of boundaries can be harmful to them **and** the consumers; self-care as a proactive practice rather than a reactive practice; implementation of role-playing about STS later in the curriculum to better prepare students to use coping strategies; emphasizing what to do for themselves as the interpreter and not just what to do to support the consumers; letting students know that tapping out is **okay** and a better service to the clients than if you stay and allow yourself to be distracted during the interpreting process; and finally, discuss the maladaptive coping strategies that students could turn to as a way of monitoring their degrees of STS.

Additionally, as mentioned in chapter two, there are organizational interventions that would also benefit IEPs and interpreter educators. Incorporating trauma-informed practice into the curriculum of IEPs is recommended based on Sprang et al.'s (2021) findings. The increased understanding of STS and coping for national organizations such as CIT, RID, NAOBI, Mano a Mano, and CCIE would aid IEP graduate ASL interpreters in increasing their understanding of STS, its risks, and the coping mechanisms they may need to combat or prevent it. Sprang et al. (2021) provided a workshop for training institutions on becoming trauma-informed; workshops

would also benefit the interpreting community since representatives from each IEP, CIT, RID, NAOBI, Mano a Mano, CCIE, and local RID chapters could attend and return to educate their respective institutions. It is also recommended that the CCIE board consider continuing education related to trauma-informed organizational practices and additions or revisions to the standards for IEPs to reflect the continued study.

Chapter 5: Discussion

From all of the data, it is clear that research regarding the presence of coping education in IEPs is still necessary, and there are improvements to be made. In both the survey and interview data, participants noted that they wished STS and VT had been discussed more, especially because they felt unprepared for STS to occur in some settings (Participants 3 and 4). Many interpreters who responded to the survey worked in video relay service (VRS) interpreting. Upon deeper discussion with interview participants working in the same environment, VRS is a traumatic setting in which to work. There is any number of situations that may arise – 911 calls, domestic violence reports, child abuse reports, dangerous driving situations – that are likely to stick with the interpreter and may cause STS or VT due to a lack of awareness and coping strategies. Another setting participants frequently worked in was education. Participants of both the survey and interviews reported feeling unprepared to experience STS or VT in the educational setting and thus wished their IEPs had better informed them about the risks and how to cope with those traumatic experiences. Finally, participants reported an abundance of pre- and post-assignment controls that were provided to them by their IEPs but a lack of during assignment controls.

Limitations

This study was not without its limitations. Because of the requirement that graduates be no more than five years removed from their IEP, several participants had limited interpreting experience, limiting their potential exposure to traumatic situations that could cause STS or VT. Some participants also had limited life experience due to youth which limits the traumatic experiences they have been exposed to that could be triggered in an STS situation. However, if the researcher had allowed for participants who were further removed from their IEPs, there is a

risk that participants may have just forgotten what coping skills they learned from their IEPs or whether STS and VT had been discussed. The author suggests that curriculum studies may repair this limitation and provide more insight into the coping education of various IEPs.

Time was an additional limitation for this study. Due to the nature of this research as a thesis project in partial fulfillment of a master's degree program, the author was limited in the length of recruitment, how long the survey could remain open, and how much time was spent on data analysis to complete the research by the due date. In future research endeavors, the author recommends it be grant-funded and thus not constrained by a degree program's time or due date requirements.

It is mentioned in chapter two that there is a lack of literature regarding the presence of coping education for members of global majority populations including BIPOC people. This study reflects that disparity, as the number of BIPOC respondents to the survey was low, and there were no visibly non-white interview participants. This is a limitation that should be noted despite its reflection of the ASL interpreting field. In future research, BIPOC interpreters should be recruited via their professional organizations such as NAOBI and Mano a Mano, as well as direct recruitment where appropriate. In future curriculum studies, BIPOC graduates should be contacted to elicit their responses and perspectives on coping education in IEPs.

Finally, the author chose to limit the questions selected from The Proactive Coping Scale and inadvertently limited the questions selected from The Brief COPE Inventory. The use of the complete PCS may enhance the results of the study. The author had intended to use the entire Brief COPE Inventory (BCOPEI), and it was only upon data analysis that they realized eight questions had been omitted. The questions likely would not have been overlooked had the

researcher not needed to transcribe them into Qualtrics. In the future, the quantitative analysis would benefit significantly from the use of the complete BCOPEI.

Need for Further Research

As stated above, there were several limitations to this study. In future iterations of this research, the author recommends the following. Completing curriculum reviews or curriculum studies would remove the risks and limitations of the recency requirements, thus providing more accurate and explicit representations of the presence of coping education in IEPs. This research occurred on a broader scale due to its nature as the foundational research on this topic. The author additionally recommends that future research be undertaken with a less restrictive timeframe for completion to avoid the constraints of degree-seeking thesis projects and action research.

Furthermore, the author recommends more research on graduates' perceptions of the DCS as a coping strategy and its success as such. The perception of the DCS as a coping strategy could not and was not examined to the fullest extent possible in this research, and the author believes it would benefit the field greatly to have such a study. Finally, more research is necessary regarding the effects of working in K-12 educational environments as a mitigating or preventative measure against STS or VT. Participants 3 and 9 mentioned working in education to avoid STS or VT but reported experiencing more STS or VT than their freelancer peers. On the contrary, Participants 1, 5, and 10 reported that education was, in fact, a preventative or mitigating factor in their lack of STS or VT. Given the conflicting reports in this study, the field would benefit from a more in-depth, specific examination of such phenomena.

Chapter 6: Conclusion

The overwhelming theme in both the survey and interview responses is a lack of general awareness about STS and VT for graduates of IEPs. This lack of awareness has led to a lack of coping strategies for working interpreters, leading to self-blame and a heavy reliance on distraction and support from others to get through the days, weeks, months, and years of working. Educational interpreters largely felt unprepared for the possibility of STS in the educational setting. It is widely known among the ASL interpreting community that K-12 education has a high turnover rate, often because interpreters become overwhelmed or disheartened by the things they witness. This leads to high rates of burnout in the K-12 sector. Video relay service has also proven to have a risk of STS and VT that was shared by participants of this study. As stated at the start of this publication, STS and VT can occur in any setting, and thus more research should be done about the risks and implications of STS and VT on interpreters working in those settings.

The most common coping strategies are entirely neither positive nor maladaptive; they are a mix of both. Thus, broader education in IEPs regarding healthy coping and the risks of maladaptive coping would benefit graduates according to their reported feelings from this investigation. Participants in the interviews reported several recommendations for IEPs to implement in their curriculums for upcoming and prospective students. These recommendations included making sure students know to make plans for themselves to cope with traumatic content or incidents, increasing the during assignment controls offered to students when learning about the DCS, and generally more discussion about STS and VT during the programs.

While this study provided valuable insights into the coping strategies used and learned by IEP graduates, it did have limitations. Future research should be conducted with a demographic

of interpreters further removed from their IEPs than just five years, and a more concentrated effort to recruit BIPOC or other global majority interpreters. The author hopes to see future research conducted regarding the effects of working in K-12 education as it relates to STS or VT and whether that can be a mitigating or preventative measure against STS or VT. Finally, curriculum studies of the various IEPs throughout the United States could provide more precise insight into the coping strategies taught during IEPs from the IEP's perspective and allow for BIPOC graduates of the IEPs to be contacted directly for recruitment. Those perspectives are lacking here but would benefit the body of research on the topic. The author notes the breadth of such an undertaking but is hopeful that teams of researchers may work together to provide those insights.

The COVID-19 pandemic surely heightened the presence of burnout, secondary traumatic stress, and vicarious trauma in ASL interpreters, but COVID-19 is not the sole trigger of such phenomena in ASL interpreters. The perception of interpreter education programs graduates is that secondary traumatic stress, vicarious trauma, and coping strategies to mitigate, prevent, and manage those feelings are not discussed enough. Graduates are struggling to cope in the aftermath of traumatic interpreting scenarios and would benefit significantly from broader coping education in interpreter education.

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Appendix A

Survey Informed Consent – The Presence of Coping Education in American Sign Language Interpreter Education Programs as Perceived by Graduates

You are invited to participate in this research project because you have self-identified as a sign language interpreter in the United States who completed the coursework of an interpreter education program, is now working in the field, and wishes to aid in the increased awareness of secondary traumatic stress and vicarious trauma in the field. This project is being conducted by Anna N. Teitt, NIC a master's candidate in the Master of Arts Interpreting Studies and Communication Equity program at St. Catherine University in St. Paul, MN. The purpose of this study is to investigate the coping skills that interpreter training programs provide their students in preparation for possible experiences with secondary traumatic stress or vicarious trauma after interpreting for clients who have experienced traumatic events. The survey includes items about secondary traumatic stress/vicarious trauma and coping mechanisms. The data that we collect from this survey will be used for broad analysis of the degree to which interpreter education programs are educating their students about how to handle secondary traumatic stress and vicarious trauma. It will take approximately 30 minutes to complete. Your responses to this survey will be confidential and results will be presented in a way that no one will be identifiable. Confidentiality will be maintained to the degree permitted by the survey technology used, Qualtrics. Specifically, no guarantees can be made regarding the interception of data sent via the internet by any third parties.

Your participation is voluntary and your decision whether or not to participate will not affect your relationships with the researcher, your instructors, your interpreter education program, or St. Catherine University. If you decided to stop at any time, you may do so until you have submitted your survey, at which time it will be indistinguishable from other respondents' surveys. You may also skip any item that you do not wish to answer. If you have any questions about this project, please contact Anna N. Teitt, NIC at (443) 212-8685 and/or anteitt184@stkate.edu, the faculty advisor Justin Small, PhD, jmsmall508@stkate.edu, or 952-388-2158, or the Institutional Review Board Chair: John Schmitt, PT, PhD, 651.690.7739; jsschmitt@stkate.edu. By responding to items on this survey you are giving us your consent to allow us to use your responses for research and educational purposes. Additionally, should you choose to participate in the interview portion of this research, you are providing your consent to be taken to a new window by clicking the link at the end of this survey.

1. By checking yes you confirm that you have read the consent paragraphs and agree to participate in this study with the understanding that you may withdraw at any time or omit responses for any question(s) you do not wish to answer.
2. What is your age?
3. What is your ethnicity?
    a. Black
    b. African
    c. African American

   d. Latinx, Hispanic, Spanish
   e. Mexican
   f. Mexican American
   g. Puerto Rican
   h. Cuban
   i. Dominican
   j. Haitian
   k. Caucasian (White)
   l. Asian Indian
   m. American Indian or Alaska Native (Please Specify Tribe) (Qualtrics will populate a line for them to input their Tribe if they select this answer)
   n. Native Hawaiian
   o. Guamanian or Chamorro
   p. Filipino
   q. Chinese
   r. Japanese
   s. Korean
   t. Vietnamese
   u. Samoan
   v. Other Asian_____
   w. Other Pacific Islander _____
   x. Other Ethnicity or Race (Please specify) _____
4. What gender identity most accurately describes you?
   a. Transgender
   b. Transgender Man/Trans Masculine
   c. Transgender Woman/Trans Feminine
   d. Non-Binary
   e. Genderqueer
   f. Gender Fluid
   g. Two-Spirit
   h. Intersex
   i. Gender Non-Conforming
   j. Woman
   k. Man
   l. Gender Identity not listed here _____
5. Did you attend and complete an interpreter education program?
   a. Yes
   b. No (if no, the candidate will be exited from the survey)
6. Where was your program?
   a. east coast

   b. west coast
   c. midwest
   d. South
   e. Pacific northwest
   f. Central United States
7. How many years did your IEP coursework require to receive a degree in interpreting?
   a. 4 years
   b. 2 years
   c. 3 years
   d. 2 years of general education and 2 years of specialized training
   e. Other_____
8. What year did you graduate?
   a. 2021
   b. 2020
   c. 2019
   d. 2018
   e. 2017
   f. Other _____ (if other is not within 5 years, the candidate will be exited from the survey)
9. In what setting do you do most of your work? Please choose all that apply
   a. Medical
   b. Legal
   c. K-12 Education
   d. Post-Secondary Education
   e. Business/Workforce
   f. Designated Interpreter
   g. Other:_____
10. What is your definition of vicarious trauma (VT)? If you do not know what VT is, please write N/A.
11. What is your definition of secondary traumatic stress (STS)? If you do not know what STS is, please write N/A.
12. Tell me more about what your interpreter education program taught you about vicarious trauma (VT).
   a. It was not part of the curriculum.
   b. It was discussed theoretically.
   c. It was mentioned in a few courses but not often.
   d. It was discussed in depth, and we were taught how to handle it.
13. Tell me more about what your interpreter education program taught you about secondary traumatic stress (STS).
   a. It was not part of the curriculum.

   b. It was discussed theoretically.
   c. It was mentioned in a few courses but not often.
   d. It was discussed in depth, and we were taught how to handle it.
14. If you were taught about STS and VT, how did the program do so? (Ex. readings, activities, role-playing, etc.) (This question will be populated in Qualtrics, only if the participant does not answer no to the above question.)
15. Did your interpreter training program teach you how to manage feelings of secondary traumatic stress or vicarious trauma?
   a. Yes
   b. No
   c. They may have but I don't recall
   d. They did but I have not found the skills useful
16. What methods did your ITP teach you to manage these feelings?
17. What methods do you use to manage negative feelings that arise from your work?
   a. Therapy
   b. Medication
   c. Alcohol
   d. Drugs
   e. I have not had negative feelings arise from my work
   f. Other _____
18. Do you know about the Demand-Control Schema? If so, please explain your understanding of it.
   a. Yes (Will populate a short answer box for the participant to explain their understanding)
   b. No
   c. I don't recall
19. Is the Demand-Control Schema taught during your interpreter training program?
   a. Yes
   b. No
   c. I don't recall
   d. Mentioned but not elaborated on
20. Do you perceive the Demand-Control Schema as a coping mechanism?
   a. Yes
   b. No
   c. In some instances
   d. I do not know what the Demand-Control Schema is
21. Have you experienced these feelings of secondary traumatic stress or vicarious trauma in relation to an interaction you interpreted since becoming an interpreter?
   a. Yes
   b. No

    c. I wish not to answer (If the participant answers B. or C., they will skip questions 22-51 and taken straight to question 52. If they answer A., they will continue with the following questions 22-51.)

22. I tackle a problem by thinking about realistic alternatives. (REFLECTIVE COPING SCALE)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
23. I imagine myself solving a difficult problem before I actually have to face it. (RCS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
24. I address a problem from various angles until I find the appropriate action. (RCS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
25. I try to talk and explain my stress in order to get feedback from my friends. (INSTRUMENTAL SUPPORT SEEKING SCALE)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
26. I ask others what they would do in my situation. (ISSS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
27. Talking to others can be really useful because it provides another perspective on the problem. (ISSS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
28. When I am in trouble I can usually work out something with the help of others. (ISSS)
    a. Not at all true
    b. Barely true
    c. Somewhat true

d. Completely true

29. Information I get from others has often helped me deal with my problems. (ISSS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
30. When I have a problem I like to sleep on it. (AVOIDANCE COPING SCALE)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
31. If I find a problem too difficult sometimes I put it aside until I'm ready to deal with it. (ACS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true
32. When I have a problem I usually let it simmer on the back burner for a while. (ACS)
    a. Not at all true
    b. Barely true
    c. Somewhat true
    d. Completely true

Please answer the following questions in the context of a response to feelings of STS or VT: (The Brief COPE from the Science of Behavior Change)

33. I've been saying to myself "this isn't real"
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
34. I've been using alcohol or other drugs to make myself feel better
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
35. I've been getting emotional support from others
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
36. I've been giving up trying to deal with it

a. I haven't been doing this at all
b. I've been doing this a little bit
c. I've been doing this a medium amount
d. I've been doing this a lot

37. I've been saying things to let my unpleasant feeling escape
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
38. I've been getting help and advice from other people
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
39. I've been using alcohol or other drugs to help me get through it
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
40. I've been trying to see it in a different light, to make it seem more positive
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
41. I've been criticizing myself
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
42. I've been getting comfort and understanding from someone
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
43. I've been giving up the attempt to cope
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
44. I've been making jokes about it

a. I haven't been doing this at all
b. I've been doing this a little bit
c. I've been doing this a medium amount
d. I've been doing this a lot

45. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
46. I've been expressing my negative feelings
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
47. I've been trying to find comfort in my religion or spiritual beliefs
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
48. I've been trying to get advice or help from other people about what to do
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
49. I've been learning to live with it
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
50. I've been praying or meditating
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot
51. I've been making fun of the situation
    a. I haven't been doing this at all
    b. I've been doing this a little bit
    c. I've been doing this a medium amount
    d. I've been doing this a lot

52. Are you willing to participate in the interview portion of this study?
    a. Yes
    b. No
53. (IF YES) Name and Pronouns?
54. Contact information
    a. Phone
    b. Email
    c. Text friendly?
55. Which ITP did you attend?

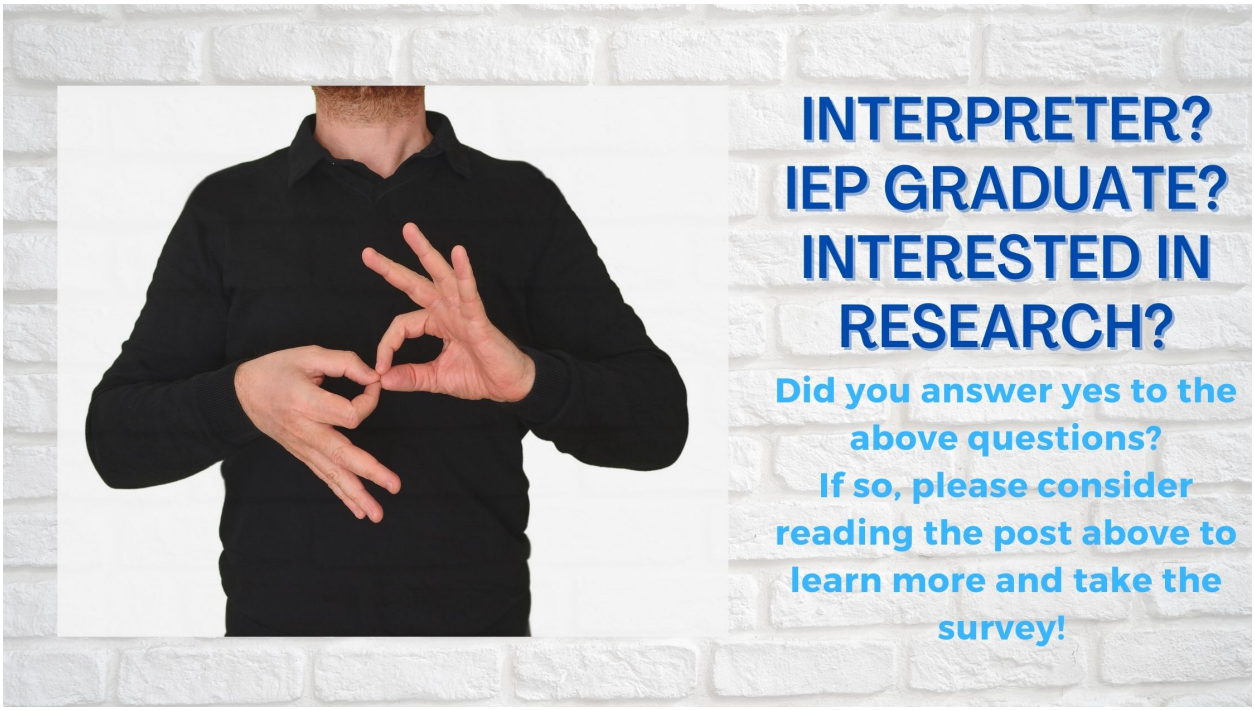
Appendix B

Hello, my name is Anna N. Teitt, and I am a master's degree candidate at St. Catherine University in St. Paul, Minnesota in the Master of Arts Interpreting Studies and Communication Equity program. I am currently completing research on the presence of coping skills and strategies in interpreter training program graduates. I am posting here in hopes that you will participate in my study. The study consists of two parts, a survey, and an interview. Please read the summary at the start of the survey regarding informed consent and consider completing the survey. To qualify for inclusion in this study, you must have completed an interpreter training program at either a two-year or four-year degree-granting institution within the last five (5) years and be currently working as an American Sign Language interpreter in any setting. If, upon completion of the survey, you find that you wish to share more about your experience, please consider participating in the interview portion as well.

Appendix C

Figure 6

The graphic that accompanied recruitment posts in the four Facebook groups.



Appendix D

ST CATHERINE UNIVERSITY
Informed Consent for the Interview Portion of a Research Study
Study Title: The Presence of Coping Education in American Sign Language Interpreter Education Programs as Perceived by Graduates

Researcher: Anna N. Teitt, NIC

You are invited to participate in a research study. This study is called The Presence of Coping Education in American Sign Language Interpreter Education Programs (IRB #1666). The study is being done by Anna N. Teitt, NIC, a masters' candidate in the Master of Arts Interpreting Studies and Communication Equity (MAISCE) program at St. Catherine University in St. Paul, MN. The faculty advisor for this study is Justin Small, EdD, Director, MAISCE Program at St. Catherine University. Below, you will find answers to the most commonly asked questions about participating in a research study. Please read this entire document and ask questions you have before you agree to be in the study.

Why are the researchers doing this study?

The purpose of this study is to investigate the coping skills that interpreter education programs provide their students in preparation for possible experiences with secondary traumatic stress or vicarious trauma after interpreting for clients who have experienced traumatic events. For the purposes of this study, secondary traumatic stress and vicarious trauma are synonymous, and will be defined as post-traumatic stress signs or symptoms in interpreters who were indirectly exposed to traumatic experiences. This study is important because evidence of the success or failure of interpreter education programs in adequately preparing their students for these experiences may aid in the development of a more comprehensive curriculum regarding these subjects. Up to 250 people are expected to participate in the survey, while 5-8 people are expected to participate in the interview portion of this research.

Why have I been asked to be in this study?

You are being invited to participate in this study because you have self-identified as a sign language interpreter in the United States who completed the coursework of an interpreter education program, is now working in the field, and wishes to aid in the increased awareness of secondary traumatic stress and vicarious trauma in the field. The survey portion collected data regarding the interpreter education program you attended. The interview will serve as a means of elaborating on the data collected in the survey to further benefit the stakeholders of this research.

If I decide to participate, what will I be asked to do?

If you meet the criteria and agree to be in this study, you will be asked to do these things:

- Complete a survey containing questions related to your interpreter education program and coping skills (which you have already completed).
- If selected, participate in an interview with Anna Teitt, NIC via Zoom lasting approximately one (1) hour during which you will discuss the following:

- Answer questions about your experience with education related to secondary traumatic stress and vicarious trauma in your interpreter education program.
- Answer questions regarding the coping methods you currently use.
- During the survey portion participants were asked if they were willing to be interviewed, and the researcher selected interviewees from those who responded affirmatively based on a first come-first serve basis. Should a Deaf participant respond affirmatively, they will be interviewed in American Sign Language

In total, this study requires one (1) hour for the interview.

What if I decide I don't want to be in this study?

Participation in this study is completely voluntary. If you decide you do not want to participate in this interview, please feel free to say so, and do not sign this form. If you decide to participate in this interview, but later change your mind and want to withdraw, simply notify me, Anna Teitt, NIC in writing or via sign language video message and you will be removed immediately. Should you choose to withdraw during the interview, any data collected from the interview at that time will be destroyed and not included in the analysis. Your decision of whether or not to participate will have no negative or positive impact on your relationship with St. Catherine University, nor with any of the students or faculty involved in the research.

What are the risks (dangers or harms) to me if I am in this study?

The possible risks of this study are limited to the potential for negative emotions to surface during participants' reflection on their experiences coping with secondary traumatic stress or vicarious trauma. The interview questions will be focused on the coping mechanisms taught by your interpreter education program and not on your direct experiences with secondary or vicarious trauma. However, should the discussion of these coping skills become so upsetting that the participant experiences signs of distress (including feeling depressed, hopeless, or having flashbacks) the researcher will end the interview and the participant's interview data will not be included in the study. The researcher will also assist the participant in accessing the attached resources for follow-up support. The likelihood that this risk will occur is low, as interview questions will remain open-ended and focused on coping skills. The risk is low that you will experience signs of distress and to maintain that low level of risk, you may decline to answer any question or part of a question without an explanation, e.g., by stating "pass" or "I prefer not to answer."

What are the benefits (good things) that may happen if I am in this study?

Providing space for you to share your thoughts, express how you feel, and an increase in your awareness of coping skills are the direct benefits to you, the participants. Additionally, the field of sign language interpreter education will benefit from the results of this study. The broader Deaf community will also benefit from this study, as the results of this study may aid interpreter education programs in developing curriculum to prepare interpreters differently for secondary traumatic stress and vicarious trauma which may lead to less interpreters experiencing these phenomena, allowing them to better serve the Deaf community. While the published data and

results will remain anonymous, should you so choose, participants may include your participation in this study on your resume or curriculum vitae.

Will I receive any compensation for participating in this study?

You will not be compensated for participation in this study.

What will you do with the information you get from me and how will you protect my privacy?

The information that you provide in the interview will be transcribed, de-identified by assigning each interviewee's data with a number and combined with other interviewees' data to draw conclusions. The researcher will keep the research results in the form of password protected files on their personal computer and only the researcher and their advisor will have access to the records while they work on this project. The researcher will finish analyzing the data by June 1st, 2022, and will then destroy all original reports and identifying information that can be linked back to you within six (6) months of study completion or by December 31st, 2022, whichever comes first. All audio or video recordings will be stored in the password protected Box Document Storage Cloud, available only to the researcher and their advisor for the purposes of this research. Any transcripts of the interview recordings and any read-outs from the analysis software will also be kept in the Box Document Storage Cloud. These recordings will be destroyed within six (6) months of the completion of the reporting and publication of this research or by December 31st, 2022, whichever comes first.

Any information that you provide will be kept confidential, which means that you will not be identified or identifiable in the any written reports or publications. If it becomes useful to disclose any of your information, the researcher will seek your permission and tell you the persons or agencies to whom the information will be furnished, the nature of the information to be furnished, and the purpose of the disclosure; you will have the right to grant or deny permission for this to happen. If you do not grant permission, the information will remain confidential and will not be released.

Could my information be used for future research?

Yes, it is possible that your data will be used for additional research. All collected data will be de-identified and may be used for future research by the same researcher without gaining additional informed consent.

Are there possible changes to the study once it gets started?

If during the course of this research study the researcher and/or their advisor learns about new findings that might influence your willingness to continue participating in the study, they will inform you of these findings.

How can I get more information?

If you have any questions, you can ask them before you sign this form. You can also feel free to contact me, Anna Teitt, NIC at (443) 212-8685 or anteitt184@stkate.edu. If you have any additional questions later and would like to talk to the faculty advisor, please contact Justin Small, EdD at jmsmall508@stkate.edu or 952-388-2158. If you have other questions or

concerns regarding the study and would like to talk to someone other than the researcher or advisor, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:

I consent to participate in the study and agree to be videotaped/audiotaped.

My signature indicates that I have read this information, my questions have been answered and I am at least 18 years of age.

_____

Signature of Participant Date

_____

Printed Name of Participant

_____

Signature of Researcher Date

Appendix E

1. Tell me about the work you typically do. (Where, what settings, etc.)
2. Tell me more about what coping strategies your IEP provided you with.
3. If not from your IEP, where did you learn your coping strategies?
4. Have you attended workshops and continuing education courses related to self-care? If so, why?
5. Have you learned to engage in self-care? If so, what kind of self-care and where did you learn it? E.g., Group meetings? Exercise? Etc
6. Tell me about a time when a Deaf consumer described or experienced trauma while you were interpreting with/for them.
7. Did you experience feelings of secondary or vicarious trauma as a result of that interaction? If so, do you mind describing or discussing those feelings? Not a description of what caused the feelings to arise or any traumatic experiences you've had, but a description or discussion of your feelings of STS or VT.
8. When that happened, what did you do? How did you respond? (Coping strategies in place?)
9. What do you wish you had learned at your IEP regarding secondary traumatic stress and vicarious trauma?
10. What settings do you believe are the most vulnerable to secondary traumatic stress and vicarious trauma? What makes those settings riskier in your opinion?
11. Do you find yourself engaging in maladaptive coping strategies due to a lack of education about healthy coping? If so, explain.
12. If you do use maladaptive coping strategies, are they influencing your life in a negative way? Do you mind explaining?