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Overcoming Language Barriers in Mental Healthcare and Other Community Settings: Interpreting Practices and Training Measures

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Table of contents

List of tables

List of abbreviations

AMIF	Asylum, Migration and Integration Fund
BSW	Berufliche Selbstwirksamkeitserwartung [Professional Self-Efficacy Expectation]
CI	Community Interpreting
CIP	Community Interpreter
COVID-19	Coronavirus Disease 2019
CRPD	Committee on the Rights of Persons with Disabilities
DAAD	Deutscher Akademischer Austauschdienst [German Academic Exchange Service]
EU	European Union
GAD-2	General Anxiety Disorder-2
LPEK	Lokale Psychologische Ethikkommission [Local Psychological Ethics Committee]
MHCP	Mental Healthcare Providers
NAATI	National Accreditation Authority for Translators and Interpreters
NCCN	National Comprehensive Cancer Network
IBM SPSS	International Business Machines Corporation - Statistical Package for the Social Sciences
ISO	International Organization for Standardization
OECD	Organization for Economic Co-operation and Development
PHQ-2	Patient Health Questionnaire-2
UK	United Kingdom
UKE	University Medical Center Hamburg-Eppendorf
SHR	Saskia Hanft-Robert
SG	Security Guard
SPSS	Sammeln, Prüfen, Sortieren, Subsummieren [collecting, reviewing, sorting, subsuming]
TA	Therapeutic Alliance
TP	Training Participants

1. Background

1.1. Language and global linguistic diversity

Language is the main medium through which we communicate with each other. It enables us to articulate our inner thoughts and feelings while facilitating understanding and engagement with others. Through language, we build rapport, connections, and relationships. Language is acquired through social interactions, evolves over time, and is transmitted across generations (1,2). However, it is not just a mere means of communication but also an essential part of our respective identities. As a symbol of belonging and connectedness, it shapes our social group identities and fosters social cohesion (3–5). Certain languages, dialects, or accents – or, more accurately, the attached social perceptions of their speakers – can also be associated with social hierarchies and power dynamics between groups, leading to perceived prestige or stigmatization (6). Moreover, language can preserve collective knowledge, cultural values, (spiritual) beliefs, and worldviews (7–9). In short, language is an expression of human diversity, with significant variations within and among societies (1,2,7,8).

Globally, about 7,000 spoken languages[1] have been documented, and linguistic diversity has always been a predominant feature of many societies due to the existing cultural and linguistic variety of distinct Indigenous populations (11–14). More than half of the world's spoken languages are Indigenous. However, 50% to 90% of them are at risk of becoming extinct by the end of this century, mainly because they are being suppressed by other larger languages promoted by governments as official languages for use in legal, social, health, authority, and education systems (9,13–15). Although a decline in the total number of languages spoken worldwide is predicted, globalization and growing internal and

[1] Since language can be categorized as either spoken/oral language, which refers to the vocal-auditory modality (i.e., articulated with the vocal tract, transmitted by sound waves, received and processed by the auditory system), or sign language, which refers to the manual-visual modality (i.e., often articulated using hands and arms, transmitted by light waves, received and processed by the visual system) (10), it should be noted that this dissertation focuses on the importance of spoken language in mental healthcare and other community settings.

international migration are increasing the diversity of languages spoken within a geopolitical context, which often go beyond those that are officially recognized and/or predominantly used (9,16–19). However, this linguistic diversity is very seldom reflected among service providers or in community settings, including healthcare (e.g., psychotherapy, psychiatric, or general hospitals), social services (e.g., housing or family counseling centers), education (e.g., schools or kindergartens), or government authorities (e.g., youth welfare or immigration offices) (20–23).

This issue appears to exist globally, presenting challenges across officially monolingual and multilingual contexts. For instance, in South Africa, which provides a geopolitical context of interest in this dissertation, colonial supremacy has led to the predominance of the colonizers' languages at the expense of the Indigenous languages (9,16). During apartheid – a system of institutionalized racial segregation and oppression that ended formally in 1994 – only English and Afrikaans were considered official, and Indigenous languages such as isiXhosa or isiZulu were actively suppressed. The government has recognized the significance of Indigenous languages in recent years, and today South Africa has 12 official languages, including South African sign language. However, the consequences of the past are still present, and colonial languages continue to dominate most community services, leading to significant language disparities and unmet linguistic needs among service users. While the majority of the South African population speaks either isiZulu (24.4%) or isiXhosa (16.3%) inside households (24), the majority of certain professional groups, such as doctors or psychotherapists, primarily speak English and, apart from Afrikaans, have limited proficiency in the Indigenous languages, despite policies to diversify the social and healthcare workforce (17). Furthermore, South Africa has become one of the most important immigration countries in Africa, often for migrants[2] from neighboring countries (29,30).

[2] When discussing migration and, in particular, individuals labeled as migrants or refugees, it is important to recognize that public discourse often mistakenly treats them as a homogeneous group. However, this homogenization overlooks their considerable diversity, complexity and uniqueness and could have dehumanizing consequences. The experience of leaving a country alone does not fully describe a person. The reasons for migration, the patterns of migration flow, and people's individual identities vary widely, encompassing different linguistic competencies, levels of proficiency in the official and/or predominant language(s) of the country or region of residence, and varying degrees of skills, capacities, and investments in learning a new language (25–28).

Over the past decades, international and internal migration has increased South Africa's linguistic landscape (17–19,29–31). A previous study revealed that only 6% of medical interactions in South Africa are conducted fully or partially in the service user's native language (32), highlighting the linguistic disparities between service providers and users.

In other officially monolingual parts of the world, globalization and international migration can be considered the main drivers for growing linguistic diversity within societies. Even though the vast majority of people remain in the country where they were born and the number of internal migrants is estimated to be much higher, international migration has increased over the last few years (25). The latest World Migration Report states that in 2020 there were 281 million international migrants, defined as people who live in a country other than their country of birth. This is 13% more than in the previous report from 2015 (248 million) and encompasses 3.6% of the world's population (25). Based on this World Migration Report, most people migrate primarily for work, family, or educational reasons (25). However, there is a lack of accurate global data. In 2020, there were an estimated 169 million labor migrants worldwide (25). The number of international students, who are just one example of migration due to educational reasons, has almost tripled over the last 20 years, from 2.2 million in 2001 to 6.39 million in 2021 (25). In 2022, 2.2 million (40%) of migrants to the 38 Organization for Economic Co-operation and Development (OECD) countries migrated due to family reasons (33). While the majority of migration is voluntary and safe, a significant number of individuals are forced to leave their region of residence due to war, persecution, conflict, or violence as evidenced by the 39.7 million internationally displaced people, including refugees or asylum seekers, and 71.2 million internally displaced people in 2022 (25,34). In addition, in recent years, the consequences of climate change, which exacerbate peoples' vulnerabilities, have emerged as a crucial force for migration and have gained increased attention (35–37).

Individuals and families moving within or across countries often bring their native language(s) to the new region or country of residency. Additionally, their proficiency in the official and/or predominantly spoken language(s) of the new country or region is often associated with their reason for migration (25–27). For instance, students migrating for educational opportunities may possess higher initial language skills and have a greater capacity and motivation to rapidly acquire the local language(s) to ensure academic

success. In contrast, those forced to flee their country or region due to war, conflict, or persecution may have to first prioritize their survival, which can delay language acquisition. A study investigated German language skills among migrants who arrived as refugees in Germany and other migrants without refugee experience. It was found that German language skills at the time of arrival were significantly lower among migrants who arrived as refugees compared to other migrants. While migrants who arrived as refugees, on average, reported no German knowledge at all, other migrants reported at least poor knowledge of German on arrival. However, the study also showed that the German language skills of refugee migrants improved considerably over time. At the time of the survey, which was conducted on average 17 years after the participants' arrival in Germany, they had almost the same level of German language skills as migrants without refugee experience (27).

Germany, the main geopolitical context of interest in this dissertation, is currently the nation with the largest foreign-born population in Europe (38). In 2022, 18.4% of the total German population has immigrated since 1950, and an additional 10.5% had at least one parent born abroad, with the leading countries of origin being Turkey, Poland, Russia, Romania, Kazakhstan, and Syria (39). Germany recognizes German as the official language of administration, legislation, education, and communication within government institutions.[3] However, due to Germany's long and complex history of immigration, the variety of spoken languages goes far beyond this. While 80% of the population speaks only German at home, 4.7% use an additional language, and approximately 15.3% primarily or exclusively speak a foreign language in their households and for daily communication. A great proportion of individuals who migrated to Germany feel very confident speaking German. However, others lack German proficiency and prefer using another language upon arrival and also after years of residence (40). Over half of migrants use mainly (35.6%) or solely (18.4%) a foreign language at home (41). These foreign languages are often significantly underrepresented among service providers and future professionals, such as medical students, in Germany (20,21,30,42). For instance, Mösko et al. (2013) found that outpatient mental health services in Northern Germany provided treatment in 16 different languages,

[3] In some regions, other languages also have official-language status. These include Danish and Frisian in Schleswig-Holstein, Sorbian in south-east Brandenburg and north-east Saxony, and Low German in parts of Northern Germany.

however, the most commonly available non-German languages were English, French, and Swedish, which did not match the languages spoken by the major migrant groups at the time of the study (20).

It can be concluded that linguistic diversity is a global reality. In addition to the wide variety of distinct Indigenous languages, factors such as globalization and internal and international migration further increase the linguistic landscapes within and among societies. However, this diversity is often not reflected among service providers in mental healthcare and other community settings, resulting in different language preferences between service users and providers.

1.2. Consequences of different language preferences in mental healthcare and other community settings

Language plays a critical role across all community settings as it serves as the primary medium through which services can be accessed by service users as well as appropriately delivered by the providers (43). Language shapes the interaction and communication between service providers and users. Needs, concerns, symptoms, and other relevant information can be shared, and services can be provided through words. Language facilitates mutual understanding, trust, rapport, and the formation of an empathetic and trusting alliance between service providers and users (43,44). Effective verbal communication is even more critical in mental healthcare settings, as symptoms are often not directly observable. How something is expressed verbally is central to diagnosis and treatment, and treatment is mainly provided through spoken words (45,46).

In linguistically diverse populations, some service users might prefer a different language than the predominant one(s) spoken by the providers. Deviating preferences can arise from perceived limited proficiency in the predominant language(s) of the country or region of residence, although this is not always the case. Language preference is context-specific and depends on the complexity of the communication. While linguistically diverse service users may feel competent and confident using the official or predominant language(s) in everyday social contexts, they can struggle with comprehension and communication when engaging, for example, with mental healthcare providers, due to the increased complexity of the communication (47,48).

The emphasis on the term language preference is a relatively new approach compared to the often-used concept of service users' "limited language proficiency or skills" (47,48). It is argued that the concept of limited language skills, which has also been used in some of the publications in this dissertation, and will thus be critically reflected on, propagates a deficit-based view of service users' variety of linguistic skills and positions minority language speakers as deficient (49). Linguistic disparities between service users and providers are often viewed as a deficiency on the part of the service users rather than as a structural issue of society (50–54). The conceptualization of limited language proficiency fails to acknowledge that language ability and comfort are contextual and overlooks the responsibility of community services in addressing systemic barriers that contribute to inequitable service provision in linguistically diverse societies (47,48).

Besides calls to be linguistically more precise when discussing language issues and to rethink and reflect on the often-used concepts, previous research has clearly demonstrated that service users who have perceived limited language competencies in the official and/or predominantly used languages(s) of the country's or region's community services, and consequently prefer a different language, have significantly poorer social and health outcomes (2,13,49–55). For instance, Tam and Page (2016) demonstrated that the perceived English competencies of migrants in Australia are associated with higher labor market participation, greater social inclusion, improved access to healthcare, better health-related lifestyle choices, and a better health status compared to those with lower English proficiencies (55). Montemitro et al. (2021) conducted a systematic literature review on the association between migrants' perceived proficiency in the language(s) of their region or country of residence and mental disorders. Most cross-sectional and longitudinal studies reported a significant negative association between language proficiency and the prevalence of mental disorders and/or severity of psychiatric symptoms, including psychosis, mood, anxiety, and post-traumatic stress disorder (PTSD). Only two studies found no association (56).

Individuals with differing language preferences can face significant inequalities in accessing and utilizing community services and receiving high-quality care compared to individuals who are fluent in and prefer the official and/or predominant language(s) (2,13,49–52,54,57). They may experience considerable challenges in finding, understanding, and using

information on the available community services, including mental healthcare, in their country or region of residence. These difficulties can lead to poorer health literacy, hindering their ability to navigate the often complex systems, impairing their capacity to make informed decisions, and consequently negatively impacting their care-seeking behavior and utilization of services (58–62). Fong et al. (2022) conducted a study among Korean parents of autistic children who reside in British Columbia, Canada. They found that a non-preference for English impacts their ability to find and understand information on available services for their families, negatively influencing their willingness to engage with support services and communicate their needs to service providers (61). The lack of adequate quality multilingual information is a significant barrier to facilitating equity in accessing and utilizing mental healthcare and other community services (54,63). In response, the World Health Organization, for example, has emphasized publishing and providing healthcare information in various languages (64).

Furthermore, the linguistic skills of front-office and administration staff, as well as the language of written information materials such as appointment letters, can impede linguistically diverse service users from accessing and utilizing mental healthcare and other community services (53,57,65). Riggs et al. (2012) demonstrated that among mothers from refugee backgrounds who had lived an average of 4.7 years in Australia, a non-preference for English led to a lack of confidence in making appointments via phone in the field of maternal and child health (53).

Another challenge is linguistic discordance between service providers, such as psychotherapists or medical doctors, and users due to differences in their linguistic skills and preferred languages (20,21,54,66). Language concordance is considered an important foundation for ensuring equity in accessing services and providing high-quality and user-centered care (43). Focusing on (mental) healthcare settings, the severe consequences and risks associated with linguistic discordance have been documented in several studies. This can lead to miscommunication, misdiagnosis, ineffective treatment, lower treatment satisfaction, and reduced service user safety (31,50,52,66–71). Fong et al. (2022) described that the Korean parents of autistic children expressed feeling uncomfortable and shy when communicating with service providers and disclosing health information in English, meaning that relevant information could be withheld (61). Olani et al. (2023) conducted a

study among Afaan Oromoo-speaking service users and healthcare providers in Addis Ababa, Ethiopia. Although Ethiopia is a multilingual country, Amharic is considered the only working language across community services in this region. The study showed that the consequences of linguistic discordance include preventable medical errors, lower treatment adherence, lower health-seeking behavior, additional treatment cost, increased length of hospital stays, weak therapeutic alliances, social desirability bias, less confidence, and dissatisfaction with the healthcare services received. In addition, healthcare providers reported that they were limited in their ability to take service users' medical histories, make diagnoses, and provide treatment, and that workloads had increased (68). In line with this, in their study among psychiatrists in South Africa, Kilian et al. (2015) revealed that although clinicians were highly persistent when trying to engage with language-discordant service users, build rapport, and gather important diagnostic information, service users often responded briefly and monosyllabically or remained silent, which negatively impacted the clinicians communication style (22). If verbal communication does not work properly, dissatisfaction and frustration can arise on the part of both service users and providers, jeopardizing the quality of the communication and the quality of the services provided (51,55).

In addition, Yeheskel and Rawal (2019) provided an overview of linguistically diverse service users' experiences in healthcare. They demonstrated that linguistic disparities could lead to discrimination against service users by providers or administrative staff, particularly in intersection with other dimensions of service users' identity, such as gender, immigration status, race/ethnicity, or socioeconomic status (57). In their study among cross-border migrants in South Africa, Hunter-Adams and Rother (2017) demonstrated that the inability to speak local South African languages (in this case, isiXhosa) led to labeling and stereotyping by healthcare providers, and medical procedures being performed without consent (31). Miteva et al. (2022) compared service users with low proficiency in the local language(s) and language-proficient service users in Switzerland, and explored how language preferences impact the help-seeking behavior, service use, treatment, and outcomes of service users with mental health issues. They revealed that low proficiency in the local language (Swiss-German) constitutes a risk factor for coercive measures. In comparison, service users with low proficiency in the local language had a higher

probability of compulsory admission and higher rates of compulsory medication and seclusion/restraint (70). Furthermore, communication difficulties due to language disparities between the service provider and the user can increase the likelihood of premature dropout (72,73).

In addition to the risks associated with language discordance when service providers and users sit in the same room, research has shown that linguistically diverse service users often fail to gain access at all, even though they need and actively seek it. For instance, Mösko et al. (2024) found that 19.6% of clinicians working in outpatient diabetological practices in Germany rejected treatment due to language barriers within the last quarter of the year (42).

In conclusion, differing language preferences and language barriers significantly impede the service users' access to and utilization of community services. They can reduce the quality of care provided, particularly in mental healthcare, where verbal communication is central to treatment. The consequences of language-related inequalities have gained increasing visibility and recognition in recent years. During the COVID-19 period, these became globally exacerbated as life-threatening health needs were not adequately met in linguistically diverse populations (74). Thus, mental healthcare and other community services are increasingly challenged to provide equal and user-centered services for all individuals, including those who prefer a different language than the predominately spoken language(s) of the service providers and community settings.

1.3. Interpreting practices to overcome language barriers in mental healthcare and other community settings

When service providers and users do not sufficiently share a common language for the type of communication, a range of practices are applied to overcome language barriers, including nonverbal communication, receptive multilingualism, technological tools, and assigning informal (untrained or lay) interpreters, such as family members or multilingual personnel, or qualified interpreters (17,45,62,71,75–85). Interpreting refers to the oral transfer of spoken words or messages between speakers of different languages (86,87). Since this dissertation focuses on interpreting practices, the following section will briefly discuss only the assignment of qualified and informal interpreters.

Qualified interpreters: Previous studies have emphasized that working with qualified or trained interpreters, often called professional interpreters, is the most effective approach to providing high-quality services when the service provider and user do not sufficiently share a common language (45,46,71,80,83,88–91). Focusing on healthcare settings, the literature indicates that assigning qualified interpreters can improve the quality of care provided to a level that approaches or equals the quality of service provision in language-concordant encounters (80). Higher levels of interpreting accuracy, less loss of relevant information, fewer role conflicts, maintained professional boundaries, adherence to professional ethical principles, a safer environment for the service users, and higher satisfaction on the part of service providers and users were reported in various studies comparing qualified versus informal interpreting practices in mental healthcare and other community settings (80,88,91–93).

However, there is often no clear definition of what makes an interpreter qualified, which can make comparisons between qualified and informal interpreting difficult. Qualified, trained, or professional interpreters usually include people who are somehow trained for the interpreting activity, even though there is a wide variation in the extent and content of such training (80,87,94–96). Generally, qualified interpreters should possess adequate linguistic skills and interpreting competencies and adhere to professional ethical principles such as accuracy, confidentiality, and impartiality (87,97–99). However, despite these general expectations, the definition of what makes an interpreter truly qualified remain vague. Note that this aspect will be further elaborated on in the following section on community interpreting.

Although assigning qualified interpreters is considered best practice, this is often unattainable in reality. The underuse of qualified interpreters has been reported across countries and in various community settings, including mental healthcare, and attributed to several individual, institutional, and systemic factors. These factors include service providers' lack of awareness and knowledge, insufficient competencies and negative attitudes toward working with interpreters, an additional bureaucratic and organizational workload, and high costs. Additionally, the convenience of using alternatives, such as family members or bilingual staff members, contributes to this issue (30,81,100–103). For instance, Maul (2012) showed that a lack of knowledge regarding the value of qualified interpreters

and how to work with them effectively is a reason physicians in the United States rely on their own linguistic skills rather than calling on a qualified interpreter (103).

Moreover, on an institutional and systemic level, qualified interpreters may not be available due to limited resources, as reported in studies conducted, for example, in mental healthcare settings in South Africa (19,22). In addition, the lack of legal regulations regarding the training of interpreters and funding of interpreting costs, particularly in (mental) healthcare, further limits the availability of qualified interpreters. They are assigned less frequently or not paid adequately due to the uncertainty regarding the coverage of costs, which often falls to the service providers or users (30,96,102,104). Gartner et al. (2024) conducted a study among outpatient psychotherapists in Germany who have not yet worked with qualified interpreters in outpatient mental healthcare. Their study aimed to identify factors that could prevent the assignment of qualified interpreters and possible incentives for outpatient psychotherapists to provide psychotherapy mediated by a qualified interpreter. The findings suggest that improving structural factors, such as secure funding, minimal additional work, and better preparation and training, could facilitate the integration of qualified interpreters into outpatient care in Germany (102).

Informal interpreters: Various studies have shown that assigning people who are not qualified to work as interpreters, such as family members, friends, or multilingual personnel, is an often-used strategy in cases of language discordance across countries and settings (19,22,71,77,81,85,86,88,89,105–110). However, appointing interpreters who lack formal training poses significant challenges across community settings, and particularly in mental healthcare, due to the emotional sensitivity and importance of language. Individuals may be deployed as informal interpreters despite lacking the necessary linguistic skills, interpreting competence, and adherence to professional ethical principles. Without proper training, these individuals may struggle to manage complex interpreting scenarios, resolve ethical dilemmas, and maintain professional role boundaries. Insufficient linguistic abilities and specialized knowledge of the interpreter can result in miscommunication and inaccurate interpretations, thereby compromising the service provider/user relationship and the effectiveness and outcomes of the communication and treatment (19,22,71,77,81,85,86,88,89,105–110). There are also disadvantages for those assigned as

informal interpreters, such as an increased emotional burden (112,113) or loss of income if family members are required for interpreting purposes and thereby miss work (31).

In contrast, it was found that family members as interpreters may be valued due to their relationship and knowledge, service user comfort, trust, cultural norms, time efficiency, and continued help outside the consultation (105–107), while being aware of the risks to the quality of communication, such as incorrect interpretation or jeopardizing service users' confidentiality, anonymity, and privacy (105). Pines et al. (2020) conducted a study involving different healthcare professionals in Australia and explored the use of family members as interpreters. They indicated that the perceived appropriateness of family members varied depending on the nature of the communication. Family members were considered acceptable for conveying basic or non-medical information, but were deemed entirely inappropriate for sensitive or confidential matters. However, in practice, for example, in emergency cases, when no other options were available, family members were still commonly assigned (106).

In conclusion, previous research has shown that assigning qualified interpreters is considered "best practice" and should be preferred. However, due to several reasons, including the lack of available qualified interpreters, lack of standards, bureaucratic hurdles, and service providers' lack of knowledge, it has been shown that individuals such as family members or multilingual staff informally serve as interpreters, which risks the quality of service provision and raises ethical questions.

1.4. Short introduction: Community interpreting and its legal regulations

Even though community interpreting (CI) is considered the oldest form of interpreting, it only established itself as a field of research in interpreting studies at the beginning of the 1990s, where, until then, the focus had mainly been on theoretical aspects and conference interpreting (86,114–116). CI is distinct from other forms of interpreting, such as conference interpreting, as it occurs within community and/or public service institutions to ensure equal access when service users and providers do not sufficiently share a common language. Usually, CI settings include (mental) healthcare, social services, education, and governmental authorities (87,96,114–117). There is an ongoing international debate about whether legal and court interpreting should be considered part of community and/or public

service settings and thus be included under the umbrella of CI (96,114). Previous research has indicated that interpreters working in community settings typically work across multiple settings, engaging with various service providers and users (118).

Pöllabauer (2013) and Hale (2007), among others, list several key aspects in which CI differs from other types of interpreting, i.e., mode of delivery, formality/orality, intimacy/emotionality, involvement, non-equality/power asymmetries, conflicting goals, social tension, and lack of awareness and level of professionalization (87,96). Interpreters working in community settings typically facilitate dialogic encounters between two or more speakers. CI usually focuses on bilateral interpretation, with community interpreters transferring utterances into both working languages, often using the consecutive mode, where interpretation occurs once the speaker has paused (87,96,119). Encounters in community and/or public services can vary from highly formal to informal, and the communication is usually unplanned. While community interpreters frequently work in face-to-face settings, they may also provide services via telephone or video (87,96). Conference interpreters typically work from an interpreting booth, which physically separates them from the interlocutors. In contrast, community interpreters sit close to both the service user and provider, making them a visible and integral part of the interaction. This proximity can result in a greater level of involvement in the interaction, contradicting the misconception that they could, or even should, remain invisible (86,87,96). Community interpreters face the challenge of simultaneously catering to the service providers' and service users' needs, which could lead to role conflicts (96). In addition, they might have to navigate inherent power imbalances between service user and provider, conflicting goals, social tensions, or racial biases, among other complexities that can occur in community settings (86,87,96).

While there is a growing demand for qualified interpreters working across community settings, they are often not seen as professionals, and the absence of legally established standards in the field of CI remains a significant issue in many countries in this regard (87,95,96,109,115,120–123). Despite fundamental principles, such as Article 2 of the United Nations Universal Declaration of Human Rights (1948), which asserts that people should not be treated differently because of their language (124), in most countries and across community settings, such as mental healthcare, there is no legal entitlement to interpretation services when service providers and users do not sufficiently share a common

language (120). Conversely, legal regulations for sign language interpreting in social and healthcare settings are generally more established. A key document, Article 9 of the United Nations Convention on the Rights of Persons with Disabilities (2006) (CRPD), mandates that all state parties to the Convention, including all EU member states and other ratified countries such as South Africa (125), are legally obligated to ensure accessibility for persons with disabilities, including deaf individuals. Consequently, many countries have clear legal regulations concerning the entitlement to sign language interpreting services in community settings, detailing their training, required qualifications, and coverage of interpreting costs. Such regulations can ensure that qualified sign language interpreting services provide deaf people with the support they need.

A consequence of the absence of legal entitlement to interpretation services in most countries and community settings is a lack of legal regulations and standards concerning the organization, utilization, funding, training, and certification of community interpreters (87,95,96,109,115,120–123). To fill the gap of the lack of standards, the global International Organization for Standardization (ISO) Guidelines for Community Interpreting was developed in 2014 and revised in 2024 (126). The ISO Guidelines address CI as a profession with specific competencies, qualifications, and ethical principles, not as an informal practice that can be provided by multilingual laypersons such as family members. It includes international recommendations, basic principles, and practices to ensure the quality of CI services (126). Despite these (international) efforts, it has been emphasized that the implementation of legal regulations in the field of CI, which specify the legal entitlement to interpretation services as well as the organization, utilization, funding, training, and certification, depends heavily on the political and social attitudes towards human rights, equity, inclusivity, and non-discrimination in any given geopolitical context (96,104).

Another consequence of a lack of regulations, and an indication of community interpreters' perceived low professional status, is the absence of a legally protected professional title for people working as interpreters in community settings in most countries. Consequently, different terms (e.g., public service, liaison, dialogue, or cultural interpreting) and more setting-specific terms like medical or legal interpreting, are commonly used in the international literature when discussing CI (96,114,119,127–129), whereas others simply call it interpreting (96,130). In the publications and manuscripts of this dissertation, both the

simple term "interpreting" and CI were chosen. The ISO uses CI in their Guidelines for Community Interpreting (ISO 13611:2024) (126) and is the most commonly used label in the English literature (115,119).

In conclusion, CI focuses specifically on interpreting within community settings, such as (mental) healthcare, social services, education, and government authorities. In many countries, there is no legal entitlement to (qualified) interpreting services for service users with differing language preferences in most settings. This results in a lack of legal regulations and standards for community interpreters' organization, utilization, funding, training, and certification, as well as no legally protected professional title.

1.5. Training measures for interpreters and service providers

Due to the lack of legal regulations in the field of CI, individuals are usually not required to possess any specialized training or formal certification to work as interpreters in most community settings. This lack of standards allows anyone to work as a community interpreter, regardless of their actual qualifications and based on their own subjective assessment of their skills (96). This raises concerns about the quality and ethical standards of the services provided and reduces the recognition and professional status of community interpreters compared to other professions (87,94,109,121,123,131,132). A handful of countries, including Canada and Australia, are more progressive in this respect. Australia strongly emphasizes adhering to legal standards and guidelines in the field of CI. The National Accreditation Authority for Translators and Interpreters (NAATI) is the national standards and certifying authority for the translating and interpreting profession in Australia (133). Interpreters seeking to work in community settings often need NAATI certification to demonstrate their competence and adherence to professional standards (133).

In comparison to the often well-educated conference interpreters, training for interpreters working in community settings is usually not offered by higher education institutions such as universities, but often as short courses by non-governmental organizations (87,94,134–136), which could be seen – as mentioned above – as a reflection of insufficient governmental recognition and commitment to this field (104,121,137). The lack of governmental standards regarding interpreters' formal training or certification results in considerable diversity in the minimal qualifications required, the availability of and access

to high-quality training, and the presence of official organizations that certify interpreters (87,88,138–141). Whereas there is almost no CI training available in some countries, others have ad hoc and semi-institutionalized training or comprehensive formal training programs (128,130). However, there is a great diversity in terms of duration, content, admission criteria, and examinations (80,87,94–96). Thus, the training of community interpreters ranges from no training at all to extensive formal education in interpreting, such as a university degree (95). Regarding CI training, the ISO Guidelines for Community Interpreting (ISO 13611:2024) recommend for example a university degree, a recognized educational certificate in CI, or an attestation of competence in interpreting certified by an appropriate government body or recognized professional organization (126).

Hale (2007) highlights the complexity and problematic nature of training, describing it across countries as one of the most challenging aspects in the field of CI. Interconnected factors such as a general lack of recognition of the need for training, an absence of compulsory pre-service training for interpreters working in community settings, a lack of adequate training programs, and differences in terms of the quality and effectiveness of existing training courses pose major challenges in this regard (87). Nevertheless, a formal qualification is increasingly acknowledged as essential for ensuring the provision of high-quality interpreting services and shaping the profession by enhancing its recognition, status, and professional legitimacy (99,114,123,142).

To conduct interpreter-mediated encounters effectively, interpreters and service providers need to be trained. Wadensjö (1998) described interpreter-mediated encounters as "a communicative pas de trois" (a "dance of three," pp. 10–12), highlighting that the quality of the communication does not depend solely on the competence of the interpreter (143). Working with interpreters can pose various challenges for service providers, such as role conflicts or dealing with feelings of being excluded (44,46,144,145). However, service providers are rarely trained for this activity and perceive working with interpreters often as an intuitive activity rather than an acquired professional skill (100,146). Previous research has shown that service providers trained in working with interpreters feel more confident, have increased knowledge, have a more positive attitude towards working with interpreters, and more often work with qualified rather than informal interpreters (147–152).

In conclusion, the absence of legal regulations regarding formal training and certification for interpreters working in community settings has led to significant variation in their training, ranging from no training at all to university degrees. This lack of standardized training and access restrictions can undermine the quality of service provision and compromise the professional recognition of community interpreters. Furthermore, research shows that both interpreters and service providers need training to effectively navigate interpreter-mediated communication, ensuring better outcomes and communication in these encounters.

2. Research objectives and questions

This dissertation explores interpreting practices in mental healthcare and other community settings, along with training measures for community interpreters and service providers to enhance the effectiveness and quality of interpreter-mediated encounters. The overall goal is to improve just and equitable access to and provision of mental healthcare and other community services when service users and providers do not sufficiently share a common language. Based on the research and theoretical background outlined above, five research objectives were developed. These are presented in *Table 1*.

Table 1. Overview of the research objectives of this dissertation

R_1	Explore who works as an interpreter in community settings – focusing on the people who consider themselves interpreters and assessing their sociodemographic profile, working conditions, (formal) training background, mental health status, and psychological distress regarding interpreting.
R_2	Explore who works as an interpreter in community settings – focusing on the people who do not consider themselves interpreters and investigating the role and consequences of informal (unqualified) interpreting practices, using security guards acting as interpreters in a psychiatric hospital as an example.
R_3	Investigate the impact of the interpreters' presence on the communicative situation, using the therapeutic alliance in a psychotherapeutic setting as an example.

R_4	Develop and evaluate the effectiveness of a training for interpreters working in community settings, including mental healthcare.
R_5	Develop and evaluate the effectiveness of educational videos to train service providers to work with interpreters in community settings, including mental healthcare.

Note: R_i are the numbered research objectives.

Research objective 1: Explore who works as an interpreter in community settings – focusing on the people who consider themselves interpreters and assessing their sociodemographic profile, working conditions, (formal) training background, mental health status, and psychological distress regarding interpreting.

Background: Interpreters working in (mental) healthcare and other community settings often receive little recognition from a public perspective. Interpreting in these settings tends to be seen as a charity or volunteer activity provided by bilinguals as an act of social support, rather than a professional service (86,88,96,131,153). In most countries, including Germany, there is a lack of legal regulations regarding interpreters' utilization, formal training, organization, and funding across many community settings, such as healthcare, social care, education, and government authorities (87,95,96,109,115,120–123). Due to the absence of professional standards and legal regulations, the population of interpreters working in community settings, their qualification background, and their working conditions remain largely unknown. Since community interpreters often work with vulnerable populations in emotionally intense and pressured situations, some attention has been drawn to interpreters' mental health and psychological distress regarding interpreting (96,154–158). However, there is a scarcity of evidence-based and comprehensive data concerning community interpreters' mental health and the psychological impact of interpreting. The following research questions are addressed in publication 1 of this dissertation.

Research questions:

i. What are the interpreters' sociodemographic profile, working conditions, (formal) qualification background, mental health status, and psychological distress regarding interpreting?
ii. What are the factors that differentiate between people who have taken part in interpreting specific training and those that have not?
iii. Which factors are associated with self-reported interpreting competence?
iv. Which factors are associated with psychological distress regarding interpreting?
v. What are the differences between the interpreting settings of interpreters in terms of sociodemographic and work-related variables?

Research objective 2: Explore who works as an interpreter in community settings – focusing on the people who do not consider themselves interpreters and investigating the role and consequences of informal (unqualified) interpreting practices, using security guards acting as interpreters in a psychiatric hospital as an example.

Background: Most studies highlight that employing qualified interpreters is the most effective way to deliver high-quality services to linguistically diverse service users, particularly in sensitive settings such as mental healthcare (45,46,71,80,83,88–91). However, this ideal is often unattainable in practice. Due to insufficient resources, regulations, and standards, service providers and institutions frequently resort to informal ad hoc practices, such as relying on family members or untrained multilingual staff, to bridge language gaps (19,22,71,77,81,85,86,88,89,105–110). Although some research has explored the consequences of using informal interpreters (19,71,77,85,88,90,109–111), there remains a significant gap in the research and a lack of studies focusing on the actual practices of informal interpreting. This research gap may be particularly evident in contexts characterized by high linguistic diversity, where qualified interpreters are often not available, and effective communication is critical for effective service provision. The following research question is addressed in publication 2 of this dissertation.

Research question:

i. What are the benefits and challenges of working with security guards as informal (unqualified) interpreters in a psychiatric hospital?

Research objective 3: Investigate the impact of the interpreters' presence on the communicative situation, using the therapeutic alliance in a psychotherapeutic setting as an example.

Background: Across various community settings, establishing a good alliance between service providers and users is one of the most important factors for effective service provision. In a psychotherapeutic context, the therapeutic alliance is particularly important as it is one of the primary mechanisms for change (159–162). Traditionally, a therapeutic setting involves a therapist and a patient who share the same (native) language, allowing them to communicate directly and fluently. The formation of a therapeutic alliance depends only on the interaction between the patient and therapist. Introducing a third person, such as an interpreter, due to linguistic differences between the patient and therapist increases complexity and might complicate the alliance formation (44,46). However, there is limited research on how the presence of an interpreter affects the communicative situation, particularly the formation of a good therapeutic alliance. The following research question is addressed in publication 3 of this dissertation.

Research question:

i. From the therapists' perspective, how does the presence of an interpreter affect the therapeutic alliance when working with trauma-affected refugee patients?

Research objective 4: Develop and evaluate the effectiveness of a training for interpreters working in community settings, including mental healthcare.

Background: While there is a growing demand for interpreters across community settings, the absence of legally established regulations and standards in this field remains a significant issue in many countries (87,95,96,109,115,120–123). For instance, in Germany, interpreters are not required to possess any specialized training or formal certification to work in most community settings, including mental healthcare (95,120). Appointing interpreters who lack formal training poses significant challenges, such as lacking the necessary linguistic skills, interpreting competence, and non-adherence to professional ethical principles (19,22,71,77,81,85,86,88,89,105–110). Formal qualification is increasingly being acknowledged as essential, not only for ensuring the provision of high-quality interpreting services, but also for shaping the profession by enhancing its recognition,

status, and professional legitimacy (99,114,123,142). The following research questions are addressed in publication 4 of this dissertation.

Research questions:

i. What motivates community interpreters to participate in the training?
ii. How satisfied were the training participants with the training?
iii. Are there changes in (subjective and objective) knowledge due to the training?
iv. Are there changes in subjective interpreting competence and skills (including subjective professional self-efficacy expectations) due to the training?
v. To what extent can what has been learned be applied in practice?
vi. What other outcomes could be observed through the training?
vii. How well qualified were the trainers?
viii. How satisfied were the trainers?

Research objective 5: Develop and evaluate the effectiveness of educational videos to train service providers to work with interpreters in community settings, including mental healthcare.

Background: While working with qualified interpreters is considered "best practice," many service providers tend not to use interpreters at all or assign untrained ones, such as family members, in situations requiring qualified/professional interpretation (19,22,81,108). There might be reservations about the effectiveness of interpreter-mediated encounters and a general lack of knowledge about working effectively with interpreters (46,102). Interpreter-mediated encounters differ from monolingual communication in many ways and could be challenging for service providers (44,46,144,145). While the importance of training interpreters is being increasingly emphasized, the training of service providers is often overlooked. However, the quality of interpreter-mediated encounters depends not only on the competencies of the interpreter. To ensure high-quality service provision, providers also need to be trained on how to effectively work with interpreters (46,87,143). The following research questions are addressed in publication 5 of this dissertation.

Research questions:

i. What can service providers learn about conducting interpreter-mediated encounters through the developed educational videos?
ii. What impact do the educational videos have on service provider's confidence to conduct interpreter-mediated encounters effectively?
iii. What are the strengths and limitations of educational videos as a (self-)learning tool in the field of interpreting?

3. Methods

Quantitative, qualitative, and mixed-methods research were used in this dissertation to pursue the research objectives and answer the questions presented in the previous chapter.

3.1. Quantitative research

Research objective 1: Explore who works as an interpreter in community settings – focusing on the people who consider themselves interpreters and assessing their sociodemographic profile, working conditions, (formal) training background, mental health status, and psychological distress regarding interpreting.

In this study, a national online cross-sectional survey was conducted among interpreters working in community settings in Germany. The research was carried out in collaboration with the Federal Association of Non-statutory Welfare and the Federal Chamber of Psychotherapists. Ethical approval was obtained in writing from the Committee of the University Medical Centre Hamburg-Eppendorf (29 July 2021; LPEK-0360).

Participants and recruitment: Any person aged 18 years or older working as an interpreter in community settings in Germany could participate in the study. No further inclusion or exclusion criteria were defined. For recruitment, a convenience snowball sampling approach was used. Institutions with access to the target population, such as interpreting pools, agencies, training institutions, and various social and healthcare organizations, were contacted via email and asked to forward the study invitation to their affiliated interpreters. A required sample size of 308 was calculated using G*Power Version 3.1.

Materials and data collection: The questionnaire was developed through a multistage process, including a literature review and interdisciplinary workshops with various experts.

It was expert-validated by six scientists and tested through cognitive interviews (163) with five interpreters. The final questionnaire consisted of 48 items divided into four sections: a) sociodemographic variables (e.g., gender, age, migration experiences, education); b) work-related variables (e.g., work experience, frequency of interpreting, interpreting settings, payment, working languages, and interpreting-related support services); c) qualification (e.g., hours of training, topics covered in training, passed exams, and structural and personal barriers to attending training); d) psychological distress, both in general and related to interpreting, measured using the NCCN Distress Thermometer and an adapted version of it; depressive symptoms measured using the German Patient Health Questionnaire-2 (PHQ-2) (164); and anxiety measured using the German General Anxiety Disorder-2 (GAD-2) (165). The questionnaire was in German. Data were collected online from June to August 2022 using LimeSurvey (Version 2.62.2+170203).

Data analysis: The data were primarily analyzed descriptively. Dependent t-test, multiple logistic, and hierarchical stepwise regression analyses were performed. All analyses were performed using IBM SPSS Statistics Version 28.0.1.1 (14) and R Studio Version 2021.09.0.

3.2. Qualitative research

Research objective 2: Explore who works as an interpreter in community settings – focusing on the people who do not consider themselves interpreters and investigating the role and consequences of informal (unqualified) interpreting practices, using security guards acting as interpreters in a psychiatric hospital as an example.

This study conducted interviews with security guards and mental healthcare professionals at a psychiatric hospital in the Western Cape of South Africa. The study was realized in cooperation with the Department of Psychology at Stellenbosch University in South Africa. The research was performed in accordance with the Declaration of Helsinki and was approved by the Ethics Committee of Stellenbosch University, South Africa (14 October 2022; SBE-2022-25557).

Participants and recruitment: The study included mental healthcare professionals, who (a) were employed at the psychiatric hospital and (b) had sufficient English language proficiency, and security guards, who (a) worked at the psychiatric hospital and (b) had

sufficient English, isiXhosa, or isiZulu language proficiency. Participants were recruited in person, via email, or by phone following a purposive sampling approach (166).

Materials and data collection: The Problem-Centered Interview by Witzel (167) was used. Two different interview guides for the security guards and mental healthcare professionals were developed following Helfferich's SPSS approach (168), covering the general experiences, benefits, and challenges of security guards working as interpreters. Interviews were conducted in English, isiXhosa, or isiZulu. Data collection was performed between October and November 2022 in person and one-on-one at a quiet place at the psychiatric facility by two interviewers. All interviews were digitally audio-recorded and professionally transcribed verbatim. Transcripts in isiXhosa and isiZulu were translated into English.

Data analysis: All interviews were analyzed following the thematic analysis approach by Braun and Clarke (169), providing a comprehensive six-phase guide: a) familiarization with the data, b) coding, c) searching for themes, d) reviewing themes, e) defining and naming themes, and f) writing up. The coding process was primarily inductive. To ensure intersubjective comprehensibility and credibility (170), four interviews with the mental healthcare professionals and all interviews with the security guards were coded separately by two independent raters. The final category system was critically reviewed and discussed within an interdisciplinary research team. Data were analyzed using MAXQDA 2020.

Research objective 3: Investigate the impact of the interpreters' presence on the communicative situation, using the therapeutic alliance in a psychotherapeutic setting as an example.

In this study, psychologists working in an outpatient clinic specializing in mental healthcare for refugees with trauma-related mental health issues in Copenhagen, Denmark, were interviewed. The study was conducted in cooperation with the Competence Centre for Transcultural Psychiatry in Denmark. No ethical approval is required in Denmark for studies using questionnaires or interviews that do not involve human biological material.

Participants and recruitment: Participants were selected based on a purposive sampling approach (166). Included in the study were participants (a) working as psychologists at the outpatient mental healthcare clinic and (b) having completed at least one course of interpreter-mediated psychotherapy (a minimum of 10 therapy sessions) at this specific

clinic with (c) trauma-affected refugee patients. The research project was presented to all psychologists working at the clinic (n = 10) at one of their weekly meetings. In addition, all of them were invited to participate in the study via e-mail.

Materials and data collection: The interview guide was developed following Helfferich's SPSS approach (168) of collecting, reviewing, sorting, and finally subsuming questions. The guide covered the following topics: the importance of the therapeutic alliance in general and specifically in interpreter-mediated psychotherapies with trauma-affected refugees, the challenges and benefits of having an interpreter involved, and factors that facilitate or complicate establishing a good therapeutic alliance. Data were collected between March and April 2022 in person and in a one-on-one setting in the participants' offices at the outpatient clinic. All interviews were conducted in English, digitally audio-recorded and transcribed verbatim by the researchers.

Data analysis: Data analysis followed Kuckartz's (2014) structuring content analysis approach. A combination of deductive and inductive coding was applied. Deductive categories were derived from the interview guide and were supplemented by inductive categories when new aspects emerged from the interview data during the coding process (171). To ensure intersubjective comprehensibility and credibility (170), three interviews were coded separately by two independent raters. All findings were discussed with the broader research team. Data were analyzed using MAXQDA 2020.

Research objective 5: Develop and evaluate the effectiveness of educational videos to train service providers to work with interpreters in community settings, including mental healthcare.

In this study, interviews with service providers across community settings and experts in the field of CI were conducted in Germany and Switzerland. The study was part of the research project *"Between Languages: Development and Evaluation of Freely Available Educational Videos to Strengthen the Communicative Competencies of Service Providers Working with Interpreters"* from July 2018 to June 2020, funded by the European Asylum, Migration and Integration Fund (AMIF). The project was conducted in cooperation with INTERPRET, the Swiss Association for Intercultural Interpreting and Mediation. Ethical approval was

obtained in writing from the Ethics Committee of the University Medical Centre Hamburg-Eppendorf (4 April 2020; LPEK-0132).

Short description of the educational videos: Eight educational videos were developed based on a systematic literature review and qualitative interviews with interpreters, various service providers, and experts. Three videos aimed to teach best practices regarding face-to-face, telephone, and video interpreting. Five videos showed common challenges when working with interpreters (e.g., interpreter and client slipping into a dialogue, confusing reaction on the client's part, or perceived gaps in interpretations) and possible ways of dealing with them. The videos last between 2:18 and 6:38 minutes and are available at: http://zwischensprachen.de/en/professionals/educational-films.

Participants and recruitment: Participants were selected based on a purposive sampling approach (166). The inclusion criteria for service providers were (a) working in one of the four settings of healthcare, social service, government authorities, or education; (b) at least five interpreter-mediated encounters conducted in the last 12 months; and (c) no previous training explicitly for working with interpreters. Various German and Swiss organizations and institutions were contacted via e-mail or telephone and asked to forward the study invitation to their employees. Further participants were recruited via snowball sampling (142). Experts in the field of interpreting were included as a key informant sample based on their expertise and experience (166). The inclusion criterion was at least three years of professional practice in the educational or scientific field of interpreting. Experts were contacted directly via e-mail or telephone.

Materials and data collection: Two different interview guides for the service providers and experts were developed following Helfferich's SPSS approach (168). Both guides covered interviewees' general impressions of the educational videos, their relevance, impact on knowledge and confidence, and the strengths and limitations of these videos as a (self-)learning tool in the field of interpreting. All interviews were conducted between June and October 2020 in person or via telephone in a one-on-one setting in Germany and Switzerland by two interviewers. The interviews were digitally audio-recorded and transcribed verbatim by a professional agency.

Data analysis: All interviews were analyzed according to Kuckartz's (2014) structuring content analysis. A combination of deductive and inductive coding was applied (171). To ensure intersubjective comprehensibility and credibility (170), six interviews were coded separately by two independent raters. The final category system was discussed in two different research groups. Data were analyzed using MAXQDA 2020.

3.3. Mixed-methods research

Research objective 4: Develop and evaluate the effectiveness of a training for interpreters working in community settings, including mental healthcare.

In this study, a mixed-methods design encompassing qualitative interviews and quantitative surveys was applied to evaluate the effectiveness of newly developed training for interpreters working in community settings in Germany. The study was part of the research project: *"Between Languages: Qualification 'Interpreting in the Community'. A Professional Qualification for Interpreters Working in Healthcare, Social Services, Authorities and Education,"* running from July 2019 to September 2022, funded by the European Asylum, Migration and Integration Fund (AMIF). Ethical approval was obtained in writing from the Ethics Committee of the University Medical Centre Hamburg-Eppendorf (29 December 2020, LPEK-0211).

Short description of the training: Based on the results of a previous research project on quality standards and minimum requirements for the qualification of community interpreters in Germany (95) and a comprehensive literature research, a generic training for interpreters consisting of 500 units and 22 modules was developed and is available at: http://zwischensprachen.de/en/interpreters/qualification. A total of three training courses (two part-time and one full-time group) were conducted between 2020 and 2022. Originally designed for in-person teaching with planned group sizes of 20 participants, the implementation had to be adapted to local COVID-19 restrictions, necessitating a reduction in group size to a maximum of 12 participants per group. The training concluded with a final oral examination. The first course was used as a pilot test and not included in this study.

Participants and recruitment: All individuals who participated in two training courses, including trainers and participating interpreters, were included in this evaluation study.

Materials and data collection: The training evaluation followed Kirkpatrick's training evaluation framework (172), focusing on the three levels of reaction, learning, and behavior. The study comprised qualitative interviews pre- and post-training, quantitative questionnaires pre-, during, and post-training for the interpreters, and post-training questionnaires for the trainers.

The development of the pre- and post-training interview guides for the interpreters followed Helfferich's SPSS approach (168). The pre-training guide covered reasons for participating in this training, expectations and concerns, an understanding of the interpreter's role, and existing knowledge about professional ethical principles. In the post-training interview, interpreters were invited to reflect on the positive and negative aspects of the training, changes regarding their comprehension of the interpreter's role, and knowledge about professional ethical principles. They were also asked about any improvements in their interpreting skills and the practical applicability of what had been learned.

The pre-training questionnaire for interpreters covered sociodemographic variables and interpreting-related variables, as well as subjective interpreting knowledge and competence. Subjective professional self-efficacy expectations were measured pre- and post-training by the BSW, a scale for assessing professional self-efficacy expectations by Abele et al. (2000) (173). A self-developed multiple-choice knowledge test was used pre- and post-training to objectively examine the impact of the training on interpreters' interpreting-related knowledge.

Interpreters were asked to evaluate their satisfaction with each training module (i.e., content, methods, materials, trainers, and overall satisfaction) during the training.

The post-training questionnaire for interpreters covered the topics of overall satisfaction with the training and, specifically, with the organization, content, methods and trainers, training relevance, and improvement in German language skills. Subjective interpreting knowledge, subjective interpreting competence, objective interpreting-related knowledge, and professional self-efficacy expectations were re-assessed in the same way as in the pre-questionnaire. Interpreters were also asked to re-assess their subjective interpreting knowledge and competence before they participated in the training.

The post-training questionnaire for the trainers covered various aspects of the trainers' expertise and experience, including their professional background, current profession, training received related to the content they have taught, professional experience in their teaching fields, previous training experiences, and any past engagements with the target group of interpreters. Additionally, trainers evaluated their satisfaction with the organization and preparation of their teaching units, their teaching practices, and the course participants as a learning group.

All interviews were conducted in person and in a one-on-one setting at the University Medical Centre Hamburg-Eppendorf (UKE). Pre-interviews were conducted between one and two weeks before the training started, and the post-interviews within two weeks after the training had ended but before interpreters had their final exam. All interviews were in German. The interviews were audio-recorded and transcribed verbatim by a professional agency. Interpreters completed the paper-pencil pre-questionnaire before the pre-interview was conducted. The paper-pencil post-questionnaire was completed after the last training unit in the classroom. The questionnaires during the training were completed at the end of each module in the classroom. All questionnaires were in German. The multiple-choice knowledge pre-test was completed at the beginning of the first training unit and the post-test at the end of the last unit in the classroom. All trainers completed their paper-pencil questionnaire within one week after their teaching unit.

Data analysis: All quantitative data from the questionnaires were descriptively analyzed using IBM SPSS Statistics Version 28.0.1.1. (14). All interview data were analyzed following the structuring qualitative content analysis by Kuckartz (2014) (171). The coding process was deductive and inductive. An interdisciplinary research team critically reviewed and discussed the final category system to guarantee intersubjective reproducibility and comprehensibility (170). Qualitative data analysis was performed by using MAXQDA 2020.

4. Results: Overview of individual publications

4.1. Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters

Hanft-Robert S, Mösko M. Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters. BMC Public Health. 2024;(24):1570. doi:10.1186/s12889-024-18988-8

Background: Community interpreters play a crucial role in various community services, including healthcare, when service providers and users do not share a common language. However, there is a lack of evidence-based data on this population globally. This explorative cross-sectional study aims to gain a better understanding of community interpreters and their work in Germany.

Methods: A nationwide online survey was conducted among community interpreters in Germany to collect data on their qualification background, working conditions, mental health, interpreting-related psychosocial distress, and sociodemographics. Participants were recruited through interpreting pools, training institutions, and migrant organizations. Data were analyzed descriptively, and dependent t-test, multiple logistic, and hierarchical stepwise regression analyses were performed to predict participation in interpreting-specific training, interpreting competence, and interpreting-related psychosocial distress.

Results: Across all 16 federal states, N = 873 responses were used for analysis. Most participants were female (74%), born abroad (77%), and had a high level of education (69%). The vast majority interpret occasionally in their leisure time (44%) and are self-employed/freelance (51%). A total of 34% interpret solely or additionally on a voluntary basis (unpaid). The median hours of interpreting per month are 10 hours, and 75% do not exceed 30 hours. On average, interpreters work in four different settings. Around 69% had attended some kind of interpreting training, with a median of 25 hours in total. Interpreting in more settings emerged as an associated factor with participation in training. Of those who have never attended any training, 69% consider themselves as rather/very competent in interpreting. Interpreting more frequently, having less severe anxiety symptoms, being paid more and paid more often, and being less satisfied with the payment is associated with self-reported interpreting competence. In total, 36% reported moderate or severe psychosocial

distress regarding interpreting. Higher general psychosocial distress and depressive symptoms, higher interpreting frequency, and lower payment satisfaction were found to be associated with higher distress regarding interpreting. Additionally, factors such as precarious work conditions, lack of recognition, and discrimination (e.g., racism and sexism) were reported as distressing.

Conclusion: This study provides an initial comprehensive, evidence-based national database on community interpreters in Germany. The findings can be valuable for the development of qualifications, guidelines, policies, and the process of professionalizing the field of community interpreters.

4.2. "The doctor doesn't understand Xhosa and the service user doesn't understand English" – exploring the role of security guards acting as informal interpreters in psychiatric care in South Africa

***Hanft-Robert* S,** Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al. The doctor doesn't understand Xhosa and the service user doesn't understand English – exploring the role of security guards acting as informal interpreters in psychiatric care in South Africa. BMC Health Serv Res. 2024;24(1):1239. doi:10.1186/s12913-024-11722-5

Introduction: Assigning qualified interpreters is considered one of the most effective approaches for facilitating communication in language-discordant encounters in mental healthcare. However, particularly in settings with fewer resources, they are not always available and informal practices are often used.

Objective: This study aimed to investigate informal interpreting practices in mental healthcare in South Africa, focusing on security guards serving as interpreters.

Methods: Guided interviews were conducted with security guards (n = 12) and mental healthcare providers (n = 18) at a psychiatric hospital in South Africa. The interviews were audio recorded, transcribed verbatim and analyzed using a thematic analysis approach.

Results: Despite recognizing that security guards serving as interpreters is not an ideal solution for overcoming language barriers, and could potentially jeopardize the quality of treatment and its outcomes, mental healthcare providers reported relying heavily on security guards due to the underrepresentation of South Africa's linguistic diversity among

themselves. Given the lack of formal interpreting services, the perceived racial, linguistic, and socioeconomic similarities between security guards and some service users, as well as their immediate accessibility, were described as beneficial to providing a minimal level of care (e.g., obtaining information about service users' backgrounds, obtaining an understanding of their symptoms, psychoeducation, and explaining treatment options). The reported drawbacks included security guards being drawn away from their actual duties, experiencing emotional distress, juggling multiple and sometimes conflicting roles, and the risk of incorrect interpretation, which could compromise the ethical standards of care. Additionally, the complexity of power became apparent: Whereas security guards hold little institutional power within the mental healthcare system, they become powerful figures when serving as interpreters.

Conclusion: It can be assumed that mental healthcare providers will resort to informal interpreting practices as long as effective alternatives are lacking. In doing so, risks such as reduced quality of care are accepted, and the consequences and effects on those serving as interpreters are neglected, which raises concerns from an ethical point of view.

4.3. A balancing act: how interpreters affect the therapeutic alliance in psychotherapy with trauma-affected refugees – a qualitative study with therapists

Hanft-Robert S, Lindberg LG, Mösko M, Carlsson J. A balancing act: how interpreters affect the therapeutic alliance in psychotherapy with trauma-affected refugees – a qualitative study with therapists. Front Psychol. 2023;14:1175597. doi:10.3389/fpsyg.2023.1175597

Objective: The therapeutic alliance has the highest predictive value concerning the success of psychotherapy. The study explored how the presence of an interpreter affects the therapeutic alliance when working with trauma-affected refugees.

Method: Semi-structured interviews were conducted with seven psychologists working in an outpatient clinic specializing in mental healthcare for migrant and refugee patients with trauma-related mental health problems in Denmark. Interviews were transcribed verbatim and analyzed using a structuring content analysis approach.

Results: The therapeutic alliance has been described as a dynamic therapist-interpreter-patient alliance triangle consisting of three distinct but highly intertwined and mutually influential dyadic alliances. Specific factors affecting the quality of the therapeutic alliance were identified, for example, the interpreter being emotionally attuned yet not overly involved, the interpreter being barely visible, and the interpreter being present as a human being. Characteristics of trauma-affected refugee patients affecting the therapeutic alliance formation were also identified, for example, a high level of personal distrust, different understandings of mental disorders and psychotherapy, stigmatization, and perceptions of authorities.

Conclusion: The presence of interpreters was perceived ambivalently, and forming a good therapeutic alliance seems to be a balancing act. Based on the findings, recommendations for forming and maintaining a good therapeutic alliance in interpreter-mediated psychotherapy are provided.

4.4. "Just having experience is not enough": development and evaluation of a training course for interpreters working in community settings – a mixed-methods study

Hanft-Robert S, Breitsprecher C, Mösko M. Just having experience is not enough: development and evaluation of a training course for interpreters working in community settings – a mixed-methods study (submitted Front Educ – Language, Culture and Diversity).

Background: Across community settings, such as healthcare, interpreters play an important role in facilitating communication when service users and providers do not sufficiently share a common language. Because most countries lack legal standards in the field of CI, community interpreters are often not adequately trained for this activity, and the need for formal training is increasingly emphasized. This study aims to evaluate a generic training for community interpreters in Germany.

Methods: The training was developed for interpreters working in Germany's healthcare, social care, education, and authorities. It consists of 500 units and a final examination. A mixed-methods design was applied to evaluate the training. Training participants' satisfaction, knowledge, competence, and professional self-efficacy expectations were measured using self-developed questionnaires. A pre-post multiple choice knowledge test

was developed to objectively assess the impact on knowledge. Pre-post qualitative interviews were conducted for an in-depth evaluation of training participants' motives for training participation, experiences, improvements in knowledge, skills, and attitude changes. Trainers' qualifications and satisfaction were assessed using self-developed questionnaires. Quantitative data were analyzed descriptively and qualitative data using a content analysis approach.

Results: In total, n = 21 training participants and n = 18 trainers were included. Quantitative analysis revealed trainers' and training participants' overall satisfaction with the training. Training participants showed increased subjective and objective knowledge, competence, and professional self-efficacy expectations. Qualitative findings showed changes in training participants' knowledge about their role and ethical principles; they reported increased skills and confidence on a professional and personal level. Due to the training, their interpreting performance changed from being relatively intuitive and "natural" to being informed and skills-based. They recognized the complexity of interpreting, thereby acknowledging their professional status. Obtaining a certificate after completing the examination increased their feeling of professionalism. However, training participants expressed the need for further in-depth training since the training was rather generic and broad.

Conclusion: The study shows that a generic training can increase community interpreters' knowledge, skills, competence, professional and personal confidence, and perceived professionalism. It highlights the critical need for formalized training, certification, and overall qualification programs to ensure the quality of interpreting services and also shape the profession of community interpreters.

4.5. Training service providers to work effectively with interpreters through educational videos. A qualitative study.

Hanft-Robert S, Emch-Fassnacht L, Higgen S, Pohontsch N, Breitsprecher C, Müller M, et al. Training service providers to work effectively with interpreters through educational videos: a qualitative study. Interpreting. 2023;25(2):274–300. doi:10.1075/intp.00090.han

Objective: To ensure the quality of interpreter-mediated encounters, both interpreters as well as service providers need to be trained. However, most service providers lack adequate

training. This study aimed to evaluate educational videos as a (self-)learning tool with which to train service providers to work with interpreters.

Method: Eight educational videos were developed in a multi-stage evidence-based process. For the evaluation, semi-structured interviews with 32 service providers across settings and 12 experts in the field of interpreting were conducted in Switzerland and Germany. The interviews were audio recorded, transcribed verbatim, and analyzed using a structuring content analysis approach.

Results and conclusion: Service providers described an increase in their knowledge (e.g., of the complexity of interpreter-mediated encounters, potential challenges, and how to deal with them appropriately) and confidence (e.g., reduced inhibitions about working with interpreters, perceived permission to feel insecure, and encouragement to deal with problematic situations in an interpreter-mediated encounter). However, the need for hands-on practice limits the effectiveness of educational videos as standalone (self-)learning tools, as noted by experts in particular. It is recommended that they be used in combination with other methods, such as face-to-face training, that provide opportunities for hands-on practice. Nonetheless, the videos can be considered a low-threshold and initial (self-)learning tool with which to increase service providers' competence in working with interpreters.

5. Discussion

5.1. Summary of results

Five distinct studies were conducted and have been or will be published separately to address the five research objectives outlined above. The results of this dissertation contribute to previous research in several ways. *Table 2* provides an overview of this dissertation's five studies and key findings.

The first and second research objectives aimed to shed light on the people who serve as interpreters in community settings, including people who consider themselves interpreters and those who do not but nevertheless perform this activity. The cross-sectional study among community interpreters in Germany explored who works as an interpreter in settings such as (mental) healthcare, social care, education, or authorities, thereby focusing on

interpreters' sociodemographic profiles, working conditions, (formal) training background, mental health status, and psychological distress regarding interpreting [research objective 1, publication 1, (94)]. The findings provide a first comprehensive and evidence-based overview of this population. To date, no comparable study nationally or internationally could be found. The findings showed that the interpreters are predominately female (74%), born abroad (77%), and have a high level of education (69%). Most work across several community settings (on average in four settings) but only occasionally in their leisure time (44%), with a median of 10 hours per month. Only a small proportion was employed (12%), and over one-third (34%) indicated that they interpret fully or additionally on a voluntary basis (unpaid). The working conditions tend to be rather precarious (e.g., high uncertainty regarding interpreting jobs, low payment with a median of 20 euros per hour), and more than one-third (36%) reported moderate or severe psychosocial distress regarding interpreting. It can be assumed that the precarious working conditions may discourage individuals from pursuing full-time careers in this field. While the vast majority had attended some kind of interpreting training in the past (69%), the time of training received was relatively low, with a median of 25 hours in total. Of those, only 29% successfully passed a final interpreting examination. This shows that although many interpreters possess substantial practical experience (on average nine years among this study's participants), most lack adequate formal training and examination. In addition, the findings indicate that community interpreters can be considered a vulnerable group, evidenced by the reported moderate or high level of general distress (52%), personal migration history (e.g., 28% stated political, legal, or humanitarian reasons for migration), post-migration stressors (e.g., 36% had no German citizenship), and precarious conditions when working as an interpreter.

The second research objective [research objective 2, publication 2, (174)] focused on informal interpreting practices and their consequences, using security guards serving as interpreters in a psychiatric hospital in the Western Cape of South Africa as an example. The qualitative interview study with security guards and mental healthcare professionals demonstrated that although it is recognized that unqualified individuals serving as informal interpreters jeopardize the quality of communication, treatment, and its outcomes (e.g., due to incorrect interpretation, loss of relevant information, confidentiality concerns), mental healthcare professionals rely on these interpreters due to the language disparities between

themselves and service users and a lack of effective alternatives to overcome language barriers, such as qualified interpreters or mental healthcare professionals who are fluent in the service users' languages. The consequences for the individuals serving informally as interpreters, such as increased psychological distress, being pulled away from their actual duties, or role conflicts (e.g., serving as an interpreter while maintaining safety), are often not taken into account or are simply accepted out of necessity. Perceived benefits were also reported, however, mostly from the perspective of the mental healthcare professionals, such as convenient and easy access. Additional power dynamics were identified, which can influence the communicative situation. Security guards usually have little formal institutional power – they reported a lack of recognition and poor treatment by mental healthcare professionals and service users. However, when serving as interpreters, they find themselves in powerful positions since both service providers and users rely on their language skills.

The third research objective [research objective 3, publication 3, (175)] explored the impact of the interpreters' presence on the communicative situation by using the therapeutic alliance in a psychotherapeutic setting as an example. The results of this qualitative interview study with psychologists working in a specialized mental health clinic for trauma-affected refugees in Denmark revealed that the presence of an interpreter significantly changes the communicative dynamic, especially the alliance formation. Contrary to the common assumption that interpreters should adopt an invisible role, it was found that they actively and inevitably shape the interaction and thus have to be considered an active part of the communicative situation. Due to the interpreters' presence, the therapeutic alliance changes to a dynamic therapist-interpreter-patient alliance triangle consisting of three distinct but highly intertwined and mutually influential dyadic alliances. Forming a good therapeutic alliance in this triadic setting was described as a balancing act. For instance, interpreters were expected to be emotionally attuned without becoming overly involved. Further factors, also in relation to the personal background and history of the service users, such as a high level of personal distrust due to previous traumatic experiences, that impact the alliance formation, were identified. Overall, the findings demonstrate the differences between dyadic and triadic encounters and highlight the need for both interpreters and service providers to receive specialized training for effective collaboration.

The fourth research objective [research objective 4, publication 4, under review] addressed community interpreters' training. The findings provide valuable knowledge on the development and evaluation of the effectiveness of a generic training, consisting of 500 units and a final exam, for interpreters working across community settings in Germany. The mixed-methods study included both interpreter participants and trainers. The primary motives of interpreters for partaking in this training were to become more professional by improving knowledge, skills, and self-esteem. Desired work opportunities, finding employment, and earning money in the short term were further reasons. The findings demonstrate that partaking in this training improved both interpreters' subjective and objective knowledge, perceived interpreting competence, and professional self-efficacy. Additionally, the training contributed to a clearer understanding of the interpreter's role as well as a deeper knowledge of professional ethical principles and the complexity of interpreting, ultimately enhancing interpreters' self-perceived professional status. Interpreters reported that their interpreting performance changed from being relatively intuitive and "natural" to being informed and skills-based. Obtaining a certificate after completing the training and examination increased their feeling of professionalism. It can be concluded that formalized training is needed to ensure the quality of interpreting services and also to shape and increase the recognition of the profession of CI in Germany.

The fifth research objective [research objective 5, publication 5 (176)] focused on service providers' training to effectively conduct interpreter-mediated encounters. The corresponding study provides insights into the development and evaluation of educational videos as a (self-)learning tool aimed at training service providers to work with interpreters across community settings. The findings of this qualitative study with service providers across settings and experts in the field of CI in Germany and Switzerland showed that these videos proved to be beneficial in enhancing service providers' knowledge and confidence in working effectively with interpreters, including how to deal with challenges in interpreter-mediated encounters. While the videos were valued as a vivid and flexible learning tool that helps service providers reflect on themselves, the findings also showed that the effect of videos alone is limited, and interpreter-mediated communication has to be practiced in person.

Overall, this dissertation contributes significantly to the understanding of individuals working as interpreters, including those who consider themselves community interpreters and those serving informally as interpreters, such as security guards in this case. It was found that informal interpreting practices can risk the quality of the communication and its outcomes. It can also be challenging and negatively impact the well-being of the individuals serving informally as interpreters. The findings demonstrate that the presence of an interpreter significantly changes interactions and communication, and highlight that both service providers and interpreters should be trained to ensure the quality of interpreter-mediated encounters. The research provides valuable knowledge and practical recommendations on how to effectively facilitate training for interpreters and service providers. The findings may be beneficial in improving the quality of interpreter-mediated encounters when service users and providers do not sufficiently share a common language, thus promoting equitable access and service provision in mental healthcare and other community settings in linguistically diverse societies.

Table 2. Key findings of this dissertation

R_i	Key findings	Publication
R_1	**Explore who works as an interpreter in community settings – focusing on the people who consider themselves interpreters and assessing their sociodemographic profile, working conditions, (formal) training background, mental health status, and psychological distress regarding interpreting.** ⇒ The interpreters are predominately female (74%), born abroad (77%) and have a high level of education (69%). ⇒ Most work across several community settings (on average in four settings) but only occasionally in their leisure time (44%), with a median of 10 hours per month. ⇒ The minority is employed (12%), and 34% interpret fully or additionally on a voluntary basis (unpaid). ⇒ The working conditions tend to be rather precarious (e.g., high uncertainty regarding interpreting assignments, no regulated payment). ⇒ The median payment of 20 euros per hour is not satisfactory for most participants.	**Hanft-Robert S**, Mösko M. Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters. BMC Public Health. 2024;(24):1570. Doi:10.1186/s12889-024-18988-8

	⇒ Most lack adequate formal training (69% participated in some kind of training, with a median of 25 hours in total) and examination (29% successfully passed a final interpreting examination). ⇒ Community interpreters can be considered a vulnerable group (52% reported a moderate or high level of general distress, 28% had migrated due to political, legal, or humanitarian reasons, various post-migration stressors were found, e.g., 36% did not have German citizenship). ⇒ More than one-third (36%) reported moderate or severe psychosocial distress regarding interpreting.	
R_2	**Explore who works as an interpreter in community settings – focusing on the people who do not consider themselves interpreters and investigating the role and consequences of informal interpreting practices, using security guards acting as interpreters in a psychiatric hospital as an example.** ⇒ Serving as an informal interpreter can have severe consequences for the security guards, such as increased psychological distress, being drawn away from their actual duties, or role conflicts. ⇒ Unqualified individuals serving as informal interpreters can jeopardize the quality of treatment and its outcomes (e.g., incorrect interpretation, loss of relevant information, confidentiality concerns). ⇒ Service providers rely on security guards and other multilingual non-mental healthcare staff due to the language disparities and a lack of effective alternatives. ⇒ There are also perceived benefits, mostly from the perspective of the mental healthcare professionals, e.g., convenient and easy access. ⇒ Additional power dynamics between security guards, service users, and mental healthcare professionals can influence the communicative situation.	**Hanft-Robert S**, Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al. The doctor doesn't understand Xhosa and the service user doesn't understand English – exploring the role of security guards acting as informal interpreters in psychiatric care in South Africa. BMC Health Serv Res. 2024;24(1):1239. Doi: 10.1186/s 12913-024-11722-5
R_3	**Investigate the impact of the interpreters' presence on the communicative situation, using the therapeutic alliance in a psychotherapeutic setting as an example.**	**Hanft-Robert S**, Lindberg LG, Mösko M, Carlsson J. A balancing act: how interpreters affect the therapeutic alliance in psychotherapy with trauma-affected refugees – a qualitative study with therapists. Front

	⇒ The presence of an interpreter significantly changes the communicative dynamic, especially the therapeutic alliance formation. ⇒ Interpreters actively and inevitably shape the interaction and should be considered an active part of the communicative situation. ⇒ A dynamic therapist-interpreter-patient alliance triangle consisting of three distinct but highly intertwined and mutually influential dyadic alliances was identified. ⇒ Specific factors affecting the quality of the therapeutic alliance were found, e.g., interpreters being emotionally attuned yet not overly involved. ⇒ The personal background and history of the service users are also important. ⇒ Alliance formation emerged as a balancing act, which requires both interpreters and service providers to receive specialized training.	Psychol. 2023;14:1175597. Doi: 10.3389/fpsyg.2023.1175597
R_4	**Develop and evaluate the effectiveness of a training for interpreters working in (mental) healthcare and other community settings.** ⇒ Valuable knowledge on the development and evaluation of the effectiveness of a generic training, consisting of 500 units and a final exam, for interpreters working across community settings. ⇒ Primary motives for partaking in this training: become more professional by improving knowledge, skills, and self-esteem; expected work opportunities, obtaining employment, and earning money in the short term. ⇒ Improved subjective and objective knowledge, perceived interpreting competence, and professional self-efficacy of interpreters. ⇒ Clearer understanding of the interpreters' role, a deeper knowledge of professional ethical principles, and the complexity of interpreting, ultimately enhancing interpreters' self-perceived professional status. ⇒ Interpreting performance changed from relatively intuitive and "natural" to informed and skills-based. ⇒ Completing the examination and obtaining a certificate increases interpreters' feeling of professionalism.	**Hanft-Robert S**, Breitsprecher C, Mösko M. Just having experience is not enough: development and evaluation of a training course for interpreters working in community settings – a mixed-methods study (submitted Front Educ – Language, Culture and Diversity).

	⇒ Formal training is needed to ensure the quality of interpreting services and to shape the profession of CI. ⇒ When evaluating training programs, the qualifications and satisfaction of trainers should also be included.	
R_5	**Develop and evaluate the effectiveness of educational videos to train service providers to work with interpreters in (mental) healthcare and other community settings.** ⇒ Valuable knowledge about the development and evaluation of educational videos as a (self-)learning tool aimed at training service providers to work effectively with interpreters across community settings. ⇒ Enhancing service providers' knowledge and confidence in working with interpreters effectively, including dealing with challenges. ⇒ Vivid and flexible learning tool, helping service providers to reflect on themselves. ⇒ The effect of videos alone is limited; interpreter-mediated communication has to be practiced in person.	**Hanft-Robert S**, Emch-Fassnacht L, Higgen S, Pohontsch N, Breitsprecher C, Müller M, et al. Training service providers to work effectively with interpreters through educational videos: a qualitative study. Interpreting. 2023;25(2):274–300. Doi: 10.1075/intp.00090.han

Note: R_i are the numbered research objectives.

5.2. Comprehensive discussion

Linguistic diversity within geopolitical contexts is a global phenomenon, yet this diversity is often not adequately reflected among service providers in mental healthcare and other community settings (20,21,23,30,32,42,177). Alongside the variety of distinct Indigenous languages, factors such as increased globalization and internal and international migration further enrich the linguistic landscapes within and among societies worldwide. Consequently, varying proficiency levels in the official and/or dominant language(s) can exist, resulting in different language preferences between service users and providers. This dissertation included different officially multilingual and monolingual contexts: Germany, Denmark, Switzerland, and South Africa. Despite their differences, the findings of this dissertation support the fact that language barriers are a common reality and that a lack of effective strategies, such as adequately qualified interpreters or multilingual service

providers, poses significant challenges for just and equitable mental healthcare and other community systems globally (30,81).

In general, interpreting in community settings, especially in (mental) healthcare settings, is often viewed not as a profession but as a welfare activity or charitable act (86,96,131,153). This perception can undermine the professional status of interpreters and contribute to the undervaluation of their work. Bahadır (2021) further elaborates that when migrants in particular take on the role of interpreters, for example, in countries like Germany, the interpreting task may be considered a voluntary duty for well-integrated bilingual individuals (*"Bringschuld"*). Bahadır argues that if this perception becomes a social and moral norm among both the broader society of residence and the migrants themselves, it may make the professionalization of interpreting in community settings either unnecessary or unattainable (153). This is also supported by findings in this dissertation (publication 1), which reveal that the majority of community interpreters in Germany are born abroad, work only occasionally in this capacity, often voluntarily (unpaid), and under precarious working conditions, such as low compensation and job insecurity.

Furthermore, and in line with previous research (99,114,123,142), it was found that the lack of formal training and certification procedures in the field of CI could not only risk the quality of communication but further compromise interpreters' professional recognition and status, as demonstrated in the study in this dissertation on training community interpreters in Germany (publication 4). By participating in comprehensive training, it was shown that interpreters learned about the complexity of their work and acknowledged their professional status. After participating in training, interpreters perceived that their interpreting performance changed from being relatively intuitive and "natural" to being informed and skills-based, and thus more professional. For instance, they reported a clearer role understanding and how to maintain professional boundaries, and felt more confident in demanding (appropriate) compensation for their services. In line, Urdal (2024) reports that interpreters perceive themselves as professionals and feel they belong to a professional group after attending a one-year training course (178).

Similar results were found on the part of service providers. The findings of this dissertation demonstrate that the presence of an interpreter significantly changes the communicative

dynamic, particularly in terms of forming a good therapeutic alliance and beyond. Thus, specific competencies are required to work effectively together (publication 3). However, service providers often view working with an interpreter as an intuitive rather than an acquired skill that requires training (100,146). This misconception was echoed in the present research, where service providers admitted that they had underestimated the complexity of interpreter-mediated encounters. Through training interventions and watching educational videos, they realized the differences and complexity, the required professional skills on the part of the interpreter, and their need for specialized training to work effectively with interpreters (publication 5). These findings suggest that formal and institutionalized training is crucial in preparing service providers to effectively work with (qualified) interpreters and acknowledge their professional status. Thus, interpreter-mediated communication should be implemented in service providers' education programs (43).

In both previous studies and this dissertation, it has been consistently emphasized that assigning adequately qualified (often called professional) interpreters is considered "best practice" and should always be prioritized, especially in mental healthcare settings where verbal communication is crucial for effective treatment (45,46,71,80,83,88–91). However, often there is no further definition of what makes someone a "qualified" or "professional" interpreter, raising questions about the required qualification standards. As outlined in the introduction of this dissertation, many countries lack legally established standards and regulations regarding community interpreters' organization, utilization, funding, training, and certification. Often, the professional title is not protected, allowing individuals to refer to themselves as qualified or professional interpreters without undergoing any formal training, certification, or verification process. In addition, the absence of legal regulations regarding formal training and certification for interpreters working in most community settings has led to a significant variety of training programs and variations in community interpreters' training, ranging from no training at all to university degrees (95). The consequences of this are reflected in the findings of the study conducted among community interpreters in Germany (publication 1). Among the individuals who consider themselves community interpreters and actively work in this capacity, only 69% had attended any kind of interpreting training, with a median of 25 hours in total, and 29% of those had successfully passed a final interpreting examination. Thus, the majority lack comprehensive formal

training and certification, questioning whether they possess the necessary interpreting competencies to handle the complex and sensitive nature of their work.

In line with previous studies (19,71,77,88,90,109–111), it was found that individuals acting informally as interpreters usually lack adequate linguistic and interpreting competencies, which can compromise the quality of communication and violate the ethical principles of service provision, particularly in sensitive settings such as (mental) healthcare. Moreover, such practices can have adverse effects on the individuals serving informally as interpreters, such as role conflicts and increased emotional distress (publication 2). Although this dissertation examined informal interpreting practices within South Africa's mental healthcare system, similar practices are widely documented in other countries and settings (30,83,85,88,89,92,106–108,111,146). For example, Jaeger et al. (2019) found that family members and friends frequently serve as informal interpreters in primary healthcare settings in Switzerland. According to their study, 60% of primary healthcare providers reported using informal interpreters for more than half of their interactions with service users, including minors in 23% of cases (108).

The present findings highlight that the use of informal interpreters, such as security guards in the South African study, may arise out of necessity, despite the acknowledgement that this solution is not ideal and may jeopardize the ethical principles of service provision, especially in mental healthcare settings (22,77). However, a reliance on informal interpreters can also be attributed to further factors, including (bureaucratic) challenges in employing qualified interpreters when they are available. In addition, there is a lack of knowledge about the risks that informal interpreting harbors for all parties involved and about the benefits of qualified interpreters. The absence of knowledge and skills for effectively conducting interpreter-mediated encounters can also contribute to this issue (22,81,102,105,108,146). Thus, formal and institutionalized training for service providers could also be beneficial in preventing untrained or lay individuals from serving informally as interpreters.

Furthermore, most community settings lack legal regulations or clear institutional guidelines that define the required qualifications of individuals serving as interpreters. These regulatory gaps may give rise to ambiguity around who is responsible for ensuring effective communication when language barriers exist between service providers and users. Despite

the associated risks, it can be assumed that assigning informal interpreters, such as family members or multilingual staff, will most likely continue to occur, which raises ethical concerns (22,89,106).

In conclusion, while linguistic diversity enriches societies worldwide, it presents significant challenges in settings like mental healthcare, where accurate communication is critical. While a continued reliance on informal interpreters may be understandable, it compromises the quality of services provided and further undermines the professional status of CI. It has been previously argued that the development of legally anchored standards and regulations in the field of CI is closely tied to broader political and social attitudes toward human rights, equity, inclusivity, and non-discrimination within specific geopolitical contexts (96,104). In contexts where these values are less prioritized on a political and social level, the absence of robust frameworks for interpreters' organization, utilization, funding, training, and certification can hinder the professionalism of CI and may reflect broader systemic neglect of marginalized populations. This dissertation's findings highlight the urgent need for formal training, institutional guidelines, and legally anchored standards and regulations to strengthen interpreting as a profession, ensure the use of qualified interpreters, prepare service providers for conducting interpreter-mediated encounters effectively, and consequently overcome language barriers to promote just and equitable mental healthcare and other community services.

5.3. Strengths and limitations of the individual studies

This dissertation examines interpreting practices and training measures for interpreters and service providers working in mental healthcare and other community settings through an interdisciplinary lens. It integrates knowledge and methods from the fields of psychology, global public health, and translation and interpreting studies. The research employs a multi-method approach, encompassing quantitative, qualitative, and mixed-methods studies. The experiences and perspectives of different service providers and formal and informal interpreters were included. The five publications that form the basis of this cumulative dissertation were conducted in four distinct geopolitical contexts – Germany, Denmark, Switzerland, and South Africa – highlighting the global relevance of the dissertation's topic and findings.

Publication 1: The main strength of this cross-sectional online study among community interpreters in Germany is the large sample size and broad reach. In total, N = 873 interpreters from all 16 federal states in Germany were included in the data analysis. Following a participatory approach, individuals from the target group, as well as other significant stakeholders, were involved in the development of the study design, questionnaire, and recruitment processes. The survey covered a wide range of variables to assess interpreters' socio-demographic profile, working conditions, training, mental health status, and psychosocial distress regarding interpreting. To date, no other national or international study has been found to be comparable in terms of scope and sample size. The findings of this study provide an evidence-based, comprehensive, and valuable database, which can be useful for future studies and for policy decisions in Germany, such as the establishment of training standards or the improvement in interpreters' working conditions.

However, despite the large sample size, it remains unclear whether the sample accurately represents the overall population of community interpreters in Germany. CI is not yet recognized as an official profession, making it difficult to estimate the number of people working in this capacity, which limits the generalizability of the results. Additionally, potential biases arising from the use of convenience snowball sampling and online survey methods cannot be ruled out. The findings are based solely on self-reporting measures, lacking objective data. Furthermore, the cross-sectional study design does not allow causal conclusions. Longitudinal studies are recommended to determine the directionality of the associations identified.

Publication 2: The qualitative approach allowed for an in-depth exploration of the complex dynamics surrounding security guards serving informally as interpreters in psychiatric hospitals. A key strength is the heterogeneity of the sample, which included different mental healthcare professionals and security guards speaking English, isiXhosa, and isiZulu. Two raters performed data analysis independently, and the final themes were discussed within an interdisciplinary research team to guarantee intersubjective comprehensibility and credibility (170). The COREQ checklist was used to report the results in a structured and comprehensive way (179).

Despite a relatively large sample size for qualitative research (n = 18 healthcare providers and n = 12 security guards), achieving data saturation remains unclear. Additionally, the interviews were conducted by two researchers: a Black female psychology student from South Africa and a White female PhD student from Germany. Despite their close collaboration, it is important to acknowledge that the differing backgrounds may have influenced the participants, the interview process, and the research findings. Furthermore, this research was limited to a single psychiatric hospital in the Western Cape of South Africa, which may restrict the generalizability of the results to other settings. To improve the variability and applicability of future research, including multiple psychiatric hospitals across various regions and incorporating the perspectives of service users is recommended.

Publication 3: This qualitative study investigated the impact of an interpreter's presence on the communicative situation by focusing specifically on therapeutic alliance formation in a psychotherapeutic setting. Based on the findings, recommendations for developing and maintaining a good therapeutic alliance in interpreter-mediated psychotherapy were derived. Although the study focused specifically on the therapeutic setting, the recommendations may also be applicable to other settings, as building a good relationship is crucial in any community setting. All interviews were conducted by the same person to avoid interviewer bias. Only one person conducted the data analysis. However, the final themes were discussed within an interdisciplinary research team to ensure intersubjective comprehensibility and credibility (170). The COREQ checklist was used to report the results in a structured and comprehensive way (179).

All participants were exclusively recruited from one outpatient clinic in Denmark that specializes in mental healthcare for trauma-affected migrant and refugee patients. While most therapists had extensive experience working with interpreters, which contributed to valuable insights, future research should incorporate multiple inpatient and outpatient clinics and include less experienced therapists as well as service users and interpreters. It is important to note that only one male participant was included in this study (n = 1), and the majority of participants were trained in cognitive behavioral therapy (CBT). A more diverse sample in terms of gender and therapeutic approaches could yield different results. Overall, the sample size (N = 7) was too small to guarantee data saturation.

Publication 4: This study evaluated a generic training for community interpreters in Germany following Kirkpatrick's training evaluation (172) framework. A mixed-methods study design was applied, including qualitative pre-post interviews and quantitative pre-post measures. This allowed for an in-depth exploration of the training's impacts and effectiveness on multiple levels. The self-developed multiple-choice knowledge test proved effective in assessing interpreters' knowledge in this study and could be used in future research after being adapted for the specific context. It should be emphasized that this evaluation study included not only the training participants (community interpreters) but also assessed the qualifications and satisfaction of the trainers to ensure transparency of the training implementation and a more comprehensive understanding of its effectiveness.

Due to COVID-19 restrictions at the time of the in-person training, the sample size (n = 21 training participants and n = 18 trainers) was relatively small, which may limit the generalizability of the results. In addition, most data were collected through self-reported measures, which could lead to bias. Although it was communicated that training and evaluation were to be conducted completely separately, participants may have provided socially desirable responses and favorable outcomes. Furthermore, the absence of a control group makes it difficult to attribute improvements solely to the training, as external factors, such as increased interpreting experience over the time of the training, could have played a role in this regard. The psychometric properties of the self-developed quantitative instruments (e.g., the knowledge test) also require further assessment.

Publication 5: This study's main strength is its large heterogeneous sample. In total, n = 32 service providers across different settings and n = 12 experts in Germany and Switzerland were included in the study. The qualitative and explorative study design enabled an in-depth evaluation of the effectiveness of educational videos on working effectively with interpreters. Data analysis was conducted by two experienced researchers. The final themes were discussed within an interdisciplinary research team to ensure intersubjective comprehensibility and credibility (170). The COREQ checklist was used to report the results in a structured and comprehensive way (179).

The qualitative approach, however, does not allow for generalization of the results about the effectiveness of the educational videos. Moreover, only self-reported methods were

used, not allowing for any measurable conclusions. However, the results can inform future quantitative studies. Due to COVID-19 restrictions, most interviews were conducted online or by phone. However, there were no signs that the participants felt less comfortable or did not speak freely. It should be noted that a self-selection bias on the part of participants who are exceptionally interested in and open-minded towards the topic could not be ruled out. Similar to other qualitative studies, the impact of social desirability and the Hawthorne effect on the study results could not be altogether avoided.

5.4. Implications for research and practice

For research: Despite the abovementioned limitations, this dissertation's findings have several implications for future research. The first study presents an initial comprehensive and evidence-based database assessing various aspects of community interpreters in Germany, shedding light on this often-overlooked group. While the generalization of the results may be limited, they can inform future studies. For instance, it would be interesting to further investigate the association between interpreters' working conditions, their mental health status, and emotional distress regarding interpreting by using validated instruments that measure the variables more precisely and comprehensively. In addition, motives and barriers to participating in interpreting specific training could be looked at in more detail, including measuring (perceived) interpreting competence more comprehensively and with (adapted) validated competence scales.

Moreover, the findings could be beneficial in exploring what impacts interpreters' (perceived) professional status. Variables such as compensation, training, examination and certification, employment, or the attitude of other parties involved may play a role in this regard. Finally, expanding this research to other countries would enable cross-country comparisons, for example, in other German-speaking regions such as the DACH region, the European Union, or even beyond. In particular, a comparison with countries where CI is already more regulated and professionalized by the state, such as Australia, would be interesting.

The second study examined informal interpreting practices at a psychiatric hospital in South Africa, a phenomenon that also occurs in various other countries and contexts. While most research focuses on family members as informal interpreters (30,83,88,89,92,106–

108,111,146), relatively few studies explore the role of multilingual staff, such as cleaners, in these situations (19,77,85). Future research could investigate informal interpreting by multilingual staff in different countries and settings, enabling comparisons for assessing the impact of such practices depending on the services provided. Some studies have highlighted certain benefits of informal interpreters, even suggesting that they may be considered appropriate for specific encounters (106,107). While this may be concerning from an ethical point of view, it might be interesting to explore this attitude further. Based on this dissertation's findings (publication 5), it may be possible that these findings stem from a lack of knowledge about the crucial role of language and a limited understanding of the complexities of interpreter-mediated interactions, including that this task is not intuitive but requires skills.

The third study explored the impact of interpreters' presence on the communicative situation, using the therapeutic alliance in a psychotherapeutic setting as an example. While this study's findings demonstrated significant changes and implications for forming and maintaining a good therapeutic alliance from the therapists' perspective, it is recommended that the experiences of interpreters and service users also be included in future research. Moreover, it would be interesting to quantitatively measure the quality of the therapeutic alliance between interpreter-mediated versus dyadic and language-concordant therapies and look at different therapeutic approaches, i.e., psychodynamic, psychoanalysis, or systemic psychotherapy. Further, it could be valuable to look at different settings and investigate whether the presence of an interpreter might be perceived differently depending on the services provided.

The fourth and fifth studies addressed community interpreters' and service providers' training. Both community interpreters and service providers realized the complexity of interpreting through training, which may help explain why the number of training hours among community interpreters, as found in the first study, is relatively low. It could also explain why informal interpreting practices still commonly occur (146). Both studies indicated the effectiveness of the training programs, but further research is needed to verify these preliminary findings. For instance, using control groups for comparison and including follow-up assessments to measure the long-term effects of training is recommended. It may

also be useful to conduct an experimental study and measure differences between interpreter-mediated communication before and after training.

For practice: Implications and recommendations for practice are made at an individual, institutional, and systemic level. It should be noted that these implications and recommendations are more generic and may have to be adapted depending on the geopolitical context. At an individual level, service providers need to adopt a more welcoming attitude toward working with linguistically diverse service users and interpreters. They must acknowledge that ensuing equitable, high-quality, and user-centered care for all individuals, including those with whom they do not sufficiently share a common language for effective communication, is part of their professional commitment and responsibility. Previous research has shown that service providers are often skeptical regarding the involvement of an interpreter and lack confidence in how to work with them (46), which highlights the need for training. Service providers must be equipped with the necessary knowledge and skills. This includes, for example, the complexity of interpreting, the risks of informal interpreting practices, such as family members or multilingual staff, and how to effectively organize and work with qualified interpreters if they are available. It is recommended that service providers receive the opportunity to practice interpreter-mediated encounters under supervision. When qualified interpreters are not available, service providers face a challenging dilemma: On the one hand, continuing to rely on informal interpreting practices risks reinforcing suboptimal procedures, while on the other hand, these practices allow some communication and at least minimal service provision. In these cases, service providers should receive specific training on the risks of informal interpreting and practical strategies to mitigate these risks, ensuring the best possible communication (89,107).

Looking at the interpreters, this dissertation's findings suggest that interpreters working across community settings themselves may not fully recognize their professional status. Thus, implementing formalized training and certification procedures is recommended to increase interpreters' knowledge, skills, and perceived professionalism.

Although the experiences and perspectives of service users who prefer a different language than the official and/or predominantly spoken language(s) were not directly included in this

dissertation, it is important to empower and educate them to advocate for their rights and – where available - ask for qualified interpreters when experiencing language barriers.

It has been emphasized that the development of legal regulations in the field of CI depends heavily on the political and social attitudes towards human rights, equity, inclusivity, and non-discrimination in any given geopolitical context (96,104,121). As described above, the global lack of legal entitlement to interpreting services in most community settings could be considered the main cause of a lack of legal regulations and standards in this field. On an institutional and systemic level, the findings of this dissertation can inform policymakers to argue for the need for legal entitlement to interpreting services and, thus, for legally anchored standards and regulations regarding interpreters' training and certification. Moreover, a protected professional title is required, and uniform qualification standards must be fulfilled in order to work as an interpreter in mental healthcare and other community settings. This could increase interpreters' professional status and recognition (96,99,114,123,142) and, consequently, their working conditions. It could also help service providers find adequately trained interpreters. In addition, uniform and comprehensive training programs and certification procedures must be implemented, whereby the ISO Guidelines for Community Interpreting may provide valuable guidance (126). Training and certification should be mandatory for interpreters. However, this requires improved working conditions, such as higher compensation. The overarching and formalized funding and organization of CI services must be established. In addition to institutional and systemic changes regarding the interpreters, it is recommended that these topics be implemented in the educational programs of service providers or that further training courses be provided (mandatory) for people who have already completed their professional training.

5.5. Conclusion

The findings of this dissertation highlight that language barriers between service providers and users are a global reality and emphasize the critical role of interpreting practices for promoting just and equitable service provision in mental healthcare and other community settings across different geopolitical contexts. The research included individuals describing themselves as interpreters and sheds light on their (precarious) working conditions, lack of formal training, examination and certification, and the psychological distress they

experience regarding interpreting. Furthermore, this dissertation investigates informal interpreting practices, i.e., individuals not considering themselves interpreters but nevertheless acting in this capacity. The findings support previous research by showing that informal interpreting practices not only jeopardize the quality of communication but also have negative consequences for the individuals themselves. However, due to a lack of alternatives, such practices apparently continue to occur. The research further demonstrates the significant impact interpreters have on communication dynamics, focusing on the therapeutic alliance, and highlights the complexities of interpreting. Therefore, both interpreters and service providers must be equipped with appropriate skills and knowledge. The results provide valuable knowledge on how to effectively train community interpreters and service providers and reveal that training and certification are not only required to ensure the quality of interpreter-mediated communication but also to increase the professional status of community interpreters. The dissertation indicates that changes at the individual, institutional, and systematic levels are required, including the formalization and legal regulation of interpreting services and training to ensure high-quality and equitable service provision across different community settings.

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7. Publications

7.1. Publication 1

Hanft-Robert S, Mösko M. Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters. BMC Public Health. 2024;(24):1570. doi:10.1186/s12889-024-18988-8

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Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters

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Abstract

Background Community interpreters (CIPs) play a crucial role in various community services, including healthcare, when service providers and users do not share a common language. However, there is a lack of evidence-based data on this population globally. This explorative cross-sectional study aims to gain a better understanding of CIPs and their work in Germany.

Methods A nationwide online survey was conducted among CIPs in Germany to collect data on their qualification background, working conditions, mental health, interpreting-related psychosocial distress and sociodemographics. Participants were recruited through interpreting pools, training institutions and migrant organizations. Data were analyzed descriptively, dependent t-test, multiple logistic and hierarchical stepwise regression analyses were performed to predict participation in interpreting-specific training, interpreting competence and interpreting-related psychosocial distress.

Results Across all 16 federal states, $N=873$ responses were used for analysis. Most participants are female (74%), born abroad (77%) and have a high level of education (69%). The vast majority interpret occasionally in their leisure time (44%) and are self-employed/freelance (51%). 34% interpret solely or additional on a voluntary basis (unpaid). The median hours of interpreting per month are 10 h, 75% do not exceed 30 h. On average interpreters work in four different settings. 69% attended any kind of interpreting training with a median of 25 h in total. Interpreting in more settings emerged as an associated factor with participation in training. Of those who have never attended any training, 69% consider themselves as rather/very competent in interpreting. Interpreting more frequently, having less severe anxiety symptoms, getting higher and more often paid and being less satisfied with the payment is associated with self-reported interpreting competence. In total, 36% reported moderate or severe psychosocial distress regarding interpreting. Higher general psychosocial distress and depressive symptoms, higher interpreting frequency and lower payment satisfaction were found to be associated with higher distress regarding interpreting. Additionally, factors such as precarious work conditions, lack of recognition and discrimination (e.g. racism and sexism) were reported as distressing.

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Conclusion This study provides a first comprehensive evidence-based national database on CIPs in Germany. The findings can be valuable for the development of qualifications, guidelines, policies and the process of professionalizing the field of CIPs.

Keywords Community interpreting, Public service interpreting, Qualification, Working conditions, Psychosocial distress

Introduction

Growing linguistic diversity and the need for community interpreters

Ongoing globalization and migration are leading to increased cultural and linguistic diversity of populations worldwide [1, 2]. However, the growing cultural and linguistic diversity is often not reflected among public service providers or in community settings, such as health care [3, 4]. The severe consequences and risks associated with linguistic discordance between service users and providers, such as miscommunication and, particularly in healthcare settings, misdiagnosis, ineffective treatment and lower treatment satisfaction, have been demonstrated in several studies [5–12], which emphasizes the importance of language-sensitive services. When the service provider and user do not share a common language, the use of community interpreters (CIPs) can be one approach to facilitate effective communication, in addition to nonverbal communication, receptive multilingualism, technological translation tools and family members or multilingual personnel as interpreters [12–20].

Although Community Interpreting (CI) can be considered the oldest form of interpreting, it established itself as a field of research at the beginning of the 1990s and is thus a relatively young research topic [21–23]. In the international literature, terms such as public service, liaison, dialogue, or cultural interpreting as well as more setting-specific terms such as medical or legal interpreting are commonly used when discussing CI, demonstrating the lack of consistent terminology [21, 24–27]. The terminological ambiguity stems from the fact that most countries, such as Germany, do not have a legally protected professional title for people working as interpreters in community settings. In this study, the term CI was chosen because it is used by the International Organization for Standardization (ISO) in their Guidelines for CI (ISO 13611:2024) [28]. CI is often defined in distinction from other types of interpreting, such as conference interpreting, in that it takes place within the community to facilitate equal access for community service users when they do not share a common language with the service provider [21–23, 25, 29–31]. Community Interpreters (CPIs) usually work in a dialogic encounter between two, sometimes more, speakers either on-site or via telephone or video remote link. Most often, the focus is on bilateral interpretation (CIPs transferring utterances into both working languages) with an emphasis on the consecutive mode (translation once the speaker stops speaking) [23, 25, 27, 29]. In many countries, there is no legal entitlement to the provision of interpreting services in most community settings, resulting in a lack of formal standards regarding CIs' qualifications, organization and funding.

Qualification of community interpreters

In the public perception, CI often receives little recognition and tends to be seen as a charity or volunteer activity provided by bilinguals as an act of social support, rather than a professional service, resulting in a lack of legal regulation regarding CIPs' formal qualification [25, 32]. However, over the past decades, CI's recognition has evolved in some countries to a profession that requires qualifications, including specific training and certification, as well as legal and ethical regulations [30, 32]. Despite this evolution, many countries lack legally anchored standards regarding CIPs' formal qualification, resulting in a great diversity of training institutions and programs as well as official organizations that certify CIPs [23, 29, 33–37]. The absence of standardized requirements allows anyone to work as a CIP based primarily on the subjective self-assessment of their skills rather than their actual qualification [25]. Australia stands out as an exception, placing a strong emphasis on adhering to legal standards and guidelines in CI. The National Accreditation Authority for Translators and Interpreters (NAATI) serves as the authoritative body for certifying translators and interpreters nationwide, with NAATI certification often being a prerequisite for interpreters working in community settings [38]. Recognizing the need for globally applicable standards, the International Organization for Standardization (ISO) developed the Guidelines for Community Interpreting first in 2014 [28]. It addresses CI as a profession characterized by specific competencies, qualifications and ethical principles, and not as an informal practice that can be provided by multilingual laypersons such as family members. By offering international recommendations, fundamental principles, and best practices, the ISO guidelines aim to ensure the quality of CI services [28].

Consistent governmental regulations and frameworks in terms of CIPs' qualifications are also lacking in Germany [39, 40]. Only court interpreting could be considered an exception in Germany, as it is the only setting in which swearing-in is usually required. However, the

criteria to be met to be sworn-in vary among the federal states, formal qualification is not always needed, and ad hoc swearing-in without examining the interpreter's qualifications still occurs [39]. In recent decades, numerous training and certification programs have also emerged in Germany. However, these programs differ significantly in terms of content, scope, teaching approach, duration, and certification. This lack of standardization has contributed to an even less regulated and more confusing CI market. As a result, CIPs' level of qualification spans a wide spectrum, ranging from no training at all to a few hours of interpreting-specific training to a formal university degree in interpreting [40]. In Switzerland, the Swiss Association for Intercultural Interpreting and Mediation (INTERPRET) reported that out of 3,122 interpreters among 18 interpreting pools, 12% had no interpreting-specific qualification and an additional 33% were currently in training in 2022 [41]. In Germany, a recent study conducted by Geiling et al. (2022) showed that among interpreters working in refugee care (e.g., (mental) health care, authorities, psychosocial counseling or police), 15% have an interpreting degree from a university or college, and 67% have any kind of training for interpreting for refugees [42]. However, there is still a scarcity of comprehensive evidence-based and national data regarding the qualifications of CIPs in Germany. Moreover, in the absence of professional standards in many community settings that determine who can officially practice as a CIP, the composition of the CIP population remains largely unknown.

Organization and funding of community interpreting services

In most countries, a lack of legally established standards also exists regarding the organization and funding of CIPs, leading to CI services usually being organized and funded on a nongovernmental level [34, 35, 39]. Additionally, it must be acknowledged that the provision and funding of (qualified) interpreting services always depend on the context and resources of the respective country. For instance, in some countries like South Africa [16], formal interpreting services and specifically trained CIPs are rarely available, and CI usually occurs informally and on a voluntary basis [43, 44].

In Germany, there is no legal entitlement to interpretation services, with a few exceptions such as sign-language interpretation or criminal proceedings at court [39]. Consequently, there is no formal legal framework governing the funding or organization of CI services [39]. CI services in Germany are mostly organized on a local level, used on a voluntary basis and funded through nongovernmental organizations or by the individuals who hire CIPs to facilitate communication, e.g., service providers or service users [39]. However, the lack of evidence-based data makes it difficult to comprehensively assess the organization and funding of CIPs in Germany and across countries.

Community interpreters' working conditions and psychosocial distress

CIPs often work with vulnerable populations in emotionally intense and pressured situations, such as hospitals, legal proceedings, or social services, where they play a crucial role in facilitating communication between service providers and users [25]. Thus, some attention has been drawn to the psychological impact of interpreting in community settings and it is emphasized that not only the content (e.g., interpreting traumatic experiences) but also the poor working conditions (e.g., lack of training, supervision and preparation, time pressure, low payment, unregulated labor market) and the interaction with the interlocutors (e.g., conflicting expectations, discrimination, lack of recognition, identification with the service user) could be emotionally distressing for CIPs [45–49]. However, there is a paucity of evidence-based data across countries concerning CIPs' working conditions and the psychosocial distress associated with interpreting. The few studies available tend to focus on specific migrant groups or interpreting settings. For instance, Geiling et al. (2022) found increased psychological distress among CIPs working in refugee care in Germany. In addition, dissatisfaction with payment and more traumatic content were linked with work-related exhaustion in their study [46].

Aim of the study

The purpose of this epidemiological study was to shed light on the work of CIPs in Germany. While most research on CI addresses one specific setting, e.g. medical, legal, or social service settings [50] or a specific migrant group, e.g. refugees [42], we did not focus on a particular setting or group of clients since CIPs most often work in more than one setting with diverse migrant groups [51]. We aimed to.

1) collect data to make a start on describing CIP's sociodemographic profile, working conditions, (formal) qualification background, mental health status, and psychological distress regarding interpreting;
2) investigate factors that differentiate between people who have taken part in interpreting specific training or not;
3) identify factors associated with self-reported interpreting competence;
4) identify factors associated with psychological distress regarding interpreting;

5) explore differences between interpreting settings of CIPs in terms of sociodemographic and work-related variables;

Materials and methods

The study was conducted at the Department of Medical Psychology at the University Medical Centre, Hamburg-Eppendorf, in cooperation with the Federal Association of Nonstatutory Welfare and the Federal Chamber of Psychotherapists. A national cross-sectional study design was applied.

Development of the questionnaire

Due to missing similar studies, the questionnaire was developed by the authors in a multistage process. (A) Based on the literature review, relevant themes were selected. (B) These themes were initially discussed and supplemented in an interdisciplinary workshop with four experts from the fields of interpreting and translation studies, linguistics, and psychology. (C) A second workshop with twelve experts working in different CI pools, agencies, and training institutions across Germany was conducted online to discuss the selected themes as well as potential recruitment strategies. (D) The questionnaire was subsequently expert-validated by six scientists from the fields of translation and interpreting studies, linguistics and psychology. (E) Finally, cognitive interviews were conducted with five CIPs to examine whether participants' interpretations were consistent with the intended meanings of items. The probing approach with a mix of proactive and reactive probes was chosen [52]. The cognitive interviews were also used to evaluate the questionnaires' comprehensibility and feasibility with people from the target group. Based on their feedback, some questions were rephrased and linguistically simplified. The final questionnaire consisted of 48 items, divided into four sections:

1) Sociodemographic variables The survey included single- or multiple-choice questions on gender, age, migration (including reasons for migration, citizenship, country of origin, and length of stay in Germany in years), educational level, recognition of highest educational qualifications in Germany, employment in addition to interpreting and participants' federal state.

2) Work-related variables Single- or multiple-choice and open questions were developed to assess work experience as a CIP in years, frequency of interpreting per month in hours, type of employment as a CIP (freelancer, employed, both), interpreting settings (healthcare in general, psychotherapy, social service, authority, education, legal service, court, police, other), type of interpreting (onsite, telephone, video), frequency of payment (5-point Likert scale ranging from "1 = never" to "5 = always"), amount of payment in Euros, satisfaction with payment (5-point Likert scale ranging from "1 = very low" to "5 = very high"), working languages and availability and need of interpreting-related support services.

3) Qualification Hours of training, topics covered in training, and passed exams were assessed with single- or multiple-choice questions. Additionally, specific structural and personal barriers to attending training were assessed on a 5-point rating scale ranging from "1 = Does not apply at all" to "5 = Fully applies". An open question was included to capture other factors that prevent participation in training. Subjective training need was also assessed on a 5-point rating scale ranging from "1 = Not at all needed" to "5 = Highly needed". Similarly, self-reported interpreting competence was assessed on a 5-point rating scale ranging from "1 = Not competent at all" to "5 = Very competent".

4.1) Psychological distress The German version of the NCCN Distress Thermometer was used to assess general psychological distress [53]. The easy-to-use screening tool was originally developed by the National Comprehensive Cancer Network (NCCN) to assess psychosocial distress in oncology patients [54]. To date, it has also been used in several other settings due to its high acceptance, brevity, and practice orientation [55]. The NCCN Distress Thermometer is an 11-point Likert scale ranging from "0 = no distress" to "10 = extreme distress". Participants indicate their levels of distress over the course of one week before the assessment. A cutoff of 4 + is recommended to identify moderate to severe levels of distress [56]. A meta-analysis found a pooled sensitivity of 81% and a pooled specificity of 72% [57].

The NCCN Distress Thermometer was slightly adapted to measure psychological distress regarding interpreting: "Please indicate the number (0–10) that best describes how stressful you currently experience interpreting."

4.2) Mental health outcomes CIPs' mental health was measured as depressive symptoms with the German Patient Health Questionnaire-2 (PHQ-2) [58] and anxiety with the German General Anxiety Disorder-2 (GAD-2) [59]. Both instruments are part of the Patient Health Questionnaire-4 (PHQ-4) [60].

The PHQ-2 is a validated screening instrument for depression [58, 61]. On a two-item scale, participants had to rank the frequency of symptoms (little interest or pleasure in doing things; feeling down, depressed, or hopeless) in the last two weeks on a 4-point Likert scale ranging from "0 = not at all" and "3 = nearly every day." The sum score (range 0 to 6) indicates the degree

of depression, whereby a higher score suggests stronger depressive symptoms (0–2 = "low depressive symptoms", scores of 3 and above = "high depressive symptoms") [61]. With a sensitivity of 79% and a specificity of 86% for any depressive disorder, the scale shows adequate psychometric properties [58]. The Cronbach's alpha reliability score, which calculates the internal consistency of a test or scale [62], was 0.66 for the present sample. While this score is slightly below the conventional threshold of 0.70, it can still be considered acceptable [63, 64].

The GAD-2 is a two-item screening instrument for general anxiety, consisting of the two psychometrically best items from the GAD-7 [59]. Participants had to rank the frequency of symptoms (feeling nervous, anxious or on edge; not being able to stop or control worrying) in the last two weeks. Each item score ranges from "0=not at all" to "3=nearly every day", resulting in a sum score between 0 and 6. A higher score suggests stronger general anxiety symptoms, with a cutoff of 3+ [59, 65]. A systematic review and diagnostic meta-analysis showed adequate psychometric properties, with a pooled sensitivity of 76% and a specificity of 81% for identifying any anxiety disorder [65]. The Cronbach's alpha reliability score for the present sample was 0.68.

Participants and data collection

Any person aged 18 years or older working as a CIP in community settings in Germany could participate in the study. No further inclusion or exclusion criteria were defined. In preparation for conducting logistic regression analyses, the required sample size was calculated using G*Power Version 3.1. To reliably demonstrate Odds Ratios of 1.5 and above, a total sample size of 308 participants was needed.

Since CIPs are not organized in a formal way in Germany, a convenience snowball sampling approach was used by reaching out to institutions that had access to the target population. Based on an online search, 112 interpreting pools, agencies, and training institutions for interpreters (including the ones that participated in the second workshop of the questionnaire development) across all federal states as well as relevant nationwide organizations were contacted directly via email explaining the purpose of the study and asking them to forward the study invitation to their affiliated CIPs. The survey was also sent to various social and healthcare institutions that work with CIPs on a regular basis. Following the snowball sampling approach, participants were asked to share the study link with other CIPs at the end of the survey. Of the first 250 participants who provided an email address at the end of the survey, every second participant received a 20 Euro voucher from wunschgutschein.de. The costs for the vouchers were fully covered by the Department of Medical Psychology at the University Medical Center Hamburg-Eppendorf. Data collection was conducted from June to August 2022 using the online survey tool LimeSurvey (Version 2.62.2+170,203).

Data analysis

In a first step and to answer our first research objective (describe CIP's sociodemographic profile, working conditions, (formal) qualification background, mental health status, and psychological distress regarding interpreting), we computed descriptive statistics and reported means (*M*), standard deviations (SD), frequencies (n), and percentages (%). Concerning our second research objective (investigate factors that differentiate between people who have taken part in interpreting specific training or not), we employed dependent t-tests to examine differences between participants who have participated in training and those who have not. Subsequently, we conducted logistic regression analyses to identify variables contributing to the likelihood of being trained specifically for interpreting. Due to the exploratory nature of the study, we included variables that revealed significant differences in the t-test in the regression analyses.

For the third (identify factors associated with self-reported interpreting competence) and fourth objectives (identify factors associated with psychological distress regarding interpreting), we used Spearman's correlation analyses and multiple hierarchical stepwise regression analyses. Variables were included in the regression analyses as independent variables if they correlated significantly with the outcome variable in the correlation analyses.

To investigate the fifth objective (explore differences between interpreting settings of CIPs in terms of sociodemographic and work-related variables) crosstabs as well as multiple logistic regression analyses on various outcome variables, using the interpreting setting variables as predictors, and a stepwise forward selection procedure for variables were performed. To this end, the following variables were dichotomized into "0" and "1": Age, gender, education, interpreting experience, frequency of interpreting, hours of training, interpreting competence, frequency of payment, amount of payment, and appropriateness of payment. All metric variables were dichotomized using the median split. For the variables education, frequency of payment, appropriateness of payment and interpreting competence, dummy variables were computed with "low education" = 0, "never payment" = 0, "payment is very or rather low" = 0 and "no competence" = 0. Complete case analyses were conducted, and participants with any missing data were excluded. No further analyses regarding missing data were conducted. All analyses were performed using IBM SPSS Statistics Version 28.0.1.1 [14]. and R Studio Version 2021.09.0.

Ethical considerations

We obtained Ethical approval in writing from the Ethics Committee of the University Medical Centre Hamburg-Eppendorf (29 July 2021; LPEK-0360). At the beginning of the survey, we informed participants about the aim and procedure of the online survey; the chance to win a voucher after completing the questionnaire; and that study participation is voluntary and data collection anonymous. A detailed study and data protection information sheet could be downloaded via an external link. Before starting the questionnaire, participants had to give their consent for the data to be used for the purpose of this study.

Results

In total, 1,199 people clicked on the online survey and 897 answered at least one question. We excluded participants with several nonlogical answers (e.g. country of origin "Klingon") or repeated participation ($n=6$) from the analysis. Since sign language interpreters differ from the group of CIPs in terms of legal regulations, qualifications and working conditions, we excluded them ($n=18$) from this study. Finally, we analyzed data from 873 participants across all 16 federal states in Germany, with most participants residing in Baden-Württemberg (28.4%), Bavaria (15.3%) and North Rhine-Westphalia (9%). The least represented federal states were Brandenburg (0.1%) and Saxony-Anhalt (0.6%).

Descriptive statistics

Sociodemographic variables

Age, gender, education level, occupational status The majority of the sample is female (74.2%) and aged from 18 to 88 years ($M=43.84$, $SD=12.77$). Following the International Standard Classification of Education (ISCED) [66], the vast majority reported a high level of education (69.1%). In addition to interpreting, most of the participants are employed part-time (25%), full-time (20.1%) or were self-employed/freelancers (18.1%).

Migration history A total of 77.1% were born abroad, with Russia (9.9%), Syria (9.5%) and Ukraine (9.5%) being the most common countries of origin. The main reasons for migration are family reunion (39.2%) and political, legal or humanitarian reasons (28.2%). Those who immigrated are residing in Germany for $M=21.51$ years on average ($SD=13.12$). All sociodemographic variables are summarized in Table 1.

Work-related variables

Interpreting experience, frequency and occupational status At the time of the survey, 23.2% of the participants had been interpreting for less than 1 year. Those who had been interpreting for more than a year had on average $M=9.21$ years of work experience ($SD=8.82$) with a median of 6 years ($IQR=3–10$). The longest-serving CIP has worked for a total of 55 years as an interpreter. Participants interpret on average $M=20.92$ h ($SD=27.56$) with a median of 10 h per month as CIPs and 75% of the sample do not exceed 30 h ($IQR=5–30$ h). Most of them interpret every now and then (43.7%), 28.3% in part-time and 17% in full-time. A total of 11.8% are employed as CIPs, 50.8% are self-employed/freelance, and 2.7% are both. Just over one-third (34.4%) indicated that they interpret fully or additionally on a voluntary basis (unpaid).

Settings and type of interpreting CIPs work on average in $M=4.17$ different settings ($SD=2.06$). Most of the time participants work on-site ($M=82.76\%$, $SD=24.75$; $MED=90\%$), followed by telephone ($M=12.33\%$, $SD=19.82$, $MED=5\%$) and video interpreting ($M=4.91\%$, $SD=13.39$, $MED<0\%$).

Payment While most participants (74.3%) reported getting often or always paid, 8.1% were paid sometimes and 17.7% were rarely or never paid. The average payment is $M=26.06$ Euros ($SD=19.54$) with a median of 20 Euros ($IQR=15–30$ Euros). A total of 65.3% consider the payment too low, and 33.5% consider it appropriate. Among those who rate the payment to be inadequate, the desired payment is on average $M=40.67$ Euros ($SD=23.27$) with a median of 35 Euros per hour ($IQR=25–50$).

Working languages In total, 91.2% stated German as one of their working languages. Among those, 23.8% are German native speakers. Of those who are non-native speakers, 80.6% have a German language certificate according to the Common European Framework of Reference (GER), whereas 91.6% possess B2 or a higher level. The average number of working languages is $M=2.74$ ($SD=1.01$). In addition to German, the most common working languages are English ($n=227$), Russian ($n=205$) and Arabic ($n=161$). All work-related variables are displayed in Table 2.

Interpreting-related support services The survey asked about specific support services available to CIPs (see Table 2.1 in the supplement files). A total of 43.5% reported having access to supervision. Among those who do not have or do not know if they have access to supervision, 43.9% would like to have it. Three-thirds of the sample (74.8%) have access to interpreting-specific training. Among those who stated that they do not have or do not know if they have access to any training, 69.8% desire to participate in such training. In response to the open question about further aspects of improving working conditions, the following were mentioned: better payment; more security regarding interpreting jobs; more informa-

Table 1 Sociodemographic characteristics of the sample ($N = 873$)

	n	value
Gender	**708**	
Female	525	74.2%
Male	163	23%
Other	6	0.9%
Not specified	14	2%
Missing value	*165*	-
Age (in years)	**706**	MED = 43 years (IQR 34–53) MW = 43.84 years (SD = 12.77, range = 18–88)
Missing value	*167*	-
Own migration history	**708**	
Born abroad (1. Generation)	546	77.1%
Born in Germany	162	22.9%
Missing value	*165*	-
Migration history of parents (if born in Germany)	**162**	
Both parents born in Germany	74	45.7%
Both parents born abroad (2. Generation)	60	37%
One parent born abroad (2. Generation)	28	17.3%
Missing value	*0*	-
Reasons for migration (if born abroad)	**505**	
Family reunion	197	39.2%
Political, legal or humanitarian	142	28.2%
Education	126	25%
Work	40	7.6%
Missing value	41	-
German citizenship	**708**	
Yes	453	64%
No	255	36%
Missing value	*165*	-
Duration in Germany (in years, if born abroad)	**545**	MED = 21 years (IQR 9–30) MW = 21.51 years (SD = 13.12, range = < 1–71)
Missing value	*1*	-
11 most common countries of origin (if born abroad)	**537**	
Russia	53	9.9%
Syria	51	9.5%
Ukraine	51	9.5%
Iran	32	6%
Romania	28	5.2%
Turkey	27	5%
Kazakhstan	23	4.3%
Iraq	22	4.1%
Afghanistan	21	3.9%
Bulgaria	15	2.8%
France	15	2.8%
Missing value	*8*	-
Educational level (ISCED)	**703**	
High	486	69.1%
Medium	183	26%
Low	34	4.8%
Missing value	*170*	-
Highest school-leaving qualification	**690**	
General university entrance qualification	591	85.7%
General certificate of secondary education	88	12.8%
Primary school	5	0.7%
Still in school	3	0.4%

Table 1 (continued)

	n	value
No school leaving qualification	3	0.4%
Missing value	*183*	-
Highest educational attainment	**674**	
Doctorate/PhD/Habilitation	30	4.6%
University - Master's degree	249	36.9%
University - Bachelor's degree	157	23.3%
University of Applied Sciences	31	4.6
Vocational college	66	9.8%
Completed apprenticeship	63	9.4%
Still in vocational training	34	5%
No professional qualification	44	6.5%
Missing value	*199*	-
Is the highest educational attainment received abroad (if completed)?	**596**	
Yes	256	43%
No	440	57%
Missing value	*0*	-
Is the highest educational attainment recognized in Germany (if received abroad)?	**256**	
Yes	160	62.5%
No	77	30.1%
On-going	19	7.4%
Missing value	*0*	-
Occupational status (additionally to interpreting)*	**708**	
Full-time	142	20.1%
Part-time	177	25%
Mini job (less than 15 h/week)	67	9.5%
Freelancer/self-employed	128	18.1%
Not employed, job-seeking	52	7.3%
Not employed, not job-seeking	33	4.7%
Retired	42	5.9%
No working permission	8	1.1%
Unable to work	7	1%
Full-time as interpreter and no other job	78	11%
Missing value	*165*	-

*Multiple answers were possible

tion to prepare for interpreting jobs; professional organisation of CIPs; training of service providers; permanent employment as CIPs; and more appreciation and recognition of CIPs in general.

Qualification

Amount and content of training In total, 69% of the participants reported that they had attended some kind of training on interpreting in the past (on-site or online). On average participants had $M=114.04$ h of training ($SD=359.52$) with a median of 25 h ($IQA=10–70$). Among those who attended any kind of training, 29.4% participated in a training course with a final exam and successfully passed it. In most cases, the training was not specifically tailored to one setting, but rather generic (85.2%).

Attitude toward training In total, 26.1% of respondents reported no need for interpreting-specific training, 34.6% expressed a partial need for training, and 39.3% indicated a need for training. The main reasons for not participating in (further) training are that training courses are not known, training is not considered worthwhile because no financial benefit is expected or because participants felt sufficiently experienced. Other reasons for not participating in (further) training provided in open questions are as follows: training offers do not match personal needs; lack of interest and motivation; excessive effort; training not suitable for certain languages; no certificate/no proof of participation; and lack of online training.

Self-reported interpreting competence In terms of interpreting competence, the majority of participants perceive themselves as rather competent (46.8%) or very competent (28.1%). Of those who have never attended any

Table 2 Interpreting related work characteristics of the sample ($N = 873$)

	n	value
Interpreting experience	**852**	
Less than 1 year	198	23.2%
1 year or more	654	76.8% MED = 6 years (IQR 3–10) MW = 9.21 years (SD = 8.82, range = 1–55)
Missing value	*21*	-
Working hours per month	**839**	MED = 10 h (IQR 5–30) MW = 20.91 h (SD = 27.56, range = 1-170)
Missing value	*34*	-
Occupational status as interpreter	**854**	
Every now and then	373	43.7%
Part-time	242	28.3%
Full-time	145	17%
Other	94	11%
Missing value	*19*	-
Employment status	**854**	
Freelancer/self-employed	434	50.8%
Only or additionally on voluntary basis	294	34.4%
Employed	101	11.8%
Both	23	2.7%
Other	98	34.7%
Missing value	*19*	-
Settings*	**855**	
Authority	700	81.9%
Social service	634	74.2%
Education	610	71.4%
Health care	580	67.8%
Psychotherapy	356	41.6%
Legal service	283	33.1%
Police	222	20.7%
Court	177	26%
Other	98	11.5%
Missing value	*18*	-
Number of interpreting settings	**855**	MED = 4 settings (IQR 3–6) MW = 4.17 settings (SD = 2.06, range = 1–8)
1	88	10.3%
2	110	12.9%
3	165	19.3%
4	133	15.6%
5	131	15.3%
6	94	11%
7	59	6.9%
8	75	8.8%
Missing value	*18*	-
Type of interpreting in %	**829**	
On-site	829	MED = 90% (IQR 80–100) MW = 82.76% (SD = 24.75, range = 0-100)
Telephone	829	MED = 5% (IQR = 0–20) MW = 12.33% (SD = 19.82, range = 0-100)
Video	829	MED < 0% (IQR = 0–2) MW = 4.91% (SD = 13.39, range = 0-100)
Missing value	*44*	-
Interpreting in German	**761**	
Yes	694	91.2%

Table 2 (continued)

	n	value
No	*67*	8.8%
Missing value	*112*	-
German native language (if interpreting in German)	**694**	
Yes	163	23.8%
No	521	76.2
Missing value	*10*	-
Certificate for German language (non-native speaker)	**521**	
No	101	19.4%
Yes	420	80.6%
A1	5	1.5%
A2	0	0%
B1	24	7%
B2	72	21.1%
C1	147	43%
C2	94	27.5%
Missing value	*78*	-
Number of working language	**761**	MED = 3 (IQR 2–3) MW = 2.74 (SD = 1.01, range = 1–6)
Missing value	*112*	-
10 most frequent working languages*	**761**	
English	227	-
Russian	205	-
Arabic	161	-
Persian	101	-
French	93	-
Ukrainian	74	-
Turkish	61	-
Spanish	51	-
Kurdish	45	-
Rumanian	38	-
Missing value	*112*	-
Payment	**780**	
Never	84	10.8%
Rarely	54	6.9%
Sometimes	63	8.1%
Often	137	17.6%
Always	442	56.7%
Missing value	*93*	-
Amount of payment in EUR		
Highest pay	690	MED = 25 Euros/h (IQR 15–48) MW = 36.53 Euros/h (SD = 33.28, range = 5-400)
Missing value	*183*	-
Lowest pay	687	MED = 15 Euros/h (IQR 12–25) MW = 19.75 Euros/h (SD = 13.94, range = 1-100)
Missing value	186	-
Average pay	690	MED = 20 Euros/h (IQR 15–30) MW = 26.06 Euros/h (SD = 19.54, range = 1-200)
Missing value	*183*	-
Appropriateness of payment	**777**	
Very low	208	26.8%
Somewhat low	299	38.5%
Adequate	260	33.5%
Somewhat high	8	1%
Very high	2	0.3%

Table 2 (continued)

	n	value
Missing value	*96*	-
Desired payment per hour (if not adequate)	**515**	MED = 35 Euros/h (IQR 25–50) MW = 40.67 Euros/h (SD = 23.27, range = 0-150)
Missing value	*2*	-

*Multiple answers possible

training, 68.5% rated themselves as rather or very competent. All training-related data are displayed in Table 3.

Mental health status

General psychosocial distress, anxiety and depression In total, 51.1% reported a score above the cut-off of 4 on the NCCN distress scale, showing a moderate to severe level of general psychosocial distress. The average score is $M = 3.78$ ($SD = 2.78$). Concerning depressive and general anxiety symptomatology, measured with the PHQ-2 and GAD-2, the average scores are $M = 0.89$ ($SD = 1.21$) and $M = 0.89$ ($SD = 1.16$), respectively. In total, 9.7% reported a score above the cut-off of 3 indicating high depressive symptoms and 7.7% reported a score above the cut-off of 3 indicating high anxiety symptoms.

Psychosocial distress related to interpreting Concerning the psychosocial distress related to interpreting, 36.1% of the sample reported a score above the cutoff of 4 on the NCCN distress scale, showing a moderate to severe level of general psychosocial distress. The average score is $M = 2.85$ ($SD = 2.6$). Distressing factors that were additionally mentioned in open answers are displayed in Table 4.

Differences depending on the training of community interpreters

To explore differences depending on the training of CIPs, we conducted dependent t-tests between participants who have participated in any kind of training and people who have not. In this sample, people who have participated in any training are significantly older (t (382) = 2.57, p-value = 0.011), stay for a longer period in Germany (t (382) = 2.38, p-value = 0.018), perceive themselves as more competent (t (382) = 2.01, p-value = 0.045), are more experienced (t (382) = 2.53, p-value = 0.012), work in more settings (t (382) = 4.64, p-value < 0.001), are less distressed in general (t (382) = -2.44, p-value = 0.015), and less distressed regarding interpreting (t (382) = -2.2, p-value = 0.029). Differences in terms of gender, education, interpreting frequency, frequency and amount of payment, and need to receive training were not found.

Relevant factors for participating in interpreting-specific training

To explore how these variables contribute to the likelihood of partaking in interpreting-specific training, we conducted a logistic regression analysis. We included the identified factors that differed between participants with and without training in the regression model. Beforehand, we used the Pearson statistic to test for multicollinearity, whereby none of the predictors correlated more strongly than $r = .603$. Most variables are not associated with participation in interpreting specific training in this regression model. Only the number of settings was found to be significantly associated with participating in interpreting-specific training when the remaining six variables were controlled for (OR: 1.31, CI 95%: 1.15–1.48). The full model explains 11.7% of the variance in whether CIPs in this study have participated in interpreting-specific training (Table 5).

Correlates of psychosocial distress regarding interpreting

In a first step, Spearman's correlation analyses were calculated to identify possible relationships between psychological distress regarding interpreting and sociodemographic, work-related training and mental health variables (see Table 6). When examining the correlates of psychological distress regarding interpreting, a significant association can be observed with the frequency of interpreting ($r_s = 0.243$, p-value < 0.001), meaning that individuals interpreting more frequently experience higher psychosocial distress. Additionally, significantly negative relationships were found with length of stay ($r_s = -0.105$, p-value < 0.05), meaning that participants who stay for a longer period of time in Germany show less psychosocial distress regarding interpreting. Frequency and satisfaction with payment ($r_s = -0.155$, p-value < 0.001 and -0.124, p-value < 0.01) were also significantly negatively associated, meaning that CIPs who are paid more often and are more satisfied with their pay show less psychological distress regarding interpreting. The strongest positive relationships were found with depressive and anxiety symptoms as well as psychological distress in general ($r_s = 0.306$, 0.259, 0.516, p-value < 0.001, respectively), suggesting that individuals with more severe depressive and anxiety symptoms and higher psychological distress in general experience more distress regarding interpreting. No significant correlations could be found with interpreting experience or the need to receive training.

Table 3 Training of the sample ($N = 873$)

	n	value
Training received	**725**	
Yes	500	69%
No	225	31%
Missing value	*148*	-
Numbers of hours trained (if training received)	**498**	MED = 25 h (IQR 10–70) MW = 114.04 (SD = 359.52, range = 1–3,000)
Missing value	*2*	-
Interpreting degree excluded	452	MED = 20 h (IQR 10–60) MW = 87.23 (SD = 293,24, range = 1–3,000)
Missing value	*1*	-
Interpreting degree	44	MED = 75 h (IQR 36.35–375.00) MW = 389.43 (SD = 707.72, range = 2–3,000)
Missing value	*3*	-
Without exam	352	MED = 20 h (IQR 8–40) MW = 38.07 (SD = 71.48, range = 1-800)
Missing value	1	-
With exam	144	MED = 80 h (IQR 30–200) MW = 299.74 (SD = 621.24, range = 2–3,000)
Missing value	*3*	-
Exam passed (if training received)	**500**	
Yes	147	29.4%
No	353	70.6%
Missing value	*0*	-
Type of exam* (if exam passed)	147	
Interpreting degree	47	32%
State-certified interpreter	22	15%
Chamber of Commerce	19	12.9%
Other	85	57.8%
Missing value	*0*	-
Sworn-In for interpreting at court	**725**	
Yes	93	12.8%
No	632	87.2%
Missing value	*148*	-
Topics covered in training* (if training received)	**500**	
Roles of interpreters	357	71.4%
Ethical principles in interpreting	270	54%
Interpreting techniques	254	50.8%
Self-care & mental health	207	41.4%
Legal aspects of interpreting	177	35.4%
Telephone/video interpreting	139	27.8%
Note taking	130	26%
Entrepreneurial skills	86	17.2%
Setting specific training		
Generic training	426	85.2%
Authority	193	38.6%
Psychotherapy	173	34.6%
Education	170	34%
Social service	169	33.8%
Health care	164	32.8%
Legal	97	19.4%
Court	65	13%
Police	60	12%
Other topics	11	2.2%
Missing value	*0*	-

Table 3 (continued)

	n	value
Subjective need to receive trained	**725**	MED = 3 (IQR 2–4) MW = 3.22 (SD = 1.23)
Not at all needed	79	10.9%
Rather not needed	110	15.2%
Partly needed	251	34.6%
Rather needed	146	20.1%
Highly needed	139	19.2%
Missing value	*148*	-
Barriers to attend training*		
Trainings not known	725	MED = 3 (IQR 1–4) MW = 2.74 (SD = 1.51)
Not worth it, no financial benefit	725	MED = 3 (IQR 1–4) MW = 2.31 (SD = 1.26)
No need, as sufficient experience already	725	MED = 3 (IQR 2–3) MW = 2.47 (SD = 1.36)
Distance	725	MED = 2 (IQR 1–3) MW = 2.75 (SD = 1.38)
Family or work commitments	725	MED = 2 (IQR 1–3) MW = 2.64 (SD = 1.21)
Not worth it, interpreting too rarely	725	MED = 2 (IQR 1–3) MW = 2.21 (SD = 1.22)
Have already participated in a sufficient number of trainings	725	MED = 2 (IQR 1–3) MW = 1.94 (SD = 1.15)
Missing value	*148*	-
Interpreting competence	**725**	MED = 3 (IQR 2–4) MW = 3.01 (SD = 0.77)
Not competent	2	0.3%
Rather not competent	10	1.4%
Averagely competent	170	23.5%
Rather competent	339	46.8%
Very competent	204	28.1%
Missing value	*148*	-

*Multiple answers were possible

Table 4 Distressing factors

Structural/institutional factors	Interpersonal factors	Interpreting situation
• Poor compensation for CI services. • Precarious financial situation of CIPs. • Lack of planning certainty with regard to interpreting jobs and demanded high flexibility. • Lack of training of service providers to work with CIPs. • Lack of training of CIPs, leading to low confidence in own interpreting skills.	• Lack of respect, appreciation, and recognition on the part of the service provider and user. • Perceived discrimination, such as racism and sexism, on the part of the service provider and user.	• Emotional distress due to translating the details of service users' stressful/traumatic experiences. • High time pressure. • Overlapping talks. • Cultural conflicts. • Role conflicts and difficulties in maintaining professional boundaries.

Note Factors were reported in open answers by participants

Relevant factors for interpreting specific distress

In a second step, we conducted exploratory multiple hierarchical stepwise regression analyses to examine the variables that significantly correlated with psychosocial distress regarding interpreting in more detail. No evidence of multicollinearity was found regarding the variance inflation factor. The residual plots showed homoscedasticity and normal distributions of the residuals. There were four hierarchical regression models whose variables are displayed in Table 7. The first model only included general distress as an independent variable and explained 28.4% of the variance. The second model added 1.7% and the third another 1.9% explained variance. The final model, which included perceived distress in general ($\beta = 0.433$, p-value < 0.001), interpreting frequency ($\beta = 0.013$, p-value < 0.001), depressive symptoms ($\beta = 0.293$, p-value < 0.001) and appropriateness of payment ($\beta = -0.324$, p-value $= 0.004$), added 1.0%

Table 5 Logistic regression analyses for participation in interpreting specific training ($N=873$)

	Model 1 ($n=420$)		
Independent variable	**OR**	**95% CI**	***p*-value**
1) Age	1.012	0.987-1.038	0.337
2) Duration of stay in Germany	1.007	0.984-1.031	0.545
3) Interpreting competence	1.212	0.892-1.647	0.218
4) Interpreting experience in years	0.987	0.952-1.024	0.496
5) Number of settings	**1.305**	1.154–1.475	< 0.001
6) NCCN Distress general	0.958	0.870-1.055	0.386
7) NCCN Distress re interpreting	0.943	0.852-1.043	0.252
Nagelkerkes R^2	0.117		

explained variance, leading to $R^2=0.326$. This means that being more distressed in general, interpreting more often, having more severe depressive symptoms and being less satisfied with the payment emerged as significant correlates with perceived distress regarding interpreting and accounted for 32.6% of the variance in the present study.

Correlates of self-reported interpreting competence

Spearman's correlation analyses were calculated to identify possible relationships between interpreting competence and sociodemographic, work-related training and mental health variables (see Table 6). Significant positive correlations were found with age (r_s = 0.089, $p<.05$), education (r_s = 0.112, $p<.01$) and length of stay in Germany (r_s = 0.165, $p<.001$), meaning that CIPs who are older, have a higher educational level and stay for a longer period of time in Germany perceive themselves as more competent. Significant positive associations were also found with hours of training (r_s = 0.250, $p<.001$), frequency of interpreting (r_s = 0.270, $p<.001$), overall interpreting experience (r_s = 0.281, $p<.001$), number of different interpreting settings (r_s = 0.257, $p<.001$), frequency of payment (r_s = 0.149, $p<.001$) and amount of payment received for interpreting services (r_s = 0.300, $p<.001$). This suggests that participants who have completed more hours of training, interpret more frequently, are more experienced, work in many different settings, and receive more often as well as a higher amount of payment perceive themselves as more competent regarding interpreting. Furthermore, self-reported interpreting competence exhibited significant negative correlations with the appropriateness of payment ($r_s=-0.153$, $p<.001$), the subjective need for training ($r_s=-0.124$, $p<.001$), depressive symptoms ($r_s=-0.140$, $p<.001$) and anxiety symptoms ($r_s=-0.114$, $p<.01$), meaning that individuals who perceive themselves as more competent are less satisfied with their payment, have a lower need for training, and show fewer depressive and anxiety symptoms.

Relevant factors for interpreting competence

Following the correlational analysis, exploratory multiple hierarchical stepwise regression analyses were conducted to examine the variables that significantly correlated with interpreting competence in more detail. No evidence of multicollinearity was found regarding the variance inflation factor. The residual plots showed homoscedasticity and normal distributions of the residuals. There were five hierarchical regression models whose variables are displayed in Table 8. The first model only included the frequency of interpreting as an independent variable and explained 6.4% of the variance. The second model added 4.5%, the third another 3.3%, and the fourth 1.8% explained variance. The final model, including interpreting frequency (β=0.006, p-value<0.001), anxiety symptoms (β = −0.125, p-value<0.001), amount (β=0.007, p-value<0.001), frequency (β=0.131, p-value=0.001) and appropriateness of payment (β =- 0.127, p-value=0.005), added 1.7% explained variance, leading to $R^2=0.168$. This means that interpreting more often, having less severe anxiety symptoms, receiving a higher payment, getting paid more often and perceiving the payment as less appropriate emerged as significant correlates with perceived competence regarding interpreting and accounted for 16.8% of the variance in this study.

Differences between interpreting settings

Since participants could state multiple interpreting settings in the present study, variables of interest were dichotomized, afterwards, crosstabs and multiple logistic regressions were performed to identify differences between the eight settings of health care, psychotherapy, social service, education, authority, legal service, police and court. The settings were examined regarding the selected variables: age, gender, education, interpreting experience, frequency of interpreting, qualification and interpreting competence and frequency and amount of payment. Individuals working in court emerged as a subgroup, significantly associated with being older (>median 43 years) (OR: 2.16, CI 95%: 1.47–3.19, p-value<0.00); having more work experience (>median 6 years) (OR: 3.73, CI 95%: 2.24–6.21, p-value<0.00); being trained (OR: 1.83, CI 95%: 1.1–3.07, p-value=0.02) and receiving a payment above 20 Euros (median) (OR: 6.09, CI 95%: 3.68–10.06, p-value<0.00). The results are displayed in more detail in the supplement files.

Discussion

Selected personal characteristics of community interpreters: gender, migration history, education

Although the total population of CIs in Germany remains unknown, the study findings provide preliminary evidence that the interpreting profession might be predominantly female. Almost three-quarters of the participants

Table 6 Correlations of sociodemographic and work-related variables, training and mental health outcomes ($N = 873$)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1) Age	1.000															
2) Education	**0.154*** **	1.000														
3) Length of stay	**0.601*** **	**−0.085***	1.000													
4) Training hours	**0.158*** **	0.054	**0.131****	1.000												
5) Interpreting competence	**0.089***	**0.112****	**0.165*** **	**0.250*** **	1.000											
6) Interpreting frequency	< 0.000	0.030	0.021	**0.089***	**0.270*** **	1.000										
7) Experience	**0.415*** **	0.076	**0.362*** **	**0.237*** **	**0.281*** **	**0.249*** **	1.000									
8) Number of settings	**0.158*** **	0.051	**0.178*** **	**0.344*** **	**0.257*** **	**0.281*** **	**0.308*** **	1.000								
9) Frequency of payment	0.043	0.057	**0.143****	**0.201*** **	**0.149*** **	0.021	**−0.089***	**0.116****	1.000							
10) Amount of payment	**0.129****	**0.202*** **	**0.157****	**0.325*** **	**0.300*** **	**0.238*** **	**0.346*** **	**0.264*** **	**0.279*** **	1.000						
11) Appropriateness of payment	**−0.085***	0.021	−0.025	−0.049	**−0.153*** **	**−0.092***	**−0.089***	**−0.182*** **	**0.156*** **	**0.081***	1.000					
12) Need to receive training	**−0.083***	−0.031	−0.079	0.004	**−0.124****	−0.057	**−0.118****	**−0.089***	−0.057	−0.088*	−0.024	1.000				
13) PHQ-2 Depression	**−0.091***	−0.024	**−0.116****	0.023	**−0.140*** **	0.003	−0.041	−0.042	**−0.077***	−0.046	**−0.090***	0.066	1.000			
14) GAD-2 Anxiety	**−0.155*** **	−0.027	**−0.177*** **	−0.001	**−0.114****	−0.035	**−0.101***	−0.043	−0.048	0.009	−0.020	**0.122****	**0.518*** **	1.000		
15) NCCN Distress general	**−0.131*** **	−0.014	−0.035	**−0.090***	−0.024	0.019	**−0.089***	−0.059	−0.058	−0.011	**−0.084***	0.044	**0.390*** **	**0.464*** **	1.000	
16) NCCN Distress re interpreting	−0.073	−0.007	**−0.105***	−0.043	−0.041	**0.243*** **	0.020	−0.025	**−0.155*** **	0.042	**−0.124****	0.021	**0.306*** **	**0.259*** **	**0.516*** **	1.000

Note *$p < .05$; **$p < .01$; ***$p < .001$

Table 7 Hierarchical regression for interpreting specific distress

Variable	B	SE B	β	*p*
Step 1[a]				
Constant	0.998	0.157		< 0.001
NCCN distress general	0.496	0.034	0.533***	< 0.001
Step 2[b]				
Constant	0.767	0.168		< 0.001
NCCN distress general	0.486	0.034	0.523***	< 0.001
Interpreting frequency	0.012	0.003	0.132***	< 0.001
Step 3[c]				
Constant	0.650	0.168		< 0.001
NCCN distress general	0.437	0.035	0.470***	< 0.001
Interpreting frequency	0.013	0.003	0.141***	< 0.001
PHQ2 Depression	0.311	0.079	0.149***	< 0.001
Step 4[d]				
Constant	1.360	0.298		< 0.001
NCCN distress general	0.433	0.035	0.465***	< 0.001
Interpreting frequency	0.013	0.003	0.139***	< 0.001
PHQ2 Depression	0.293	0.079	0.140***	< 0.001
Appropriateness payment	−0.324	0.113	−0.102**	0.004

Note *$p < .05$; **$p < .01$; ***$p < .001$; [a]$R^2 = 0.284$, $p < .001$ [b]$\Delta R^2 = 0.017$, $p < .001$ [c]$\Delta R^2 = 0.019$, $p < .001$ [d]$\Delta R^2 = 0.010$, $p = .004$

Table 8 Hierarchical regression for interpreting competence

Variable	B	SE B	β	*p*
Step 1[a]				
Constant	1.948	0.046		< 0.001
Frequency of interpeting	0.006	0.001	0.258***	< 0.001
Step 2[b]				
Constant	2.074	0.053		< 0.001
Frequency of interpeting	0.006	0.001	0.247***	< 0.001
GAD-2 anxiety	−0.133	0.030	−0.212 ***	< 0.001
Step 3[c]				
Constant	2.864	0.076		< 0.001
Frequency of interpeting	0.006	0.001	0.232***	< 0.001
GAD-2 anxiety	−0.127	0.030	−0.202 ***	< 0.001
Amount of payment	0.008	0.002	0.183***	< 0.001
Step 4[d]				
Constant	2.386	0.185		< 0.001
Frequency of interpeting	0.006	0.001	0.232***	< 0.001
GAD-2 anxiety	−0.120	0.030	−0.191 ***	0.002
Amount of payment	0.007	0.002	0.152***	0.005
Frequency of payment	0.115	0.041	0.137**	< 0.001
Step 5[e]				
Constant	2.567	0.195		< 0.001
Frequency of interpeting	0.006	0.001	0.232	< 0.001
GAD-2 anxiety	−0.125	0.030	−0.199	< 0.001
Amount of payment	0.007	0.002	0.166	< 0.001
Frequency of payment	0.131	0.041	0.157	0.001
Appropriateness of payment	−0.127	0.046	−0.134	0.005

Note *$p < .05$; **$p < .01$; ***$p < .001$; [a]$R^2 = 0.064$, $p < .001$ [b]$\Delta R^2 = 0.045$, $p < .001$ [c]$\Delta R^2 = 0.033$, $p < .001$ [d]$\Delta R^2 = 0.018$, $p = .005$ [e]$\Delta R^2 = 0.017$, $p = .005$

in this study identified as women. Similar gender distributions were also found in other studies [42, 47, 67]. CI is largely characterized by its caring and social nature, placing it in line with other caring professions, such as social work, nursing and psychology, which are dominated by females [67, 68].

Overall, more than 77% of the sample has a first-generation migration history and another 12% has a second-generation migration history. The main reasons for immigrating to Germany were family and political, legal or humanitarian reasons, accounting for approximately 39% and 28% of the participants who were born abroad respectively. In addition, other studies revealed that 25–27% of CIPs have a personal history of flight [46, 47]. The foreign-born participants in the current study have lived in Germany for an average of 21.5 years at the time of the survey and more than one-third of the total sample does not have German citizenship. In comparison, among all migrants in Germany, 53% do not hold German citizenship [69].

In line with previous studies [46, 47], the level of education in this sample was high according to the ISCED [66]. Almost 65% of the CIPs in this study had at least a Bachelor's university degree (5.4% completed an interpreting degree). However, it should be emphasized that 43% of the participants who have completed an educational qualification received their highest educational attainment abroad and almost one-third of them stated that their degree is not recognized in Germany. Based on the results of the present study it can be assumed that a significant proportion of those working as CIPs may in fact have acquired other professional qualifications. As

shown in previous studies, if migration is not primarily due to education or work reasons, the (non-)recognition of foreign-acquired qualifications is one of the biggest obstacles for first-generation migrants to access the labor market of the country of arrival [70]. Two-thirds of the participants in this study reported full-time or part-time employment or self-employment/freelance work in addition to working as a CIP, indicating that CI functions most often as a supplementary occupation. The reasons for this should be investigated in more detail in future studies.

Mental health status of community interpreters

More than 50% of this study's sample reported moderate or severe psychosocial distress in general, which is in line with other findings [46, 47, 49, 71]. For instance, Geiling et al. (2022) showed increased psychological distress among CIPs in refugee care settings in Germany [46]. Jurado et al. (2017) reviewed factors associated with psychological distress in migrant populations around the world. Female gender and forced and poorly planned migration, such as migration for political, legal, or humanitarian reasons, are associated with a higher level of distress [72]. Mylord et al. (2023) specifically demonstrated that migrants without German citizenship have less social support, less psychological resilience, and experience more discrimination, which could affect their mental health [73]. Such risk factors are also predominantly present in this study's sample. In contrast, almost 45% of the participants in the current study are employed full- or part-time. The CIPs who were born abroad have been residing in Germany on average for 21.5 years and the vast majority possess medium levels of German language skills. These factors have been found to be associated with lower levels of psychosocial distress in migrant populations [72].

While most CIPs in this study reported no or only low levels of depression and anxiety symptoms, previous research found significant differences in anxiety and depression among CIPs [46] and a significantly higher prevalence of secondary traumatization or posttraumatic stress disorder in comparison to the general German population [46, 47, 71]. However, most of these studies focus on interpreting in mental health or refugee settings, where psychological strain can be particularly high. Future studies could build on these findings by employing different instruments, e.g. General Health Questionnaire [74], to assess various aspects of mental health.

Interpreting related psychological distress and its associated factors

Concerning interpreting-related psychological distress and its associated factors, this study's findings complement previous research [42, 46]. The present study found that more than one-third of the participants perceive interpreting in community settings as psychologically distressing, emphasizing the need for further psychosocial support services for CIPs. The frequency of interpreting was positively associated with psychological distress regarding interpreting, meaning that participants who reported higher levels of psychosocial distress interpreted more frequently. Furthermore, the correlation analysis showed that interpreters who get paid more often and are more satisfied with the payment are less distressed. Depression, anxiety and general distress were also positively linked to distress regarding interpreting.

In the regression analyses, having more stress in general and more severe depressive symptoms, interpreting more often and being less satisfied with the payment for interpreting were associated with higher perceived distress regarding interpreting. This suggests that CIPs' overall psychological well-being as well as their workload and working conditions, such as the payment, play a significant role in CIPs' experience of distress related to interpreting. This is in line with previous studies, reporting dissatisfaction with pay to be linked with higher work-related exhaustion [46]. Moreover, higher workload was identified as a risk factor in a recent systematic review of the mental health and work experiences of interpreters in mental health care settings [42]. Although it must be taken into account that no causal conclusions can be drawn based on our study findings, the open responses in our study indicate that precarious working conditions, such as poor compensation, lack of planning certainty and high flexibility, could negatively impact CIPs' psychosocial distress.

Furthermore, in line with previous literature [25, 29, 45–49], participants described in open questions interpersonal aspects as distressing, such as lack of respect, appreciation, and recognition as well as discrimination. In the interpreting situation, factors such as role conflicts and difficulties in maintaining professional boundaries were reported as distressing. In-depth research on psychosocial distress and its determinants among CIPs and across settings, e.g. by measuring further job-related data, such as professional recognition, relationships with other professional groups and experienced discrimination; using qualitative methods or a longitudinal study design is needed for future studies.

Community interpreters' working conditions

The results indicate that the vast majority of participants in this study primarily work as freelance/self-employed CIPs, with a smaller percentage (15%) reporting employment in this capacity. One-third (34%), interpret solely or additional on a voluntary basis (unpaid), which underlines the caring nature of CI. In a study by Kindermann et al. (2017), the number of volunteer CIPs

was almost twice as high, at 67% [47]. CIPs in the present study interpret a median of 10 h per month, and 75% of the sample does not exceed 30 h per month. A survey conducted in 2019 by a professional association for interpreters in Germany showed similar results. Among those who interpret part-time, 75% interpret 2–3 times a month or less [51].

Since there is no legal entitlement to interpretation in most community settings in Germany, there is also no legally regulated remuneration for CIPs leading to a great variation of payment [39]. Low and dissatisfying payment can be associated with work-related exhaustion [46] and undermine CIPs' professionalism [75, 76]. While 11% of the participants in the present study indicate that they get never paid, most of them reported getting sometimes, often or always paid with a median rate of 20 Euro per hour. Although the majority of participants were not satisfied with the payment, as 65% considered it to be too low, the desired payment was still relatively low, with a median of 35 Euros. Sample calculations for CIPs in Germany show that even an hourly rate of 60 Euros only generates an income that is close to the poverty threshold [76]. It would be interesting to investigate CIPs' attitude toward payment in more detail in future studies and explore potential influencing factors, such as the perceived status and recognition of the CI profession or caring and voluntary attitudes of CIPs.

Previous studies described that low and insecure working conditions could affect CIPs' commitment to interpreting, resulting in interpreting often being only fitted in between other (work) commitments [77, 78]. This is supported by the results of this study. Based on the study results, it can be assumed that CI in Germany currently may be more commonly pursued on the side or on a voluntary basis rather than as a full-time profession. This aligns with previous findings that only a small percentage of interpreters working in Germany derive their main income from interpreting in community settings, such as authorities, health and social services (3%) or the judicial sector (6%) [51].

As often discussed in the literature [21, 32, 39, 79], individuals who interpret at court emerged as a subgroup in the present study for a number of sociodemographic and work-related variables. Court interpreting is one of the few settings in Germany in which standards are already established, for instance, remuneration is regulated by law. Based on our findings, this subgroup tends to be older, more experienced, have a higher probability of being trained, have received more training and completed a final exam more often, and are more likely to get always and also higher paid. Based on our study results, setting-related differences should be further investigated.

Qualification, interpreting competence and its associated factors

Qualification is widely recognized not only as a crucial component in ensuring the delivery of high-quality interpreting services but also as a fundamental factor in shaping a profession and improving its recognition and status [21, 80, 81]. While a significant proportion of the participants in this study reported previous participation in some form of training (69%), the median hours of received training are relatively low at 25 h. Among those who had undergone training, 75% of the sample had received no more than 70 h of training.

In this study, we found that CIPs who have attended any kind of interpreting-specific training tend to be older, stay for a longer time in Germany, perceive themselves as more competent, are more experienced, work in more settings and are less distressed in general and also perceive interpreting as less distressing. However, the regression analyses showed that only the number of interpreting settings was associated with CIPs partaking in training. Thus, CIPs who worked in a greater variety of settings were more likely to have undergone interpreting-specific training. However, as no causal conclusions can be drawn based on the present study, it is not possible to say whether participation in training leads to CIPs working in more settings or vice versa. This, and other influencing factors that may not have been taken into account in this study, should be investigated in future studies.

Although the majority expressed a subjective need for training, there were notable barriers to attending such training. These barriers include the perception that participation in (further) training is not worthwhile due to a lack of financial benefits. Similarly, Ozolins (2004) reported that CIPs' interest in training is strongly related to their working conditions and that interpreters might only partake in such training if it leads to higher remuneration [77, 82]. Another barrier identified in this study was a lack of training opportunities. This could be attributed to the absence of accessible local training and certification programs, as well as a widely varied and potentially confusing training landscape. Conversely, it may also stem from a lack of knowledge about existing training offerings in the CI community. For future studies, the use of qualitative methods could be useful to investigate barriers to attending training and CIPs' attitudes toward training. The implementation of national and legally anchored minimum requirements for the qualification of CIPs could be beneficial in terms of increasing the level of qualification in Germany in the long term [40]. Since participants in this study work on average in four different settings, it is recommended to establish generic training and certification programs rather than tailoring training to specific individual settings or client groups.

The majority of participants in this study assessed their subjective interpreting competence as rather high. The regression analyses demonstrated that CIPs' interpreting more frequently, having less severe anxiety symptoms, receiving higher pay, getting paid more often and perceiving the payment as less appropriate perceived themselves as more competent. Surprisingly, training was not associated with perceived competence in the regression analysis. In line, among those who never attended any kind of training, 69% perceived themselves as rather or very competent and the belief that no (further) training is needed because one already has sufficient interpreting experience emerged as one of the main barriers to attending training in this study. However, when looking at the differences between participants being somehow trained vs. participants not being trained, it could be found that the participants who have participated in training also reported higher interpreting competence.

A study conducted by Fitzmaurice (2020) among educational interpreters working in public schools showed that the least skilled interpreters tend to overestimate their interpreting skills and that more skilled interpreters underestimate their interpreting competence. One possible explanation could be the effect that individuals with limited knowledge lack the expertise to accurately evaluate their own performance or level of competence. Such individuals may mistakenly believe they possess a high level of expertise due to their lack of awareness about the complexities and nuances of a task or topic, also called the Kruger and Dunning effect [83]. It also emphasizes the need for CIPs to get trained to bridge the gap between perceived and actual competence. Through training, CIPs may gain a more comprehensive understanding of the demands of interpreting, which can lead to a more accurate self-assessment of their competencies. A more in-depth understanding of factors influencing CIPs' subjective competence may be achieved through the use of qualitative methods in future studies.

Strengths and limitations of the study

Despite the large sample size, whether the sample represents the CIP population in Germany is unclear. Since working as a CIP is not an officially recognized occupation in Germany, no national statistics exist and it is unknown how many people are actually working as CIPs in Germany. Therefore, it is not known if the results of this survey are generalizable. Moreover, the generalizability of the study's results is potentially compromised due to systematic biases that may arise from the use of convenience snowball sampling and online survey methods. By choosing an online survey, it could not be ruled out that some people not belonging to the target population might have participated. While dichotomization facilitated data analysis and proved useful for investigating differences between interpreting settings, it may have resulted in a loss of detail for some variables. This limitation implies that certain nuances or variations within the variables might have been overlooked, potentially limiting the depth of understanding. When interpreting the results, it must be taken into account that no causal statements can be made based on the data collected. To assess the direction of the associations found in this study, longitudinal studies are recommended for future studies.

The main strength of this study is its large sample size, indicating that a substantial number of the CIP population was included in the research. Furthermore, the national study explored a wide range of variables across interpreting settings and client groups, resulting in a comprehensive overview of CI in Germany. No other study could be found either nationally or internationally that is comparable in terms of its scope and sample size in the field of CI. This broad examination of aspects also allowed for a more thorough exploration of potential factors associated with participation in interpreting training, interpreting competence and perceived distress regarding interpreting. The results can guide future research by narrowing the focus to the variables identified as relevant in this study. Moreover, including individuals from the target group, as well as other significant stakeholders, in the development of the study design, questionnaire, and recruitment processes is a notable strength of this study. This approach enhances the relevance and validity of the study by incorporating the perspectives and insights of those directly affected by the research topic.

Conclusion and implications

Despite increasing recognition in Germany of CI as a profession requiring legal and ethical regulation, along with a formal qualification including training and certification, this study uncovers a notable absence of formal training and certification among most CIPs. Moreover, CI activities were found to be predominantly conducted on-site and often carried out voluntarily (unpaid). Only a small proportion of the participants are employed and work as CIPs full-time. It can be assumed that precarious working conditions, particularly low compensation, may play a role in preventing many individuals from pursuing full-time employment in CI. Furthermore, this study's findings indicate that CIPs can be considered a vulnerable group, which becomes evident, for instance, by the reported high level of general distress, reasons for migration, the post-migration stressors, such as lack of German citizenship, and precarious working conditions.

As highlighted previously by Pöllabauer (2012) and others, CI often receives scant recognition in the public eye and is not regarded as a professional service, which may reflect broader societal attitudes toward equal access, civil rights, and immigration [25, 84, 85]. This lack of acknowledgement,

coupled with the absence of legal regulations regarding qualifications and funding for CI services, as well as the prevalence of poor working conditions and low wages, could be considered as repercussions of this undervaluation [32]. To further promote the professionalization of CI in Germany, it is imperative to establish national, legally binding qualification standards for CIPs, as well as implement uniform and comprehensive training programs and certification procedures. Moreover, overarching and formalized funding and organization of CI services must be established.

Supplementary Information

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Supplementary Material 1

Supplementary Material 2

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Author contributions
SH and MM conceptualized the study, developed the questionnaire and implemented the study. SH analyzed the data and wrote the manuscript in close consultation with MM. All authors have read and agreed to the published version of the manuscript.

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Data availability
Data included in this report are available on request. Please contact Saskia Hanft-Robert: s.hanft-robert@uke.de.

Declarations

Ethics approval and consent to participate
Informed consent was obtained from the study participants. Ethical approval was obtained in writing from the Ethics Committee of the University Medical Centre Hamburg-Eppendorf (29 July 2021; LPEK-0360).

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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7.2. Publication 2

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RESEARCH Open Access

'The doctor doesn't understand Xhosa and the service user doesn't understand English' - exploring the role of security guards acting as informal interpreters in psychiatric care in South Africa

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Abstract

Introduction Assigning qualified interpreters is considered one of the most effective approaches to facilitate communication in language-discordant encounters in mental healthcare. However, particularly in settings with fewer resources, they are not always available and informal practices are often used.

Objective This study aimed to investigate informal interpreting practices in mental healthcare in South Africa, focusing on security guards (SGs) serving as interpreters.

Methods Guided interviews were conducted with SGs ($n=12$) and mental healthcare providers (MHCPs) ($n=18$) at a psychiatric hospital in South Africa. The interviews were audio recorded, transcribed verbatim and analyzed using a thematic analysis approach.

Results Despite recognizing that SGs serving as interpreters is not an ideal solution to overcome language barriers and could potentially jeopardize the quality of treatment and its outcomes, MHCPs reported relying heavily on them due to the underrepresentation of South Africa's linguistic diversity among them. Given the lack of formal interpreting services, the perceived racial, linguistic and socioeconomic similarities between SGs and some service users, as well as their immediate accessibility, were described as beneficial to providing a minimal level of care (e.g. obtaining information about service users' backgrounds, getting an understanding of their symptoms, psychoeducation, explaining treatment options). Drawbacks reported are SGs being pulled away from their actual duties, experiencing emotional distress, juggling multiple sometimes conflicting roles, and the risk of incorrect interpretation, which could compromise ethical standards of care. Additionally, the complexity of power became apparent: While SGs hold little institutional power within the mental healthcare system, they become powerful figures when serving as interpreters.

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Conclusion It can be assumed that MHCPs will resort to informal interpreting practices as long as effective alternatives are lacking. In doing so, risks such as reduced quality of care are accepted, and the consequences and effects on those serving as interpreters are neglected, which raises concerns from an ethical point of view.

Keywords Interpreting, Security guards, Language Barrier, Mental Healthcare, Psychiatry, South Africa

Introduction

Verbal communication and language barriers in mental healthcare services

Language discordance between service users and healthcare providers is a challenge which may compromise healthcare outcomes. This issue may be even more pronounced in mental healthcare, as symptoms are often not directly observable and effective verbal communication is even more critical [1]. Language-discordant communication can lead to a higher risk of misunderstandings, misdiagnosis, ineffective treatment, lower treatment satisfaction and poorer health outcomes than language-concordant encounters [2–4]. Since verbal communication is essential for building rapport and trust, language barriers can also negatively affect the therapeutic alliance [5]. Lack of fluency in the official or dominant language(s) of a region or country and its healthcare systems is recognized as one of the main global barriers to accessing healthcare services for individuals from linguistically diverse backgrounds [6–8].

Qualified interpreters: the ideal vs. reality

Different practices exist globally in mental healthcare to facilitate verbal communication in language-discordant encounters. These include nonverbal communication, family members, multilingual personnel or other service users as interpreters, receptive multilingualism (interlocutors using different languages but still understanding each other), technological translation tools, or qualified (often called professional) interpreters [1, 9–16]. Although most studies emphasize that assigning qualified interpreters is the most effective approach to providing high-quality mental health care to linguistically diverse service users [1, 10], this ideal often remains unattainable in reality.

On the systemic and institutional level, providing qualified interpreting services is linked to a political and social attitude towards human rights, equity, inclusivity and non-discrimination, and the provision of resources [17, 18]. While the importance of language and the consequences of language barriers are increasingly emphasized in research and clinical practice, this is hardly reflected at the socio-political level in many countries [19, 20]. In most countries, there are no legal standards defining what characterizes a qualified or so-called professional interpreter or what their minimum qualifications should be [21]. Qualified or professional interpreters often comprise individuals with varying levels of training and certifications, ranging from a few hours of training to a graduate degree [17, 22]. Furthermore, there are usually no institutional guidelines regulating when an interpreter must be called in. Therefore, the presence of an interpreter in a language-discordant encounter usually depends on the initiative and knowledge of the mental healthcare provider (MHCP) [23] or established standards within an institution. Even when MHCPs are eager to include a qualified interpreter, none may be available or financial, personnel or time resources may be insufficient. Although using qualified interpreter services may prevent the escalation of long-term costs (through minimization of unnecessary repeat visits, for example), the initial financial costs are estimated to be higher and might be a burden [24, 25]. In many countries, the funding of interpreting costs is still largely unregulated, leading to uncertainty about who is supposed to cover the costs [22, 26]. The lack of resources and standards results in MHCPs and institutions continuously using ad hoc practices such as family members or untrained multilingual staff to overcome language barriers. This may seem more cost-effective and less time-consuming, but it could negatively impact the treatment process and outcome [11, 17, 27]. Most of what has been published about language discordance in mental healthcare comes from high-income countries [28]. These issues, however, are just as salient in low and middle-income countries, including South Africa [27], where this study is located.

The South African context

South Africa is currently considered an upper-middle-income country [29]. With its past of colonialization and 12 official languages (including South African Sign Language), it emerges as a particularly interesting context in terms of language barriers in mental healthcare. In many parts of the world, colonial supremacy has led to the dominance of the languages of the colonizers at the expense of indigenous languages [30, 31], including South Africa. During apartheid, a system of institutionalized racial segregation and oppression that formally ended in 1994, only English and Afrikaans were considered as official languages and various indigenous languages were suppressed. The consequences of the past are still present in today's mental healthcare system. While the majority of the population speaks isiZulu (24.4%) or isiXhosa (16.3%) inside households [32], the majority of MHCPs in higher positions, such as psychologists and psychiatrists, primarily speak English and have

limited proficiency in local languages, apart from Afrikaans, despite measures to diversify the workforce, such as departmental and provincial policies for proficiency in other languages for newly hired MHCPs [20]. The linguistic disparities between MHCPs and service users demonstrate that even 30 years into democracy, access to high-quality mental healthcare remains deeply entwined with one's racial and socioeconomic status [27, 33].

Despite the linguistic diversity of South Africa's population and the disparities between languages spoken by MHCPs and service users, limited formal interpreting systems exist in mental healthcare settings [34]. Consequently, informal ad hoc practices often take place, including nurses, family members, cleaners or security guards (SGs) being used as informal interpreters to bridge the gap and facilitate verbal communication [11, 20, 27, 35]. Though some work has been done on the role of cleaners, family members, and nurses in South Africa, the role of SGs has not yet been explicitly explored [11, 20, 27, 35]. This study aimed to shed light on informal interpreting practices conducted by SGs in mental healthcare in the South African context, focusing on practices at a large psychiatric hospital.

Materials and methods

Research design

As part of a larger qualitative research project on the role of SGs, we conducted semi-structured interviews with SGs and MHCPs at a psychiatric hospital in the Western Cape of South Africa. Here, findings from a small sub-analysis focusing on SGs acting as informal interpreters are presented. The reporting of methods is in accordance with the consolidated criteria for reporting qualitative research (COREQ) [36].

Setting

The study was conducted with SGs and MHCPs working at a psychiatric hospital in the Western Cape of South Africa. The hospital consists of different inpatient units, including forensic and acute ones. It provides mental health care assessments, crisis intervention and (short-term) treatment for adults with a broad range of psychiatric disorders. Most SGs working at the hospital are not directly employed by the hospital but by an external private security company and contracted to work in government hospitals. MHCPs are employed directly by the hospital.

Participants and data collection

SGs were recruited in person following a purposive sampling approach [37]. SGs who worked at the psychiatric hospital with sufficient English, isiXhosa or isiZulu language proficiency were asked to participate. All SGs included in this study were employed by a private company and not directly by the hospital (outsourced). The aim was to select SGs of diverse genders, ages and work experiences to reach a maximum variation sample [37].

MHCPs were recruited in person, via email, or by phone following a purposive sampling approach [37]. Included in the study were MHCPs who were employed at the psychiatric hospital with sufficient English language proficiency. The aim was to select MHCPs who differ with respect to their profession, years of work experience, gender, and age [37].

Semi-structured guided interviews with SGs and MHCPs were conducted in person and one-on-one between October and November 2022. Two different interview guides for the SGs and MHCPs were developed following Helfferich's SPSS approach of collecting, reviewing, sorting and finally subsuming questions formulated by the research team members [38]. SHR pilot tested both guides with research assistants to assess the feasibility and interview duration, resulting in no significant changes.

The interview guide was developed for this study but will be published elsewhere (Hanft-Robert S, Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al: The role of security guards in psychiatric care. A qualitative study with security guards and mental health care professionals in South Africa, forthcoming). The interviews with MHCPs covered their experiences with SGs acting as informal interpreters, the perceived challenges and benefits for themselves, the service users, SGs and the institution. Similarly, the interview guide for SGs covered their personal experiences, perceived challenges and benefits of acting as informal interpreters. Furthermore, a short questionnaire was administered to collect information on socio-demographics, work experience and SGs' training. MHCPs were interviewed in English by SHS, a female M.Sc. psychologist. SGs were interviewed in isiXhosa and isiZulu by LSh, a female M.Sc. researcher. There was no previous relationship between the interviewers and the interviewees. All interviews were digitally audio-recorded. The interviews conducted in English were professionally transcribed verbatim. The interviews with SG speaking isiXhosa or isiZulu were transcribed verbatim and translated into English by a research associate. SHR and LSh proofread all transcripts. Any personal data that could potentially lead to the identification of interviewees (e.g., participant names, employers, institutions) was either deleted or altered. Transcripts were not returned to participants.

Data analysis

Data analysis was conducted collaboratively by SHR and LSh, in close coordination with LSw and QC, employing the Thematic Analysis (TA) approach by Braun and

Clarke [39]. All authors have experience with qualitative research projects and conducting and analysing interviews. Braun and Clarke [39] provide a comprehensive six-phase guide that includes familiarization with the data, coding, searching for themes, reviewing, defining and naming themes, and writing up. The coding process was primarily inductive, meaning the categories were formulated based on the interview data. The interviews with the SGs and the MHCPs were analyzed as one set. The main and sub-themes were created jointly across both groups. It was then checked whether themes were mentioned in both or just by one group. Since most themes were mentioned by both groups, we decided to present the results from both groups together but indicated by whom the themes were mentioned. Intersubjective comprehensibility and credibility [40] were ensured by SHR and LSh independently analyzing and discussing four interviews of MHCPs and all interviews of SGs. SHS analyzed the remaining interviews with MHCPs. Additionally, the final category system was critically reviewed and discussed within an interdisciplinary research team to guarantee intersubjective reproducibility and comprehensibility [40]. Study participants did not provide feedback on the results. Data was analyzed using MAXQDA 2020.

Ethical considerations

Before the interview started, all interviewees provided oral and written informed consent to participate in the interview, to have the interview recorded, and to allow for the subsequent processing of the anonymized interview data for scientific purposes. Participation in the study was voluntary and not remunerated. The research was performed in accordance with the Declaration of Helsinki and has been approved by the Ethics Committee of Stellenbosch University, South Africa (Ethics reference number: SBE-2022-25557).

Table 1 Identified main and sub-themes

Main theme	Sub-themes
The healthcare system's reliance on SGs serving as informal interpreters	1. South Africa's linguistic diversity is often not represented among MHCPs 2. Lack of formal interpreting services
Benefits and challenges of SGs acting as informal interpreters	1. Perceived racial, linguistic and socioeconomic similarity between SGs and some service users 2. Immediate access 3. SGs being pulled away from their actual duties 4. Emotional distress for SGs 5. Lack of training and incorrect interpretation 6. Loss of therapeutically relevant information 7. Confidentiality concerns
SGs' (expected but conflicting) roles while interpreting	1. Dual role of ensuring safety while interpreting 2. SGs as a valuable source of information 3. Service users' confidant 4. Co-MHCP
Power dynamics surrounding interpreter-mediated encounters	1. Lack of recognition 2. The impact of status differentials

Sample

In total, $n=18$ MHCPs from different professions participated in this study. Among the MHCPs, $n=11$ identified as female and $n=7$ as male. Their mean age was 43 years (SD=12.07), and their mean work experience in their respective profession was 16.81 years (SD=12.16). Included were social workers ($n=2$), nurses ($n=3$), psychiatry registrars (trainee specialist, $n=2$), doctors ($n=2$), occupational therapists ($n=2$), (clinical) psychologists ($n=4$), and (forensic) psychiatrists ($n=3$). All MHCPs reported having contact with SGs daily or weekly. Two said that they have received some kind of training on the role and work of SGs in that specific psychiatric hospital.

In addition, $n=12$ SGs were included in the study. Among them, $n=8$ identified as male and $n=4$ as female. Their mean age was 39.08 years (SD=10.51), and their mean professional experience was 5.92 years (SD=7.94). SGs from forensic and acute units were included.

Results

The following four main themes were identified, including several sub-themes (Table 1):

The healthcare system's reliance on SGs serving as informal interpreters

South Africa's linguistic diversity is often not represented among MHCPs

While English was described as the most commonly used language by MHCPs, a significant proportion of service users primarily speak another language. Consequently, in order to facilitate communication in language-discordant encounters, both groups reported that SGs were frequently asked to provide interpreting services: *'Yes, it helps both of them because you find that the doctor cannot understand Xhosa and the patient does not understand English, so now they both get helped.'* (SG03).

Some MHCPs voiced the concerns that their own language skills were insufficient in meeting the linguistic diversity of service users adequately: *'So I speak Afrikaans, I speak English, and I speak a fair level of Xhosa to build rapport and show empathy. But I'm not going to be able to engage in a conversation that's going to lead into three or four paragraphs.'* (MHCP01). In addition, some participants from both groups critically reflected on South Africa's colonial past and the apartheid era, along with its lasting effects on the current healthcare system, which encompasses institutionally rooted racial and linguistic disparities between MHCPs and service users. One MHCP expressed that there is still reluctance on the part of the MHCPs to reflect and overcome

such differences: '*But I think also that just speaks to us as a people, I mean, why don't we speak each other's languages? I think that is just poor. You know, it would be like if I lived in Germany for 25 years and didn't learn a word of German and then complained every time someone said something in German. It would be bizarre, right? It is once again that colonial mindset of 'I don't have to change, I don't have to do anything, I don't have to be interested in this nation.' So someone else must do it. And even then, the idea that a professional would call a security guard to translate relates to the disrespect and the disdain that they have for the patient, the disdain they have for the security officer because nobody has asked the security officer whether he wants to listen to that.*' (MHCP14).

Lack of formal interpreting services

Due to a lack of formal interpreting services available for psychiatric institutions, almost all MHCPs stated that people who are not qualified as interpreters but speak service users' language, such as relatives, nurses, cleaners or SGs, were asked on a regular basis to act as interpreters in language-discordant encounters. This was perceived as the only way to be able to communicate with service users: *'Sometimes in the isiXhosa speaking groups where there's a language barrier, if there isn't a nurse available and they don't understand something that's been said or asked, then the patient might say to them [the SG] in their mother tongue, and they will translate for me. So that would be informal assistance that they give us.'* (MHCP16).

Nonetheless, some MHCPs pointed out that limited formal interpreting services do exist. However, they are usually external and either not known, or the commissioning process is overly complex and time-consuming and does not fit the dynamic reality of psychiatric services: '*It's more often used, I think, with psychometric assessment. And even then, I still don't think, if I had to pull the stats now and ask how many times have we used the translators, […] I'm not sure that we're accessing them to their full potential.*' (MHCP11).

Benefits and challenges of SGs acting as informal interpreters

Perceived racial, linguistic and socioeconomic similarity between SGs and some service users

SGs working at the psychiatric hospital where the current study was conducted were perceived by the some MHCPs to be similar to some service users regarding their racial, linguistic and socioeconomic background. This perceived similarity proved convenient for them to serve as informal interpreters when needed, as explained by one MHCP: *'And sometimes it's also because of language. Because a lot of security guards (...) they speak Xhosa. And patients understand that, so they get along with these patients in their home language, which is also helpful to kind of get information.*' (MHCP09).

Immediate access

Compared to formal interpreting services, some MHCPs preferred the use of SGs as interpreters due to the time constraints and immediate and convenient access: *'I think only later did our department make interpreters available. But because it's such a tedious process also to pick up the phone and make a booking, often you use what is on hand, and you don't call upon these people. Sometimes with us, also families just pitch. It's an opportunity you don't want to miss, especially when you have to get collateral and you've been trying to trace family and suddenly they arrive. There's no way you can pick up the phone and ask for an interpreter to come now. So you make of course use of whoever is there to interpret for you. So I think those are some of the challenges that we face.*' (MHCP08).

SGs being pulled away from their actual duties

SGs stated that acting as an interpreter is an additional duty, not part of their core responsibilities. Similarly, MHCPs expressed concerns about utilizing SGs as interpreters because it hinders them from fulfilling their primary responsibilities and creates a gap somewhere else: *'I just wonder what happens to the rest of the ward then if we are using the Security as an interpreter, then we sometimes lose the Security for the rest of the ward.'* (MHCP04).

Some MHCPs wondered if acting as interpreters might make SGs feel more valued and part of the team, increase their job satisfaction and perceived responsibility: *'I would hope that maybe it would make them feel like they're contributing more positively and that the medical team actually also needs them. So I think from an inclusivity perspective and feeling part of the team…in terms of job satisfaction and job reward, and a person just sitting on a chair and watching patients go up-and-down in the courtyard, actually being able to have a constructive role and they feel like, well, actually, doctors need me, the nurses need me, the OTs need me. I would hope that that would make them feel like they have a bigger and more important role.'* (MHCP12). However, most SGs reported that they perceive serving as an interpreter merely as being helpful and supporting the MHCPs in their work: *'It's just to help, otherwise, it's not our job. […] No, there's nothing I benefit.'* (SG03).

Emotional distress for SGs

Both MHCPs and SGs described interpreting as emotionally distressing for SGs: *'But I think for the security guard it won't be okay because our patients experience a lot of trauma and no one knows how then that could trigger the specific security guard into bringing up their own traumas. They have to sit in there and tolerate whatever*

conversation is happening, and they have to be part of this literally now because they are responding in their own language to what the patient is saying. So it's like they are talking about themselves as well.' (MHCP05). This could be particularly difficult to manage because SGs usually lack training and knowledge in mental health: *'I think for the security guard if you think no training on mental health, often the material that is shared is extremely traumatic and I would be concerned about exposing someone to trauma vicariously if we haven't done any work to prepare them.'* (MHCP11).

Many SGs expressed anxiety about their own competence to interpret, especially when the structure of the language used by service users was challenging: *'You find that you don't know what to take and what not to take; like, what am I going to say! [.] They [the MHCP] think I am not doing well…!'* (SG02).

While MHCPs had access to supervision or psychosocial support services, such offers are unavailable for SGs: *'And like I said, as government workers we have an outlet. You can speak to your colleague. You can phone up a counsellor, and access a counsellor immediately. You can go to a counsellor or a counsellor can come here. They can do a debriefing. But as a security guard, you can't.'* (MHCP08).

Lack of training and incorrect interpretation

All MHCPs expressed concern about incorrect interpretation when using SGs as interpreters. SGs usually lack mental health knowledge and are not familiar with specific mental health terms: *'But having them as an interpreter can be a drawback also because obviously, they don't have any medical training, they don't know any medical terms and I know in some of the languages, some of the words might have a different meaning altogether when they tell the patients and it might be interpreted completely in a different way and you would get eventually the wrong assessment of the patient. So I don't think that is their role…they shouldn't be taking on that additional role. But … I do know sometimes I do know people have asked them.'* (MHCP03). Thus, MHCPs expressed their preference of having another professional with a mental health background, e.g. nurses, to assist with interpretation: *'But sometimes we have…I've told you that I don't on principle ask security guards to interpret for me. I'll always ask a nurse.'* (MHCP17).

SGs' lack of mental health knowledge could result in abbreviated, summarized and incomplete interpretations. Especially when the service user experiences delusions or uses vulgar language, MHCPs experience SGs struggling with providing complete and correct interpretation. SGs added that they tend to make sense of what service users say when conveying it to the MHCP. However, sometimes they do not understand that particularly what the service users say and how they say it is crucial to the diagnosis and treatment process: *'There's only one problem; you find that the patient is answering something that is off-topic, now you have to structure it the way that the patient, without rectifying it, and you find that something you cannot say to them, because these people are not well.'* (SG03). Additionally, MHCPs stressed the importance of linguistic nuances in mental healthcare: *'Because for me it is fascinating that in mental health we cannot always see what is wrong with the patient. We'd need them to tell us how they experience their symptomatology. So, we look for nuance. We look for details. And so if someone is not trained to catch the nuance and to catch the detail, then we don't get a full picture.'* (MHCP18).

Additionally, some SGs revealed that they sometimes lack sufficient language skills for interpreting properly, which could have a negative impact on their interpreting service: *'But the doctor has asked me, they asked if I could try and make them understand, and I tried. I also don't know English well, but I tried, I tried and pushed through […]. I can understand, but sometimes I realize that I am just guessing'* (SG04).

Loss of therapeutically relevant information

The incorrect interpretation could result in a loss of therapeutically relevant information about the service user, as feared by almost all MHCPs: *'So my worry would be that again when we're interviewing someone, we are obviously looking for clinical signs, so because I don't know what's getting lost in translation, how much of what is related to the patient are my words versus the security guard's interpretation on them and what do they choose to relay back. I think I'm worried that important facts aren't relayed back because it's assumed that it's irrelevant or not useful. Because they are not aware of clear signs of symptoms or they don't understand why we are asking something that we're asking, so I think that that's one massive concern just for a clinical understanding and a medical knowledge perspective.'* (MHCP12).

Confidentiality concerns

The presence of SGs could make the service user more cautious about speaking openly due to concerns about their professionalism and confidentiality as reported by MHCPs: *'Something for me, of course, it does impact on the information the patient is going to give you. I think it really hampers because you don't know it for sure, but you can pick up on the milieu. You can pick up on the patient's anxiety. I mean, a lot of the information, as I've said, is confidential. In the forensic unit, sometimes it's horrific crimes you have to relive, you have to retell it. Or, say, in a therapy session where patients have to really grapple and face what it is they've done and the impact on their families, and impact on the community. So you sometimes feel*

that patients are not fully participating in that process.' (MHCP10).

It could also be unsettling for service users that the same SG, who has heard personal things about the service user, will also be around them in the ward: *'Ja, I mean, it's obviously unsettling for the patient because the patient knows that the security guard is going to be in their environment and now the security guard knows something about them that maybe they don't want the security guard to know.'* (MHCP17). Another MHCP added that service users might be afraid of getting stigmatized by SGs: '*And then also, the difficulty would then come with a stigma, you know with the patient feeling that a security guard who is now sitting with them in the ward, amongst other patients might be stigmatizing them because of what they know about them.'* (MHCP04).

SGs' (expected but conflicting) roles while interpreting

Dual role of ensuring safety while interpreting

It was described by both groups that SGs acting as interpreters were also expected to perform their duties as SGs and ensure safety in the room: *'So focusing on them on what their primary task is, because they often get more into an interpreter role and then not observing other, I don't know what the word, hazards, or dangerous situations, so they could then lose that role as a security person. […] Also you feel safer in the situation because you know there is a security present, so automatically you feel calmer; the patient responds to that calmness; it's just a more pleasant interview.'* (MHCP04).

It was described by MHCPs that service users might see SGs primarily as individuals responsible for ward safety, which could be an obstacle to establishing rapport: *'Absolutely! Because the security guard has a dual role there. When they go outside, the security guard is going to tell them what to do and what not to do. And then, in the room, where you want to create a safe space for the client, I don't know how that dual role of a security guard can be because interpretation in the room versus their role outside the room is quite different. […] And that could impact on the rapport you build with the client, or how safe they feel in the room with the client, for example.'* (MHCP13). Past negative encounters between service users and SGs could contribute to feelings of mistrust and reluctance on the part of the service users: *'Because, like I say, they might, you know, the patient has had a negative experience with a security guard in the past, or you know, they view security guards as, you know as, this is my enemy, kind of, you know, so they might not want to talk to them.'* (MHCP03). In general, service users might perceive SGs as figures of authority who have the capacity to use force, which could affect the therapeutic process: *'I just mean, for example, if there's something that perhaps reminds the patient of the abuser or the perpetrator, that may lead to them becoming more withdrawn and so are they not going to want to be forthcoming with information. And perhaps if you remove that person, they suddenly will reveal it to you.'* (MHCP07). Furthermore, one MHCP emphasized that the dual role of SGs within the MHCP-service user interaction could place the SG in a potentially conflicted situation. Because they bear the responsibility for ensuring safety, they might feel hesitant to interpret something that could potentially trigger aggressive behaviour in the service user: *'Because I suppose the highest point of risk for them is when they are with a staff member, that if they become violent or aggressive, they might have to intervene. So they don't want to say anything that might be triggering, which an interview might do from time to time to test certain reactions or defence mechanisms or something like that.'* (MHCP10).

SGs as a valuable source of information

SGs serving as interpreters were also perceived as a valuable source of information for MHCPs. MHCPs described that they have received important information about service users and their current mental state through the SGs, who are always around them at the wards. Sometimes SGs and service users came even from the same communities, which was perceived as beneficial for getting background information: *'They also sometimes come from the same community setting, so they already have a performed, or they know someone who's in the church with this patient or lives in the same area, or they understand the gangs involved, or they understand the dynamics in that community better than we do understand it. So they can relate to the patients a bit more.'* (MHCP04).

Service users' confidant

Since SGs spend a lot of time with service users at the ward, sometimes share a racial, linguistic, cultural and socioeconomic background or come from the same community, it was reported by both groups that service users might relate more to SGs, and both form a strong personal bond. This bond could result in the SG being the service users' confidant, providing a safe space in the interpreter-mediated encounter: *'Like, maybe you find that the doctor didn't know that the patient isn't able to, you see? So, they just asked me, 'Because you speak isiXhosa, can't you help me?' […] Yeah, to adjust. But in my case, at least I can understand. And I try for my patient to, yeah, to be alright.'* (SG02). The presence of SGs as interpreters was described as helpful for service users to open up and for MHCPs to build rapport with service users, as reported by some MHCPs: *'And then because he had a good relationship with the patient, the patient was willing to engage as long as he [the SG] was in the room constantly. […] So it just opens channels of*

communication.' (MHCP04). However, this could lead to meshed relationships and blurred boundaries between SGs and service users as described by both groups: *'The pros obviously understand well, understand what sets you off, understand your ins-and-outs, but the adverse is that there are also negative connotations that are attached where I feel like I can speak to you the way I want to or I feel I can treat you the way I want to. That's the negative.'* (MHCP01).

Co-MHCP

During the interviews, it became evident that despite a lack of mental health knowledge and training, SGs acting as interpreters are seen as a crucial part of the mental health assessment of service users and might be pushed into the role of a co-MHCP as described by one MHCP: *'So I asked the translator, and that's the example where I said that the security just said, no, he's not right. And I was like, we need to try and delve a bit further. And then he said that no, when he asks questions he doesn't reply appropriately and he talks off points. And then that helped a bit more in terms of saying he's psychotic because his thoughts are disordered. Then, he also had delusions. I mean, because it makes it a bit difficult to assess someone just based on the effect. So that was the one case.'* (MHCP07).

Power dynamics surrounding interpreter-mediated encounters

Lack of recognition

It was described by MHCPs that SGs usually have a lower educational status and come from lower socioeconomic backgrounds, often without any formal training for working as SGs. This results in SGs being frequently overlooked and lacking respect and recognition from both MHCPs and service users: '*So there is no job satisfaction. There is no day where you go home, and you feel like I did good work today. Because the whole day, either the patients are telling you all kinds of expletives about who you are, or the nursing staff are complaining about the fact that you are not responsive and you're not doing what you're supposed to do. Or, you're getting feedback from your line managers that the hospital managers complain that the security staff are not behaving appropriately. It's a no-win scenario. Whichever way you cut it, you are not going to come out a winner. You're not going to come out feeling like, okay, I'm valued, I matter. Because at that level, you are expendable, and because of the unemployment rate in this country, that position is filled within minutes.*' (MHCP14).

Participants from both groups expressed that despite SGs being an important part of psychiatric hospitals, they are not considered integral members of the professional team: *'Because when you are the security guard sometimes in some places you are looked down upon as though you are someone insignificant; when someone wants something from you, or they want to come in, and I say; 'Sister, you are not allowed to enter here!''* (SG05).

The lack of professional recognition results in the perception of SGs being blamed easily by MHCPs or service users. SGs are often targeted and seen as scapegoats, particularly by service users. One SG described: "*Here, there's just one thing I don't like- most of the time, whenever an incident occurs, they make it as if it is the security guard's fault.*" (SG11). And one MHCP added: *'I think that they are kind of overlooked, and so their opinion or their kind of say doesn't mean much in an argument. The patient always kind of, what makes it even more difficult is that if it's a revolving ward patient, that knows how that ward works, so they are looking for a scapegoat, there is that person to blame in the Security.'* (MHCP9).

Given that most SGs frequently rotate through various wards rather than being permanently assigned to one, MHCPs described it as not possible or worth it to invest in forming personal relationships with SGs: '*And then six months later, we had somebody new. And I realized you will never really form a connection.'* (MHCP11).

The impact of status differentials

The MHCPs are perceived by SGs as having a higher status, and their requests, including being asked to provide interpretation, may not be refused. SGs may perceive themselves as not suitable for acting as interpreters, e.g., because their own English language skills are insufficient or because they feel overwhelmed with interpreting for individuals who are mentally not well. One MHCP reflected on their privileged position within the mental healthcare system and possible power dynamics between them and SGs: *'So even though South Africa has decolonized itself from a political aspect, they haven't really done that in terms of institutionally. So because of the virtue of the position that I occupy, I have a top-down kind of power where I can exercise a disproportionate amount of force, not physically, but just through the words I say and through the things…my actions. And so there's still the sense of disempowerment […]. And then they come into a workspace and here I am with my privileged voice saying, you are not doing this and you are not doing that, you should be doing this. So they are frustrated. They are not protected by their own organization. They are not protected by our members of staff. They are not protected by the patients. So they are on their own. So a lot of the time they are working in unfairly distressing conditions. That obviously does need some reflection and pause for thought.'* (MHCP14).

Participants from both groups expressed SGs' precarious working conditions, and lack of job security lead to a constant fear of being replaced or fired, which

contributes to SGs' compliance with MHCPs' demands: *'And that whatever is asked of them, they just comply and do. Also, out of fear of getting bad reports, of being moved out of the area or possibly being out of a job. So I think they are also in a very vulnerable position where, as I've said, they often comply.'* (MHCP8).

Furthermore, one MHCP shared the historical context of mental health institutions. During apartheid, the policy of all government institutions, including the hospital where the study was conducted, was to segregate White and Black individuals in their treatment. Consequently, SGs, who are predominantly Black, still encounter the challenge of working in an environment that was previously characterized by high levels of institutionalized racial segregation and discrimination: *'Whereas this environment is a reminder for everybody of their own suffering […]. So I think that there is something about this facility that also triggers something in the staff.'* (MHCP11). It was reported by both groups that SGs often find themselves mediating between a White MHCP and a Black service user: *'Yes, it has happened. Well, let me not say it has happened; it happens…you can translate for them. For example, maybe the doctor is White, then the patient is Black, so now you have to; the patient does not understand English, […] so I translate.'* (SG10).

Discussion

This qualitative study explored informal interpreting practices conducted by SGs in a psychiatric hospital in the Western Cape of South Africa. The perspectives and experiences of MHCPs and SGs were assessed through qualitative interviews. Four main themes emerged comprising several subthemes: (1) the healthcare system's reliance on SGs serving as informal interpreters, (2) benefits and challenges of SGs acting as informal interpreters, (3) SGs' (expected but conflicting) roles while interpreting, and (4) power dynamics surrounding interpreter-mediated encounters.

Is a little communication better than no communication?

Participants in this study reported that most MHCPs speak predominately English and that their language skills were often insufficient to communicate effectively with service users from linguistically diverse backgrounds. This is in line with previous findings and emphasizes the historically rooted racial and linguistic disparities between MHCPs and service users in South Africa's healthcare system [27, 33, 41]. Although there are departmental and provincial policies for language proficiency for newly hired MHCPs, such as the requirement to speak two of the three main languages of the province, the language profile of MHCPs in the hospital does not appear to have changed, which raises the question of whether these guidelines are being adhered to. Although participants in the present study stressed that interpreting is a profession that requires special skills and competencies [17, 42], a lack of formal interpreting services and qualified interpreters was expressed. This created a challenging dilemma for MHCPs: they were caught between a desire to offer high-quality care and the practical need for immediate communication and quickly accessible solutions. Additionally, SGs were valued as a convenient and easily accessible solution to bridge the language gap due to their perceived racial and linguistic similarities with some service users. However, to avoid racial bias, it should be noted that people cannot be perceived as a homogenous group simply because they share racial, linguistic and socioeconomic similarities or come from the same community. There might also be great diversity within these groups, e.g., regarding language proficiency or cultural beliefs.

The reliance on SGs as informal interpreters, while far from an ideal solution, was described as necessary in a system with a great diversity of languages but lacking or not easily accessible formal interpreting services. Similar findings have been found in other countries. For example, Keller and Carrascoza-Bolanos (2023) reported that healthcare professionals often resort to using informal interpreters in Southern California due to time constraints, heavy workloads and urgent service user needs [43]. In this study, MHCPs acknowledged that this reliance on SGs may compromise the quality of care. SGs lack the necessary training and expertise in interpreting and mental health; some may even have inadequate English language skills. This is in line with previous studies on informal interpreting practices reporting that lacking interpreting and language competencies could lead to a loss of information, misunderstandings, frustration or even misdiagnosis [11, 41, 44–46]. Hagan et al. (2020) noted that untrained interpreters might "clean up" what service users are saying, potentially leading to the unintentional omission of symptoms or other relevant information [41]. Similarly, MHCPs in this study expressed the importance of nuances and how things are said in mental healthcare, which might get lost when SGs serve as interpreters. However, due to the urgency of providing care and the absence of better alternatives, SGs were often perceived as the only solution to establish at least some sort of verbal communication with service users. Previous studies concluded that the utilization of informal interpreters, such as SGs or cleaners, on the one hand, potentially compromises ethical standards of care. On the other hand, they emerged as the sole viable option for verbal communication and were thus regarded as beneficial for providing minimal care to service users [11, 41].

Security guards' multiple roles while interpreting

The primary role and responsibility of SGs in a psychiatric hospital is to maintain safety for both the staff and the service users [47]. The present study revealed that SGs are expected to shoulder the dual responsibility of interpreting while simultaneously ensuring safety. While MHCPs perceived this role duality as beneficial and reassuring, especially when interacting with agitated or aggressive service users, balancing these two crucial tasks at the same time can be challenging and conflicting for SGs. It was shown that SGs' primary responsibility for ensuring safety could influence their interpretation service, for instance, leading to hesitation to convey information that could potentially provoke aggression or violence. Both formal SG and informal interpreting roles may be compromised by role confusion. Despite the clear benefits of multiple roles for the current provision of services, this complexity is a major challenge.

In addition, it was described that SGs might be perceived as figures of authority who lack trustworthiness in the eyes of service users. Prior negative interactions between SGs and service users may foster feelings of mistrust and reluctance on the part of the service user to share sensitive information and impede the rapport and the development of the therapeutic alliance with the MHCP.

Due to their continuous presence at the wards, SGs might become familiar with service users and form a strong personal bond over time. While this was described as helpful for the service user to open up and for MHCPs to facilitate trust and rapport, it also led to meshed relationships and blurred boundaries in the interpreter-mediated encounter. This complements previous findings demonstrating that cleaners acting as informal interpreters fail to maintain a consistent focus on their role as interpreters [44] and tend to align with either the MHCPs or the service user, thus creating a clinical situation characterized by asymmetrical relationships [11, 48]. Moreover, it was shown that cleaners serving as informal interpreters may use their prior observations and knowledge of service users to convey information to the MHCPs, which goes beyond merely interpreting what has been said in the specific situation [11]. These practices raise ethical concerns regarding service users' privacy and confidentiality, as information might be shared without their consent.

Power dynamics outside and within an interpreter-mediated encounter

In the present study, the profession of SGs was found to be generally undervalued and received little recognition, largely because it typically does not require formal professional training or certification. SGs described being overlooked and lacking respect and acknowledgement from both MHCPs and service users. Although SGs' vital role in the healthcare system became evident in this study, they were not perceived as equal team members at the psychiatric hospital where the study was conducted. The role of SGs in psychiatric hospitals and their precarious working conditions are described in more detail elsewhere (Hanft-Robert S, Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al: The role of security guards in psychiatric care. A qualitative study with security guards and mental health care professionals in South Africa, forthcoming). MHCPs were commonly perceived as holding superior positions with higher status within the healthcare system. Consequently, SGs often found themselves in a precarious situation where they were reluctant to decline requests made by MHCPs, such as serving as an interpreter, even if they felt unqualified. The fear of potential repercussions, such as being fired, often compelled SGs to comply with these demands. In addition, racial differences between SGs, MHCPs and service users might exacerbate such power disparities. In line with findings by Smith et al. (2013), some SGs described that taking on the role of an interpreter made them feel more valued and integrated into the team, which in turn could increase their job satisfaction and sense of fulfilment [11]. However, the majority perceived it as additional work and experienced interpreting as emotionally distressing due to being exposed to service users' traumatic experiences while lacking training in mental health and psychosocial support or supervision. In addition, it might be possible that the pressure of fulfilling an additional role which is not part of their job description can be distressing for SGs.

Though SGs hold little formal institutional power, they may gain more informal power when serving as interpreters since both MHCPs and service users rely on their language skills. Mason and Ren (2012) elaborated that while lacking institutional power, interpreters are often equipped with power within the encounter due to their bilingual and bicultural expertise [49]. Rudvin (2005) noted that the person who interprets is the only person who can understand what all interlocutors are saying at all times, which can be considered an enormous source of power [50]. Regarding SGs acting as informal interpreters, the power dynamics might be especially crucial. SGs are usually perceived as powerful figures or authorities. At the same time, they lack professional recognition for their work, are often overlooked and have little institutional power within the mental healthcare system. This changes when they are used as interpreters and find themselves in a powerful position because of their language expertise. An in-depth analysis of the power dynamics surrounding SGs serving as interpreters would be interesting for future research.

Strengths and limitations of the study

This study was conducted in just one psychiatric hospital in South Africa. Therefore, the results may be context-specific and it is not clear how generalizable they are. To increase the variation in results, it would be useful to include multiple psychiatric hospitals in different regions in future studies. The qualitative approach allowed for an in-depth exploration of the complex dynamics surrounding SGs serving as interpreters. Despite the relatively large sample size for qualitative studies, data saturation cannot be ensured. Due to time constraints, this study could not conduct further interviews. In future studies, as many interviews as possible should be conducted until data saturation is reached. In addition, the interviews were conducted by two different interviewers, which may lead to differences in how the interviews were conducted. However, both interviewers had a high level of expertise in qualitative research and conducting interviews; the interview guide was developed jointly and served as an orientation during the interviews. Moreover, the two interviewers made it possible to include people who speak English, isiXhosa and isiZulu. The heterogeneity of the sample and the inclusion of different MHCPs, such as psychologists, doctors, nurses and social workers, as well as SGs working at different wards in the psychiatric hospital, can be considered the greatest strengths of the study. While our study has already explored the two perspectives of MHCPs and SGs, it would be useful for future studies to also include service users' perspectives. The study results provide in-depth and comprehensive insights, and the themes identified can serve as a database for further quantitative studies.

Conclusion and implications

Despite recognizing this is not an ideal solution, the reliance on SGs serving as interpreters by MHCPs reflects the lack of effective alternatives to address language barriers in South Africa's mental healthcare system. It can be assumed that informal interpreting practices will be continuously used due to the absence of better options. Thus, institutions should offer training and organizational support to enable effective communication between MHCPs and service users in all situations [51]. Based on the study results, some recommendations can be made for this practice. For instance, SGs acting as interpreters should be asked for their consent before assigning them as interpreters. The service users should also be asked for their consent. It should be ensured that serving as an interpreter does not interfere with their primary duties. Additionally, they should be informed about the situation they will be in and educated about mental health. Given the potential psychological distress that interpreting can cause, a debriefing session should be conducted afterwards. MHCPs should know the risks associated with SGs serving as interpreters, e.g., information loss due to limited language skills. The acceptance of risks and neglect of the impact on the individuals serving as interpreters (e.g. emotional distress) raises ethical concerns and highlights the urgent need for the development and implementation of effective, ethically appropriate alternatives in mental healthcare systems to ensure that the quality of care remains uncompromised despite language barriers.

Abbreviations

SG Security guard
MHCP Mental health care provider

Supplementary Information

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Supplementary Material 1.

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Authors' contributions

All authors helped with conceptualizing the research project. SHR and LSh collected and analyzed the data in close consultation with LSw and QC. LSw and QC supervised the project. SHR wrote the first draft of the manuscript. All authors read, edited and approved the final manuscript.

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Availability of data and materials

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

Before the interview started, all interviewees provided oral and written informed consent to participate in the interview, to have the interview recorded, and to allow for the subsequent processing of the anonymized interview data for scientific purposes. Participation in the study was voluntary and not remunerated. The research was performed in accordance with the Declaration of Helsinki and has been approved by the Ethics Committee of Stellenbosch University, South Africa (Ethics reference number: SBE-2022-25557).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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A balancing act: how interpreters affect the therapeutic alliance in psychotherapy with trauma-affected refugees—a qualitative study with therapists

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Objective: The therapeutic alliance (TA) has the highest predictive value concerning the success of psychotherapy. The presented study aimed to explore how the presence of an interpreter affects the TA when working with trauma-affected refugees.

Method: Semi-structured interviews were conducted with seven psychologists working in an outpatient clinic specialized in mental health care for migrant and refugee patients with trauma-related mental health problems in Denmark. Interviews were transcribed verbatim and analyzed using a structuring content analysis approach.

Results: TA has been described as a dynamic therapist-interpreter-patient alliance triangle consisting of three distinct but highly intertwined and mutually influential dyadic alliances. Specific factors affecting the quality of the TA were identified, e.g., interpreter being emotionally attuned yet not overly involved; interpreter being barely visible yet present as a human being. Characteristics of trauma-affected refugee patients affecting the TA formation were also identified, e.g., a high level of personal distrust, different understandings of mental disorders and psychotherapy, stigmatization, perceptions of authorities.

Conclusion: The presence of interpreters was perceived ambivalently and the formation of a good TA seems to be a balancing act. Based on the findings, recommendations for forming and maintaining a good TA in interpreter-mediated psychotherapy are provided.

KEYWORDS

therapeutic alliance, interpreter, trauma, refugees, psychotherapy

1. Introduction

With 30.9% (87 million) of the international migrant population residing in Europe, Europe is the primary destination for international migrants (McAuliffe and Triandafyllidou, 2021). While some people leave their country of origin voluntarily for educational, professional or family purposes, others are forced to leave due to on-going conflicts and wars, increased political instability, persecution, poverty, violence or geophysical and climate-related disasters. By the end of 2021, 89.3 million forcibly displaced people were estimated by the UN Health Refugee Agency worldwide (UNHCR, 2022). 27.1 million of them were refugees fleeing mainly from the Syrian Arab Republic, Venezuela, Afghanistan, South Sudan and Myanmar (UNHCR, 2022). Due to pre-migration traumatic experiences and post-migration stress, refugees are considered a particularly vulnerable group that is more prone to mental disorders. Compared to people without refugee experience, they have a significantly higher prevalence of mental disorders with PTSD, depression and anxiety disorders being the most prominent ones (Turrini et al., 2017; Blackmore et al., 2020). Despite their high need for psychological support, refugees tend to underutilize mental health care services (Satinsky et al., 2019). Due to a lack of multilingual mental health care professionals (Mösko et al., 2013) and policies for the use of qualified interpreters (Solano and Huddleston, 2020), language barriers are considered one of the main obstacles for refugees accessing mental health care services and receiving appropriate treatment (Ohtani et al., 2015; Satinsky et al., 2019).

1.1. Working with interpreters in psychotherapy

While there are already some qualitative studies exploring general challenges and benefits of interpreter-mediated psychotherapy (IMP) (Bauer and Alegría, 2010; Hanft-Robert et al., 2018; Gryesten et al., 2021) or potential risks of untrained interpreters, such as patients' friends, family members or multilingual staff (Flores, 2005; Karliner et al., 2007; Kilian et al., 2014), only a few studies measured the effectiveness of psychotherapy mediated by (qualified) interpreters quantitatively. Most of these studies focus on the treatment of trauma-affected refugee patients and compared interpreter-mediated Cognitive Behavioral Therapy (CBT) with CBT conducted without an interpreter. Almost all studies found that psychotherapy mediated by qualified interpreters can be as effective as psychotherapy conducted without an interpreter (Schulz et al., 2006; d'Ardenne et al., 2007; Brune et al., 2011). In contrast, a more recent study conducted by Sander et al. (2019) showed that in comparison to no use of qualified interpreter, the use of an qualified interpreter in CBT with trauma-affected refugee patients is associated with less improvement in mental health outcomes, such as PTSD, depression and anxiety symptoms. The authors argued, among other things, that the presence of an interpreter might affect the TA, which could be a possible reason for the poorer treatment outcomes.

1.2. The concept of therapeutic alliance

The TA is considered one of the most important mechanisms for change in psychotherapy (Bordin, 1979; Horvath and Luborsky, 1993; Ardito and Rabellino, 2011). Over the last decades it has been shown that a good TA is moderately but consistently associated with positive treatment outcomes across therapeutic orientations, patient characteristics, countries and outcome measures (Ardito and Rabellino, 2011; Flückiger et al., 2018). Historically, the concept of the TA has its roots in Freud's transference theory (1912) and the assumption that as a result of the therapist's supportive attitude, patients would project onto their therapist early images of people from whom they had been treated with affection (Freud, 1958; Horvath and Luborsky, 1993). Over the decades, however, the understanding of the therapeutic alliance evolved away from projection and transference toward a reality-based, non-neurotic and non-transferential therapeutic collaboration between patient and therapist (Horvath and Luborsky, 1993). One of the most commonly used definitions today, which can be applied beyond psychoanalytical approaches to any therapeutic orientation and is thus known as the pan-theoretical conceptualization (Horvath and Luborsky, 1993), was formulated by Bordin (1979). According to him, a good TA consists of three essential components: agreement on the goals of the therapy, agreement on the tasks, and the development of a personal bond between therapist and patient (Bordin, 1979). The latter component is fundamental for the development of the first two (Bordin, 1979; Ardito and Rabellino, 2011).

1.3. Therapeutic alliance in interpreter-mediated psychotherapy

A traditional therapeutic setting consists of a therapist and a patient, both sharing one (native) language and communicating verbally with each other. The formation of the TA depends solely on the interaction between the patient and therapist. Referring to Bordin (1979), both have to agree on the therapeutic goals and tasks and form a personal bond. However, if a third person, an interpreter, gets involved, the formation of an alliance seems to become more complex and complicated.

To date, only one study could be found that measured specifically the association between the use of interpreters and the TA. In a study with 458 Spanish-speaking patients in the U.S. Villalobos et al. (2016) could not find significant differences in the TA between interpreter-mediated mental health care consultations and consultations conducted with a bilingual practitioner. However, in additionally conducted qualitative interviews with patients with limited language proficiency (LLP), practitioners and interpreters, Villalobos et al. (2016) found that most practitioners and LLP patients would prefer a treatment without an interpreter. Bilingual practitioners described a better rapport and a stronger sense of collaboration when working without an interpreter. Reasons for LLP patients' preference of treatment without an interpreter included a feeling of greater privacy, enhanced communication, and a stronger TA especially in terms of trust and mutual understanding. However, both considered interpreters to be an excellent alternative to LLP patients not being able to use services at all (Villalobos et al., 2016).

Similarly, other qualitative studies have shown that the presence of an interpreter is often perceived by therapists and patients as a double-edged sword in terms of the TA (Raval and Smith, 2003; Miller et al., 2005; Tribe and Thompson, 2009a; Hanft-Robert et al., 2018, 2021). A previous interview study exploring the perspective of trauma-affected refugee patients on the TA in IMP found that

especially at the beginning of the therapy, the presence of an interpreter as a second unknown person as well as the perceived lack of professionalism were described as disruptive factors for building trust and sharing personal, intimate experiences. At the same time the interpreter was considered as necessary to convey words as well as emotions and to form an alliance with the therapist (Hanft-Robert et al., 2021). Interview studies with therapists demonstrated that they are often concerned that an interpreter will hinder the development of a personal bond with the patient and make it more difficult to use therapeutic techniques to foster trust and rapport, such as reflective listening and conveying empathy (Raval and Smith, 2003; Miller et al., 2005; Krystallidou et al., 2018). In contrast, a recent study conducted by Delizée and Michaux (2022) found that an interpreter can actively co-create a supportive alliance, promoting patient's self-expression and thus strengthen the therapeutic work. In line, other studies have shown that the presence of an interpreter is also perceived as beneficial. For instance, if the concept of psychotherapy and mental disorders is not familiar and patients are afraid of stigmatization, the presence of an interpreter as a representative of the patients' cultural and linguistic backgrounds can normalize the experience of psychotherapy (Miller et al., 2005; Tribe and Thompson, 2009b). In the literature, it is described that the interpreter can also act as a cultural mediator between the patient and the therapists (Westermeyer, 1993; Miller et al., 2005; Hunt and Swartz, 2017; Hanft-Robert et al., 2018). While the interpreter is often perceived by therapists as a beneficial source of cultural information (Hanft-Robert et al., 2018), it should be kept in mind that individual differences and heterogeneity exist also within cultural groups (Palmer, 2004). If the interpreter acts on his or her own cultural interpretations, beliefs, and perceptions that do not align with those of the patient, the therapeutic process may be compromised (Kaufert and Koolage, 1984; Kilian et al., 2014).

Although, the presence of an interpreter is perceived ambiguously, it is repeatedly emphasized that, just as in traditional dyadic therapy, a good TA is also a prerequisite for a successful IMP (Miller et al., 2005; Tribe and Thompson, 2009a; Hanft-Robert et al., 2021). However, studies examining this specific therapeutic mechanism in IMP are scarce. The presented study aimed to explore from the therapists' perspective how the presence of an interpreter affects the TA when working with trauma-affected refugee patients. Based on the results, recommendations will be derived on how to form a good TA.

2. Materials and methods

In the current study, semi-structured interviews were conducted with psychologists working in an outpatient clinic specialized in mental health care for migrant and refugee patients with trauma-related mental health problems in Denmark. The reporting of methods is in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

2.1. Participants and recruitment

Selection of participants was based on a purposive sampling approach (Marshall, 1996). Included in the study were participants (1) working as psychologists at the outpatient mental health care clinic and (2) having completed at least one course of IMP (a minimum of 10 therapy sessions) at this specific clinic with (3) trauma-affected refugee patients. The research project was presented to all psychologists who were working in the outpatient mental health care clinic at the time of the study at one of their weekly meetings. In addition, all of them were invited to participate in the study *via* e-mail. One psychologist did not wish to participate and two did not respond to the email. The remaining seven participants were provided with oral and written information in Danish about the study prior to the interview. All gave their written, informed consent to be interviewed and for the interview to be digitally audio recorded, transcribed and analyzed for the purpose of the study. The study was not reviewed by a research ethics committee. In Denmark no ethical approval is required for studies using questionnaires or interviews that do not involve human biological material.[1]

2.2. Interview guide

The interview guide for this study was based on a literature review and the research question. It was developed by SHR in close consultation with LGL and JC following Helfferich's (2009) SPSS approach of collecting, reviewing, sorting and finally subsuming questions. The guide covered the following topics: importance of TA in general and specifically in interpreter-mediated psychotherapies with trauma-affected refugees, challenges and benefits of having an interpreter involved, factors that facilitate or complicate establishing a good TA. Since the aim of the study was to explore new aspects and get in-depth insights into the psychologists' experiences, open-ended questions were asked which aimed to encourage interviewees' self-reflection (e.g., "Could you tell me a little about how a good TA between you and the patient can be build?" and "How did you know that you and the patient had a good alliance?"). The concept of TA can be rather abstract and theoretical and difficult to grasp or describe verbally. Therefore, participants were also invited to give examples (e.g., "Can you give me an example where you perceived the presence of the interpreter affected the alliance between you and the patient negatively?"). The guide was pilot tested twice with clinical psychologist by SHR, no significant changes were made.

2.3. Data collection and transcription

The interviews were conducted between March and April 2022 by SHR in person and in a one-on-one setting in the participants' offices at the outpatient clinic. All interviews were conducted in English. SHR had no previous relationship with the participants. All interviews were conducted using the semi-structured interview guide described above. The guide allowed to deviate from the pre-formulated questions and ask individual questions to explore new or unexpected aspects that arose during the interview. Additionally, participants completed a short questionnaire on sociodemographic data. The interviews lasted between 51 and 117 min. The interviews were digitally audio recorded and transcribed verbatim by SHR and a trained student research assistant. All transcripts were proofread by SHR and not returned to

1 More information: http://en.nvk.dk/how-to-notify/what-to-notify

participants. In order to protect participants' identity, any personal data that could lead to identification (e.g., names of participants, patients or interpreters) was deleted or changed. Participation in the study was voluntary and not remunerated.

2.4. Data analysis

Data analysis followed Kuckartz' (2014) structuring content analysis approach. A combination of deductive and inductive coding was applied. Deductive categories were derived from the interview guide and were supplemented by inductive categories when new aspects emerged from the interview data during the coding process (Kuckartz, 2014). To ensure intersubjective comprehensibility and credibility (Creswell, 2013), three interviews were coded separately by LGL and SHR. Coders read the interviews to get familiar with the data. Text fragments ranging from a sentence to one or more paragraphs were allocated to categories (inductive or deductive), which were later summarized and combined into main and subcategories. Subsequently, the coded text fragments and assigned codes were discussed by LGL and SHR. SHR analyzed the remaining interviews in close consolation with LGL. Final results were discussed with JC and MM. Study participants did not provide feedback on the final results. Data was analyzed using MAXQDA 2020.

2.5. Researchers' characteristics

Qualitative researchers are intimately involved in the research process and personal preconceptions cannot be completely avoided. Therefore, researchers should clarify their identity, credentials, occupation, gender, experience and training (Tong et al., 2007). SHR is a female psychologist (M.Sc.) and doctoral student. She has many years of experience in conducting semi-structured interviews and qualitative data analysis. LGL is a female MSc and PhD in Public Health and has considerable experience with qualitative research methods and the field of cultural psychiatry. MM is a male psychotherapist and professor for clinical psychology with comprehensive experience in qualitative research. JC is a female MD, a research associate professor at the University of Copenhagen and head of research at the outpatient mental health clinic. She has many years of experience in conducting and supervising research in mental health consequences of trauma in refugees and in transcultural psychiatry.

2.6. Sample

The sample consisted of seven psychologists ($n = 6$ female, $n = 1$ male) working at the outpatient mental health care clinic specialized in treatment of migrant and refugee patients with trauma-related mental health problems in Denmark. The participants were between 30 and 50 years old ($M = 39$ years). They had between 3.5 and 19 years of working experience as a psychologist ($M = 10.6$ years) and between 3.5 and 11 years of experience in conducting IMP with trauma-affected refugee and/or migrant patients ($M = 7.9$ years). All participants had their licence in Cognitive Behavioral Therapy (CBT). Two psychologists were additionally trained in Acceptance and Commitment Therapy (ACT) and one psychologist in Narrative Exposure Therapy. All study participants conducted interpreter-mediated therapy several times a week (range 2–9 times per week). The majority ($n = 6$) had never received explicit training for working with interpreters. However, one interviewee noted that working with interpreters is a focus of and an ongoing dialog within the clinic. One psychologist had participated in a 60-h course about working with interpreters. Two psychologist had a migration background themselves (European countries) and two had a second-generation migration background (Global South). Three participants had no first- or second-generation migration background.

3. Results

In total, 3 main categories with 14 subcategories and several sub-subcategories were identified. The first main category addresses the different types of alliances and their interconnections in IMP. It consists of 4 subcategories and several sub-subcategories. The second main category refers to factors positively or negatively affecting the alliance formation in IMP. It encapsulates 7 subcategories and several sub-subcategories. During the interviews it became evident that, in addition to the presence of an interpreter, certain characteristics of trauma-affected refugees must be taken into account in order to establish and maintain a good TA. Thus, the third main category comprises characteristics of trauma-affected refugee patients that were described as crucial for the TA. It consists of 3 subcategories, which in turn encapsulates several sub-subcategories (see Figure 1). Based on the results, recommendations are made on how to form a good TA (see Table 1).

3.1. Types of alliances and their interconnections

3.1.1. Interpreter-therapist-patient triangle

The psychologists described that the TA cannot be thought of without the interpreter which, in turn, makes the development and maintenance of a good TA more complex and challenging: *"I do not really see it as me only with the patient […]. It's like a triangulation, so they [the interpreters] are part of, you can say, the constellation, so they play a major role in me being able to build a good TA with the patient." (IP06).*

The therapist emphasized that they need to be aware not only of their alliance with the patient but also of their working alliance with the interpreter as well as the patient-interpreter alliance. The desired goal is the development of a sense of teamwork between therapist, patient and interpreter.

3.1.2. Therapist-interpreter working-alliance

All participants stressed the importance of having a good working alliance with the interpreter, which was described as being close, but not too close, as having a good balance between being friendly and professional with each other. This also includes mutual appreciation of each other's professions and, especially on the part of psychologists, recognition of interpreters' professionalism. The collaboration should include briefing and debriefing and allow mutual honest and constructive feedback. One psychologist pointed out that a good

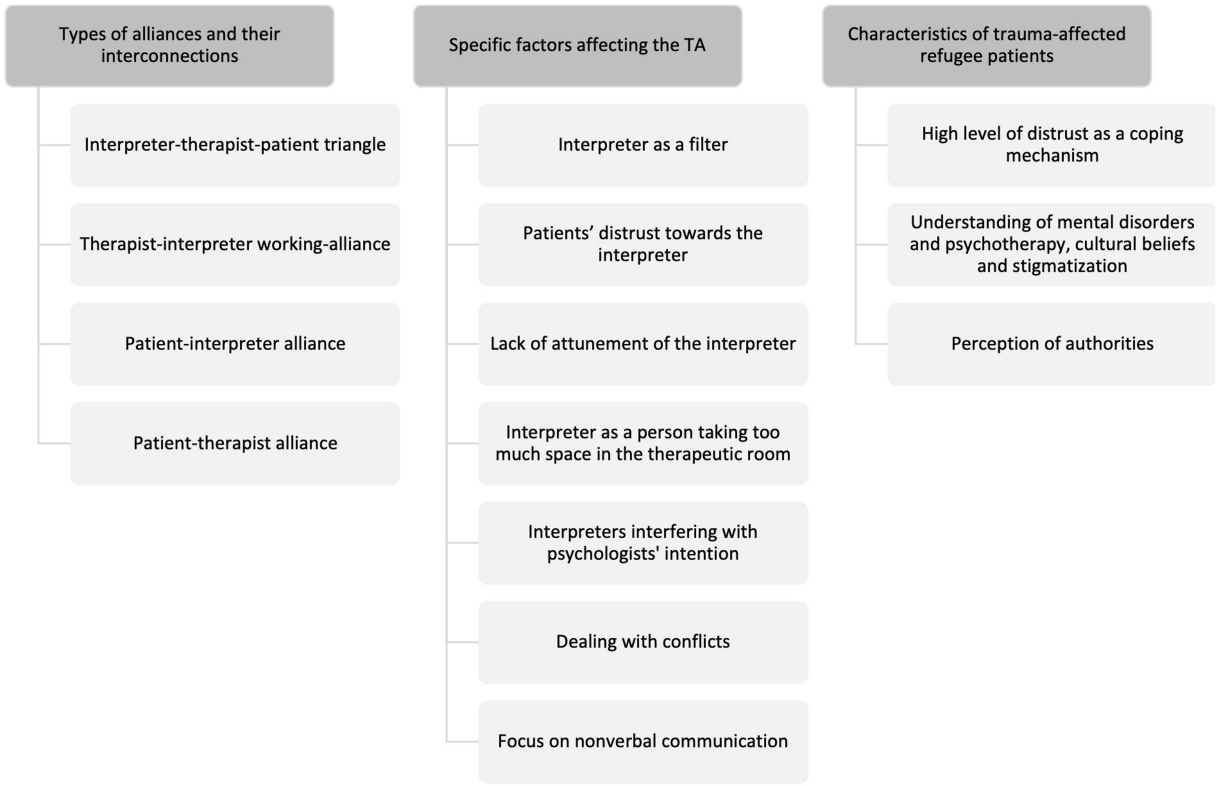

FIGURE 1
Identified main and subcategories regarding how interpreters affect the TA.

working alliance between the interpreter and therapist makes it possible to overcome irritations or ruptures due to misconduct on the part of the interpreter: *"She made a small correction of something I did because it was-, there was something cultural I missed in my intervention that she wanted me to be aware of […]. It did not put any harm to the alliance. […] Because she does not do it very often and I know her well. And I work with her and we have a good alliance. So it was just, you know, if she did that every time I would be so annoyed […]. So, you know, it's very important to have a good alliance with the interpreter as well" (IP03).*

The participants stated that a good working alliance with the interpreter can give the patient a sense of a safety. Moreover, perceived ruptures or distrust in the working alliance can also affect the patient: *"If the patient can feel that I do not really trust the interpreter, then, it's a rupture in the connection. Because we need that person. You know, so then there is distrust in the entire room. Which is, it's not good." (IP01).*

However, it was also noted that a too strong alliance between the psychologist and interpreter could make the patient feel excluded.

3.1.3. Patient-interpreter alliance

The participants explained that the interpreter is often perceived as a person holding a safe space by the patient, as someone who can comfort them and, especially at the beginning of the therapy, facilitate the development of a trusting TA between the patient and the therapist. However, if the patient is permanently mainly attached to the interpreter, frustration and a sense of competition can arise. Psychologists described feeling excluded, superfluous, overlooked, powerless and incompetent. Some noted that the interpreter can help shifting the patients' focus away from them and toward the therapist for example by using an eye or gentle hand gesture to indicate that the patient should look at the psychologist. One psychologist mentioned to disengage, when they have the feeling that there is no chance to build an alliance with the patient that is as strong as the interpreter-patient alliance. However, they also described that in some cases when there is such a strong alliance perceived between the interpreter and patient, they try to use it and work through that strong interpreter-patient alliance with the patient*: "I think it would be like leaning back more. And accepting that the alliance is very much there. And that the person is receiving help through the interpreter. From the interpreter. It feels for the patient like it's from the interpreter, but then I can remember – remind myself that it is through the interpreter […]. So, the change or therapeutic effect is sort of shifted on to whatever is going on between them. And that can be OK. That can be OK. It can work. And also be very mindful of it's still my responsibility. That is not just the interpreter that is doing whatever or saying whatever. I'm also still the one who is actually leading the conversation. And structuring the conversation. Asking the questions." (IP05).*

Another psychologist described that ruptures in the alliance between the patient and the interpreter, such as the interpreter coming late, laughing about something the patient says, being distracted while interpreting, breaking confidentiality, or interpreting incompletely, can also affect the therapist-patient alliance. These ruptures occur in a space where the therapist is not only physically present but also in charge of what is happening: *"Yeah, in some ways you are representing this place you know, and in some ways, if the rupture is happening in the relation to the interpreter, it's still happening in your room. It's still in the*

TABLE 1 Therapists' recommendations for forming a good TA in IMP based on the study results.

Therapist	• Being aware that the interpreter is an active part of the alliance • Creating a personal bond and agreement on tasks and goals of the therapy with patient and interpreter • Attention to (distrust, ruptures and conflicts in) all three dyadic alliances • Finding a balance between closeness and professional distance in the working alliance with the interpreter • Use of qualified (professional) interpreters and recognition of interpreters' professionalism • Briefing the interpreter about therapeutic interventions and goals to avoid contradictory behavior on part of the interpreter • Explain interpreters' role and their obligation to adhere to professional ethical principles, such as confidentiality, impartiality and transparence • Appropriate handling of conflicts during or after the session, depending on whether the conflict affects the patient and therapeutic process directly • Focus on nonverbal behavior to strengthen the therapist-patient alliance, including body language (e.g., leaning a bit forward toward the patient), tone variation in the voice, having eye contact with the patient also when the interpreter is talking, active listening (saying "hmm," nodding), and reacting with facial expressions toward the patient when the interpreter speaks • Arrange seating position so that the patient and therapist have eye contact • Awareness of that interpersonal trauma can prolong and complicate alliance formation and use of interventions focusing on strengthen the TA • Cultural-sensitive psychoeducation: - Exploring patients' understanding of mental health disorders and psychotherapy/healing and creating a shared understanding (i.e., shared goals and tasks of the therapeutic process) - Explaining the framework of psychotherapy - Clarifying therapists' role to the patient in contrast to other authorities
Interpreter	• Shifting patients' attention toward the therapist by eye movements or gentle hand gestures • Continuous presence • Sufficient language skills in both languages • Adherence to professional ethical principles, such as confidentiality, impartiality, transparence, interpreting completely • Emotional attunement by adapting the way of interpreting (e.g., tone of voice, volume, tempo, timing, body language) • Finding balance in terms of personal and emotional involvement depending on the therapeutic process

psychotherapeutic room that this is happening. So it's impossible to-. I think it's impossible that it does not in some way transfer, you know, contaminate the [therapist-patient] relationship. "(IP04).

In contrast, one psychologist described that even if there are ruptures in the interpreter-patient alliance and a lack of trust toward the interpreter, there can be at the same time a strong trusting TA between the therapist and the patient. He/she described a situation where both, he/she and the patient were irritated by the interpreter. Although neither had a good alliance with the interpreter, there was a good alliance between them*: "I had a very good alliance with a patient even though there was an interpreter in the room, but not very good with the interpreter and she had not a very good one with the interpreter as well. But there was something between me and her [the patient] that understood, even though the interpreter wasn't that good. She was quite irritating, the interpreter. And I think the patient also had that opinion. "(IP03)."*

3.1.4. Patient-therapist alliance

All psychologists emphasized that, although an interpreter is involved, the TA between a therapist and a patient is still the focus. A clear communication of the role of the interpreter and therapist was described as crucial. However, the participants expressed that the patient-therapist alliance is dependent on a third person, which can be challenging. On the one hand, it was stated that interpreters can facilitate the development of the alliance between the therapist and patient, as they enable linguistic communication. On the other hand, interpreters can impede the alliance. Some psychologists mentioned that they try to talk to the patient directly every now and then, for example if the interpreter is late or has already left after therapy. If they feel that the patients' language skills are reasonably sufficient, some therapists prefer to continue the therapy without an interpreter. One psychologist described how deciding to work without an interpreter changed the therapist-patient alliance significantly for the better*: "And she [the patient] was actually quite good at English and Danish. So after maybe first half of the whole therapeutic course we started doing our session without the interpreter. And that really did a massive change in the TA. That she [the interpreter] wasn't there anymore. So, it wasn't that she wasn't nice or that she did not interpret correctly. She just had this presence that somehow disturbed the alliance between me and my patient. "(IP05).*

3.2. Specific factors affecting the therapeutic alliance

3.2.1. Interpreter as a filter

Two psychologist pointed out that due to the language barrier the interpreter is the first person who gets the information from the patient and the also first chance to react to what the patient has said. The therapist, however, receives the (verbal) information with a delay which can lead to a feeling of distance in the therapist-patient alliance and in turn to a closeness in the interpreter-patient alliance, especially at the beginning of the therapy.: *"Here is the interpreter, the first person who gets the information that you have said. I, as psychologist, I'm left out, I do not know what they are talking about, but I can see this interaction and response from the interpreter. […] Generally it is easier to be a therapist when you do not have an interpreter. […] There is no filter, you get through with your message or your intervention directly and quickly to the patient." (IP02).*

3.2.2. Patients' distrust toward the interpreter

All psychologist stated that the existence of mutual trust is the core of a good TA. The presence of an interpreter, however, can lead

to mistrust on part of the patient for various reasons. Firstly, patients have to establish trust not only with one but with two strangers. This can be particularly challenging when taking into account that trauma-affected refugee patients generally have difficulties building trust. Secondly, the patients can perceive the interpreter as a representative of patients' own culture who might judge them negatively based on cultural beliefs and norms. Thirdly, a suspected connection of the interpreter to the patients' community can lead to distrust. Patients are worried that interpreters do not adhere to confidentiality and share sensitive information about them and the therapy within their community. Mistrust toward the interpreter can lead to the patient becoming less engaged in the therapy and even withholding therapy-relevant information: *„So, if I am in the position of the patient. I think that I would be worried about what the interpreter is going to think about me. I would be worried that I am being judged. I would be worried that the interpreter is going to talk in the community about me and my problems. Then I do not want to even engage in this therapy and open up. "(IP05).*

The participants named a number of factors that they believed could increase patients' trust in the interpreter. This includes the continuous presence of the same interpreter; being impartial; having sufficient language skills and interpreting precisely and completely: *"I'm just thinking of one [case] where the patient was really happy about the interpreter too. And it wasn't necessarily that the therapy had a big effect on the person, but I could just feel that there was a big trust from the patient both to me and the interpreter because the interpreter was so calm and so precise it made the patient feel really safe in the room […] and that she could express herself freely "(IP04).*

3.2.3. Lack of attunement of the interpreter

Another challenge mentioned by all psychologists is when the interpreter is not appropriately attuned to them or the patient. All psychologists agreed that a good interpreter must sense the atmosphere, be emotionally attuned to what is happening in the room and be able to adapt the way of interpreting to it (e.g., tone of voice, volume, tempo, timing, body language). A lack of attunement can lead to irritation on the part of the patient and the therapist, resulting in a loss of trust in the interpreter and ruptures in the TA: *"Because the attunement is the basis of the alliance. And with some patients it's totally fine, but with some patients where the relation is fragile, if they have a lot of mistrust and just one small like-, if you say something where it just sounds like-, you know, your tone of voice is such a big part of how they interpret what is happening, and a small disattunement can make a huge rupture in the relation. So if the relation is difficult already then small ruptures can actually go in and destroy quite a lot in the relation because the patient does not feel like you [the interpreter] take it serious. […] And suddenly you yourself can become a bit frustrated, like, do not drop my alliance on the floor with yawning or with laughing inappropriately." (IP04).*

3.2.4. Interpreter as a person taking too much space in the therapeutic room

One aspect, stated by all psychologists, that leads to interpreters being perceived as disruptive to the TA is when they take up too much space in the therapeutic room. This includes the interpreter being emotionally too much involved, showing own emotions in an inappropriate way, giving advice during therapy, comforting or touching the patient, being dressed in a way that attracts a lot of attention, speaking very loud or moving a lot. Most interviewees said that they prefer an interpreter who is barely visible, but at the same time acknowledged that an interpreter changes the relational dynamic just by being physically present. One interviewee described it as disruptive when the interpreter as a person, with his/her personality, is too present: *"And the less the interpreter is there as a person in the room, the more easy it is to do therapy with an interpreter."*

However, the same psychologist also mentioned at another time of the interview that especially the warm and calm personality of some interpreters was perceived as beneficial for the TA: *"And then I think a lot of interpreters have a very good calm way of being. And that can create a strong alliance, you know, with what they come with. If they come with a warmth and a calmness that can make it actually so you are-, so you become an even stronger alliance all together. "(IP04).*

3.2.5. Interpreters interfering with psychologists' intention

All psychologists have experienced situations where the interpreter acted in a way that was contrary to the psychologists' intention or the therapeutic goal. Such contrary and interfering behavior can lead to irritation, frustration and anger on the part of the psychologist. Reasons for such interfering behavior were seen in cultural beliefs (e.g., shame and stigma), a lack of knowledge, a lack of empathy or the fact that patient's narratives are too terrible and thus unbearable for the interpreter. One interviewee explained that some interpreters tend to avoid the heaviness especially of traumatic narratives by talking faster, changing the tone of their voice, making jokes, laughing and trying to lighten the mood. However, this could perceived by the patient that the TA is not stable enough for their (traumatic) experiences and that it is better not to talk about them: *"They [the interpreters] think sometimes they help the patient, 'we make it lighter, we need some laugh, we need to have something else because I want to help'. […] It's avoidance. As a psychologist, I do not want the patient to learn that. As human beings, we have this tendency to go this avoidance path because it's too hard. And when the patient learns from me or the interpreter that it's too heavy, you have to do something else to compensate it, then, what is the learning point here? I should not talk about it." (IP02).*

3.2.6. Dealing with conflicts

All psychologist emphasized the necessity of dealing with conflicts which could lead to ruptures in the TA. However, finding the right time to address such conflicts was described as a fine line. In the case of interpreter misconduct most psychologists prefer to talk to the interpreter in private afterwards. One psychologist explained that dealing with conflicts during the therapeutic session could make the interpreter-therapist alliance too prominent in the therapeutic room, take the focus away from the patient and resulting in an even bigger rupture. Moreover, it was feared that addressing a conflict during the therapy session would lead to the patient no longer perceiving the interpreter and therapist as a team and thus losing trust in both. However, if there is a risk that the conflict will make the patient feel uncomfortable, it should be addressed directly in the therapy session: *"I would probably do it afterwards. Unless it was very obvious in the conversation, and I could see it made the patient distrustful, uncomfortable. Then, I might in a nice way ask, ‚Oh, it seems like she talked for way longer. Would you mind just repeating what she said? 'Something like that, because if I do not point it out, if it seems like*

something is wrong, and I do nothing, the patient's trust in me can also go down, you know, so it can affect the TA." (IP01).

Although all participants stressed the importance of clarifying conflicts with the interpreter (during or after the therapy session), there was also a tendency to avoid such confrontation because they were concerned to offend the interpreter and thus jeopardize their working alliance with the interpreter. Criticism was described to be particularly difficult on a personal level, for example when interpreters appear disinterested, yawn or laugh during a conversation. It was described as easier to express criticism on a more technical level, e.g., when the interpretation seems to be incomplete or when interpreter and patient start a conversation during the therapy session: *"But how they present themselves in the room, when you sometimes think that they are not acting very professional, that's also vulnerable for the interpreter[…]. In those instances I wait until after the session, if I do it at all actually. I would say with those things, with the yawning and laughing, it's a bit sore. That's hard to talk about. It feels like-, it can be a bit vulnerable because I'm sure no interpreter does this on purpose, you know." (IP04).*

3.2.7. Focus on nonverbal communication

Due to the language barrier all psychologist stressed the importance of building an alliance with the patient through nonverbal behavior. This includes for instance the body language (e.g., leaning a bit forward toward the patient), tone variation in the voice, having eye contact with the patient also when the interpreter is talking, active listening (saying "hmm," nodding), and reacting with facial expressions toward the patient when the interpreter speaks: *"I think it is a lot the nonverbal communication, how important that becomes when it is interpreted. To very much show that I'm focusing on the patient, that I'm not turning towards the interpreter and listening to them, and then I also set an example for the patient. So I want our communication to be direct. And then it goes through a third person, but the alliance is between us, we are in communication."(IP01).*

To facilitate the development of a good therapist-patient alliance through nonverbal behavior all participants emphasized the seating position and that the patient and therapist should sit facing each other so that they can look each other in the eyes.

3.3. Characteristics of trauma-affected refugee patients

3.3.1. High level of distrust as a coping mechanism

All psychologist experienced a high level of distrust among most trauma-affected refugee patients, mainly because of traumatic experiences, especially interpersonal ruptures and breaches of trust, as well as post-migration problems. The distrust was described as a natural and almost necessary coping mechanism which the patients learned over time to survive their traumatic experiences: *"I mean, for example, people who have experienced war, who have been imprisoned, who have experienced genocide and what not. They have really seen the worst of human beings in behavior. And that, in itself, obviously impacts the way you trust other people in general. […] And if your coping mechanism or the way you have been used to-, the way you also take care of yourself is being cautious of others, then that is also in the room obviously." (IP06).*

3.3.2. Understanding of mental disorders and psychotherapy, cultural beliefs and stigmatization

All psychologists described a lack of knowledge about the concept of psychotherapy as a barrier for building a trusting TA. Patients not only need to trust the therapist, they also need to engage in the method of psychotherapy. The existence of different treatment expectations and explanatory models of mental disorders were described as challenging. The importance of psychoeducation was particularly emphasized. Four psychologists mentioned that especially when the concept of psychotherapy is foreign, patients' cultural beliefs and fear of stigmatization can be hampering the formation of a good TA. Some patients might feel ashamed to talk to a psychologist and thus hesitant to trust them: *"Because it is so new, it's so foreign, the idea of psychotherapy, going to see a psychologist, it's a lot of stigma. So, it takes extra time to kind of get comfortable and create an alliance sometimes, before we can actually start to work. "(IP01).*

3.3.3. Perception of authorities

Four participants pointed out that refugees often have to meet certain immigration requirements in their host country. They explained that psychotherapy could feel like such a requirement and psychologists might be equated with other representatives of authorities whose orders they have to obey. This equation can negatively impact the TA in that patients sometimes do not have good experiences with authorities: *"Some people feel like they have to be here, even though it's voluntary. And that, of course, can make it hard to create an alliance […]. Often they do not have a very good experience with the government. Sometimes they think we are the government as well. "(IP01).*

4. Discussion

This study explored how the presence of interpreters affect the TA in psychotherapy with trauma-affected refugee patients. Semi-structured interviews with psychologists working in an outpatient mental health care clinic in Denmark were conducted.

The presence of interpreters was perceived ambivalently with regards to the TA. On the one hand, therapist expressed great appreciation toward the interpreters and valued their presence as highly beneficial mainly because they enable mutual linguistic understanding between the therapist and patient, a fundamental component of forming a therapeutic alliance. On the other hand, various concerns were expressed, and some therapists seemed to view the interpreter more as a necessary but unstable variable that can impede the formation of a good TA easily.

4.1. Interpreter as an (not too) active part of the therapeutic alliance

The interpreter as a person was seen by all participants as an integral and active component of the TA. This is consistent with role conceptualizations that move beyond the conduit role of interpreters in psychotherapy (i.e., interpreters as a non-thinking and non-feeling translation machines (Dysart-Gale, 2005; Hsieh, 2008)) to an understanding of interpreters as an interactive variable of the therapeutic process whose presence changes the therapeutic and

relational dynamics (Dysart-Gale, 2005; Miller et al., 2005; Hsieh, 2006, 2008; Hunt and Swartz, 2017; Chang et al., 2021; Delizée and Michaux, 2022). However, viewing the interpreter as an integral and active part of the TA, instead of a mere translation machine, entails increased relational complexity which was experienced as challenging by all participants.

Although, the interpreter was perceived as an active part of the TA, finding the right amount of activeness seems to be challenging. While therapists expressed the preference of an interpreter who is barely visible as a person in the therapeutic room, they also requested that the interpreter is present as a human being and emotionally attuned to what is happening in the therapeutic room. A lack of emotional attunement as well as being too emotionally involved was perceived as hampering the formation of the TA. Authors, like Angelelli (2004) and Gryesten et al. (2021) discuss that while interpreters' visibility is usually defined as something categorial (visible vs. invisible), it seems to be more a flexible continuum of visibility in reality, depended on, for instance, the therapeutic stage and content. Also, based on the examples described by the participants in this study, it appears that the visibility of the interpreter is not categorical, but should vary depending on the situation.

4.2. Balancing the therapist-interpreter-patient alliance triangle

Based on the study findings the TA in IMPs can be described as a therapist-interpreter-patient alliance triangle consisting of three distinct alliances which were perceived as different but strongly intertwined and mutually influential: the therapist-patient, therapist-interpreter and interpreter-patient alliance. In line, Delizée and Michaux (2022) elaborate that by actively forming an alliance with the therapist and the patient, the interpreter might indirectly influence the alliance formation between therapist and patient. Participants in this study stated that forming and maintaining a good TA requires balancing all these three dyadic alliances, whereby forming a trustful therapist-patient alliance is still viewed as the main focus. Referring to Bordin (1979) there needs to be a personal bond and an agreement on the therapeutic tasks and goals between the three of them.

Previous authors described a good alliance triangle as dynamic with constantly changing distances between the parties involved depending on the therapeutic stage and content (Miller et al., 2005; Tribe and Thompson, 2009a; Hsieh and Hong, 2010). Also, participants in this study experienced shifting and changing relational dynamics. For instance, at the beginning of the therapeutic process, some patients might be closer to the interpreter due to the cultural and linguistical proximity. As the therapy progresses patients' primary orientation (ideally) shifts from the interpreter to the therapist. However, if one of the dyadic alliances is consistently either too strong (meaning too close) or too weak (meaning too distant), or if ruptures or conflicts occur, the alliance triangle can become unbalanced. As reported in other interview studies with therapists (Raval and Smith, 2003; Miller et al., 2005; Hanft-Robert et al., 2018), participants in this study expressed feelings of distance, being excluded, powerless, and incompetence resulting in disengagement from the TA, if they perceive that the patient is solely orientated toward the interpreter. In such cases, it was described as helpful if the interpreter uses subtle gestures or facial expressions to direct the patient slowly toward the therapist during the course of therapy.

4.3. Forming a good therapist-interpreter working alliance

Keeping the alliance triangle in balance requires the establishment of a good working alliance between therapist and interpreter. Participants described it as challenging to find the right balance between a friendship-like closeness and professional distance with the interpreter. Gryesten et al. (2021) stated that the collaboration between interpreters and psychologists can range from a friendship to a collegial to an employer-employee alliance. Raval and Smith (2003) noted that the therapist-interpreter working alliance differs greatly compared to the alliance between two therapists especially due to potential power and hierarchical differentials. A lack of professional recognition can place the interpreters in an unequal, less powerful position. Moreover, the interpreter perceiving the therapist as a White professional authority figure can affect the working alliance between them (Raval and Smith, 2003). Also, therapists in this study expressed that a good working alliance requires mutual appreciation of each other's profession and emphasized that therapists need to acknowledge interpreters as professionals. Delizée and Michaux (2022) added that the interpreter needs to understand the goals and methods of psychotherapy and that besides mutual trust and respect, a clear understanding of roles is necessary for alliance formation. This highlights why the use of untrained individuals as interpreters (e.g., family member, multilingual staff members) should be avoided and the use of qualified or so called professional interpreters encouraged (Flores, 2005; Karliner et al., 2007; Flores et al., 2012; Kilian et al., 2014).

4.4. Changes in the therapist-patient alliance

On the one hand, participants strongly emphasized that the interpreter can facilitate the formation of an trustful therapist-patient alliance. Patients tend to perceive the interpreter, who is often someone who shares the same cultural backgrounds as the patient, as a confidant and holding a safe space in an often unfamiliar and unsettling environment. Especially in early stages of the therapy and when the concept of psychotherapy is new to some of the patients, the presence of an interpreter can demonstrate and encourage that the therapist and the method of psychotherapy are trustworthy. Similar, therapists in other studies reported that the presence of an interpreter can enhance the feeling of trust and security in patients, which in turn is seen as a foundation to form the therapist-patient alliance (Delizée and Michaux, 2022). On the other hand, interpreters were perceived as a filter between the therapist and the patient. The interpreter is automatically the first person to hear and react to what the patient has said. The therapist receives the linguistic information with a delay, which can lead to a sense of distance, emotional misattunement and less intimacy in the therapist-patient alliance, especially for therapists who are inexperienced in working with interpreters. In line, Raval and Smith (2003) found that therapists feel shielded and losing the emotional context due to the translation process. Also other studies

have shown that while both therapists and patients consider the involvement of interpreters as the best alternative to no treatment, they prefer a dyadic setting and especially therapists perceive the interpreters' presence as disruptive for developing rapport with patients (Raval and Smith, 2003; Miller et al., 2005; Villalobos et al., 2016; Hanft-Robert et al., 2021).

4.5. Dealing with distrust, conflicts, and ruptures in the alliance

It is known that patients' distrust toward the interpreter can negatively affect the therapeutic process (Hunt and Swartz, 2017; Dabic, 2021; Hanft-Robert et al., 2021; Delizée and Michaux, 2022). Also, participants in this study emphasized that patients' distrust, arising for example from doubts about the interpreter's professionalism and commitment to confidentiality, hinders the formation of a good TA. The interpreter being continuously present, being impartial, having sufficient language skills, interpreting precisely and completely can help to strengthen the patient-interpreter alliance. Before the actual therapeutic work starts, the role of the interpreter and their obligation to adhere to professional ethical principles, such as confidentiality, should be explained to the patient. Moreover, interpreters' behavior that interferes with the therapists' intention, such as joking or laughing to lightening the atmosphere, can lead to frustration and ruptures especially in the working alliance between interpreter and therapist. However, having a strong personal bond can prevent that interpreters' misconduct leads to ruptures in the TA.

The therapists described that distrust, ruptures and conflicts in one of the dyadic alliances can also be transferred to one of the other alliances. For example, if the interpreter laughs about something the patient has said, this could lead to a rupture in the patient-interpreter alliance. However, such ruptures are happening in the therapeutic room, for which the therapist holds the responsibility. If they are not noticed and not handled appropriately by the therapist, they will also affect the quality of the patient-therapist alliance. Thus, therapists described it as crucial not only to ensure the quality of their respective alliances with the patient and the interpreter, but also to be continuously attentive to (ruptures in) the interpreter-patient alliance. Similar results can be found in other therapeutic settings where more than two persons are involved, such as couple and family therapies. Dyadic yet mutually interdependent alliances exist, thus ruptures in one dyad can be transferred to the other (Rait, 2000).

Participants stated various factors that can jeopardize the alliance formation. However, dealing appropriately with distrust, conflicts or ruptures seems to be challenging. Therapists expresses uncertainty when and how to address conflicts with the interpreter. They feared that addressing a conflict in front of the patient could make the interpreter-therapist alliance too prominent in the therapeutic room. However, if the conflict affects the therapeutic process or makes the patient feel uncomfortable, it should be addresses immediately. A tendency of avoiding confrontation with the interpreter was shown, especially when a conflict or misbehavior appears on a personal level, e.g., if the interpreter seems to be bored. In line, Gryesten et al. (2021) found on part of therapists an inherent conflict between maintaining a friendly and collegial alliance with the interpreter and their responsibility for the therapeutic process.

4.6. Impact of trauma and flight on the therapeutic alliance

The findings revealed that besides the presence of an interpreter, specific characteristics of trauma-affected refugees can affect the formation of the TA. However, it should be noted that these characteristics can also impact the TA formation when working with migrant patients in general. Firstly, it was emphasized that traumatic experiences, especially interpersonal breaches of trust, can lead to a high level of general interpersonal distrust as a form of coping mechanism, which can hamper the formation of a trusting TA. Morina et al. (2016) found that interpersonal trauma experiences, such as torture, are associated with more avoidant attachment tendencies in refugees. In turn, it could be shown that patients with an avoidant attachment style have more difficulties in establishing and maintaining a good TA (Smith et al., 2010). The therapist needs to be aware that a possible high level of general distrust functioning as a coping mechanism can prolong the formation of a TA. Therapeutic interventions focusing on the establishment of a stable alliance at the beginning of the therapy seem to be particularly significant when working with trauma-affected refugee patients.

Secondly, and in line with previous findings (Sandhu et al., 2013; Byrow et al., 2019; Satinsky et al., 2019; Hanft-Robert et al., 2021), participants perceived patients' unfamiliarity with the concept of psychotherapy as well as possible stigmatization of mental disorders and psychotherapy as challenging for the TA formation. It is well-investigated that in psychotherapy with migrants and refugees, both the professional as well as the patient are shaped by their cultures, and that their treatment expectations can differ greatly due to culturally based beliefs (Sandhu et al., 2013). According to Bordin (1979), therapist and patient, however, need to have an agreement on the therapeutic goals and tasks in order to form a good alliance, which requires a shared understanding of the therapeutic concept and treatment process between therapist and patient.

Thirdly, the therapists stated that they might be equated by refugee patients with representatives of other, often negatively associated, authorities, which can hinder the development of a trusting personal bond, which is the foundation of any good TA according to Bordin (1979). Similarly, Sandhu et al. (2013), who interviewed mental health care professionals in 16 European countries, reported that the development of trust with migrant patients can be affected by a general distrust to any form of authority or public service stemming from negative experiences, such as torture, oppression and ethnic conflicts (Sandhu et al., 2013).

Based on these study findings, preparatory sessions focusing on cultural-sensitive psychoeducation might be useful before beginning the actual therapeutic process when working with trauma-affected refugee patients. These preparatory sessions should include an explanation of the framework of psychotherapy and the clarification of the therapists' role, especially in distinction to other institutions and authorities. Moreover, different treatment expectations, cultural beliefs and explanatory modules of mental disorders should be explored and a shared understanding of the following psychotherapeutic process developed.

4.7. Strengths and limitations of the study

When interpreting the study findings some limitations must be taken into account. First, due to the relatively small sample size data saturation cannot be ensured. However, all possible participants at the specific clinic were invited to participate. Secondly, the study participants were recruited only from one outpatient clinic that is specialized in mental health care for migrant and refugee patients with trauma-related mental health problems. Thus, most of the therapists were experienced in working with trauma-affected refugees and interpreters. To increase the variation in results, it would be useful to interview therapists from multiple inpatient and outpatient clinics, and especially include less experienced therapists. It must also be critically noted that only one male participants could be included in this study. This may have shaped our findings, as gender seems to be a relevant factor for the TA formation (Wintersteen et al., 2005). Moreover, most participants were trained in CBT. Further studies should include different therapeutic orientations. Even though the TA can be considered as a common factor in psychotherapy, there can be differences in how the alliances are formed. One inclusion criteria in this study was that the interviewed therapists have completed at least one course of IMP, which is a minimum of 10 therapy sessions. Since the duration of therapy can have an influence on the quality of the TA (Sharf et al., 2010; Mander et al., 2013), it would be useful to focus in future studies on how the TA in IMP changes over time, e.g., by assessing the quality of TA at different time points during the therapeutic process. Furthermore, the interviews were conducted in English as participants second language. However, this does not seem to have resulted in linguistic limitations.

The greatest strength of this study is that it focuses exclusively on the TA formation. Most of the studies to date focus more on general benefits and challenges of working with interpreters and the successful collaboration between interpreter and therapist. With the exception of gender and therapeutic orientation, the sample was as heterogeneous as possible in terms of, for example, professional experience and ethnicity. Further studies should include interpreters as well as patients and include different methods, e.g., quantitative measurement of the quality of the TA or observation. In addition, it would be interesting to focus more on cross-racial aspects and how the interplay of different ethnic and cultural backgrounds of therapists, interpreters and patients affect the TA in IMP.

5. Conclusion

The presence of an interpreter on the TA formation in therapy with trauma-affected refugees was perceived ambivalently. It became clear that the interpreter is an active part of the TA, although there were contradictory perceptions regarding the amount of activeness and personal representation on part of interpreter. An alliance triangle was described, consisting of different but intertwined and mutually influencing dyadic alliances. Compared to other settings where the interpreter's skills are of greater importance for the quality of the conversation (e.g., conference interpreting), in psychotherapy the formation of a good TA between all parties involved seem to be most relevant. However, building a good TA in IMP seems to be complex and an act of balance depending on various factors. The study results and derived recommendations can be used to develop guidelines or training for IMP.

Data availability statement

The datasets presented in this article are not readily available because public availability of data could potentially compromise participant privacy. Participants did not consent to have their full transcripts made publically available. Requests to access the datasets should be directed to s.hanft-robert@uke.de.

Ethics statement

Ethical review and approval was not required for the study on human participants in accordance with the local legislation and institutional requirements. The patients/participants provided their written informed consent to participate in this study.

Author contributions

SH-R, LGL, JC, and MM contributed to conception and design of the study. SH-R collected the data, analyzed the data with support of LGL, and wrote the first draft of the manuscript. SH-R, LGL, JC, and MM discussed the results. LGL, JC, and MM read the manuscript several times and provided significant feedback. All authors contributed to manuscript revision, read, and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

Supplementary material

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7.4. Publication 4

Hanft-Robert S, Breitsprecher C, Mösko M. Just having experience is not enough: development and evaluation of a training course for interpreters working in community settings – a mixed-methods study (submitted Front Educ – Language, Culture and Diversity).

Title: *"Just having experience is not enough"*: Development and Evaluation of a Training for Interpreters Working in Community Settings - A Mixed-Methods Study.

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Abstract

Background: Across community settings, such as health care, interpreters play an important role in facilitating communication when service users and providers do not sufficiently share a common language. Because most countries lack legal standards in the field of Community Interpreting, Community Interpreters (CIPs) are often not adequately trained for this activity, and the need for formal training is increasingly emphasised. This study aims to evaluate a generic training for CIPs in Germany.

Methods: The training was developed for interpreters working in health and social care, education and authorities in Germany. It consists of 500 units and a final examination. A mixed-methods design was applied to evaluate the training. Training participants' (TPs) satisfaction, knowledge, competence, and professional self-efficacy expectations were measured by self-developed questionnaires. A pre-post multiple-choice knowledge test was developed to assess the impact on knowledge objectively. Pre-post qualitative interviews were conducted for an in-depth evaluation of TPs' motives for training participation, experiences, improvements in knowledge, skills, and attitude changes. Trainers' qualifications and satisfaction were assessed using self-developed questionnaires. Quantitative data were analyzed descriptively and qualitative data using a content analysis approach.

Results: In total, n = 21 TPs and n = 18 trainers were included. Quantitative analysis revealed trainers' and TPs' overall satisfaction with the training. TPs showed increased subjective and objective knowledge, competence, and professional self-efficacy expectations. Qualitative findings showed changes in TPs' knowledge about their role and ethical principles; they reported increased skills and confidence on a professional and personal level. Due to the training, their interpreting performance changed from being relatively intuitive and 'natural' to being informed and skills-based. They recognized the complexity of interpreting, thereby acknowledging their professional status. Obtaining a certificate after completing the examination increased their feeling of professionalism. However, TPs expressed the need for further in-depth training since the training was rather generic and broad.

Conclusion: The study shows that a generic training can increase CIPs' knowledge, skills, competence, professional and personal confidence, and perceived professionalism. It highlights the critical need for formalized training, certification, and overall qualification programs to not only ensure the quality of interpreting services but also shape the profession of CIPs.

Keywords: community interpreting, public service interpreting, evaluation, training, mixed-methods research

1 Introduction

While cultural and linguistic diversity has always existed in many parts of the world due to the distinct indigenous populations (1,2), ongoing globalization and international and internal migration further increase the diversity of languages spoken within populations worldwide (3–6). However, this linguistic diversity of populations is often not adequately reflected among service providers working in community settings, such as healthcare providers (7–10). This can lead to linguistic disparities between service providers and users, necessitating language mediation through interpreting and translation services (11–14). Community Interpreters (CIPs) usually work in different community settings, such as healthcare, social care, education, and authorities (15). They play an important role in facilitating communication between service providers and users when there is no shared language or sufficient proficiency level for the type of interaction (9,16–20). In this study, the term CIP was chosen because it is used by the International Organization for Standardization (ISO) in their Guidelines for Community Interpreting (CI) (ISO 13611:2014) (21). However, there is a terminological ambiguity, and terms such as public service or liaison interpreting are also commonly used (17,19,22–24).

While there is a growing demand for CIPs due to increased linguistic diversity, the absence of legally established standards in the field of CI remains a significant issue in many countries (16,17,20,25). In Germany, this shortcoming becomes apparent by the lack of protection for the professional title of CIPs, the lack of professional admission restrictions, and the lack of legal entitlement to interpretation services, except for specific cases such as sign-language interpretation or criminal proceedings in court (26). The latter, in particular, leads to a lack of statutory regulations concerning the organization, funding, utilization, and training of CIPs (26–29). Currently, CIPs are not required to possess any specialized training or formal certification to work in most community settings in Germany. This raises concerns about the quality and ethical standards of the services provided and often reduces the recognition and professional status of CIPs compared to other professions (15,16,25,27,29–31). It has been emphasized that each country's institutional policies affect the professionalization of CI (25,29,32). Similar to other countries and compared to the often well-educated conference interpreters, training for CIPs in Germany is usually not offered by higher education institutions but often as short courses by non-governmental organizations (15,16,33–35). This could be seen as a reflection of insufficient governmental recognition and commitment to this field (29,36,37).

Although various training and qualification programs have emerged over the past decade, they vary extensively in scope, objectives, content, and examination. In addition, their effectiveness is often not evaluated (15,28,33,38). Consequently, the training of CIPs covers a broad spectrum, ranging from no training at all to extensive formal education in interpreting, such as a university degree (15,28). A survey among CIPs in Germany demonstrated that even though the majority (69%) of them had received some form of training, the median hours of training received was only 25 hours, and just 29.4% of them had completed a training that concluded with a final examination and successfully passed it (15). Barriers to attending (further) training include a lack of available training, the belief that training does not lead to financial benefits or the fact that one already has sufficient interpreting experience (15). Moreover, CIPs often receive interpreting assignments regardless of their qualifications, primarily due to the absence of legal regulations or qualification standards and insufficient funding for formal interpreting services (33). The lack of structured professional development in the field of CI may demotivate CIPs from participating in training courses, perpetuating the cycle of unstandardized and unqualified practice.

Appointing interpreters who lack formal training poses significant challenges (13,27,39–43). Individuals may be deployed as lay interpreters despite lacking the necessary linguistic skills, interpreting competence, and adherence to professional ethical principles, such as accuracy, confidentiality, and impartiality. Without proper training, these individuals may struggle to manage complex interpreting scenarios, resolve ethical dilemmas, and maintain professional role boundaries. Insufficient linguistic abilities and specialized knowledge can result in miscommunications and inaccurate interpretations, thereby compromising the service provider and user relationship, as well as the effectiveness and outcomes of the communication (39–43).

Hale (2007) highlights the complexity and problematic nature of training, describing it across countries as one of the most challenging aspects in the field of CI. Interconnected factors such as a general lack of recognition of the need for training, an absence of compulsory pre-service training for CIP, a lack of adequate training programs, and differences in the quality and effectiveness of existing training courses pose significant challenges in this regard (16). Pöllabauer (2020) adds that CIP training 'may be viewed as a Herculean and, some might say, frustrating project' (p. 37) (36). Nevertheless, formal training and certification are increasingly acknowledged as essential not only for ensuring the provision of high-quality interpreting services but also for shaping the profession by enhancing its recognition, status, and professional legitimacy (22,25,44,45).

2 Aim of the Study

We conducted a mixed-methods study to evaluate the effectiveness of newly developed training for interpreters working in community settings. We followed Kirkpatrick's Training Evaluation (46) framework, encompassing the three levels of reaction, learning, and behavior, and aimed to answer the following questions from the perspective of the training participants (TPs):

1. What motivates them to participate in the training?
2. How satisfied were they with the training?
3. Are there changes in (subjective and objective) knowledge due to the training?
4. Are there changes in subjective interpreting competence and skills (including subjective professional self-efficacy expectations)?
5. To what extent can what has been learned be applied in practice?
6. What other outcomes could be observed through the training?

In addition, we assessed the trainers' qualifications and asked them to evaluate the organization and preparation of their teaching within the overall training. We also examined their satisfaction with their teaching and the TPs as a learning group.

3 Methods

3.1 Training Description

Based on the results of a previous research project on quality standards and minimum requirements for the qualification of CIPs in Germany (28) and a comprehensive literature research on training programs for CIPs internationally and in Germany, we developed a generic training for CIPs: http://zwischensprachen.de/en/interpreters/qualification.

Target group and requirements for participation: The training was targeted to people with German and one (or more) relevant working languages who interpret in community settings, such as healthcare,

social care, education and authorities, or aspire to do so in the future. Eligibility criteria for enrollment in the training included that TPs had to be proficient in at least one relevant working language at a native speaker level. In addition, their other working language proficiency had to be equivalent to at least B2.2, per the Common European Framework of Reference for Languages (CEFR). Desirable qualifications encompassed prior interpreting experience, an intermediate level of education (equivalent to a minimum of eight years of schooling), and professional qualifications. Participation in the training was free of charge due to the funding of the research project by the Asylum, Migration and Integration Fund (AMIF) of the European Union (AM19-HH5109).

Type, scope, and content: The in-person training was designed to be generic and not tailored to a specific setting. It consists of 500 units of 45 minutes each with face-to-face teaching (224 units), self-study time (224 units), a practical part (20 units) and exam preparation (32 units). The training encompassed 22 modules covering ten topics listed in *Table 1*. The compulsory practical part had to be completed during the training period. It included organizing and conducting three interpreting assignments in different community settings and writing a reflection report for each assignment. The training was conducted by different trainers qualified for the respective course content modules. They were experts in Translation and Interpreting Studies or were professionals in a specific community setting, such as lawyers or psychotherapists. Even though the training was planned in an in-person format, some theoretical sessions were conducted online due to governmental COVID-19 restrictions. However, the majority, especially the practical interpreting exercises during the face-to-face training, were carried out in person.

Final exam: The training ended with a final examination consisting of two parts. Based on the interpreting staging method by Bahadır (2010), the TPs interpreted a simulated conversation and then reflected on their interpreting performance (27). The examination process employed a five-point grading system ranging from 1 (very good) to 5 (fail) and was done by two qualified examiners. Those who successfully passed the exam received a certificate with their final grade.

Timeline and group sizes: Between 2020 and 2022, we had three training groups, two part-time (7 months) and one full-time (3 months). The first group was used for pilot testing and was therefore excluded from this evaluation study. While we initially planned for group sizes of 20 TPs, governmental COVID-19 restrictions required us to reduce the maximum group size to 12 TPs to be able to conduct (most parts of) the training in person.

Please insert Table 1 here.

3.2 Study Design

The study was conducted in the Research Group of Migration and Psychosocial Health at the Department of Medical Psychology at the University Medical Centre Hamburg-Eppendorf. Our mixed-methods evaluation comprised qualitative interviews pre- and post-training and quantitative questionnaires pre-, during, and post-training. We included all individuals participating in the second and third training groups in this evaluation study. Data collection was done from March 2021 to August 2022. We obtained ethical approval in writing from the Ethics Committee of the University Medical Centre Hamburg-Eppendorf (LPEK-0211).

3.3 Instruments

3.3.1 Qualitative interviews

SHR developed the pre- and post-training semi-structured interview guides based on a literature review and the research questions in close consultation with CB, EI, and MM. We followed Helfferich's (2009) SPSS approach of collecting, reviewing, sorting, and finally subsuming questions (47). The pre-training guide covered the following topics: reasons for participating in this training, expectations and concerns, understanding of the interpreter's role, and existing knowledge about professional ethical principles. In the post-training interview, TPs were invited to reflect on the positive and negative aspects of the training, changes regarding their comprehension of the interpreter's role, and knowledge about professional ethical principles. They were also asked about improvements in their interpreting knowledge and skills, changes in their attitudes and the practical applicability of what had been learned.

3.3.2 Quantitative questionnaires

Due to a lack of appropriate validated instruments, we self-developed the pre-, during, and post-training questionnaires for the TPs and the post-teaching questionnaire for the trainers.

Pre-training questionnaire for TPs: This questionnaire captured TPs' sociodemographic variables and interpreting-related variables, which are displayed in *Table 2*. Moreover, subjective interpreting knowledge and competence were measured on a five-point Likert scale, ranging from "1 = no knowledge" to "5 = extensive knowledge" and from "1 = not competent at all" to "5 = very competent".

In addition, we self-developed a multiple-choice test to objectively examine the impact of the training on TPs' interpreting-related knowledge. We developed the pre- and post-test in a multi-stage procedure in cooperation with CIPs and researchers from the field of Translation and Interpreting, specializing in the field of CI. The test was designed for CI in Germany, consists of 22 questions and can be found in the supplement files (in German and English). Correct answers get 1 point, and incorrect answers or "I don't know" 0 points. Finally, the sum score will be calculated, with a higher value indicating more knowledge.

To measure subjective professional self-efficacy expectations, a slightly adapted version of the "BSW - scale for assessing professional self-efficacy expectations" by Abele et al. (2000) was used (48). This is a reliable (α = .78) and valid one-dimensional scale comprising six items, which measures a person's assumptions about whether their ability and motivation are sufficient to cope with their professional tasks. The items are rated on a five-point rating scale from "1 = not true" to "5 = exactly true". The overall mean value across all six items is calculated for the sum score, whereby a higher value indicates a higher self-efficacy expectation (48). In the adapted version, we replaced the word "job" with "interpreting". Cronbach's alpha reliability score for the present sample was .71 in the pre-training and .72 in the post-training assessment.

Questionnaire for TPs during the training: A self-developed questionnaire assessed TPs' satisfaction with each training module on a five-point Likert scale ranging from "1 = strongly disagree" to "5 = strongly agree." The content, methods, materials, trainers, and overall satisfaction were evaluated.

Post-training questionnaire for TPs: The post-questionnaire included items to assess TPs' overall satisfaction with the training and specifically with the organization, content, methods and trainers. We also asked about the relevance of the training and the improvement in German language skills. Items

could be answered on a five-point Likert scale ranging from "1 = strongly disagree" to "5 = strongly agree". Subjective interpreting knowledge, subjective interpreting competence, objective interpreting-related knowledge and professional self-efficacy expectations were re-assessed in the same way as in the pre-questionnaire. In addition, TPs were asked to assess their subjective interpreting knowledge and competence in retrospect before the training began on the same five-point Likert scale (see *Table 3*).

Post-questionnaire for trainers: The questionnaire covered various aspects of the trainers' expertise and experience. Firstly, we asked for their professional background, including their current profession, received training related to the content they have taught, and their professional experience in their teaching fields. Secondly, we assessed their overall training experiences and specifically focused on their experiences with their teaching content and any past engagements with the target group of CIPs. Additionally, trainers evaluated their satisfaction with the organization and preparation of their teaching units, teaching practices, and the TPs' dynamics as a learning group.

Please insert Table 3 here.

3.4 Data Collection

We verbally and in writing informed all study participants, including trainers and CIPs, about the aim and procedure of the interviews and questionnaires, that study participation is voluntary, and that data collection is anonymous. We provided a detailed study and data protection information sheet in German. All study participants gave their verbal and written consent to participate.

Qualitative interviews with TPs pre-and post-training. SHR conducted the pre- and post-training interviews with all TPs in person and one-on-one at the University Medical Centre Hamburg-Eppendorf. She conducted the pre-interviews 1-2 weeks before the training started and the post-interviews within two weeks after the training had ended but before TPs had their final examination. SHR was not actively involved as a trainer in the training to avoid potential researcher bias. For all interviews, we used the self-developed semi-structured guides, which allowed the interviewer to deviate from the pre-formulated questions and to ask individualized questions to explore new or unexpected topics raised by the interviewee during the interview. The first author, SHR, conducted all interviews in German and filled in a postscript to document the interview situation and any potentially disruptive factors during the interview. With TPs' permission, SHR audio recorded the interviews, which were transcribed verbatim by a professional agency. SHR proofread all the transcripts. She either deleted or altered any personal data that could lead to the identification of interviewees (e.g., participant names). We did not return the transcripts to the TPs. The pre-training interviews lasted between 17.24 and 55.40 minutes (M = 33.32), and the post-training interviews were between 38.05 and 71.32 minutes (M = 56.48).

Quantitative questionnaire for TPs pre-, post, and during the training. All questionnaires were in German. TPs filled out the paper-pencil pre-questionnaire before the pre-interview was conducted. The questionnaires during the training were completed at the end of each module in the classroom. The paper-pencil post-questionnaire was completed after the last training unit in the classroom. The multiple-choice knowledge pre-test was completed at the beginning of the first training unit and the post-test (together with the post-questionnaire) at the end of the last unit in the classroom under the supervision of SHR.

Quantitative questionnaire for trainers post-teaching. All trainers completed their paper-pencil questionnaire within one week after their teaching unit.

3.5 Data Analysis

We examined the quantitative data from the questionnaires using descriptive analyses. All analyses were performed using IBM SPSS Statistics Version 28.0.1.1. (14). We analyzed all interviews following the structuring qualitative content analysis by Kuckartz (49). The coding process was deductive and inductive. All interviews were analyzed by SHR, a white female researcher with extensive experience conducting interviews and analyzing them using qualitative content analysis. We critically reviewed and discussed the final category system within an interdisciplinary research team to guarantee intersubjective reproducibility and comprehensibility (50). Study participants did not provide feedback on the results. We analyzed the qualitative data using MAXQDA 2020.

4 Results

4.1 Description of the training participants

During the training, *n* = 3 TPs dropped out and were thus excluded from the study. In total, *n* = 21 TPs were included in the training evaluation, of which *n* = 10 completed the full-time and *n* = 11 the part-time training. All sociodemographic and work-related characteristics are displayed in *Table 2*.

Please insert Table 2 here.

4.2 Qualification of the trainers

All trainers participated in the evaluation (*n* = 18), with *n* = 12 having taught more than one module. Most (95.2%) of the trainers were professionally trained in the content they taught, with an average of *M* = 12.74 years of experience in this capacity (*SD* = 8.03). In total, 72.2% had previously worked with the target group of CIP with an average of *M* = 11.73 years (*SD* = 15.8). Moreover, 83.3% of them possessed prior teaching experience, and most of the trainers (79.5%) had previously taught the content of their assigned modules.

4.3 Outcome evaluation of the trainers

On average, the trainers 'strongly agreed' with being satisfied with the organization of their teaching within the training (*M* = 4.83, *SD* = 0.44) and their overall teaching performance (*M* = 4.41, *SD* = 0.59). They 'strongly agreed' with feeling professionally confident in the content taught (*M* = 4.78, *SD* = 0.53), that they were able to answer TPs' questions adequately (*M* = 4.61, *SD* = 0.49), adapt their teaching to the TPs' performance level (*M* = 4.49, *SD* = 0.55), to achieve previously defined learning objectives (*M* = 4.32, *SD* = 0.61), to ensure variability in their teaching methods (*M* = 4.27, *SD* = 0.81). On average, they 'strongly agreed' with being satisfied with the TPs as a learning group (*M* = 4.79, *SD* = 0.42), that the TPs understood the topic in terms of content (*M* = 4.33, *SD* = 0.57) and language (*M* = 4.24, *SD* = 0.58), were interested (*M* = 4.64, *SD* = 0.58) and participated well (*M* = 4.67, *SD* = 0.61).

4.4 Qualitative pre-training analysis

The qualitative pre-training analysis explored TPs' motives for working as a CIP, reasons for participating in this training, expectations and concerns, understanding of the interpreter's role, and knowledge about professional ethical principles. The results are displayed in *Table 4*.

Motives for attending the training, expectations, and concerns. Many TPs shared that they voluntarily started interpreting to help family members, friends, or acquaintances. Many have already done

this as children. In addition, most of them had previously found themselves in a situation where they could not communicate due to limited language skills. They were now trying to help others in this regard.

Furthermore, some reported bad experiences with interpreters and wanted to do it better. Although many already worked as interpreters, they reported needing more training. The primary motivation for attending the training was to enhance one's interpreting knowledge, skills, and self-esteem. Interpreting was described as a solitary activity, and exchanging experiences with other interpreters was another reason for participation.

Some TPs said that they want to learn about interpreting in different settings, receive a clearer understanding of the interpreter's role and how to maintain role boundaries, increasing their vocabulary and German language skills. They hoped to learn how to deal with interpreting-related challenges. In addition, they expressed the wish to learn more about the professional side of CI, such as self-employment and taxes. At the time of the pre-data collection, some TPs were unemployed and working only occasionally or completely voluntarily as CIPs. Thus, they expressed hopes of completing the final examination to obtain formal certification, which they believed could help to reach a more professional level, get more interpreting assignments, receive better payment, or even permanent employment: "*That's why it's better to be qualified, of course. And with a certificate in hand, of course, you have a better chance of getting a job somewhere."* (IP19_Pre).

The main concerns expressed were about managing the training and other professional or family obligations as well as the heterogeneous group composition leading to potential conflicts: *"I have nothing against Arabs, but I am a black woman, a black person. And I've heard from some Arabs that black people, there is discrimination, so to speak, between Arabs and black people. That's no secret. Everyone knows that. I hope that the Arabs who are in this course are not like the others, so in the negative sense I mean-that we get along well and so."* (IP13_Pre).

Understanding of the interpreter's role and knowledge about professional ethical principles. Most TPs clearly stated that they viewed their role as merely a mediator on a linguistic and cultural level, defined as translating what is said and helping with questions regarding the service users' background. However, throughout the interview, the vast majority gave examples that go beyond the task of mere interpreting, e.g. helping the service user outside of the interpreting situation, self-descriptions like 'a brother' or emotional supporter who aims to empower service users. While a few TPs were aware that they were overstepping their role in such cases, most were not: *"Then I say, please take a breath. Take a sip of water. I'm like a brother or something. Then after five, six minutes, everything was okay again, and we continued the conversation."* (IP03_Pre).

Honesty, completeness, accuracy, confidentiality, empathy, understanding, and humanity were most mentioned regarding known ethical principles. However, the question about principles was generally answered based on personal opinions, experiences, and intuition rather than existing knowledge. *"What principles? Simply humanity. And respect. Not being arrogant. So that's what's important to me, for example."* (IP18_Pre).

4.5 Quantitative outcome evaluation

During the training. On average and across all modules, TPs 'strongly agreed' with being satisfied with the content (M = 4.68, SD = 0.36), the organization (M = 4.7, SD = 0.33), and the trainers (M = 4.83,

SD = 0.27). They 'strongly agreed' with perceiving the used materials (*M* = 4.64, *SD* = 0.35) and the exchange with others (*M* = 4.56, *SD* = 0.47) as helpful and the general atmosphere as positive (*M* = 4.71, *SD* = 0.35). Moreover, they 'strongly agreed' with having learned something new (*M* = 4.5, *SD* = 0.48), perceiving the modules as helpful (*M* = 4.66, *SD* = 0.35) and feeling empowered in their future work as a CIP (*M* = 4.59, *SD* = 0.43). They 'strongly agreed' with being generally satisfied with the modules (*M* = 4.72, *SD* = 0.35).

Post-training. The results from the post-training questionnaire can be found in *Table 3*. The vast majority were satisfied with the training (95.2%) and would recommend it to other CIPs (95.2%). The TPs perceived the training as helpful for their work as interpreters (*M* = 4.90, *SD* = 0.3), stated that they had learned something new (*M* = 4.71, *SD* = 0.64), and felt empowered to do the job as interpreters better in the future (*M* = 4.81, *SD* = 0.4).

Regarding subjective interpreting knowledge, the average pre-training score was *M* = 2.95 (*SD* = .669), and the post-training score was *M* = 4.10 (*SD* = .436). In retrospect (at the end of the training), TPs rated their interpreting knowledge before the training slightly lower than they did at pre-training (*M* = 2.67, *SD* = .856). The average score of the multiple choice pre-training knowledge test was *M* = 10.67 (*SD* = 4.317), while the average post-training knowledge score test was *M* = 16.38 (*SD* = 3.263). This indicates an increase in knowledge, both subjectively and objectively.

Regarding subjective interpreting competence, the average pre-training score was *M* = 3.05 (*SD* = .669), and the post-training score was *M* = 3.71 (*SD = .463*), indicating a slight increase in perceived competence. In retrospect (at the end of the training), the TPs rated their interpreting competence before the training lower than they did at the pre-time point *M* = 2.43 (*SD* = .746). Similarly, a slight increase could be observed regarding the subjective professional self-efficacy expectations, with a score of *M* = 4.38 (*SD* = .546) before and a score of *M* = 4.55 (*SD* = .461) after the training.

4.6 Qualitative post-training analysis

Content, methods, organization, and trainers. TPs reported overall satisfaction with the training's content, format, methods, and trainers. They highlighted the in-person format and interpreting exercises as beneficial components, as they allowed for direct and personal feedback on TPs' interpreting performances, which helped to increase knowledge and skills: *"So, as an interpreter, I don't realize what I've done well or wrong. But when I get this kind of external reflection, feedback from another person, it helps me. That's also important."* (IP20_Post). Most wished for more practical exercises. Some TPs complained that some theoretical sessions were conducted online and preferred to have them in person.

The duration of the training led to mixed reactions; some TPs felt it needed to be longer, whereas others considered it too short, regardless of whether they participated in the full-time or part-time course. It was noticeable that people who were German native speakers or had very good German language skills would find the training somewhat lengthy, suggesting a possible association with TPs' German language proficiency. Some highlighted that the generic training only covered the basics of CI and expressed the need for further in-depth training opportunities. All TPs valued the generic orientation of the training and, in particular, the introduction of different interpreting settings, which was perceived as beneficial for making informed decisions about TPs' future work-setting preferences.

While the trainers, in total *n* = 18, were generally well-received and even perceived as role models in some cases, some criticism was expressed towards boring teaching styles or occasional reliance on

stereotypes and prejudices: *"So, the person can't do that [the teaching] well - in my opinion, they can't present it well and explain the differences because they are full of prejudices."* (IP06_Post).

The heterogeneous group composition, i.e. in terms of country of birth, languages, religion, interpreting experience, and interpreting status, was appreciated in general. However, it was emphasized that there should be at least two TPs per working language, particularly for the interpreting exercises.

Exchange with other CIPs. The work as a CIP was described as predominantly solitary. Consequently, interactions with other interpreters within the training were highly appreciated. TPs valued these exchanges for several reasons, including gaining insights into different contexts, cultural backgrounds, and languages; developing personal friendships; learning about job opportunities and working conditions, such as the differences in the amount of remuneration and or self-employment options; professional networking; and sharing experiences and challenges related to interpreting: *"And through this course I learned, there are kind service providers everywhere and also those who are unfriendly. One colleague said: 'I also had the same problem with some service providers.' And I'm like, 'Okay.' I didn't know that before."* (IP05_Post).

Perceived increase in knowledge and skills. All TPs reported a significant increase in their perceived knowledge and skills following the training, encompassing aspects such as understanding the role and tasks of an interpreter, ethical principles, interpreting strategies and techniques, the rights and duties of an interpreter, navigating various cultural contexts; dealing with emotional distress and self-care; and effective note-taking. They also learned how to prepare for interpreting assignments properly, e.g. by creating a glossary for specific vocabulary. In addition, the training also increased TPs' German language skills and their vocabulary for working in different settings. Moreover, they learned how to arrange the communicative situation in such a way that they can perform their task well, e.g. through an appropriate seating arrangement and the introduction of one's role and working methods, such as transparency or impartiality: *"And then I make it clear in those five minutes. […] I'll introduce myself. And tell you how I work to avoid misunderstandings. And I didn't do that before either, because I didn't know that. I only knew that nobody in Germany was interested in my name. Who am I, and where do I come from? Nobody."* (IP04_Post)

Realizing the complexity of the interpreting task. Many TPs reported that only through the training did they learn about and experience the complexity of interpreting. Most acknowledged that their initial approach to interpreting before the training was predominantly spontaneous and intuitive rather than grounded in actual knowledge and trained skills: *"I'm not an interpreter by profession, as I said, I only got into it by chance, and I just did it by gut feeling and never attended a seminar or further training in that direction"* (IP14_Post).

Professional ethical principles and role understanding. All TPs admitted a lack of knowledge about professional ethical principles before participating in the training but have learned about them and their importance in the training. In addition, all TPs reported a clearer perception of the interpreters' role and tasks and described 'just' conveying the spoken word from one party to the other as their primary task, whose complexity in itself was previously not recognized. In retrospect, many TPs acknowledged previous misconceptions and behaviors: They perceived themselves as advocates of service users' interests or supporters of the service provider and often took responsibility for the process and outcome of the entire communication; they intervened in the middle of a conversation; advised service users; and did not adhere to professional, ethical principles, such as transparency, impartiality or confidentiality: *"I*

thought that an interpreter must do everything, an interpreter must help. I was sometimes with mothers with a baby and bags, I say, give me the bag; I have to help. The children are screaming, and I calm them down. For example, if the woman is sad, I have to comfort the woman all the time, even before the conversation. I don't know; I have no idea. I've done a lot of things wrong." (IP17_Post).

Moreover, TPs learned about strategies on how to maintain role boundaries, including explaining their role in the communication process and their adherence to professional ethics to the service provider and user and not giving their phone numbers to service users: *"It changed, that I am then clearer in it - so I can see clearly, that is my role. When I do my job now, I'm an interpreter, not a social worker. And that I can then really set boundaries very well. I can say: 'No, I'm only here for this conversation, but nothing more.'"* (IP02_Post). Learning about their role and how to explain it to the other interlocutors was considered particularly important because they perceived that many service providers (and users) lack knowledge about how CIPs work.

Perceived increase in (personal and professional) confidence. All TPs expressed a perceived increase in professional confidence. TPs learned strategies for managing conflicts and addressing challenging situations that arise during interpreting, which resulted in confidence in handling them adequately. For example, they have learned to interrupt when they realize that they can no longer do their work correctly, e.g. because people are speaking too quickly, more than two people are talking at the same time or in a non-logical manner. Most TPs described in retrospect that they were often afraid of being perceived as incompetent and therefore tried to hide experienced difficulties, e.g. if they did not understand an expression correctly. During the training, however, they learned that it is, in fact, a sign of competence to make challenges and mistakes transparent to all parties: *"Yes, you don't have to be afraid if you don't know a word. That's the best thing. Before, you were like, oh God. Help, I don't know that word and now? What am I going to do? No, you can ask if you don't understand something acoustically or actually."* (IP11_Post).

While most TPs felt, through the gained knowledge and competence, empowered and more confident in their work as a CIP, one candidate mentioned that the increase in knowledge also comes with an increase in perceived pressure to perform adequately, making them sometimes feel more insecure: *"So before, of course, I expected interpreting everything correctly, so that both people understood what it was supposed to be, that it was correct, yes. But my expectations have increased because of the knowledge, and I know myself. I have quite high expectations. And if I fail, if I don't do it the way I imagined, that annoys me and simultaneously slows me down; the pressure just slows me down."* (IP18_Post).

In addition to the increased confidence regarding working as an interpreter, the majority expressed overall personal growth and higher self-esteem: *"Well, my self-esteem isn't that good; in other words, it's not there. Yes, that means that maybe a bit of this self-esteem is somehow coming through the earth again. Yes, the earth breaks open, and like a plant when it's freshly emerged from the bulb."* (IP12_Post).

Recognizing and promoting the value and professionalization of CI. Most TPs reported that the training heightened their awareness of their roles and responsibilities as CIPs. They recognized interpreting as a profession which requires specialized competencies. Mere experience is not enough, but qualification is needed: *"They [other interpreters] say, 'No, we're doing it right. We already have experience". I say, 'No, experience is not enough. Really, that's not enough at all. The right thing is a qualification that helps you incredibly.' […] Yes, experience, you gain experience through several situations, you experience many situations, you see several people, several professionals, several clients, but that doesn't mean that*

you're doing it right, that you're qualified. […] I have experience, but I'm doing it wrong. I interpret wrong, I don't have confidentiality, I do everything my way." (IP17_Post).

While most TPs previously perceived interpreting as an act of social and voluntary (i.e. unpaid) support, the training contributed to the perceived value of interpreters' work. Following the completion of the training and, in particular, the acquisition of a certificate, some TPs would now feel justified in demanding compensation for their services instead of volunteering: *"Now I know what, well, I'm competent, I'm qualified, it's worth working like this and earning money for it. I also want to do it as a profession."* (IP17_Post). This empowerment also motivated some to consider interpreting as a full-time profession. Learning about self-employment, including tax and legal issues and client acquisition, was perceived as beneficial for pursuing interpreting as a profession.

Implementation into practice. Since most TPs worked as interpreters parallel to the training, the post-interview also asked about implementing the learning outcomes into practice. Challenges mostly related to keeping role boundaries, dealing with emotionally stressful situations, and a need for knowledge, respect or consideration on the part of the service providers and users. It was mentioned that service providers often do not know or do not care what is needed so that the interpreters can do their job effectively, e.g. seating position or speaking in short segments. Thus, some recommended training for service providers on conducting interpreter-mediated conversations: *"Yes, that's difficult. I have to constantly interrupt the specialist and then continue interpreting. That makes the work difficult. Unfortunately, that's the case, even though we say, please speak in short sections, they carry on. That means, well, perhaps it would be better if the specialists also did some training so that they could work well with the interpreter. That could make things easier for the interpreters."* (IP20_Post).

Please insert Table 4 here.

5 Discussion

5.1 The training participants and their motives for attending the training

Most studies on training for interpreters do not examine the motives for participation, yet in the field of CI, where no formal training requirements exist, understanding these motives may be crucial to increasing CIPs' qualification. TPs' primary motives for partaking in this training were to become more professional by improving their knowledge, skills, and self-esteem. This intrinsic commitment to enhancing one's interpreting performance echoes findings from Pöllabauer's (2020) study on public service interpreter training in Austria (36). In addition, TPs were hoping for personal and professional exchange with colleagues, which could also be seen as a sign of the lack of professional organization in the CI community in Germany or a lack of knowledge about existing structures and network opportunities.

TPs believed obtaining a formal certificate would lead to more interpreting jobs, higher pay, or permanent employment as a CIP. At the time of the pre-training data collection, almost one-third of TPs were unemployed and seeking paid work, possibly indicating that enrollment in the training course might be seen as an opportunity for work and earning money in the short term. This complements previous research, which identified perceived financial and time costs as the main barriers to attending training, as these expenses are not always justified by expected (financial) returns for CIPs (15,16,33,36,51,52). This study's findings highlight that interpreter training must be financially rewarding. This could be achieved by setting legal standards for training, remuneration, and funding of interpreters working in community settings (16).

5.2 The trainers

Training programs' effectiveness also relies on trainers' expertise, making their qualifications crucial when evaluating training courses. In the field of CI, this is even more significant due to the lack of standards for the qualification of both CIPs and trainers. However, information about trainers is often not available (36). In the literature, the following fundamental competencies of trainers independent of the subject are described: field competence, interpersonal competence, organizational competence, instructional competence, and assessment competence (53,54). Moreover, socio-communicative and individual competencies, such as emotional skills, empathy, and ethical decision-making, are also required (54). In this study, all trainers were experts in interpreting or the specific setting. Most had experience with the target group, felt confident in their teaching, and were satisfied with their performance. Also, TPs generally expressed satisfaction with the trainers, even viewing some as role models. However, problematic behavior, such as using inappropriate stereotypes and prejudices, which can be hurtful to those affected, was also reported about one trainer. This highlights the need for qualified trainers and their inclusion in training program evaluations. In CI, a lack of suitable trainers is frequently reported (55), which is why "train-the-trainer" approaches are gaining prominence and could be promising methods to increase trainers' competencies (36,54,56).

5.3 Design of the training course

Generic orientation. On average, TPs reported working in three different settings, justifying the generic approach of the current training. Previous studies reported that CIPs usually work in several community settings and recommended rather generic than setting-specific training (15,57). The introduction to diverse potential interpreting settings by experts from the field was positively received, enabling TPs to decide which settings they would or would not prefer to work in.

Heterogenous and linguistically diverse group. Despite initial concerns regarding the heterogeneous group composition, such as potential conflicts, TPs described the exposure to different cultures, contexts, languages and interpreting experiences as valuable. However, it was recommended that at least two persons per language should be included in the training to enhance the effectiveness of practical interpreting exercises. It might also be essential to consider the courses' language(s) proficiency level. While those with lower language skills can learn from others and improve, it can quickly become tedious for advanced or native speakers of the German language.

In-person training format. Given the often solitary nature of the interpreting job in community settings, the in-person training format, interpreting exercises, and providing personal feedback were described as particularly beneficial. Some TPs criticized the fact that some theoretical sessions were conducted online. Although online training and blended-leaning approaches are becoming more prominent, it should be considered that interpreting is an activity that needs to be practiced, experienced, and reflected, which can only be achieved in person (27).

Examination and certification. Due to the lack of legal standards, various training courses for interpreters working in community settings exist, but not every training is concluded by a final examination, and not all of them test TPs' actual interpreting competence as part of it. For instance, among CIPs in Germany who attended any training, only 29.4% participated in a training with a final examination and successfully passed it (15). A final exam and certification can serve as formal verification and quality assurance, differentiating trained interpreters from untrained ones. Moreover, it can increase their

recognition by others, status and professionalization (58). It can also be a helpful tool for service providers in assessing interpreters' competence when choosing with whom to work. As uniform regulations regarding CIP training in Germany are not expected any time soon, the introduction of a certificate of completion, which states the hours and content of the training, can also help to get an overview of the often confusing landscape of existing training programs.

5.4 Effectiveness of the training

Satisfaction. The quantitative and qualitative results showed that TPs were highly satisfied with the training, perceived the training beneficial for their work, and would recommend it to other CIPs.

Interpreting specific knowledge, skills, and competence. The TPs reported in the post-questionnaire that they learned new skills and felt more empowered to interpret effectively. This aligns with an observed increase in self-assessed knowledge and competence and a rise in the average multiple-choice test score by almost 6 out of 22 points. Also, during the post-interviews, TPs listed a range of aspects and skills they have learned, such as interpreting strategies and techniques or dealing with challenges. In addition, a slight increase in subjective professional self-efficacy expectations could be measured, indicating increased ability and motivation to cope with upcoming professional tasks, such as pursuing interpreting as a full-time profession, as mentioned in the qualitative interviews.

TPs retrospectively assessed their pre-training knowledge and competence as slightly lower, which could be explained by increased awareness during the training. This aligns with Fitzmaurice's (2020) research on educational interpreters in public schools, which revealed that less skilled interpreters often overestimate their abilities, while more skilled interpreters tend to underestimate their competence (59).

Complexity and responsibility of working as a CIP. In the qualitative interviews, TPs explained that they interpreted mostly intuitively rather than based on knowledge and trained skills before attending the training. Only through this training did they learn about the complexity and responsibility of working as an interpreter. This is also described by other authors, such as Hale (2007). She explains that bilingual volunteers often act as 'natural interpreters' (42); they do not realize the complexity of the task and perceive interpreting as merely summarizing, instead of accurately conveying, what has been said (16). Thus, our results support previous research, showing that TPs learned about professional ethical principles, such as transparency and accuracy in the training.

Shift in CIPs' role understanding and ethical principles. Commonly mentioned ethical principles pre-training included honesty, empathy, and humanity, highlighting the more natural and intuitive approach to interpreting (16). One candidate stated he merely followed his gut feeling while interpreting. In retrospect, all TPs acknowledged their lack of awareness and knowledge of the principles. Gaining this knowledge provided a valuable foundation they could rely on in their professional practice, resulting in increased confidence and reduced distress.

In the pre-interviews, TPs perceived their role as merely being a linguistic and cultural mediator. Yet, many shared actions did not align with this role, such as acting as service users' emotional supporters or advising them. Post-interviews revealed that TPs recognized these previous role oversteps and better understood their professional role boundaries. They learned to establish an appropriate work environment, which included clearly defining their methods and roles to service providers and users. As demonstrated in previous research, this was emphasized as important because service providers often lack

knowledge or appreciation of interpreters' work (16,60). In addition, the TPs were introduced to various community settings, which enabled them to make informed and professional decisions about their preferred working settings. TPs initially felt accountable for all aspects of the communication and the parties involved; however, training redirected their sense of responsibility towards themselves and their interpreting performance, revealing its previously unrecognized importance and responsibility. In addition, a clearer role understanding helped TPs feel more confident and reduced the perceived interpreting-related distress. Future studies should investigate the impact of training on CIPs' role understanding in more detail. Conducting pre and post-training observational studies could provide valuable insights into these dynamic shifts.

Impact on professional and personal confidence. After completing the training, all TPs in the course felt more confident professionally due to the increased knowledge and skills. However, it was also mentioned that the newly acquired knowledge, recognized complexity, and responsibility of the interpreting task could also lead to more pressure and make TPs even less confident. Besides, almost all TPs stated that the training taught the basics of interpreting and that further, in-depth training is desired. In addition, the training seems to positively impact TPs' confidence beyond their role as an interpreter, which should be investigated in-depth in future qualitative studies.

Training (and certification) leads to perceived professionalism. The increase in knowledge, skills, competence, and confidence led to or reinforced the attitude that interpreting is not just an act of charity but a profession that deserves to be recognized and paid accordingly. Numerous authors have pointed out that the field of CI still lags behind other professions in terms of professionalism (16,25,29–31). Some TPs in this study expressed that after completing the training and (hopefully) receiving the certificate, they felt justified and encouraged to demand (higher) payment for their service provided. The study findings highlight the link between training participation, formal certification, perceived competence, and professional status. Moreover, our study supports previous findings emphasizing that formal training is essential for enhancing the quality of interpreting services, promoting professional recognition, and ultimately shaping the CI profession (15,22,25,44,45).

Apply what has been learned in practice and the need for further training. Although TPs reported that their interpreting practice changed from natural and intuitive to informed and skill-based, they wished for additional and more in-depth training. They also revealed that implementing what they have learned in practice can be difficult and needs to be practiced further. This indicated a need for ongoing educational opportunities to fully address the complexities of CI and reflect and change interpreting practices accordingly. It would be helpful to carry out follow-up assessments in future studies, e.g., three months post-training, to identify challenges and determine the long-term effects of interpreting training. A lack of respect, consideration, or knowledge on the part of service providers was stated as one of the main reasons why it can be difficult to implement what has been learned into practice. Research has shown that training for service providers alone or jointly with CIPs could be effective (60–62).

5.5 Strengths and limitations

The strength of this study is the mixed-methods design, which allowed evaluation of the training on different levels. Pre- and post-questionnaires provided quantitative evidence of TPs' satisfaction and improvement in knowledge, skills, competence, and professional self-efficacy expectations. In particular, the self-developed multiple-choice knowledge test proved valuable for assessing interpreters' knowledge. It may be particularly useful in light of the lack of standardized measurements for training

evaluation in CI research (63). However, it should be noted that the knowledge test was specifically designed for CI in Germany and has to be adapted if used in other countries. By conducting qualitative interviews, more profound insights into the TPs' experiences and perceptions could be explored.

A few limitations should be noted, including a small sample size, which may limit the generalizability of the findings. Additionally, the study's reliance on self-reported data could introduce bias, as participants might have provided socially desirable responses. The absence of a control group makes it difficult to attribute improvements solely to the training, as external factors could have influenced the outcomes. Moreover, the psychometric properties of the self-developed quantitative instruments still need to be evaluated. However, this study provides valuable insights into training effectiveness for CIPs. The findings could be used by other practitioners or researchers who want to conduct and evaluate such training.

5.6 Conclusion

As societies are increasingly linguistically diverse, resulting in a high demand for CIP, the absence of standardized training and certification becomes more problematic in CI. In a previous study, it was shown that 31% of CIPs in Germany had not attended any training. Among those who have participated in training, the median was only 25 training hours (15). While it was previously highlighted that formal training is necessary to recognize the professional status of CI from the outside, such as service providers or political stakeholders, this study indicates that a generic training also appears necessary to increase perceived professionalism within the CIP community.

The evaluated training “Between Languages” (www.zwischensprachen.de/en/), consisting of 500 units and a final exam, was found to be a valuable qualification program enabling CIPs to work in various community settings. The developed training not only increased CIPs’ skills, knowledge, and confidence but also gave a clearer understanding of their role, the importance of professional ethics, and the value of the service they provide. CIPs realized the responsibility and complexity of CI and that this task requires knowledge and skills gained by formal training and certificated through examination. Thus, this generic training proved effective in training CIPs to work settings such as (mental) health and social care, education, or authorities.

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7 Conflict of Interest

The authors declare that the research was conducted without any commercial or financial relationships that could potentially create a conflict of interest.

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9 Author Contributions

SHR, CB, and MM contributed to the study's conception and design. SHR collected the data, analyzed it, and discussed the findings with CB, and MM. SHR wrote the first draft of the manuscript. CB and MM read the manuscript several times and provided significant feedback. All authors contributed to the manuscript revision and read and approved the submitted version.

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Table 1. Content and scope of the training.

Units (1 unit = 45 min)	**Modules**
224	Face-to-face teaching:
20	1. Basic knowledge of the profession
56	2. Interpreting modes, techniques and strategies
20	3. Language competences
8	4. Cultural competences
12	5. Role(s) of interpreters
28	6. Professional ethics
12	7. Psychosocial stress and self-care
4	8. Legal framework
12	9. Interpreting as a self-employed activity
52	10. Comparing 11 different interpreting settings
224	Self-study time
20	Three interpreting assignments in different settings (including written reports)
32	Exam preparation (two 2-day workshops)
500 in total	

Table 2. Sociodemographic characteristics and interpreting-related variables (*N* = 21)

Variables	Categories	n	%	M(SD)	min-max
Sociodemographic characteristics					
Gender	Male	3	14.3	-	-
	Female	18	85.7	-	-
	Divers	0	0	-	-
Age	-	-	-	43.62 (10.08)	24-61
Place of birth	Syria	4	20.0	-	-
	Iran	2	10.0	-	-
	Marokko	2	10.0	-	-
	Germany, Niger, Russia, Urkaine, Poland, Algeria, Burkina-Faso, Serbia, Vietnam, Afghanistan, Kazakhstan, Yugoslavia, Turkey	each 1	each 5.0	-	-
Residence in Germany (if born abroad; in years)	-	-	-	16.10 (11.08)	5-45
Number of spoken langauges	-	-	-	3.33 (2.63)	1-14
Level of education according to ISCED	High	13	61.9	-	-
	Medium	8	38.1	-	-
	Low	0	0	-	-
Highest level of education received abroad	In Germany	9	42.9	-	-
	Abroad	12	57.1	-	-
Employment status (not as a CIP)	Full-time employed	2	9.5	-	-
	Part-time employed	2	9.5	-	-
	Minor employment	3	14.3	-	-
	Self-employed	3	14.3	-	-
	Unemployed, looking for work	6	28.6	-	-
	Unemployed, not looking for work	2	9.5	-	-
	Other	3	14.3	-	-
Interpreting-related characteristics					
Interpreting experience (in years)	-	-	-	5.81 (2.75)	0-10
Frequency of interpreting (in the last 12 months)	Not at all	3	15.0	-	-
	Less then once a month	4	20.0	-	-
	Once a month	3	15.0	-	-

	Several times per month	7	35.0	-	-
	Several times per week	2	10.0	-	-
	Daily	1	5.0	-	-
	Missing	*1*	-	-	-
Number of interpreting settings	-	-	-	3.35 (1.57)	1-6
Health care	Yes	17	85.0	-	-
Social services	Yes	15	75.0	-	-
Authorities	Yes	15	75.0	-	-
Education	Yes	12	60.0	-	-
Police	Yes	5	25.0	-	-
Court	Yes	3	15.0	-	-
Number of assignments per interpreting setting (in the last 12 months)					
Health care	-	-	-	24.07 (34.55)	1-130
Social services	-	-	-	12.23 (13.94)	0-40
Authorities	-	-	-	10.64 (14.56)	0-55
Education	-	-	-	5.50 (4.21)	0-15
Police	-	-	-	3.25 (3.30)	0-7
Court	-	-	-	1	1
Less interpreting jobs due to COVID-19 pandemic	Yes	21	100.0	-	-
Prior interpreting training	Yes[a]	9	42.56	-	-
	University degree	1	4.76	-	-
	Hamburg Chamber of Commerce	1	4.76	-	-
	Sworn in (at court)	1	4.76	-	-
	Other	9	42.56	-	-
Status of interpreting	Full-time	6	25.0	-	-
	Part-time	6	15.0	-	-
	Unpaid for known persons	5	30.0	-	-
	Unpaid for unknown persons	3	30.0	-	-
	Missing	*1*	-	-	-
Number of working langauges	-	-	-	3.48 (1.47)	2.8

[a]Multiple answers were possible.

Table 7. Quantitative post-training evaluation (*N* = 21)

	Strongly disgree	Disagree	Partially agree	Agree	Strongly agree	Mean	SD
Organisation							
The overall duration (hours) of the training was appropriate.	1 (4.8%)	2 (9.5%)	3 (14.3%)	10 (47.6%)	5 (23.8%)	3.76	1.091
The number of course participants in the course was appropriate.	1 (4.8%)	-	-	6 (28.6%)	14 (66.7%)	4.57	.746
Overall, I am satisfied with the organization of the training.	1 (4.8%)	-	1 (4.8%)	8 (38.1%)	11 (52.4%)	4.38	.805
Content							
The balance between the single topics/modules (amount of time) was appropriate.	2 (9.5%)	-	5 (23.8%)	9 (42.9%)	5 (23.8%)	3.81	.928
I was missing important content on the subject of interpreting in community and public service settings.	12 (57.1%)	5 (23.8%)	2 (9.5%)	2 (9.5%)	-	1.71	1.007
Overall, I am satisfied with the selection of topics in the training.	1 (4.8%)	-	-	7 (33.3%)	13 (61.9%)	4.52	.750
Methods							
The practical interpreting exercises were helpful for me as an interpreter.	-	-	-	7 (33.3%)	14 (66.7%)	4.67	.483
Overall, I am satisfied with the balance between theory, discussions and exercises.	1 (4.8%)	-	1 (4.8%)	10 (47.6%)	9 (42.9%)	4.24	.944
Language skills							
The qualification has improved my German language skills.	2 (9.5%)	1 (4.8%)	1 (4.8%)	5 (23.8%)	12 (57.1%)	4.14	1.315
General evaluation							
I learned new things during training.	-	-	2 (9.5%)	2 (9.5%)	17 (81.0%)	4.71	.644
Overall, the training is helpful for my work as an interpreter.	-	-	-	2 (9.5%)	19 (90.5%)	4.90	.301
I feel empowered by the training to do my job as an interpreter better in the future.	-	-	-	4 (19.0%)	17 (81.0%)	4.81	.402
Overall, I am satisfied with the training.	-	1 (4.8%)	-	5 (23.8%)	15 (71.4%)	4.62	.740
I would recommend the training to other interpreters.	-	1 (4.8%)	-	1 (4.8%)	19 (90.5%)	4.81	.680

	Not at all competent	Rather not competent	Average competent	Rather competent	Very competent	Mean	SD
Subjective competence (pre-training)	-	3 (14.3%)	15 (71.4%)	2 (9.5%)	1 (4.8%)	2.95	.669
Subjective competence (post-training)	-		6 (28.6%)	15 (71.4%)	-	4.10	.436
Subjective competence (retrospectively, pre-training)	2 (9.5%)	9 (42.9%)	9 (42.9%)	1 (4.8%)	-	2.67	.856

	No knowledge	Little knowledge	Moderate knowledge	Substantial knowledge	Extensive knowldge	Mean	SD
Subjective knowldge (pre-training)	-	5 (23.8%)	12 (57.1%)	4 (19.0%)	-	3.05	.669
Subjective knowledge (post-training)	-	-	1 (4.8%)	17 (81.0%)	3 (14.3%)	3.71	.463
Subjective knowledge (retrospectively, pre-training)	1 (4.8%)	9 (42.9%)	7 (33.3%)	4 (19.0%)	-	2.43	.746
Multiple Choice knowledege test (pre-training)	-	-	-	-	-	10.67	4.317
Multiple Choice knowledege test (post-training)	-	-	-	-	-	16.38	3.263
Subjective professional self-efficacy expectations (BSW-Scale) (pre-training)	-	-	-	-	-	4.38	.546
Subjective professional self-efficacy expectations (BSW-Scale) (post-training)	-	-	-	-	-	4.55	.461

Table 4. Results from qualitative pre- and post-training interviews.

Main categories	Sub-categories
Pre-training	
Motives for attending the training, expectations and concerns.	Motives: • Starting interpreting by helping out family members, friends, or acquaintances voluntarily • Previously been in a similar situation, where they were unable to communicate due to limited language skills; now trying to help others in this regard • Previously bad experiences with interpreters and wanting to do it better • Perceived lack of interpreting-specific training • Enhancing interpreting knowledge, competence and self-esteem • Exchanging of experiences with other interpreters Expectations: • settings, such as self-employment and taxes • Reaching a more professional level, getting more interpreting assignments, receiving better payment and permanent employment through training completion and certification • Learning about interpreting in different settings • Clearer understanding of the interpreter's role and how to maintain role boundaries • Increasing vocabulary and German language skills • Learning how to deal with interpreting related challenges Concerns: • Managing the training and other professional or family obligations • Heterogenous group composition
Understanding of the interpreter's role and knowledge about professional ethical principles.	Interpreter's role: • Being a mediator on a linguistic and cultural level • Providing examples that go beyond the role of mere interpretation, e.g. helping the service users outside of the interpreting situation, self-descriptions like 'a brother' or emotional supporter who empowers the service users. Professional ethical principles: • Most often mentioned principles: honesty, completeness, accuracy, confidentiality, empathy, understanding and humanity • Based on personal opinions, experiences and intuition rather than informed knowledge
Post-training	
Content, methods, organization and trainers	Positive: • Overall satisfaction with the training's content, format, methods, and trainers • In-person format and interpreting exercises allowed direct and personal feedback on interpreting performances

	• Generic orientation of the training • Introduction to different interpreting settings allowing informed decisions about future work settings • Trainers perceived as role models • Heterogeneous group composition Negative: • Training too long or too short (possibly associated with TPs' German language competences) • Basics covered, however, need for further training • Trainers' boring teaching style • Trainer using stereotypes and prejudices Suggestion for improvement: • At least two candidates who speak a common language for interpreting exercises • More practical interpreting exercises
Exchange with other interpreters	• Working as an interpreter is predominantly solitary and isolating • Gaining insights into different cultures, contexts and languages • Developing personal friendships • Learning about job opportunities and working conditions • Professional networking • Sharing experiences and challenges related to interpreting
Perceived increase in knowledge and skills	• Role and tasks of interpreters • Ethical principles • Interpreting strategies and techniques • Rights and duties of an interpreter • Different cultural contexts • Dealing with emotional distress and self-care • Effective note-taking • Effective preparation for interpreting assignments (e.g. glossary) • Improved German language skills and vocabulary • Actively arranging the communicative situation (e.g. appropriate seating position, introduction of interpreter's role and working methods to tnterlocutors)
Realizing the complexity of the interpreting task	• Understanding and experiencing the complexity of the interpreting task • Initial approach to interpreting was predominantly spontaneous and intuitive ('natural' interpreting)

Professional ethical principles and role perception	• Lack of knowledge about professional ethical principles and interpreter's role before training
	• Main role perception retrospectively before training:
	  o Advocates of the service users;
	  o Supporters of the service providers;
	  o Taking responsibility for the process and outcome of the entire communication

	• Main role perception after training: 'Just' conveying the spoken word from one party to the other (realizing the complexity this) • Retrospectively recognizing inadequate actions, e.g. advising service users, intervening in the middle of the communication; not adhering to professional ethical principles • Strategies on how to maintain role boundaries, e.g. explaining role to service provider and user
Perceived increase in (personal and professional) confidence	• Strategies for managing conflicts and addressing challenging situations • Before training: Concerns to be perceived as incompetent led to hiding experiences difficulties • After training: Sign of competence to be completely transparent (including mistakes made) • Increased knowledge leads to more confidence • Increased knowledge leads to higher pressure to perform adequately and to insecurities • Overall personal growth and higher self-esteem
Recognizing and promoting the value and professionalization of CI	• Increases awareness about interpreter's roles and responsibilities • Recognizing CI as a profession, which requires specialized competencies • Pre-training perception: interpreter as social and voluntary (i.e. unpaid) support • Competition of training and acquisition of a certificate leads to justification in demanding remuneration for interpreting services instead of volunteering • Considering interpreting as a full-time profession

Implementation into practice	• Challenges:
	  o Keeping role boundaries;
	  o Dealing with emotionally stressful situations;
	  o Lack of knowledge or recognition on the part of the service providers and users
	• Recommendation to train also service providers for interpreter-mediated communication

Training Interpreting in Community Settings

Training for interpreters in the fields of health, social services, authorities and education in Germany

knowledge test for participants (pre-post training)

A Personal Data

Code: | 1 | 2 | 3 | 4 | 5 | 6 | Date: | T | T | M | M | J | J |

Please enter **the first two letters of one of you care givers first name** in boxes 1-2 (e.g. N - A for Nadia),
in boxes 3-4 **the first two letters of your place of birth** (e.g. H - A for Hamburg),
in boxes 5-6 **the first two digits of your birthday** (e.g. 0 - 2 for 02.03.1977).

B Knowledge about interpreting

The following questions are part of the **scientific evaluation** of the *Training Interpreting in Community Settings*. The aim of the questions is to find out what you know about interpreting.

- Please take **enough time** to answer the questions. It will take about 30 minutes.
- **Please answer all questions.**
- There is **only one correct answer**.
- If you do not know the answer to a question, please do not guess, but mark the **option „I don't know**".
- Please mark the box with a **cross** ☒. Please only check **one box** at a time.
- You can **correct** your answers by completely coloring in the box you originally checked and checking the box you think is correct.
- If you have any questions, please contact the study director directly.

The evaluation of the questions in **anonymous**. Your answers **will not be evaluated** and have **no influence** on your participation in the training or the final examination.

We appreciate your participation in the survey and thank you for your support!

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1	Who can officially call themselves an "interpreter" in Germany?

☐ only persons who have taken a general oath at a Regional Court, Higher Regional Court or a Department of Internal Affairs and are therefore sworn or publicly appointed interpreters

☐ only persons who have completed formal interpreting training (e.g. interpreting degree or state interpreting examination)

☐ only persons who are fluent in at least two languages and can transfer spoken utterances orally from one language to another

☒ any person in Germany may call themselves an interpreter, even if they do not speak a foreign language

☐ I don't know

2	Which of the following skills is *not* required for interpreting specifically?

☐ communication competence

☐ research competence

☒ arbitration competence

☐ cultural competence

☐ I don't know

3	"*The ability to transfer a spoken utterance from the source language into the target language in such a way that the speaker's intention, the communication objective and the effect on the listener remain the same*." What competence is meant here?

☐ self-reflection competence

☐ integration competence

☒ interpreting competence

☐ information competence

☐ I don't know

4	"*Interpreters should be able to put themselves in the position of their counterpart (e.g. service user or provider) in order to understand why the person acts the way they do*." What competence is meant here?

☒ empathy competence

☐ language competence

☐ expert competence

☐ role competence

☐ I don't know

5	Which type of interpreting is characterized by the fact that the interpretation of an utterance from the source language into the target language takes place with a time delay, i.e. one after the other?

☐ simultaneous interpreting
☒ consecutive interpreting
☐ conference interpreting
☐ relay interpreting
☐ I don't know

6	With an impromptu translation...

☐ ... a written statement is translated into the target language in writing
☒ ... a written statement is translated orally into the target language
☐ ... an oral statement is translated orally into the target language
☐ ... an oral statement is translated into the target language in writing
☐ I don't know

7	"*For a good note-taking technique, it is not necessary to use only the abbreviations and symbols from the textbook - I can develop my own note-taking system*." Is this statement true or false?

☒ true
☐ false
☐ I don't know

8	Which of the following strategies is *not* an interpretation strategy?

☐ interpreting in the 1st or 3rd person
☒ structured interpreting
☐ summarized interpreting
☐ explanatory interpreting
☐ I don't know

9	"*If I make a mistake while interpreting and realize it, I correct myself so that everyone notices*." Is this statement true or false?

☒ true
☐ false
☐ I don't know

10	"*I can use terms from existing bilingual or multilingual glossaries without any concerns.”* Is this statement true or false?

☐ true
☒ false
☐ I don't know

11	"*I speak the same language and come from the same country as the service user. Therefore, I don't need to acquire any knowledge or information about the country of origin*." Is this statement true or false?
	☐ true ☒ false ☐ I don't know
12	A typical problem in intercultural settings is "*culturalization*" (Kulturalisierung). What is meant by this?
	☒ explain a person's behavior solely on the basis of their cultural origin ☐ ignore the cultural characteristics and behavior of others ☐ adopting cultural habits and behaviors from others ☐ cultural conflicts that arise between people who come from different cultures ☐ I don't know
13	"*To protect the feelings of the other person, I always leave out insults or swear words when interpreting*." Is this statement true or false?
	☐ true ☒ false ☐ I don't know
14	"*When interpreting, only a verbatim rendition is correct*." Is this statement true or false?
	☐ true ☒ false ☐ I don't know
15	"*If I notice while interpreting that one person involved in the conversation is making false statements, I should always intervene in the conversation and ask questions*." Is this statement true or false?
	☐ true ☒ false ☐ I don't know
16	"*Even if a person repeats themselves for the third time, I basically have to interpret it exactly the same way.*" Is this statement true or false?
	☒ true ☐ false ☐ I don't know

17	"*A mentally ill patient speaks incoherently and confusedly during the consultation. It's not my job to explain what has been said to the psychotherapist*." Is this statement true or false?

☒ true
☐ false
☐ I don't know

18	Which of the following is *not* one of the principles of professional ethics for interpreters?

☐ confidentiality
☐ impartiality
☒ language skills
☐ accuracy
☐ I don't know

19	To whom do the principles of professional ethics in the field of interpreting apply?

☐ only for interpreters who are sworn or publicly appointed
☐ only for interpreters who have signed a contract with a corresponding clause
☐ only for interpreters who are paid for their interpreting services
☒ for all interpreters
☐ I don't know

20	When does the interpreter's contractually agreed duty of confidentiality end usually?

☐ six months after completion of the interpreting assignment
☐ ten years after completing the interpreting assignment
☐ when the contract ends
☒ never
☐ I don't know

21	"*Interpreting as a freelance activity is not a trade under German law and is therefore not subject to the trade regulations or trade tax".* Is this statement correct or incorrect?

☒ true
☐ false
☐ I don't know

Please turn the page!

22	The payment of interpreting assignments by judicial and official clients is based on the...

☒ ... JVEG
☐ ... VBVG
☐ ... BMJV
☐ ... TSVG
☐ I don't know

Please check that you have answered all the questions.

Thank you very much for completing the questionnaire!

Evaluation

Correct answers: D, C, C, A, B, B, True, B, True, False, False, A, False, False, False, True, True, C, D, D, True, A

- Correct answer = 1 point
- Wrong answer or „I don't know" = 0 points
- Add up the points to form the total score (maximum score: 22 points; minimum score: 0 points)

True	False	A	B	C	D	**Total**
5x	5x	3x	3x	3x	3x	**22**

This project is co-financed by the Asylum, Migration and Integration Fund (AMIF) and the Social Welfare Department of the Free and Hanseatic City of Hamburg.

Qualifizierung Dolmetschen im Gemeinwesen

Eine Professionalisierung für Dolmetscher*innen in den Bereichen Gesundheit, Soziales, Behörden und Bildung in Deutschland

Wissenstest für Teilnehmer*innen (Prä-Post Qualifizierung)

A Persönliche Daten

Code: | 1 | 2 | 3 | 4 | 5 | 6 | Datum: | T | T | M | M | J | J |

In den Kästchen 1-2 tragen Sie bitte die **ersten zwei Buchstaben einer der Bezugspersonen** ein (z.B. **N – A** für Nadia),
in den Kästchen 3-4 die **ersten zwei Buchstaben Ihres Geburtsortes** (z.B. **H - A** für Hamburg),
in den Kästchen 5-6 die **ersten zwei Ziffern Ihres Geburtstags** (z.B. **0 - 2** für den 02.03.1977).

B Wissensfragen zum Thema Dolmetschen

Die folgenden Fragen sind **Teil der wissenschaftlichen Evaluation** der *Qualifizierung Dolmetschen im Gemeinwesen*. Ziel ist es, zu erfahren, was Sie zum Thema Dolmetschen wissen.

- Bitte nehmen Sie sich **ausreichend Zeit**, um die Fragen zu beantworten. Es dauert ca. 30 Minuten.
- **Bitte beantworten Sie alle Fragen.**
- Es ist immer nur **eine Antwortoption richtig**.
- Wenn Sie die Antwort auf eine Frage nicht wissen, raten Sie bitte nicht, sondern kreuzen Sie die **Option „Ich weiß es nicht“** an.
- Bitte markieren Sie das für Sie zutreffende Kästchen mit einem **Kreuz** ☒. Bitte kreuzen Sie **immer nur ein Kästchen** an.
- Sie können Ihre Antworten **korrigieren**, indem Sie das ursprünglich angekreuzte Kästchen ganz ausmalen und das zutreffende Kästchen ankreuzen.
- Bei Fragen wenden Sie sich gerne direkt an die Studienleiterin.

Die Auswertung der Fragen erfolgt **anonym**. Ihre Antworten werden **nicht bewertet** und haben **keinen Einfluss** auf Ihre Teilnahme an der Qualifizierung oder die Abschlussprüfung.

Wir freuen uns sehr, dass Sie an der Befragung teilnehmen, und danken Ihnen herzlich für Ihre Unterstützung!

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1	Wer darf sich in Deutschland als „Dolmetscher*in“ bezeichnen?

☐ Nur Personen, die bei einem Landgericht, Oberlandesgericht oder einer Innenbehörde einen allgemeinen Eid abgelegt haben und damit beeidigte bzw. öffentlich bestellte Dolmetscher*in sind

☐ Nur Personen, die eine formale Dolmetschausbildung (z.B. Dolmetschstudium oder staatliche Dolmetschprüfung) abgeschlossen haben

☐ Nur Personen, die mindestens zwei Sprachen fließend sprechen und gesprochene Äußerungen mündlich von einer Sprache in eine andere Sprache übertragen können

☒ Jede Person in Deutschland darf sich als Dolmetscher*in bezeichnen, auch wenn sie keine Fremdsprache beherrscht

☐ Ich weiß es nicht

2	Welche der folgenden Kompetenzen wird *<u>nicht</u>* spezifisch zum Dolmetschen benötigt?

☐ Kommunikationskompetenz

☐ Recherchekompetenz

☒ Schlichtungskompetenz

☐ Kulturkompetenz

☐ Ich weiß es nicht

3	*„Die Fähigkeit, eine gesprochene Äußerung von der Ausgangs- in die Zielsprache so zu übertragen, dass die Absicht des Sprechers oder der Sprecherin, das Kommunikationsziel und die Wirkung auf den Zuhörer oder die Zuhörerin gleich bleiben.“* Welche Kompetenz ist hier gemeint?

☐ Selbstreflexionskompetenz

☐ Integrationskompetenz

☒ Dolmetschkompetenz

☐ Informationskompetenz

☐ Ich weiß es nicht

4	*„Dolmetscher*innen sollten sich in ihr Gegenüber (z.B. Klient*in oder Fachperson) hineinversetzen können, um zu verstehen, wieso der Mensch so handelt, wie er handelt.“* Welche Kompetenz ist hier gemeint?

☒ Empathiekompetenz

☐ Sprachkompetenz

☐ Fachkompetenz

☐ Rollenkompetenz

☐ Ich weiß es nicht

5	Welche Dolmetschart ist dadurch gekennzeichnet, dass die Verdolmetschung einer Äußerung aus der Ausgangs- in die Zielsprache zeitversetzt, also zeitlich nacheinander, stattfindet?

☐ Simultandolmetschen
☒ Konsekutivdolmetschen
☐ Konferenzdolmetschen
☐ Relais-Dolmetschen
☐ Ich weiß es nicht

6	Beim Stegreifübersetzen wird…

☐ … eine schriftlich formulierte Äußerung schriftlich in die Zielsprache übertragen
☒ … eine schriftlich formulierte Äußerung mündlich in die Zielsprache übertragen
☐ … eine mündlich formulierte Äußerung mündlich in die Zielsprache übertragen
☐ … eine mündlich formulierte Äußerung schriftliche in die Zielsprache übertragen
☐ Ich weiß es nicht

7	*„Für eine gute Notizentechnik ist es nicht notwendig, ausschließlich die Abkürzungen und Symbole aus dem Lehrbuch zu übernehmen - ich kann mein eigenes Notizensystem entwickeln.“* Ist diese Aussage richtig oder falsch?

☒ Richtig
☐ Falsch
☐ Ich weiß es nicht

8	Welche der folgenden Strategien ist *keine* Dolmetschstrategie?

☐ Dolmetschen in der 1. oder 3. Person
☒ Strukturierendes Dolmetschen
☐ Zusammenfassendes Dolmetschen
☐ Erklärendes Dolmetschen
☐ Ich weiß es nicht

9	*„Wenn ich einen Dolmetschfehler mache und das bemerke, dann korrigiere ich mich, sodass es jeder merkt.“* Ist diese Aussage richtig oder falsch?

☒ Richtig
☐ Falsch
☐ Ich weiß es nicht

10	*„Termini aus bereits vorhandenen zwei- oder mehrsprachigen Glossaren kann ich bedenkenlos übernehmen.“* Ist diese Aussage richtig oder falsch?

☐ Richtig
☒ Falsch
☐ Ich weiß es nicht

11	*„Ich spreche dieselbe Sprache und komme aus demselben Land wie der Klient oder die Klientin. Daher muss ich mir kein Wissen und keine Informationen zum Herkunftsland aneignen.“* Ist diese Aussage richtig oder falsch?
	☐ Richtig ☒ Falsch ☐ Ich weiß es nicht
12	Ein typisches Problem in interkulturellen Settings ist „*Kulturalisierung*“. Was ist damit gemeint?
	☒ Verhaltensweisen einer Person allein aufgrund ihrer kulturellen Zugehörigkeit erklären ☐ Kulturelle Besonderheiten und Verhaltensweisen anderer ignorieren ☐ Kulturelle Gewohnheiten und Verhaltensweisen von anderen übernehmen ☐ Kulturelle Konflikte, die zwischen Personen, die aus unterschiedlichen Kulturen stammen, entstehen ☐ Ich weiß es nicht
13	*„Um die Gefühle des Gegenübers zu schützen, lasse ich Beleidigungen oder Schimpfwörter beim Dolmetschen grundsätzlich weg.“* Ist diese Aussage richtig oder falsch?
	☐ Richtig ☒ Falsch ☐ Ich weiß es nicht
14	*„Beim Dolmetschen ist nur eine wortwörtliche Wiedergabe richtig.“* Ist diese Aussage richtig oder falsch?
	☐ Richtig ☒ Falsch ☐ Ich weiß es nicht
15	*„Wenn ich während eines Gesprächs feststelle, dass eine der beteiligten Personen falsche Angaben macht, sollte ich in jedem Fall in das Gespräch eingreifen und nachfragen.“* Ist diese Aussage richtig oder falsch?
	☐ Richtig ☒ Falsch ☐ Ich weiß es nicht
16	*„Auch wenn sich eine Person zum dritten Mal wiederholt, muss ich es grundsätzlich genau so dolmetschen.“* Ist diese Aussage richtig oder falsch?
	☒ Richtig ☐ Falsch ☐ Ich weiß es nicht

17	*„Ein psychisch erkrankter Patient oder eine Patientin spricht während des Behandlungsgesprächs zusammenhangslos und durcheinander. Es ist nicht meine Aufgabe, das Gesagte für den Psychotherapeuten oder die Psychotherapeutin zu erklären.“* Ist diese Aussage richtig oder falsch?

☒ Richtig
☐ Falsch
☐ Ich weiß es nicht

18	Welches der folgenden Prinzipien ist *kein* berufsethisches Prinzip von Dolmetscher*innen?

☐ Verschwiegenheit
☐ Allparteilichkeit
☒ Sprachkenntnisse
☐ Genauigkeit
☐ Ich weiß es nicht

19	Für wen gelten berufsethische Prinzipien im Bereich Dolmetschen?

☐ Nur für Dolmetscher*innen, die beeidigt bzw. öffentlich bestellt sind
☐ Nur für Dolmetscher*innen, die einen Vertrag mit einer entsprechenden Klausel unterschrieben haben
☐ Nur für Dolmetscher*innen, die für ihren Dolmetscheinsatz bezahlt werden
☒ Für alle Dolmetscher*innen
☐ Ich weiß es nicht

20	Wann endet die normalerweise vertraglich vereinbarte Schweigepflicht für den Dolmetscher oder die Dolmetscherin?

☐ Sechs Monate nach Abschluss des Dolmetscheinsatzes
☐ Zehn Jahre nach Abschluss des Dolmetscheinsatzes
☐ Mit Ende des Vertragsverhältnisses
☒ Nie
☐ Ich weiß es nicht

21	*„Dolmetschen als freiberufliche Tätigkeit ist nach deutschem Recht kein Gewerbe und unterliegt daher nicht der Gewerbeordnung und nicht der Gewerbesteuer“.* Ist diese Aussage richtig oder falsch?

☒ Richtig
☐ Falsch
☐ Ich weiß es nicht

Bitte das Blatt umdrehen!

22	Die Bezahlung von Dolmetscheinsätzen von gerichtlich-behördlichen Auftraggeber*innen richtet sich nach dem…

☒ … JVEG

☐ … VBVG

☐ … BMJV

☐ … TSVG

☐ Ich weiß es nicht

Bitte überprüfen Sie noch einmal, ob Sie alle Fragen beantwortet haben.

Herzlichen Dank für das Ausfüllen des Fragebogens!

Auswertung

Richtige Antworten: D, C, C, A, B, B, Richtig, B, Richtig, Falsch, Falsch, A, Falsch, Falsch, Falsch, Richtig, Richtig, C, D, D, Richtig, A

- Richtige Antwort = 1 Punkt
- Falsche Antwort oder “Ich weiß es nicht” = 0 Punkte
- Punkte addieren, um den Summenscore zu bilden (maximum Score: 22 Punkte; minimum Score: 0 Punkte)

Richtig	Falsch	A	B	C	D	**Gesamt**
5x	5x	3x	3x	3x	3x	**22**

Das Projekt wird kofinanziert aus Mitteln des Asyl-, Migrations- und Integrationsfonds (AMIF) sowie durch die Sozialbehörde der Freien und Hansestadt Hamburg.

7.5. Publication 5

***Hanft-Robert S*,** Emch-Fassnacht L, Higgen S, Pohontsch N, Breitsprecher C, Müller M, et al. Training service providers to work effectively with interpreters through educational videos: a qualitative study. Interpreting. 2023;25(2):274–300. doi:10.1075/intp.00090.han

Training service providers to work effectively with interpreters through educational videos

A qualitative study

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To ensure the quality of interpreter-mediated encounters, not only interpreters but also service providers need to be trained. However, most of them lack adequate training. This study aimed to evaluate educational videos as a (self-)learning tool with which to train service providers to work with interpreters. Eight educational videos were developed in a multi-stage evidence-based process. For the evaluation, semi-structured interviews with 32 service providers across settings and 12 experts in the field of interpreting were conducted in Switzerland and Germany. The interviews were audio recorded, transcribed verbatim, and analyzed using a structuring content analysis approach. Service providers described an increase in their knowledge (e.g. of the complexity of interpreter-mediated encounters, potential challenges, and how to deal with them appropriately) and confidence (e.g. reduced inhibitions about working with interpreters, perceived permission to feel insecure, and encouragement to deal with problematic situations in an interpreter-mediated encounter). However, the need for hands-on practice limits the effectiveness of the educational videos as a standalone (self-)learning tool, as noted in particular by the experts. It is recommended that they be used in combination with other methods, such as face-to-face training, which provide opportunities for hands-on practice. Nonetheless, the videos can be considered a low-threshold and initial (self-)learning tool with which to increase service providers' competence in working with interpreters.

Keywords: interpreter-mediated encounter, training, service provider, competence, educational videos

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1. Introduction

1.1 Overcoming language barriers by using interpreters

As a result of globalization, migration and displacement, service-providers (SPs) across all kinds of settings may increasingly be faced with the challenge of providing services to a culturally and linguistically diverse population. According to the latest World Migration Report, the estimated number of people living in a country other than their country of birth was 281 million in 2020. That is 3.6% of the world's population and 128 million more than in 1990 (McAuliffe & Triandafyllidou 2021). Whereas a great proportion of migrants possess sufficient proficiency in the respective national language, some have limited language proficiency (LLP), not only upon arrival but also after years of residence (Liebau & Romiti 2014). LLP is one of the main barriers to migrants' receiving appropriate services (Kim et al. 2011; Lebrun 2012; Wilson et al. 2005) and to SPs' providing these services (Al Shamsi et al. 2020; Ali & Watson 2018; Corsellis 1997).

When the SP and their client do not share a common language, a range of (informal) practices are used to overcome the language barrier, including the use of family members or multilingual personnel as interpreters (Gill et al. 2011; Kilian et al. 2014; Mösko et al. 2013; Smith et al. 2013; Swartz et al. 2014), receptive multilingualism (ten Thije 2018), machine translation technologies (Dew et al. 2018), or professional interpreters (Gill et al. 2011; Karliner et al. 2007). It should be noted that in most countries – including Germany, where the presented study was conducted – no quality standards or legal regulations exist that define what distinguishes a professional interpreter or who is allowed to work as an interpreter at all. Consequently, the level of qualification of interpreters varies greatly (Breitsprecher et al. 2020). A professional interpreter is usually defined as a person who is somehow trained for the interpreting task in a specific setting (Karliner et al. 2007), although there is wide variation in the extent and content of such interpreter training. Despite the vague definition, the literature indicates that the use of trained interpreters can improve the quality of a service to a level that approaches or equals the quality of the service provided to people who are proficient in the particular language and do not rely on an interpreter (Karliner et al. 2007). However, many SPs tend not to use interpreters at all or use inappropriate interpreters, such as family members, in situations actually requiring professional interpreting (Gill et al. 2011; Jaeger et al. 2019b). Previous studies exploring the reasons for the underuse of professional interpreters have shown that SPs might not be able to recognize when LLP poses a problem (Jacobs et al. 2010) or they believe that they can 'get by' and deal with the language barrier through gestures and the use of limited second-language skills, despite the possible neg-

ative effects on the quality and outcome of the communication (Diamond et al. 2008). Besides cumbersome organization and the absence of financial coverage (Jaeger et al. 2019a), reservations about the effectiveness of interpreter-mediated encounters (IMEs) and a general lack of knowledge about working with interpreters effectively (Jaeger et al. 2019a; Patriksson et al. 2019) are major reasons why SPs tend not to use professional interpreters when communicating with LLP migrants. To overcome these barriers and to ensure that LLP migrants receive appropriate services, SPs should be trained in the consequences of language barriers, the importance of using professional interpreters, and also how to work with them appropriately (Hsieh 2010; Jacobs et al. 2010).

1.1 Training service providers for interpreter-mediated encounters

Referring to Wadensjö (1998), who described IMEs as 'a communicative pas de trois' (a dance of three, pp. 10–12), it becomes clear that the quality of IMEs does not depend solely on the competence of the interpreter. As Hale (2007) stated, it is a shared responsibility between all of the parties involved. SPs, however, are rarely trained for this activity (Costa 2017; Perez & Wilson 2007) and perceive working with interpreters as an intuitive activity rather than an acquired professional skill (Hudelson et al. 2012). Hudelson et al. (2012) showed that even if SPs consider themselves highly competent to work with interpreters, it does not mean that they actually are. This is largely because IMEs differ from monolingual communication in many ways (Perez & Wilson 2007; Tebble 2003). They therefore pose specific challenges for SPs, such as the adjustment of turn-taking and the speed of speech (Juckett & Unger 2014) or dealing with conflicts about expertise and authority with the interpreter (Hsieh 2010). In previous interview studies, SPs reported feelings of being excluded or under observation, experienced a lack of control, and described having to deal with mistrust of the accuracy of their renditions as challenging (Hanft-Robert et al. 2018). In contrast, trained SPs displayed greater confidence in working effectively with interpreters (Bansal et al. 2014; Coetzee et al. 2020; McEvoy et al. 2009; Quick et al. 2019; Woll et al. 2020) and also displayed increased knowledge and a more positive attitude towards doing so (Jacobs et al. 2010). Shriner and Hickey (2008) reported that trained SPs, compared to SPs without prior training, demonstrated improved skills in a simulated healthcare setting, such as speaking directly in the first person to the patient instead of speaking to the interpreter and instructing the interpreter about their role. Furthermore, prior training is associated with an increased use of professional interpreters and increased satisfaction with the service provided to LLP clients (Karliner et al. 2004).

1.2 Educational videos as a learning tool

In recent years, there has been an increasing amount of research on the effectiveness of educational videos (EVs) in imparting knowledge, teaching and learning skills across a variety of disciplines (Bäwert & Holzinger 2019; Denny et al. 2017; Jang & Kim 2014; Kim et al. 2020). In the field of interpreting, too, initial studies have been examining the use of videos as a learning method (Ikram et al. 2015; Kalet et al. 2005). For example, Kalet et al. (2005) have developed a web-based module for medical students on working with interpreters. The participants were asked to analyse patient – physician – interpreter videos presenting the common pitfalls of and effective strategies for IMEs. Kalet et al. (2005) showed a significant increase in SPs knowledge and improved attitudes towards interacting with LLP patients and interpreters. Ikram et al. (2015) developed an e-learning module aimed at teaching medical students the skills needed to work effectively with interpreters and imparting knowledge of the benefits of using professional instead of non-professional (untrained) interpreters. The participants were presented with patient – physician – interpreter videos (either with a family member, an untrained bilingual staff member or a professional interpreter) and asked to answer two questions per vignette, followed by feedback that compared their responses to expert information. The participants showed significantly improved knowledge of and higher self-efficacy in using professional interpreters (Ikram et al. 2015).

Whereas the importance of the interpreter undergoing training is increasingly being emphasized (Ertl & Pöllabauer 2010; Hale & Ozolins 2014; Mikkelson 2014), the role of the SP is often still overlooked. In the light of the need to train SPs to work effectively with interpreters, coupled with growing evidence indicating the effectiveness of EVs as a learning approach, eight EVs for training SPs on how to conduct IMEs effectively were developed as part of an interdisciplinary research project. In this study, semi-structured interviews were conducted with SPs across disciplines and with experts in the field of interpreting to evaluate whether these newly developed EVs are a suitable (self-)learning tool for training SPs and increasing their competence in conducting IMEs effectively.

2. The study

2.1 Aim of the study

The purpose of this study was to evaluate whether the newly developed EVs are a suitable (self-)learning tool with which to train SPs and increase their competence

in conducting IMEs effectively. The aim was to explore (1) what SPs can learn about conducting IMEs through these EVs, (2) the impact that the EVs have on SPs' confidence to conduct IMEs effectively, and (3) the strengths and limitations of EVs as a (self-)learning tool in the field of interpreting.

2.2 Study design

A qualitative approach was chosen which allowed an in-depth, flexible exploration of the participants' perspectives and experiences with these EVs. The reporting of methods is in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al. 2007). Ethical approval was obtained in writing from the Ethics Committee of the University Medical Centre Hamburg-Eppendorf (4 April 2020; LPEK-0132).

2.3 Development of educational videos

The evidence-based development of the EVs consisted of the three modules displayed in Figure 1. Experts in the field of interpreting, SPs working with interpreters, and interpreters themselves were involved in the development of the EVs. Based on a systematic literature review and qualitative interviews with interpreters, SPs across settings, and experts, possible themes for the EVs were identified. In two separate workshops with experts and SPs these themes were discussed and prioritized. Based on these results, the scripts for the EVs were written. To make the EVs as authentic as possible, lay actors were chosen who are also interpreters or SPs in real life.

The EVs aimed to train SPs across settings in how to conduct IMEs effectively instead of focusing on just one setting. The EVs were designed to be a self-directed, independent learning tool to support SPs in the process of learning and self-reflection. In an effort to go beyond mere case-vignettes, a trainer (via voice-over) was included who directly addressed and guided the user through the presented situation. In total, eight EVs were developed with two different objectives. Three EVs aimed to teach SPs the best practices regarding the different modes of IMEs ("Best Practices in IMEs"): face-to-face, telephone, and video interpreting. Each of the three EVs demonstrated one mode. The trainer guided the user and explained the ideal procedure. Five EVs showed common challenges when working with interpreters ("Challenges in IMEs"). Each of them demonstrated one challenge: interpreter and client slipping into a dialogue; confusing reaction on the part of the client; client avoiding eye contact; perceived gaps in interpretations; cultural uncertainties. The trainer explained the problem and one possible way of dealing with the specific challenge was shown. These EVs aimed to raise

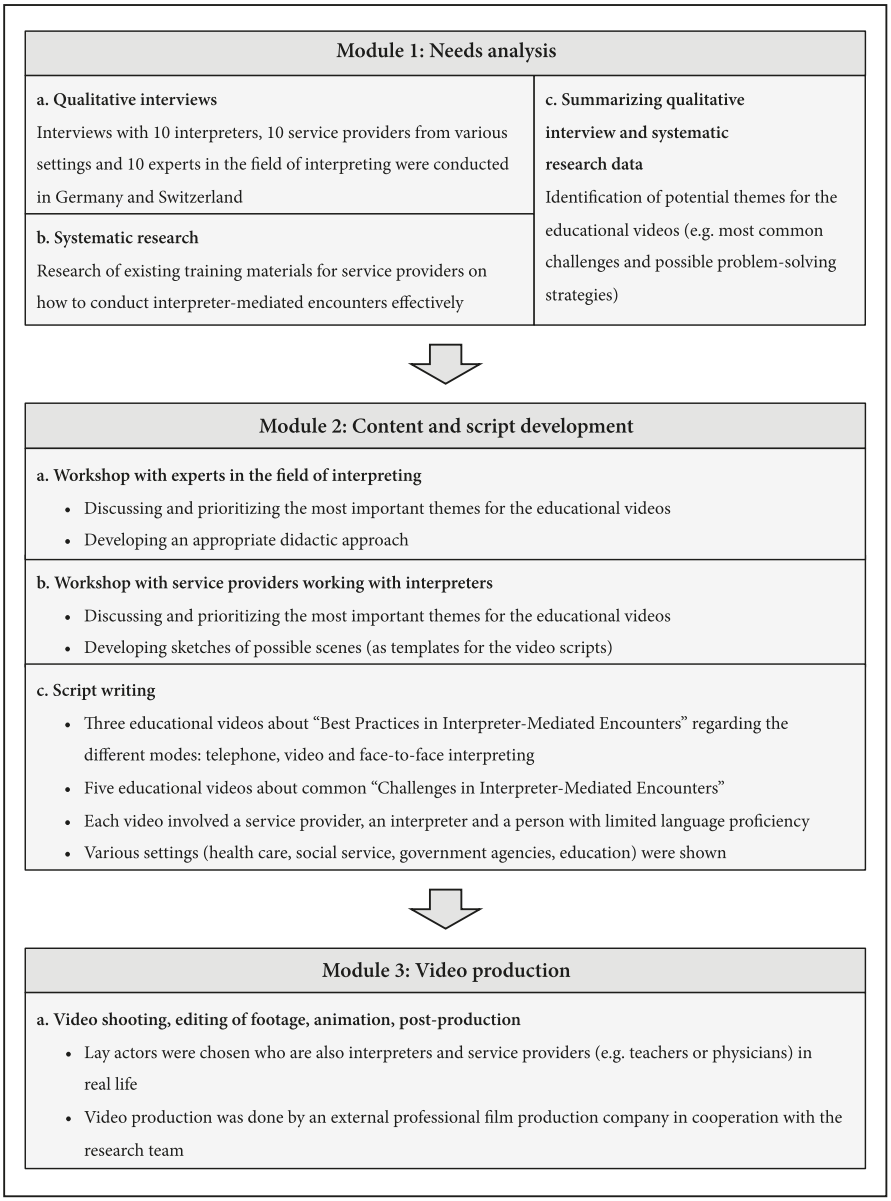

Figure 1. Overview of the evidence-based development of the EVs

the SPs' awareness of problematic situations and to encourage them to find appropriate solutions. The duration of the EVs varied between 2:18 and 6:38 minutes. After the evaluation, the EVs were made freely available online in German and English.

2.4 Participants and recruitment

The participants were selected based on a purposive sampling approach (Marshall 1996). The inclusion criteria for SPs were: (1) working in one of the four settings: health care, social service, government agencies, or education; (2) had conducted at least five IMEs in the past 12 months; and (3) no previous training explicitly on IMEs (previous attendance at general intercultural training sessions was not a criterion for exclusion). To avoid biased results, no one who had already participated in an interview or one of the workshops in the process of developing the EVs was interviewed again in this study. A maximum variation sample (Marshall 1996) was aimed at with respect to settings, years of work experience, and the frequency of work with interpreters (Figure 2).

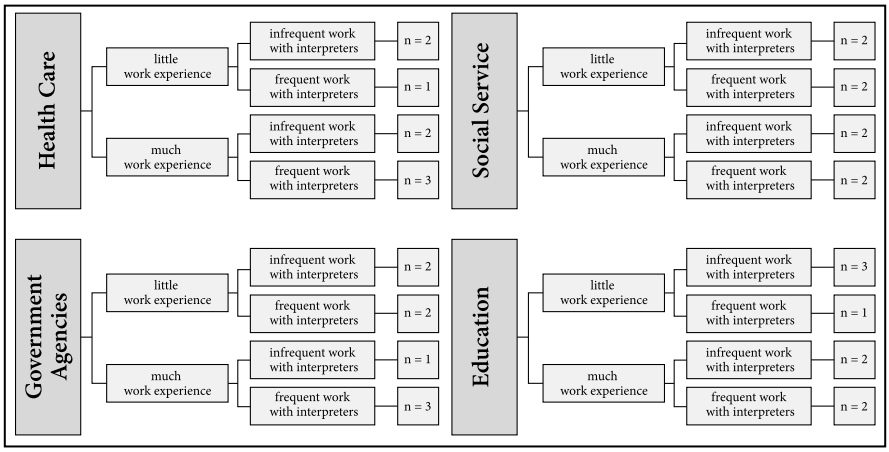

Figure 2. Recruitment of SPs
Settings: health care, social service, government agencies, education. Work experience: little (≤ 3 years) or much (≥ 7 years). Work with interpreters during the last six months: infrequent (≤ 1 per month) or frequent (≥ 2 per month).

Several German and Swiss organizations and institutions from the four settings were contacted by email or telephone and asked to forward the information on the study to their employees. Further participants were recruited by snowball sampling (Marshall 1996). Experts in the field of interpreting were included as a key informant sample based on their expertise and experience (Marshall 1996). Their inclusion criterion was at least three years of professional practice in the educational or scientific field of interpreting. Owing to the small number of eligible persons in Germany and Switzerland, experts were contacted directly by email or telephone. None of the experts refused to participate. All of the participants

were provided with oral and written information in German about the study prior to the interview. All of them gave their written informed consent to be interviewed and for the interview to be digitally audio recorded, transcribed and analyzed for the purposes of the study. Participation in the study was voluntary and not remunerated.

2.5 Development of interview guide

The semi-structured interview guide was developed by SHR (psychologist and doctoral student with many years of experience in conducting semi-structured interviews and qualitative data analysis) in close consultation with LEF (social anthropologist with many years of experience in conducting interviews), NJP (psychologist and post-doctoral researcher with comprehensive experience in teaching about and conducting qualitative (interview) studies) and MM (psychotherapist and professor of clinical psychology with comprehensive experience in qualitative research) following Helfferich's (2009) SPSS approach of collecting, reviewing, sorting and finally subsuming questions. The guide was critically discussed and refined by the research team. After two pilot interviews conducted by SHR in Germany, minor changes were made to reduce the length of the guide. The guide for both SPs and experts consisted of three parts: (*a*) evaluation of the EVs "Challenges in IMEs", (*b*) evaluation of the EVs "Best Practices in IMEs", (*c*) suitability of the EVs as a (self-)learning tool. Parts (*a*) and (*b*) were almost identical and covered the following topics: interviewees' general impression, relevance, impact on knowledge and confidence. In addition, Part (*b*) covered dealing with the challenges in IMEs. Part (*c*) explored the strengths and limitations of EVs as a (self-)learning tool in the field of interpreting.

2.6 Data collection and transcription

All of the interviews were conducted between June and October 2020 in a one-on-one setting in Germany and Switzerland. Owing to the COVID-19 pandemic, all of the interviews in Germany ($n=23$) were conducted by SHR by telephone, in Switzerland by LEF by telephone ($n=5$) and in person at LEF's office ($n=16$). All of the interviews were conducted using the semi-structured guide, which allowed the interviewer to deviate from the pre-formulated questions and to ask individualized questions in order to explore new or unexpected topics raised by the interviewee during the interview. The participants completed a short questionnaire on sociodemographic data. The interviewer filled in a postscript to document the interview situation and any potentially disruptive factors during the interview. To ensure that the interviews were of a manageable duration, three randomly

selected EVs were presented per participant: two EVs about "Challenges in IMEs" and one EV about "Best Practices in IMEs". Consequently, each EV was watched by at least ten SPs and four experts.

The interviews were digitally audio recorded and transcribed verbatim by a professional agency. All of the transcripts were proofread by SHR. Personal data that could lead to the identification of an interviewee (e.g. the names of participants, employers, institutions) were deleted or changed. The transcripts were not returned to the participants. The interviews lasted on average $M = 56{:}05$ minutes (range = 32:19–83:50) with SPs and $M = 71{:}05$ minutes (range = 46:00–102:00) with experts.

2.7 Data analysis

All interviews were analyzed according to the structuring content analysis by Kuckartz (2014). The objective of structuring content analysis is to summarize and structure interview data by developing a category system consisting of main categories and subcategories. A combination of deductive and inductive coding was applied (Kuckartz 2014). Deductive categories were derived from the interview guide and were supplemented by inductive categories during the coding process (Kuckartz 2014). To ensure intersubjective comprehensibility and credibility (Creswell 2013), SHR and SH (psychologist and doctoral student with some experience in conducting semi-structured interviews and qualitative data analysis) each coded six transcribed interviews separately and discussed the categories afterwards. Based on this, a first category system was developed. SHR analysed the remaining interviews in close consultation with SH and NJP. After finalizing the first coding process, all of the material was coded one more time by using the developed category system to ensure that no relevant aspects were missed. The final category system was discussed in two different research groups to ensure intersubjective reproducibility and comprehensibility (Creswell 2013). The study participants did not provide feedback on the findings. The data were analysed using MAXQDA 2020.

2.8 Sample

The sample consists of 32 SPs (27 female, 5 male) working in health care ($n = 8$), social service ($n = 8$), government agencies ($n = 8$) or education ($n = 8$) (see Figure 2) and 12 experts (all female). Of the participants, 17 SPs and six experts were German and 15 SPs and six experts were Swiss. The SPs were on average $M = 40.5$ years old (range = 23–62) and had $M = 9.6$ years' work experience (range = 0.42–30). Of the SPs, 16 had worked infrequently (≤ 1 per month) and

16 SPs had worked frequently (≥ 2 per month) with interpreters during the past six months. In total, they had $M = 6.9$ years' experience (range = 0.08–25) working with interpreters. Two experts worked in the scientific field of interpreting and translation studies as researchers and lecturers; four worked in the educational field as trainers of SPs (and interpreters); six experts worked in both fields. The experts were on average $M = 48.7$ years old (range = 34–61) and had $M = 16.3$ years' expertise (range = 5–30).

3. Results

Four main categories with a total of 13 subcategories were identified (Table 1). The main categories are:

- gaining knowledge;
- gaining confidence;
- strengths of the EVs as a (self-)learning tool; and
- limitations of the EVs as a (self-)learning tool.

The analysis showed little difference in the views of SPs and experts. Most aspects were mentioned by both groups, which is why the results were combined. Any differences are presented in the text. No differences were found between the participants in Germany and those in Switzerland. Most of the categories refer to both types of EV ("Best Practices in IMEs" and "Challenges in IMEs"); in cases where this does not apply, it is specified.

Table 1. Identified main and subcategories

Main categories		Subcategories	
1	Gaining knowledge	1.1	Complexity of interpreter-mediated encounters
		1.2	Basic elements of successful interpreter-mediated encounters
		1.3	Challenges and how to deal with them
		1.4	Clear division of roles, including role boundaries
		1.5	Refreshing existing knowledge
2	Gaining confidence	2.1	Reducing inhibitions about working with interpreters
		2.2	Permission to feel insecure
		2.3	Encouraging to deal with problematic situations
3	Strengths of the educational videos as a (self-)learning tool	3.1	Impetus for self-reflection
		3.2	Vivid learning tool
		3.3	Flexible learning tool

Table 1. *(continued)*

Main categories		Subcategories	
4	Limitations of the educational videos as a (self-)learning tool	4.1	Lack of exchange and discussion
		4.2	Need for hands-on practice

3.1 Gaining knowledge

Complexity of interpreter-mediated encounters

All of the SPs stated that through the EVs they came to realize the complexity of an IME and that it differs significantly from a monolingual conversation. They explained that the EVs enabled them to understand the importance of being adequately trained for this specific and complex type of communication:

> The more you learn about it, the more you realize how important it is and how many things you don't know, how much you have to think about when working with interpreters. (SP06)

Furthermore, the experts pointed out that the EVs show that, compared to monolingual encounters, IMEs have communicative peculiarities for which SPs need to be sensitized and trained:

> Yes, also to have it very clear again. What is this conversation – what is this setting about. […] We can't always communicate with the same models or with the same schemes that we usually use. Three-way communication has its own rules. (EXP02)

Basic elements of successful interpreter-mediated encounters

This category refers to the three EVs about "Best Practices in IMEs". SPs and experts perceived these EVs as being beneficial in increasing their knowledge about the basic elements needed to conduct IMEs effectively. The interviewees mentioned, for example, arranging seating; clarifying technical details when using a telephone or a video interpreter; informing the interpreter about the reason for and the content of the conversation; explaining their role and tasks to the interpreter; obtaining clients' consent; pointing out the confidentiality of the conversation; establishing clear rules of communication (e.g. everything said will be interpreted); clarifying linguistic understanding between interpreter and client; speaking slowly, clearly, and in short sentences; addressing the client directly (in the first person, maintaining eye contact); being continuously attentive and observing nonverbal behaviors and reactions; and conducting a short debriefing with the interpreter after the conversation.

SPs described these EVs about "Best Practices in IMEs" as easy-to-follow checklists, which are especially useful when working with an interpreter for the first time:

> I become aware of the procedures involved in such conversations and how they take place. I'll definitely take that away with me again. And actually some kind of little checklist in my head. (SP25)

Challenges and how to deal with them

This category refers to the five EVs about "Challenges in IMEs". Both experts and SPs considered these EVs helpful for learning about potential challenges and how to deal with them appropriately:

> SPs have to become aware of this problem. Then they have to think about how to deal with it. That's what they can learn in this EV. How I can deal with it, ideally. And then I know that, and then I can use that again and again and then – yes, it is wonderful. Then the EV has fulfilled its purpose. (EXP01)

Some SPs reported that the EVs made them realize why something might be problematic regarding the quality and outcome of an IME:

> My impression was that I immediately thought, "oh yes, I know this phenomenon" and I thought it was good to get it explained again in a very simple and understandable way and also to have it illustrated to you in a practical way that you have to do something in this case. So how you can bring the conversation back to you. (SP09)

Clear division of roles, including role boundaries

All of the experts emphasized that the EVs convey the need to have a clear understanding of the division of roles, including role boundaries:

> Yes, that is definitely the key point here. The focus is on the role of the SP. He is moderating the conversation; that is his task. And he is also responsible for the atmosphere in the conversations. (EXP02)

On the one hand, SPs described how they became more aware of their own role as the leader of the conversation, the one who bears the main responsibility. On the other, they viewed the interpreter as the person enabling and being responsible for the verbal comprehension but not possessing any responsibility for the process or content of the conversation:

> What I have become even more aware of is that the person interpreting really is providing a service and is not, for example, like the client's confidant. […] Which

> in turn means for me as a SP that I am really aware of this and that it is clearly down to me to lead and conduct the conversation. (SP26)

One SP described feeling like a bystander sometimes during IMEs, and in so doing handing over the responsibility to the interpreter. The EVs made her aware of the importance of retaining responsibility for the conversation.

Refreshing existing knowledge

Some of the SPs who were already highly experienced in IMEs reported that their existing knowledge was re-activated. They stated that they could imagine viewing the EVs every now and then to refresh their existing knowledge of IMEs: *"It has refreshed it again and also made it more understandable and clearer for me that it really makes sense to do it this way for the counselling process"* (SP09).

One expert also stated that the EVs offer experienced SPs the opportunity to re-activate their knowledge and improve certain aspects of their communication skills: *"And someone who is perhaps already familiar with this can recognize and optimize certain parts"* (EXP10).

3.2 Gaining confidence

Reducing inhibitions about working with interpreters

SPs who had little experience in working with interpreters found the EVs particularly helpful as a means of enabling them to become (more) familiar with IMEs. Some described the EVs as being helpful in enabling them to understand that working with an interpreter is less problematic than they had often feared and that communication through an interpreter can be successful. The EVs were considered to be useful in the way they reduced fears and prejudices about working with interpreters: *"It can actually be very uncomplicated. […] And from that point of view, I think you can help people to overcome their prejudices or fears"* (SP05).

Experts acknowledged that the EVs can be especially useful in enabling inexperienced SPs to become familiar with IMEs and in this way reduce possible inhibitions:

> Someone who has never done this before will have now an idea of how it could work. And they also have insight into possible little traps they could fall into and can think carefully about how they plan it. (EXP10)

Permission to feel insecure

After watching the EVs, SPs reported that they felt they were allowed to feel insecure when working with an interpreter. They described feeling relieved and encouraged to witness that they are not the only ones who experience insecurity

during IMEs. Insecurity does not seem to be a personal shortcoming but a challenge that can be dealt with:

> It shows that this probably happens to every conversation leader that you have to cope with a degree of uncertainty during the conversations. […] And I would actually also feel a bit more encouraged going in, because now you also see that it's not just you with this insecurity. (SP25)

Some SPs explained that the EVs encouraged them to deal openly with insecurities and to be authentic: *"I always feel like I need to know how to act. And this [the EVs] gives me inspiration for that: hey, just try it! Or just ask! And ask the client directly and don't do it through the interpreter"* (SP17).

In addition, most experts emphasized that IMEs can be unsettling for the SP and described the EVs as helpful in dealing with such insecurities: *"Yes, so I definitely find, as I said, that the EVs strengthen* [the SPs] *not to feel afraid to have such thoughts and insecurities"* (EXP12).

Encouraging to deal with problematic situations

This category refers to the five EVs about "Challenges in IMEs". Interviewees from both groups reported that dealing with problematic situations during an IME is associated with reluctance and might therefore be avoided. The experts explained that the EVs can encourage SPs to deal with and resolve problematic situations: *"I found that very good. I always do that in my trainings with SPs. That's just a basic strategy. When I work with SPs, I just encourage them to ask what's going on instead of saying nothing"* (EXP06).

The SPs reported that these EVs helped them to understand the need to deal with problems in order to ensure the quality of the communication. Some felt encouraged to intervene, even if they felt uncomfortable and were afraid of offending the interpreter: *"Address the issue! That's a real takeaway for me: talk to them! Even to interpreters I don't know, because the inhibitions are greater with them"* (SP17).

Some SPs described the actors (SPs) in the EVs as role models whose approaches and behaviors could be adopted.

3.3 Strengths of educational videos as (self-)learning tool

Impetus for self-reflection

Interviewees from both groups considered the EVs as a catalyst for self-reflection. However, some experts emphasized that this effect always depends on an individual SP's ability and willingness to self-reflect:

> I find that a bit difficult with EVs. If you haven't performed the action by yourself but only observed it from the outside, then it's easier to judge the person you watched. It's more difficult to go into personal reflection. (EXP06)

One SP described IMEs as a safe setting and, as a result, it is usually not possible for her to be reviewed on the way she conducts IMEs and how she behaves in certain challenging situations. She described it as helpful to get some kind of feedback through these EVs:

> Due to the fact that in our job we are often alone in such situations […] you are alone with the interpreter and the client. At that moment, you don't have anyone who can give you feedback and say, "Oh, that was a bit weird, the way you did that." Or, "You could have asked that again." I think it's good when we have the opportunity […] to have some form of feedback. That's what I like about the video. (SP30)

SPs reported that they compared the approaches shown in the EVs with their own approaches and behaviors. As a result, some SPs mentioned that they want to do things differently in the future. Other SPs stated that they felt vindicated in their way of conducting IMEs and therefore relieved and encouraged.

Vivid learning tool

Compared to text-based learning materials, all of the interviewees described the EVs as a more engaging learning tool because the situations are vivid and therefore easier to understand and remember: *"These are all points that can also be written down in a list. […] But because it is visual, it can be better memorized"* (EXP10).

Visualization helps SPs to empathize with the situation and to identify with the actors (SPs):

> I think the visuals and audio aspects are great; you can really feel emotions when you see something. I think when something is illustrated to you in this way again, it evokes even more emotion than when you read a text. Yes, I find that very helpful. (SP03)

Flexible learning tool

Interviewees from both groups described it as beneficial that the EVs can be used independently and flexibly. Therefore, the EVs could be more easily implemented in SPs' daily work than if they had to attend longer in-person training courses: *"You learn a lot and you can do it in a relatively short and easy amount of time. So you […] don't have to attend a week of an in-person training course"* (SP26).

3.4 Limitations of educational videos as (self-)learning tool

Lack of exchange and discussion

SPs expressed the need to ask questions or discuss certain aspects while and after watching the EVs, especially after watching the EVs about common challenges in IMEs: *"It would be really good if you could watch the videos and discuss them afterwards"* (SP16).

All of the SPs and experts considered it useful to embed the EVs in a setting that enables in-depth discussion and further reflection:

> From my experience in the classroom, I would say educational videos are a great element for setting a theme. I don't think educational videos alone do much. But integrating them into a course, into further education or, in our case, into our studies, in order to set topics and talk about topics, I think educational videos are great for that. (EXP05)

Some experts pointed to the blended learning concept (combining online and classroom methods) and suggested using the EVs as preparation for a (face-to-face) workshop.

Need for hands-on practice

The experts emphasized that conducting IMEs is a complex activity. They noted that comprehensive training should include a hands-on practice component, allowing SPs to practise the activity and experience it for themselves:

> It also becomes difficult to apply the whole thing to your own actions. Because the ratio does not behave in accordance with the action itself. […] The way you sit down, the way you enter, the way you leave. There are so many characteristics, facial expressions, postures in it. You can't really optimize that, so to speak, through rational input, just like that. That's why this hands-on practice part is necessary in any case. (EXP06)

They stated that it takes time and practice to reflect on and adjust one's own behavior. Most SPs acknowledged the need to practice IMEs by themselves:

> But I don't think it's enough to train SPs properly just to watch a video about it. I think you have to talk to someone who has a lot of experience with this topic and also practice, and maybe go through such difficult cases. (SP16)

8. Summary

8.1. English summary

Linguistic diversity within societies is a global reality, yet mental healthcare and other community services often fail to adequately reflect this, leading to language discordance between service users and providers. This dissertation explores interpreting practices to overcome language barriers and training measures for community interpreters and service providers. Five research objectives were developed and investigated in five individual studies.

In the first, a cross-sectional study was conducted among individuals identifying as interpreters and working in various community settings, such as (mental) healthcare, social care, education, or authorities in Germany. The findings provide an initial comprehensive and evidence-based overview of interpreters' sociodemographic profiles, working conditions, (formal) training background, mental health status, and psychological distress regarding interpreting.

The second study was conducted to explore informal interpreting practices by investigating security guards serving informally as interpreters in a psychiatric hospital in South Africa. Interviews with mental healthcare professionals and security guards showed that this compromises communication quality and poses emotional risks for the security guards, yet it can be assumed that such practices persist due to a lack of effective alternatives.

In a third study, the impact of an interpreters' presence on the communicative situation was investigated using the therapeutic alliance in a psychotherapeutic setting in Denmark as an example. Interpreters are an active part of the process, and their presence significantly changes the interaction. Conducting interpreter-mediated encounters effectively, including forming a good triadic therapeutic alliance, requires specialized training for both interpreters and service providers.

The fourth study focused on the development and evaluation of a generic training program for community interpreters in Germany. The mixed-methods study found improvements in interpreters' knowledge, competence, self-efficacy, and increased self-perceived professionalism. The importance of formalized training and certification for enhancing service quality and interpreters' professional status was highlighted.

In the fifth study, educational videos aiming at training service providers to work with interpreters across community settings were developed and evaluated. Interviews with service providers and experts in CI in Germany and Switzerland revealed that while the videos can increase providers' knowledge and confidence, in-person practice is necessary for effective interpreter-mediated communication.

Overall, this dissertation provides valuable knowledge about the individuals working (informally) as interpreters, the impact of the interpreters' presence on communication, and how to train service providers and interpreters to collaborate effectively. Beyond changes at an individual level, socio-political reforms at the institutional and systemic levels are required to ensure effective and professional interpreting practices and thus promote equitable service access to and provision of mental healthcare and other community services in linguistically diverse populations.

8.2. German summary

Sprachliche Vielfalt in der Gesellschaft ist eine globale Realität, die sich jedoch häufig nicht im psychosozialen Gesundheitswesen und anderen Bereichen des Gemeinwesens ausreichend widerspiegelt, weshalb es zwischen Fachpersonen und Nutzer:innen zu sprachlichen Barrieren kommen kann. Diese Dissertation beschäftigt sich mit verschiedenen Dolmetschpraktiken zur Überwindung von Sprachbarrieren sowie Schulungsmaßnahmen für Dolmetscher:innen und Fachpersonen. Hierbei wurden fünf Forschungsziele entwickelt, denen in fünf Studien nachgegangen wurde.

Erstens wurde eine Querschnittsstudie mit Personen durchgeführt, die sich als Dolmetscher:innen bezeichnen und im Gemeinwesen, wie dem (psychischen) Gesundheits-, Sozial-, Bildungswesen oder Behörden in Deutschland tätig sind. Die Ergebnisse liefern einen ersten umfassenden, evidenzbasierten Überblick über das soziodemografische Profil der Dolmetscher:innen, ihren Arbeitsbedingungen, (formalen) Qualifikationshintergrund, psychischen Gesundheitszustand und der psychische Belastung in Bezug auf das Dolmetschen.

Zweitens wurde eine Studie zum informellen Dolmetschen durchgeführt und der Einsatz von Sicherheitskräften als informelle Dolmetscher:innen in einem psychiatrischen Krankenhaus in Südafrika untersucht. Interviews mit Fachpersonen und Sicherheitskräften

zeigten, dass ihr Einsatz die Qualität der Kommunikation negativ beeinträchtigen kann und auch emotionale Risiken für die Sicherheitskräfte selbst birgt. Dennoch kann vermutet werden, dass informelles Dolmetschen aufgrund des Fehlens von alternativen effektiven Strategien weiterhin stattfinden wird.

Drittens wurde untersucht, welchen Einfluss die Anwesenheit einer dolmetschen Person auf die Gesprächssituation hat, wobei hier die therapeutische Beziehungsgestaltung in einem psychotherapeutischen Setting in Dänemark als Beispiel genutzt wurde. Es zeigte sich, dass Dolmetscher:innen aktive Teilnehmende sind und ihre Anwesenheit die Gesprächssituation deutlich verändert. Die effektive Durchführung gedolmetschter Gespräche, inklusive der Bildung einer guten triadischen therapeutischen Beziehung, erfordert spezifische Schulung sowohl für die Dolmetscher:innen als auch die Fachpersonen.

Die vierte Studie fokussierte auf die Entwicklung und Evaluation einer allgemeinen Qualifizierung für Dolmetscher:innen im Gemeinwesen in Deutschland. Die Mixed-Methods-Studie zeigte, dass es zu einem Zuwachs an Wissen, Kompetenz und Selbstwirksamkeit kam und es wurde ein gestärktes Bewusstsein für die Professionalität der Dolmetscher:innen berichtet. Schulung sowie Zertifizierung erscheinen nicht nur wichtig, um die Dolmetschqualität zu verbessern, sondern auch, um die wahrgenommene Professionalität von Dolmetscher:innen zu fördern.

Fünftens wurden Lehrvideos entwickelt und evaluiert, die darauf abzielen, Fachpersonen des Gemeinwesens für die Zusammenarbeit mit Dolmetscher:innen zu schulen. Interviews mit Fachpersonen und Expert:innen in Deutschland und der Schweiz zeigten, dass die Lehrvideos zwar geeignet sind, um Wissen und Zutrauen von Fachpersonen zu erhöhen, für eine umfassende Schulung jedoch das tatsächliche Üben von gedolmetschten Gesprächen in der Praxis notwendig ist.

Zusammenfassend liefert die Dissertation wertvolle Erkenntnisse über Personen, die (informell) als Dolmetscher:innen tätig sind; den Einfluss von Dolmetscher:innen auf die Gesprächssituation und wie Dolmetscher:innen und Fachpersonen für eine erfolgreiche Zusammenarbeit wirksam geschult werden können. Neben Veränderungen auf individueller Ebene, sind auch soziopolitische Reformen auf institutioneller und systemischer Ebene erforderlich, um wirksame und qualifizierte Dolmetschpraktiken zu

stärken und so den Zugang und die Versorgung im psychosozialen Gesundheitswesen und anderen Bereichen des Gemeinwesens in sprachlich vielfältigen Gesellschaften gerechter zu gestalten.

9. Statement of contribution

1. **Hanft-Robert S**, Mösko M. Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters. BMC Public Health. 2024;(24):1570. doi:10.1186/s12889-024-18988-8

   Saskia Hanft-Robert (SHR) developed the research idea, conceptualized the study, and obtained ethical approval. She developed the questionnaire, which included organizing different workshops with various experts and participants from the target group. She distributed the survey, recruited participants, and collected, analyzed, and interpreted the data. She wrote the first draft of the manuscript and revised it according to the co-author's and reviewers' feedback.

2. **Hanft-Robert S**, Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al. The doctor doesn't understand Xhosa and the service user doesn't understand English – exploring the role of security guards acting as informal interpreters in psychiatric care in South Africa. BMC Health Serv Res. 2024;24(1):1239. doi:10.1186/s12913-024-11722-5

   SHR developed the research idea and conceptualized the study. She wrote a research proposal and received funding for the study through the *DAAD – German Academic Exchange Service*. She obtained ethical approval, developed the interview guide, recruited participants, collected, analyzed, and interpreted the data in collaboration with local researchers. She wrote the first draft of the manuscript and revised it according to the co-authors' and reviewers' feedback.

3. **Hanft-Robert S**, Lindberg LG, Mösko M, Carlsson J. A balancing act: how interpreters affect the therapeutic alliance in psychotherapy with trauma-affected refugees – a qualitative study with therapists. Front Psychol. 2023;14:1175597. doi:10.3389/fpsyg.2023.1175597

SHR developed the research idea and conceptualized the study. She wrote a research proposal and received funding for the study through the University of Hamburg – *Hamburglobal* scholarship. She developed the interview guide with local researchers from Denmark. She recruited participants and collected, analyzed, and interpreted the data. She wrote the first draft of the manuscript and revised it according to the co-authors' and reviewers' feedback.

4. **Hanft-Robert S**, Breitsprecher C, Mösko M. Just having experience is not enough: development and evaluation of a training course for interpreters working in community settings – a mixed-methods study (submitted Front Educ – Language, Culture and Diversity).

   SHR developed the research idea and conceptualized the study, which was part of the *BetweenLangauges* project funded by the European Asylum, Migration and Integration Fund (AMIF). She obtained ethical approval and developed the interview guide in close consultation with interdisciplinary experts. She recruited participants and collected, analyzed, and interpreted the data. She wrote the first draft of the manuscript and revised it according to the co-authors' feedback.

5. **Hanft-Robert S**, Emch-Fassnacht L, Higgen S, Pohontsch N, Breitsprecher C, Müller M, et al. Training service providers to work effectively with interpreters through educational videos: a qualitative study. Interpreting. 2023;25(2):274–300. doi:10.1075/intp.00090.han

   SHR developed the research idea and conceptualized the study, which was part of the *BetweenLangauges* project funded by the European Asylum, Migration and Integration Fund (AMIF). She obtained ethical approval and developed the interview guide in close consultation with interdisciplinary experts. She recruited participants and collected, analyzed, and interpreted the data. She wrote the first draft of the manuscript and revised it according to the co-authors' and reviewers' feedback.

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11. Curriculum vitae

Curriculum vitae is not included due to data protection reasons.

Curriculum vitae is not included due to data protection reasons.

12. Publication list

Publications in peer-reviewed journals

The publications highlighted in grey are part of this dissertation.

1. **Hanft-Robert S***, Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al. "They are not even called by name": security guards in a South African psychiatric hospital. Soc Sci Med. 2024;117443.
2. **Hanft-Robert S***, Shongwe L, Cossie Q, Sithole P, Roos T, Mösko M, et al. "The doctor doesn't understand Xhosa and the service user doesn't understand English" – exploring the role of security guards acting as informal interpreters in psychiatric care in South Africa. BMC Health Serv Res. 2024;24(1):1239.
3. **Hanft-Robert S***, Mösko M. Community interpreting in Germany: results of a nationwide cross-sectional study among interpreters. BMC Public Health. 2024;(24):1570.
4. Gartner K, Mösko M, Becker JC, **Hanft-Robert S*** Barriers to use of interpreters in outpatient mental health care: Exploring the attitudes of psychotherapists. Transcult Psychiatry. 2024;61(2):285–97.
5. Kreienbrinck A*, **Hanft-Robert S**, Mösko M. Usability of technological tools to overcome language barriers in health care: a scoping review protocol. BMJ Open. 2024;14(3):e079814.
6. Forray AI, Oltean O, **Hanft-Robert S,** Madzamba R, Liem A, Schouten B, et al. Uncovering multi-level mental healthcare barriers for migrants: a qualitative analysis across China, Germany, Netherlands, Romania, and South Africa. BMC Public Health. 2024;24(1):1593.
7. Adedeji A*, **Hanft-Robert S**, Böhme E, Buchcik J. Access to and utilization of mental health promotion services for African migrants: a case study in two African institutions in Hamburg [Zugang und Inanspruchnahme von Angeboten zur Förderung der psychischen Gesundheit bei afrikanischen Migrant*innen: Eine Fallstudie zweier afrikanischer Vereine in Hamburg]. In: Dingoyan D & Kofahl, C. editors. Health promotion and prevention for people with a history of migration [Gesundheitsförderung und Prävention für Menschen mit Migrationsgeschichte]. Berlin: LIT Verlag Dr. W. Hopf, 2024. p.139-151.

8. **Hanft-Robert S***, Lindberg LG, Mösko M, Carlsson J. A balancing act: how interpreters affect the therapeutic alliance in psychotherapy with trauma-affected refugees – a qualitative study with therapists. Front Psychol. 2023;14:1175597.
9. Adedeji A, Langel C, Feick A, Borges Greibaum MS, Rahimi M, **Hanft-Robert S.*** Work-Life balance and mental health outcomes for Generation Z in Germany. J Occ Environ Med. 2023;65(12), 987–991.
10. **Hanft-Robert S***, Emch-Fassnacht L, Higgen S, Pohontsch N, Breitsprecher C, Müller M, et al. Training service providers to work effectively with interpreters through educational videos: a qualitative study. Interpreting. 2023;25(2):274–300.
11. **Hanft-Robert S***, Kreienbrink A, Mösko M. Community interpreting in Germany – interpreters' working conditions and qualification. Eur J Public Health. 2023;33(Suppl 2), ckad160.1710.
12. Shongwe L, **Hanft-Robert S***, Cossie Q, Sithole P, Roos T, Swartz L. Role of security guards in healthcare settings: a protocol for a systematic review. BMJ Open. 2023;13(5), e069546.
13. Adedeji A*, Olawa BD, **Hanft-Robert S**, Olonisakin TT, Akintunde TY, Buchcik J, et al. Examining the pathways from general trust through social connectedness to subjective wellbeing. Appl Res Qual Life. 2023;18: 2619–2638.
14. Lázaro Gutiérrez R*, Valero Garcés C, (…) **Hanft-Robert S**, Schouten B. MentalHealth4All: mapping and assessing existing multilingual resources in mental healthcare. Onomázein. 2023;(NEXIII):84–101.
15. **Hanft-Robert S***, Pohontsch N, Uhr C, Redlich A, Metzner F. (2021). Therapeutic alliance in interpreter-mediated psychotherapy from the perspective of refugee patients: results of qualitative interviews. Verhaltenstherapie. 2021;32(Suppl. 1):1–9.
16. **Hanft-Robert S***, Tabi K, Gill H, Endres A, Krausz RM. Mental health mobile apps for patients: psychiatrists' concerns. Eur Psychiatry. 2021;64(Suppl 1):346.
17. **Hanft-Robert S***, Pohontsch N, Uhr C, Redlich A, Metzner F. Therapeutic alliance in interpreter-supported psychotherapy from the perspective of refugee patients: results of qualitative interviews. [Die therapeutische Beziehungsgestaltung in der

dolmetschergestützten Psychotherapie aus der Perspektive geflüchteter Patienten: Ergebnisse qualitativer Interviews]. Verhaltenstherapie. 2020;30(3):200–208.

18. **Hanft-Robert S***, Morgenroth O, Metzner F. [Chancen und Herausforderungen der dolmetschergestützten Psychotherapie mit geflüchteten Menschen aus der Perspektive der Psychotherapeuten]. Verhaltenstherapie und Verhaltensmedizin, 2020;41(1):74-92.
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21. **Hanft-Robert S***, Römer M, Morgenroth O, Redlich A, Metzner F. Interpreter-supported psychotherapy with refugees and asylum seekers: results of qualitative interviews with psychotherapists and interpreters on opportunities and challenges in the triad. Verhaltenstherapie. 2018;28(2):73–81.
22. Metzner F*, Dingoyan D, Wichmann ML-Y, **Hanft-Robert S**, Pawlis S. The trust must be there – challenges and conflicts in the therapeutic work with refugee patients from the perspective of treating psychotherapists and interpreters. [Das Vertrauen muss da sein – Herausforderungen und Konflikte in der therapeutischen Arbeit mit geflüchteten Patient*innen aus Sicht der behandelnden Psychotherapeut*innen und Dolmetscher*innen]. Konfliktdynamik. 2018;7(1):30-39.

Submitted manuscripts in peer-reviewed journals

1. Wolthusen R*, Read U, Kpobi L, **Hanft-Robert S**, Ouma SA, Andrä P, Swartz L. Applying a socioecological model lens to improve equity and inclusion in global mental health conferences. World Cultural Psychiatry Research Review (accepted).
2. **Hanft-Robert S***, Breitsprecher C, Mösko M. "Just having experience is not enough": Development and evaluation of a training course for interpreters working in community settings – a mixed-methods study (submitted Front Educ – Language, Culture and Diversity).
3. Adedeji A*, Kaltenbach S, Buchcik J, Fagbemigun T, **Hanft-Robert S**. Challenges regarding integration and well-being of African Ukrainian war refugees in Germany: a qualitative exploration (submitted Front Hum Dyn - Migration and Society).
4. Kreienbrinck A*, **Hanft-Robert S**, Mösko M. Usability of technological tools to overcome language barriers in healthcare – a scoping review (submitted Arch Pub Health).
5. Gill H*, **Hanft-Robert S**, Nugent L, Nováček O, Mamdouh M, Demlová R, Krausz M. Tabi K. Recommendations for a future mobile app for psychiatric patients: qualitative interviews with psychiatrists (submitted JMIR Ment Health).
6. Adedeji A*, **Hanft-Robert S**, Metzner F, Buchcik J, Idemudia E, Boehnke K. The development and validation of the BeLiv Microaggression Scale (BMS -27) – a metacontextual measure of microaggression (submitted Nature).
7. van Lent LGG, Hodakova S, **Hanft-Robert S**, Mösko M, Roa C, Kerremans K, … MentalHealth4All consortium. Evaluating an intervention to promote access to mental healthcare for low language proficient migrants and refugees across Europe (MentalHealth4All): study protocol for a pretest-posttest cross-national survey study (submitted BMJ Open).
8. Adedeji A*, Akintunde TY, **Hanft-Robert S**, Buchcik J, Quitmann J, Boehnke K. Perceived microaggressions and quality of life: the mediating role of personal resources and social support among people with Sub-Saharan African migration background in Germany (submitted Sci Rep – Nature).
9. de Looper M, Chen Y, Mankauskiene D, Hodakova S, Okulska-Łukawska U, Czarnocka-Gołębiewska K, … **Hanft-Robert S**, … Schouten BC. Evaluation of inclusive patient

education videos on mental health (care) by migrants in Europe: a Mhealth4all think-aloud study (submitted J Med Internet Res).

10. **Hanft-Robert S***, Mösko M. Working conditions and qualification of public service interpreters in Germany (submitted book chapter).

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Conferences

1. IMISCOE Conference (International Migration Research Network)
   Participation *(2024 – Lisbon, Portugal/Online)*
2. German Psychotherapy Congress
   Talk: "Therapeutische Beziehung in der gedolmetschten Psychotherapie" [Therapeutic Alliance in Interpreter-Mediated Psychotherapy] *(2024 – Berlin, Germany)*
3. European Public Health Conferences
   Poster presentation: Community Interpreting in Germany – Interpreters' working conditions and qualifications *(2023 – Dublin, Ireland)*
4. 1st SA Mental Health Conference 2023
   Talk: "Working in the Shadow – The Role of Security Guards in Psychiatry. A Qualitative Study with Mental Health Care Professionals and Security Guards in South Africa." *(2023 – Johannesburg, South Africa)*
5. 6th International Conference on Non-Professional Interpreting and Translation
   Talk: "Results of a national survey of community interpreters in Germany" *(2023 – Nicosia, Cyprus)*
6. Nationwide symposium "Interpreting in Health and Community Services: Perspectives, Qualification & Future Developments"
   Talk: "Presentation of a nationwide study among interpreters & the project results of the *BetweenLanguages* minimum qualification" *(2022 – Hamburg, Germany)*
7. 6th World Congress of the World Association of Cultural Psychiatry
   Talk: "Therapeutic Alliance in Interpreter-Mediated Psychotherapy with Traumatized Refugee Patients" *(2022 – Rotterdam, Netherlands)*
8. German Congress for Paediatric and Adolescent Medicine

Talk: "Intercultural Opening in Health Care – Which Interventions are Effective?" *(2021 – Berlin, Germany)*

9. Joint DGMP/DGMS Congress – Psychosocial Medicine in Times of Change
   Talk: "Working Effectively with Interpreters. Development and Evaluation of Educational Videos" *(2021 – Online)*
10. 29th European Congress of Psychiatry (EPA)
    Poster presentation: "Mental Health Mobile Apps for Patients: Psychiatrists' Concerns" *(2021 – Online)*
11. Expert Talk of the Professional Association of German Psychologists e.V.
    Topic: "Interpreter-Mediated Psychotherapy" *(2020 – Online)*
12. 34th German Cancer Congress 2020
    Talk: "Interculturality in Medicine and Health Care" *(2020 – Berlin, Germany)*
13. HAM-NET Symposium
    Participation *(2020 – Hamburg, Germany)*
14. Conference Hildesheim Health Communication
    Participation *(2020 – Hildesheim, Germany)*

13. Eidesstattliche Versicherung

Ich versichere ausdrücklich, dass ich die Arbeit selbständig und ohne fremde Hilfe, insbesondere ohne entgeltliche Hilfe von Vermittlungs- und Beratungsdiensten, verfasst, andere als die von mir angegebenen Quellen und Hilfsmittel nicht benutzt und die aus den benutzten Werken wörtlich oder inhaltlich entnommenen Stellen einzeln nach Ausgabe (Auflage und Jahr des Erscheinens), Band und Seite des benutzten Werkes kenntlich gemacht habe. Das gilt insbesondere auch für alle Informationen aus Internetquellen.

Soweit beim Verfassen der Dissertation KI-basierte Tools („Chatbots“) verwendet wurden, versichere ich ausdrücklich, den daraus generierten Anteil deutlich kenntlich gemacht zu haben. Die „Stellungnahme des Präsidiums der Deutschen Forschungsgemeinschaft (DFG) zum Einfluss generativer Modelle für die Text- und Bilderstellung auf die Wissenschaften und das Förderhandeln der DFG“ aus September 2023 wurde dabei beachtet.

Ferner versichere ich, dass ich die Dissertation bisher nicht einem Fachvertreter an einer anderen Hochschule zur Überprüfung vorgelegt oder mich anderweitig um Zulassung zur Promotion beworben habe.

Ich erkläre mich damit einverstanden, dass meine Dissertation vom Dekanat der Medizinischen Fakultät mit einer gängigen Software zur Erkennung von Plagiaten überprüft werden kann.

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