Using Interpreters in Health and Mental Health Settings

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for physicians, nurses, pharmacy professionals, social workers, and mental health counselors and therapists with non-English-proficient patients.

Accreditations & Approvals

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This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

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This course is considered self-study by the New York State Board of Mental Health Counseling.

A complete Works Cited list begins on page 27.

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

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This activity has been approved for the American Board of Anesthesiology's® (ABA) requirements for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program® (MOCA®), known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. Maintenance of Certification in Anesthesiology Program® and MOCA® are registered certification marks of the American Board of Anesthesiology®. MOCA 2.0® is a trademark of the American Board of Anesthesiology®.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 5 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 5 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

NetCE designates this continuing education activity for 5 ANCC contact hours.

This activity was planned by and for the healthcare team, and learners will receive 5 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 6 hours for Alabama nurses.

AACN Synergy CERP Category B.

NetCE designates this activity for 5 hours ACPE credit(s). ACPE Universal Activity Numbers: JA4008164-0000-22-26-H04-P and JA4008164-0000-22-26-H04-T.

Social workers completing this intermediate-to-advanced course receive 5 Clinical continuing education credits.

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Special Approvals

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective
The purpose of this course is to provide an overview of the use of interpreters for clinical communication with persons who have limited understanding of English. It is intended for physicians, social workers, nurses, counselors, and psychologists, with a focus on the unique challenges and complexities of the interpreting process. Furthermore, this course will give practitioners a glimpse inside the world of interpreters so they can appreciate the dynamics involved in interpreting and assist in building a relationship of mutual respect and collaboration and an effective working environment with interpreters.

Learning Objectives
Upon completion of this course, you should be able to:

1. Identify demographic trends that speak to the multicultural diversity in the United States.
2. Explain the legal context of using interpreters.
3. Identify the merits and limitations of the different perspectives of interpreting.
4. Assess the advantages and disadvantages of the different interpreter models used in organizations and barriers to using professional interpreters.
5. Describe the challenges in the interpreting process.
6. Discuss best practices for building a positive and collaborative relationship between interpreters and practitioners.
7. Explain ethical issues for practitioners when working with patients not proficient in English and when working with interpreters.
8. Describe ethical principles for interpreters.

Pharmacy Technician Learning Objectives
Upon completion of this course, you should be able to:

1. Describe the context of interpretation in the United States, including various perspectives and models for interpretation.
2. Outline best practices for interpretation in health and mental health settings, including ethical considerations.

INTRODUCTION

By 2065, it is projected that the population of the United States will be 441 million, and 17.5% of these citizens, or 78 million, will be immigrants. In addition, persons born to immigrant parents will number 81 million, or 18.3% of the U.S. population [2]. In 2017, there were 44.9 million immigrants in the United States, with the largest immigrant populations in California (10.6 million), Texas (5 million), New York (4.4 million), and Florida (4.5 million) [1].

Given the ever-changing demographic trends in the United States and the projected growth in the racial and ethnic minority populations, the issue of limited English language proficiency is at the forefront of many providers' minds. One of the major barriers to the effective provision of health and mental health services for ethnic minority immigrants is language [3]. Language barriers are also one of the main reasons for early termination of services by patients. The ideal solution is matching the patient with a practitioner/clinician based on ethnicity and language. Unfortunately, this is not realistic due to fiscal constraints and shortages of trained racial and ethnic minority professionals who also speak their patients' languages or dialects. Therefore, the assistance of interpreters is often necessary to mitigate language barriers when non-English-speaking or minimally English-speaking patients seek services. There are many different service models for healthcare interpretation, and there are merits and limitations to each model. There are also unique challenges when a third party is introduced in a clinical setting to interact with both the practitioner and patient. This course is designed to raise practitioner knowledge and awareness of these dynamics and provide best practice guidelines when working with interpreters. The course will also highlight the interpreter's perspective and the unique experiences and challenges faced when working with practitioners to achieve effective communication across language and cultural barriers.

DEFINING LIMITED ENGLISH PROFICIENCY

The term "limited English proficiency" refers to those whose primary language is not English and have limited ability to read, speak, write, and/or understand English. In terms of its operational definition, it refers to those who are 5 years of age and older who indicated in the U.S. Census survey that they do not speak English "at all," "not well," or "well" [3]. While it is beyond the scope of this course to fully evaluate the strengths and limitations of this definition, Ortega, Shin, and Martinez argue that the definition is deficit-oriented and does not take into account context [4]. How one self-rates English proficiency skills will often vary given the context [4].

DEMOGRAPHIC TRENDS IN THE UNITED STATES

In 2019, 13.7% of the persons living in the United States were foreign-born [1]. Approximately 24% of these persons are from Mexico, the largest origin group [1]. The next largest groups are from India and China/Hong Kong-Macau (both representing about 6% of the total immigrant population) [1]. In the United States in 2019, irrespective of where residents were born, 22% of individuals (or 67.8 million people) reported speaking a language other than English at home [1]. An estimated 85% of the foreign-born population in the United States speaks a language other than English at home [5]. Not surprisingly, English-speaking proficiency is correlated with country of birth and level of education. Of immigrants with at least some college education, 60% reported they only spoke English at home and spoke English very well [5].

As noted, English language proficiency is a barrier for many racial and ethnic minorities, particularly those who have recently immigrated to the United States. In 2016, it is estimated that more than 30% of undocumented adult immigrants self-identified as being proficient in English (meaning they predominately spoke English at home or rated themselves as speaking English very well) [6]. In 2019, 46% of the 44.6 million individuals 5 years of age and older were classified as limited English proficient [3].

The most recent data indicate that 40 million residents in the United States speak Spanish (the most common non-English language) at home, a 133.4% increase when compared with 1990 [75]. In 2017, almost half (48.2%) of all United States residents in five major cities (New York, Los Angeles, Houston, Chicago, and Phoenix) spoke a language other than English at home [77]. Between 2010 and 2018, the number of Spanish speakers in the United States increased by 4 million and the number of Chinese speakers increased by 653,000. However, a 2020 report from Pew Research Center indicated that English proficiency has increased among Latinos [130]. Among those Latinos 5 years of age and older, use of Spanish at home has also declined. Languages with the greatest percentage increase were Telugu (an Indian language) (86%), Arabic (42%), and Hindi (42%) [77]. Overall, the U.S. Census estimates that there are 350 languages other than English spoken at homes in the United States [79].

Language varies geographically as well. The states with the greatest percentage of population who speak a language other than English are [77]:

- California: 44%
- New Mexico: 33%
- Texas: 36%
- New Jersey: 32%
- New York: 31%
- Nevada: 31%
- Florida: 30%

LEGAL CONTEXT: LANGUAGE ACCESS

Title VI of the Civil Rights Act of 1964 states [7]:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

As is clear, discrimination is prohibited based on national origin, and the Act was created in part to ensure that federal funds were not used to support and perpetuate discriminatory activities in government-funded programs [8]. This section has been interpreted to include individuals who cannot be denied federally funded medical, social, educational, mental health, or legal services based on their limited English proficiency [9]. In this situation, discrimination based on language is considered the same as discrimination based on national origin [8].

In 2000, President Clinton issued Executive Order 13166, which focused on the issue of limited English proficiency. Executive Order 13166, titled *Improving Access to Services for Persons with Limited English Proficiency*, stated that nonprofit organizations and healthcare systems supported by federal funds had to identify how they would comply to Title VI in a practical manner and provide equal access to services to all those who are limited in English proficiency [8; 10; 78; 131].

In 2003, this Executive Order was upheld by the Bush administration, but the policy was revised in four areas [8]. The first involves the number of language services offered, which is based on the number of limited-English-proficiency patients served. The second area deals with the frequency of contact with a specific language group. An organization, for example, that has more contact with a patient group speaking a particular language must have more interpreting and language services. The third area deals with the nature of and importance of the service provided. In other words, the more important a service offered, the more language services are needed by that organization. The last area touches on cost and resources of the organization. An organization receiving less federal funds and with a smaller budget is not expected to provide the same level of language services as an organization with a larger budget [8]. As of 2013, organizations that are federally funded must have a clear written policy on language accessibility [11].

All states as well as the District of Columbia have laws pertaining to language access, with California having the most provisions [98]. Many states have adopted a threshold language policy that "specifies a number or proportion of speakers of a language that, when exceeded, triggers a variety of programmatic steps—often echoing the Office of Civil Rights guidelines—that must be taken to accommodate the group's language-related needs and thereby provide linguistic access to public services, including mental health services" [12]. The threshold varies, but in many cases, language services must be provided if 5% or more of the agency's patient population is non-English-speaking [12]. In California, the Dymally-Alatorre Bilingual Services Act requires that the state provide for effective communication between all levels of government and all people in the state and that the state's programs and services be accessible to limited-English-proficient persons [13]. If interpreters are used, Title VI also indicates that interpreters must be proficient in English and the target language, be trained on ethical issues of interpreting, and be trained to use terms specific to the field (e.g., medicine, health, mental health) [11].

The Affordable Care Act continues to address health disparities experienced by those with limited English proficiency. The Act requires that healthcare information be delivered in simple, comprehensible, and accessible language and in a timely manner. Language services are to be provided at no cost to those with limited English proficiency [80]. However, a 2020 rule from the U.S. Department of Health and Human Services modifying Section 1557 of the Affordable Care Act lessens the requirement. In accordance, federally funded organizations are not mandated to provide taglines or short statements in non-English that inform individuals their rights to free language assistance services [132].

New Jersey, California, and Washington also have specific requirements for continuing education on English proficiency and cultural/linguistic competence for physicians and/or healthcare professionals [8]. Other states have laws about providing language assistance services in certain contexts. In Massachusetts, for example, emergency rooms must offer professional interpreting services. In Illinois, mental health facilities must offer interpreters for those patients who are not proficient in English at intake [8].

It is believed, based on the social psychological principle that people who are similar are attracted to each other, that patients and practitioners who are matched by language, race, and/or ethnicity will have a stronger therapeutic alliance, less miscommunication, and fewer biases, which would then yield improved clinical outcomes, such as patient satisfaction, reduced premature termination, and greater utilization of services [14; 15]. In one study, researchers found that Hispanic adults with limited English proficiency had fewer inpatient hospital stays, were less likely to visit emergency rooms, and were less likely to be prescribed medications compared with their English-proficient Hispanic counterparts [133].

However, research findings on the subject are mixed. There is some evidence that African American patients prefer practitioners who are also African American due to cultural mistrust of the general health and mental health system. But other studies show that Asian American patients, for example, prefer a practitioner who is not Asian, possibly due to internalized racism [14]. In a meta-analysis conducted by Shin et al., the researchers found no effects on racial/ethnic matching for African American and white patients. It has been speculated that racial/ethnic matching may be more important for patients for whom English is a second language [15].

Most health, mental health, and social service agencies attempt to employ practitioners who are bilingual in order to match the practitioner with non-English-speaking patients and minimize language barriers. This matching is extremely important, as the verbal communication process is vital to patient retention and satisfaction. In mental health settings, the diagnostic and assessment process involves the patient being able to convey his/her problems and symptoms to the practitioner and the practitioner being able to obtain as much information as possible to ascertain an accurate diagnosis or disposition. Research indicates that those with limited English proficiency are less likely to receive mental health services compared to their counterparts who were able to speak English, even after controlling for patients' race/ethnicity, insurance status, length of time in the United States, and place of birth [16; 129]. However, in terms of linguistic matching, one cannot merely assume that if patients and practitioners are racially/ethnically matched, there will be no language barriers. One study found that services with increased language access did not necessarily increase the rates of medication follow-up among Hispanic patients with limited English proficiency who were diagnosed with major depression, bipolar disorder, or schizophrenia [81]. Unfortunately, cultural and dialectic differences may still be present.

AN OVERVIEW OF INTERPRETATION

INTERPRETING AND TRANSLATING: SIMILARITIES AND DIFFERENCES

In many cases, the terms "interpreting" and "translating" are used interchangeably, but interpreting is specifically associated with oral communication while translating refers to written text. Interpreting involves analytical hearing and decoding of the original message into the targeted language. It involves much mental energy to hear, decode, and remember while taking and reading notes and then conveying the information [134]. As such, interpreting and translating require different skill sets. Translators must understand the source and target language, understand the culture, and have a good repertoire of vocabulary of the target language in order to convey the written information clearly, without losing any of the meaning [17]. They should also be proficient in using different reference materials [18]. On the other hand, interpreters must work on the spot,

listening to both parties and communicating from the language of one party to the language of another party very quickly [17]. They should be well versed in idioms and colloquialisms. When interpreting in specific settings, like health or mental health, they must be familiar with the technical language as well.

TYPES OF INTERPRETATION

There are several methods or strategies for interpretation. This section will outline a few of the most commonly used approaches, although others may also be used.

Word-for-Word Interpretation

In word-for-word interpretation, the interpreter provides a verbatim rendering of the communication into the target language. Word-for-word interpreting can be beneficial when one party is giving factual and technical information to the other party [19]. However, this mode of interpreting can be difficult because words in one language frequently cannot be easily translated into another language without losing subtle cultural nuances [19].

Summary Interpretation

Unlike word-for-word interpreting, summary interpretation involves the interpreter taking the information in parts and summarizing it, often not using the same words as the original speaker. This is a more time-efficient form of interpreting, but it involves a high degree of trust between the practitioner and interpreter [19]. In general, the National Council on Interpreting in Healthcare does not recommend the use of summary interpreting in healthcare settings because health information requires details and specificity [131].

Simultaneous Interpretation

When using simultaneous interpretation, the interpreter communicates the targeted language while the speaker has moved on to the next sentence, which requires the interpreter to simultaneously listen to the next sentence while interpreting the last sentence [20]. Simultaneous interpreting is almost like a voiceover, with nearly verbatim interpreting done immediately after the speaker has completed his/her thoughts. This is a complex process because the interpreter must simultaneously actively listen, process, and then interpret into the targeted language with minimal delay [82]. Some argue that this form of interpreting can be distracting [78]. In addition, simultaneous interpreting can be more stressful for interpreters, which can lead to more errors [21]. However, simultaneous interpreting can be useful in a situation in which not all parties require interpretation. In group work, the interpreter can softly interpret the speaker for one individual in the group without disrupting the process [22]. It is also beneficial in time-sensitive situations.

Consecutive Interpretation

Consecutive interpretation, also known as turn-taking interpretation, consists of the interpreter conveying the information in the target language after the speaker stops at the end the sentence or thought. When the interpreter has completed communicating the information, the speaker moves on to his/her next thought, then stops again for the interpreter to continue [20]. This type of interpreting is most effective when there are natural pauses in a conversation, such as when a medical provider is asking a series of questions to a patient [22]. From an interpreter's perspective, consecutive interpreting can remove some of the stress of progressing through information or questions without offering support and empathy [78]. However, it is not clear whether consecutive or simultaneous interpreting is more accurate. In one small scale study with nine interpreters, the two interpreting methods were compared [135]. Researchers found that consecutive interpreted versions were 15% more likely to have omitted information compared with the simultaneously interpreted renditions.

Culture-Relevant Interpretation

The interpreter who employs the culture-relevant interpretation method must be very knowledgeable about the patient's cultural beliefs. The interpreter using this approach communicates in a manner that takes into account the underlying cultural meaning of statements and the sociocultural and political context of the patient [19].

Culture-Expert Interpretation

In the culture-expert mode of interpreting, the interpreter does more than just culture-relevant interpreting; he or she acts as a cultural broker for either the practitioner and/or the patient. The interpreter provides information to the practitioner as a consultant, or the interpreter acts as a cultural broker for the patient in terms of both Western culture and the culture of the discipline (e.g., medicine, mental health, psychiatry) [19].

INTERPRETATION SETTINGS

Interpretation can also be categorized by setting and proximity of the involved parties. If interpretation is done with all persons in the same room or setting, this is called proximate interpreting [23]. However, if it is not conducted in the same setting and/or the interpreter is linked in through some sort of telecommunication system, this is referred to as remote interpreting.

It is not clear if one interpretation setting is more effective than another, and research in this area is ongoing. In an experiment involving medical scripts to evaluate if one configuration of interpreting was more accurate than another, interpreters were randomly assigned to one of the four types of interpreting conditions: remote simultaneous medical interpreting (RSMI), remote consecutive medical interpreting (RCMI), proximate consecutive medical interpreting (PCMI), and proximate ad hoc interpreting [23]. The study found that RSMI was more accurate and was the quickest compared to the other three modes of interpreting. Although it was expected that simultaneous interpretation would be faster, the accuracy of RSMI was unexpected [23]. The researchers speculated that it may be because interpreters had less time to edit or advocate on behalf of the patient.

In an experimental study to evaluate whether patients are more satisfied with an RSMI model versus a hospital's "usual and customary" interpreting method, 735 Hispanic (Spanish-speaking) and Chinese (Cantonese- and Mandarin-speaking) patients presenting to an urgent care hospital were randomly assigned to one of the two interpretation groups [24]. In this study, the RSMI involved a commercial language service whereby the interpreter was off-site. The usual and customary method consisted of remote consecutive interpreting, proximate consecutive interpreting, or ad hoc interpreters (e.g., a family member, volunteers, untrained staff). Overall, the findings indicated that patients in the RSMI group were more satisfied than patients in the other group. The greater levels of satisfaction stemmed from the patients' perception that they were treated with more respect by the physician and that their privacy was better protected. However, in both groups, the patients reported low satisfaction regarding being understood by the physician, comprehending the physicians' explanations of results or procedures, and instructions for a follow-up care plan [24].

Another study assessed the use of dual-handset phones at the bedside that allowed patients to call for interpreting services. Research indicated that the readmission rate decreased among those with direct access to interpretation compared with no direct access [99].

PERSPECTIVES OF INTERPRETING

The role of the interpreter can be conceptualized along a continuum, with "neutral" at one end and "active" at the other end [25]. On the neutral end of the continuum are interpreters who essentially act as conduits; at the other end are interpreters who are active cultural brokers and participants in the healthcare process.

THE "INTERPRETER AS A CONDUIT" PERSPECTIVE

As noted, interpreters acting as conduits of information fall on the "neutral" end of the continuum. In this perspective, interpreters are detached and neutral individuals who communicate information back and forth. This perspective views interpreters as tools to relay information and as the de facto voices of the clients [26; 27; 136]. Interpreters adhering to

this model attempt to channel words verbatim while remaining outside the interaction [100]. Interpreters acting in this capacity may indicate they feel they are treated just as voices, representing both the professional and the patient. In other words, they may feel they must be invisible in order to reinforce the privacy of the provider-patient relationship [28]. Westermeyer has called this perspective the "black box model," and it has been the predominant traditional perspective held by practitioners and even interpreter training programs [21; 26]. It is implicit in the assumptions of this model that interpreters should/can all be the same, with no individuality, and that the interpretation process and experience is universal [29].

The "interpreter as conduit" perspective has been widely criticized. It is impossible for interpreters to act like computers or robots, completely detached from human dynamics. In a qualitative study of 39 providers regarding the role of emotional support among interpreters, this perspective was dismissed as being unfeasible [30]. In a qualitative study conducted to understand the perspectives of interpreters and clinicians, interpreters reported tension between the ethical responsibility for speaking out and advocating for clients and being silent because clinicians and providers expect a "conduit" model. Clinicians indicated that they wanted an interpreter who can act as a cultural broker, but they were simultaneously concerned with power shifts [83].

This method also discounts the emotionality and physicality of communication. The simple presence of an interpreter, whether it is in person, on the phone, or via a video, can be comforting, as the bond of a common language can be an emotional support. When interpretation is done in person, body language, eye contact, and/or touch can offer patients reassurance and context [30].

THE "INTERPRETER AS AN ACTIVE AGENT" PERSPECTIVE

In the more active approach to interpretation, the interpreter is a participator or co-diagnostician, negotiating between two cultures and assisting in promoting culturally competent communication and practice [25; 28]. It involves continual negotiation of the meaning of the information conveyed by the parties. Furthermore, the construction and communication of meaning are influenced by social, institutional, and interpersonal factors [136]. This type of interpretation has been referred to as an "embedded interpreter" or the "triangle model." In a qualitative study with 27 healthcare interpreters conducted to obtain an inside perspective about interpreting work, participants summarized their work as "a complex mental and social activity that went beyond linguistic transformation and included deciphering body language, establishing trust with multiple stakeholders, and brokering cultural concepts and frameworks" [31]. In another qualitative study with interpreters working in a mental health setting with migrants, interpreters discussed the difficulty being neutral and invisible. They reported being expected to discern hidden meanings, serve as a cultural broker, and express opinions about treatment [84]. As co-diagnosticians, interpreters determine which medical information is valuable, seek illness-related information outside of the provider's questions, and participate in the diagnostic process by identifying symptoms the provider may not have directly asked about [28].

Some interpreters report having altered the tone or framing of a statement to clarify intent or to advocate for the patient. Most who reported this behavior realized they were blurring the established role boundaries [101]. However, some interpreters felt that it was necessary in order to improve the relationship and communication between the patient and provider [100]. In this more active role, the interpreter's behavior is also influenced by a host of cultural variables, such as gender, class, religion, educational differences, and power/authority perceptions of the patient [25]. Interpreters in this model can help

practitioners determine whether certain concepts are equivalent between languages and offer insight about the client's cultural background to inform and guide the implementation of culturally sensitive assessment and interventions [78; 85]. These interpreters perceive themselves as cultural brokers [131]. Beyond the mere conduit role, some interpreters also view themselves as clarifiers, particularly when they independently sense that further explanation of the information is necessary. Other interpreters see themselves as advocates and mediators who may intervene on the patient's behalf to ensure they can access services [137]. Some will also serve to monitor and shape the affective climate and tone of the therapeutic environment [137]. Consequently, an intricate, triangular relationship develops between all three parties.

ORGANIZATIONAL MODELS OF INTERPRETER USE

As noted, organizations access and use interpreters in a variety of ways [32]. Though the approach is often determined by practical factors (particularly availability of resources), the impact on the patient and his/her care should be the driving force.

APPROXIMATE (OR AD HOC) INTERPRETING MODEL

Interpreters in the approximate or ad-hoc model often are family members, although they may be any available person (e.g., friends, bilingual staff who were not hired to be interpreters) [102]. The ease of accessibility, the low (or no) cost, and the patient's familiarity and comfort with the interpreter are advantages of using this model [33]. In some cases, patients prefer to have a family member or friend serve the role of interpreter because they are viewed as more trustworthy and helpful [103]. In terms of logistics, family interpreters can provide additional insights to the patient's illness and medications, particularly if they are involved in caregiving for the patient [86; 103]. Family interpreters can be particularly beneficial if family interventions (e.g., multisystemic therapy) are being used [87]. However, some may not want to disclose sensitive information to an "outsider" due to cultural norms about privacy [34]. Because family members have intimate knowledge of the dynamics of the family structure, having a family member serve as an interpreter can help the practitioner establish a good rapport and clinical relationship with the patient and the entire family [34]. They can also obtain services for the patient by exaggerating symptoms, ultimately becoming advocates [86]. In addition, if the patient is unable to remember an important point, a family member may be able to assist [35]. This is particularly advantageous in cultures that emphasize collectivism.

However, employing a patient's family member as an interpreter also has its disadvantages and unique challenges regarding boundaries and role confusion. Family members may feel embarrassed or uncomfortable in having to convey potentially intimate and private information [36]. Consequently, they may unconsciously or consciously screen out or summarize information, to the point that they alter the original content or intent [34; 36; 86; 104]. For example, the family member may exaggerate symptoms in order to advocate obtaining a particular procedure or intervention [105]. In a study with 28 caregiving relatives, participants reported selectively interpreting information for the patient based on a personal assessment of the patient's emotional status [88]. This method of interpretation does not promote the patient's confidentiality and privacy, and the interpreter is not bound to uphold confidentiality [35; 37]. Family members may decide to limit information provided to the patient due to family loyalties and/or power dynamics [38]. Because family members are so close to the patient's situation, they may include their own views and opinions in the interpretation [39]. If the family member acting as interpreter has his/her own agenda, there may be three competing agendas in the clinical process—the practitioner's, the patient's, and the family member interpreter's—which can be time-consuming and render the communication process more complex [34; 105]. Family members or friends are also limited in their knowledge of medical, psychiatric, or other clinical terms compared to professional interpreters.

In a qualitative study of the complexities of culture and interpreting with Russian patients, a focus group discussed the challenges of using family members as interpreters in situations in which bad news must be delivered [40]. One participant stated:

> You cannot ask a family member to bear the burden...In a situation like this, it is very difficult to deliver this kind of news and not have it be either a terrible emotional burden or incredibly edited by the family member to take out the hard parts, to save the person from suffering at that moment.

In a 2020 study, the perspective of 69 healthcare providers from neonatal and pediatric departments in an Australian hospital were asked how and when they decide to use family members for interpreting [138]. Generally, these healthcare providers felt that using family interpreters was appropriate when interpretation of basic and non-medical information was necessary. They also felt that in emergency and time-sensitive situations in which a professional interpreter was not immediately available, family members were a viable option. Finally, they did take into consideration the family member's age, level of English proficiency, and the nature of the relationship to the patient [138].

Using a child to help interpret is strongly discouraged [104]. When a child serves as an interpreter, the boundaries of the parent-child roles are crossed, and the child carries the unnecessary burden of learning information that may not be beneficial to him/her [36; 139]. Practitioners may also feel more inhibited to raise certain issues when a child is interpreting. Consider, for example, issues of domestic violence, sexuality, abuse, mortality, and other sensitive matters for which employing a child interpreter would be uncomfortable and inappropriate [33; 89; 139].

Although many discourage the use of children as interpreters, the reality is that practitioners often resort to using children to help with interpreting, particularly in emergency situations, and it may be too simplistic to label this practice wrong or right [139]. In some cases, parents may prefer children to interpret, and to stop them from doing so could be more harmful. A 2017 study found that children and parents often work together as a team in medical interpreting situations [140].

Using the approximate (ad hoc) interpreting model, staff persons (e.g., receptionist, in-take worker) may also step in as interpreters. The advantage to this approach is that the interpreters are familiar with the agency and setting [90]. However, one of the problems with using staff who happen to be able to speak the patient's language is that it interrupts the workflow [41; 90]. Consistently eliciting interpreting assistance from staff persons who are not hired to do so can cause additional stress (because they are not professionally trained) and can trigger anger and resentment over time, affecting staff morale [41; 42; 43]. In a case study of a community health center that was training and utilizing staff members to do interpreting, these ad-hoc interpreters reported high levels of work pressure [44]. One of the main reasons was because interpreting was not their sole job responsibility; they were also doing their other tasks.

Overall, this model is the most convenient, particularly for agencies that are fiscally constrained. The approximate or ad-hoc model of interpreting has many limitations, however, such as the higher levels of communication errors and higher levels of dissatisfaction among patients [44]. Family members and untrained staff members are viewed as being conduits of information under this model, and it does not take into account that communication involves a host of nuanced verbal and nonverbal cues.

THE TELE-ACTIVE OR VIDEO REMOTE MODEL

Another method of providing interpreting services involves using the tele-active model or video remote model. For video remote interpreting, all parties are on a video conferencing platform, allowing for visual as well as verbal communication [102]. A smartphone or laptop with camera, microphone, and Internet service is required [106]. Similar to telephone interpreting, video remote interpreting typically involves a shared network of interpreters who are dispersed geographically but who can interpret within minutes using a video monitor [107].

It offers the benefit of real-time interpretation and potentially good quality video images and audio. Of course, as with any technology, there can be technologic challenges. Video remote interpreting can be somewhat less expensive than in-person interpreting. For example, remote video interpreting can cost $1.95–$3.49 per minute and in-person interpreting can cost $45–$150 per hour [106].

The tele-active model consists of a telephone program from which the patient can select from a menu of different languages/dialect. This service might be offered in house or through a commercial organization [43]. There are also national organizations that provide interpreting services via telephone to providers at any geographic location.

With the tele-active model, there is no human interaction, and it is often used after hours, when an interpreter is not available on-site. Systems are installed to allow healthcare professionals to use one handset and patients to use another. An interpreter is then called and provides interpretation in real-time [45]. Or, software may be programmed to ask initial questions in the patient's language and then connect the provider and patient to a live interpreter [46]. Within the healthcare context, administrative and routine follow-ups are more amenable to this type of interpreting [102].

Interpreting services offered through phones are particularly beneficial in crisis or emergency situation [43]. These types of interpreting services can also offer a wider range of language options, as it is not often feasible for agencies to employ multiple interpreters who can speak a host of languages. Other data have indicated that the quality of communication in interpreting by a trained interpreter through the tele-active model is comparable to an in-person interpreter [91]. Studies indicate that although clinicians tend to prefer on-site interpreters, patients may prefer phone interpreters, feeling that this method is more confidential [85; 141].

Some argue that the interpreter in the tele-active model has more difficulty establishing rapport with the patient and cannot evaluate nonverbal communication cues [90; 141]. The downsides to the tele-active model are that it is expensive and the agency has to ensure that the most up-to-date equipment is used [43].

In a systematic review comparing in-person, telephone, and video interpreting, patient satisfaction was comparable among the three models [108]. However, in general, there are more interpreting inaccuracies, omissions, additions and clarity in remote interpreting done via telephone or video compared with in-person interpreting [109].

THE BILINGUAL WORKER MODEL

The bilingual worker model relies on a staff person who is specifically hired to work with a practitioner or who sees patients under close supervision. This model is different from the ad-hoc model in that the agency has specifically hired the staff member to act as an interpreter. In many ways, this is the ideal model, assuming the bilingual worker is professionally trained to be an interpreter. It is beneficial to have staff members specifically allocated in terms of resources and time spent on interpreting and working with practitioners [43]. The problem is that this model is often not realistically attainable, as patient populations are typically diverse, with more than one target language.

It is important to keep in mind that, even using the bilingual worker model, the designated interpreter may or may not be professionally trained; often, they are not. An agency may hire a bilingual staff person to help with interpreting but not require that the individual have any formal training. In such cases, the staff member may be more suited to interpret using the conduit model [21]. One study found that non-professionally trained bilingual workers usually ultimately serve as cultural advocates [25]. This can be risky when the interpreter is not qualified and may not feel comfortable with this level of involvement. In an online survey of 55 bilingual graduate

social work students, more than half (54%) of the participants stated that they were asked to help interpret for other staff members at least once a week [47]. More than 80% of the students felt that working with patients with limited English proficiency was much more complex than working with English-speaking patients. It was assumed by staff in the agencies that the students could easily translate their language competencies into the clinical setting without formal training [47].

THE VOLUNTEER INTERPRETER POOL MODEL

The volunteer interpreter pool model relies on a group of individuals who can provide interpreting services when needed. As with many other models, the volunteers are not professionally trained. Many of the limitations identified in the section regarding bilingual worker interpreters are also applicable in the model. Essentially, the lack of formal training can both hinder the process and be a liability.

THE PROFESSIONALLY TRAINED STAFF INTERPRETER MODEL

In this model, a paid, formally trained staff person is employed to provide interpreting services. Studies have shown that professionally trained interpreters ultimately reduce the risk of miscommunication and decrease the likelihood of misdiagnosis [48]. It is important to remember that untrained bilingual staff do not have all of the tools and skills as a professional trained interpreter [102].

The training that professional interpreters attend includes aspects of ethics, impartiality, accuracy, and completeness [49]. These individuals are well-versed in interpreting both the overt and latent content of information without changing any meanings and without interjecting biases and opinions. Professionally trained interpreters are familiar with the different types of interpretation (i.e., word-for-word interpreting, concurrent interpreting, summary interpreting, consecutive interpreting, culture-relevant interpreting, and culture-expert interpreting), and they are cognizant of each's merits and limitations [19]. Differences between the denotation and connotation of words can be ascertained [19]. Interpretation of a message's denoted meaning requires the interpreter to have an excellent grasp of the two languages involved, while interpretation of the connotation, or underlying emotional meaning of a message, requires biculturality, or an understanding of the patient's culture and the culture of the helping professional [19]. These interpreters can construct a "third culture" involving the interaction of the practitioner and the patient [34]. Unfortunately, the main barrier in providers hiring professional interpreters is limited financial resources [90].

Generally, professionally trained interpreters make fewer errors than non-trained interpreters. One study found that the proportion of errors was lowest for trained interpreters (12%) compared with no interpreter (20%) or ad-hoc interpreters (22%) [110]. Professional interpreters with more than 100 hours of training made the fewest errors, regardless of the amount of experience. A study analyzing 11 peer-reviewed articles examined the cost-effectiveness of using professional interpreters [142]. The researchers concluded that with minimal additional costs for a professionally trained interpreter, medical care and treatment outcomes were improved.

Not surprisingly, employing untrained interpreters is the most common model used. In a study involving 348 physicians, researchers found that 75% of the physicians who worked with limited-English-proficient patients had used untrained interpreters within the last 12 months [50]. Slightly more than 20% had used a remote interpreter service via the telephone, and 42% had employed professionally trained interpreters. Of the non-professionally trained interpreters used, 86% were family members or friends [50]. The findings of this study, indicating that practitioners are overusing ad hoc interpreters, have been supported by other research. Overall, the choice of whether to employ professionally trained or ad hoc interpreters is affected by three predominant factors: availability of bilingual staff, views of the quality of interpreting, and financial cost [76].

BARRIERS TO USING PROFESSIONAL INTERPRETERS

Healthcare professionals' perceptions regarding the value and necessity of professional interpretation affect its utilization. In a qualitative study with 20 resident physicians in two urban hospitals with good interpreter services, researchers explored the physicians' decision-making process when determining whether to use interpreter services [51]. They found that the resident physicians knew they were not optimally using the interpreter services, but they felt that they could "get by" using hand gestures, limited second language skills, and information already communicated in the histories by other healthcare providers. The physicians tended to make interpretation decisions primarily considering the amount of time and effort necessary to obtain an interpreter and the overall perceived value. Most often, they did not feel it was a worthwhile time investment. The study participants reported feeling it was easier to use a family member or their own second language skills (even if limited), as this required minimal time and effort. Despite understanding that patients with limited English proficiency receive less adequate care compared to those who speak English well, underutilizing professional interpreters was considered the norm.

The theme of "getting by" without interpreter assistance also surfaced in a qualitative study with nurses. Although the nurses in the study expressed frustration with using family members as interpreters, they were not proactive in obtaining professional interpreters. They tended to "make do" with the easiest available option (an ad-hoc interpreter) in order to avoid additional costs and increased workload [52]. Macro or structural barriers were noted, but individual-related factors also impeded practitioners from using interpreters.

It has become evident that practitioners are underutilizing professionally trained interpreters despite clear benefits to patients and the quality of care. Identifying and addressing barriers to the use of professional interpreters are the first steps in improving care for non-English-proficient patients. Some such barriers include lack of resources, diversity of the patient population, and ambivalence.

LACK OF RESOURCES AND TIME

Many agencies' and organizations' budgets do not allow for either professionally trained interpreters on staff or easy access to remote professional interpreter services. In a 2010 survey of physicians, participants cited cost as a leading barrier in the use of interpretation services [50; 143]. In a 2021 systematic review, cost was one of the major barriers identified [144]. Because of the weak enforcement of the language-access mandate, financial concerns took precedence in the decision-making process. Demographics and practice type may also be factors, as 62% of the physicians had small or solo practices. Time constraints have also been noted as a significant barrier to the use of professional interpreters, with the act referred to as a "luxury" or "interruption" [90]. In a survey study, more than 30% of participants indicated that they resorted to using an ad-hoc interpreter due to the wait time for trained interpreters [111]. Similarly, providers cited the urgency of a situation and/or a busy workload as motivators for ad-hoc interpreter use [112].

DIVERSITY AND COMPLEXITY OF LANGUAGES

Within an ethnic group, there are often multiple dialects and regional differences in language and terminology [48]. This would require a diverse bank of interpreters, which can exacerbate the issues of cost and availability of interpreters. Consequently, providers resort to ad-hoc interpreters such as family members and available staff [143].

UNCERTAINTY AND AMBIVALENCE OF PRACTITIONERS

In general, practitioners are not accustomed to having a third party involved in patient care. Consequently, they may perceive they are being scrutinized or that their relationship with the patient is being threatened. Many are concerned about information being filtered in and/or out without their knowledge and about interpreters' competency in conveying complex medical ideas or terms [48; 145]. Undoubtedly, having a third person in the clinical environment affects the dynamics, which can impact trust and rapport building. This can make it more difficult for the practitioner to engage with the patient. These points can combine to result in a devaluation of the interpreter's contributions to the clinical encounter.

UNDERESTIMATING THE PATIENTS' DESIRE FOR AN INTERPRETER

In a study of Spanish-speaking mothers seeking pediatric services, participants were assigned either to a "control" group for routine care (with ad hoc interpreting services or no interpreting) or to the intervention group for routine care and telephonic interpreting services via headsets [53]. Nearly 95% of the women in the intervention group found the telephonic interpreting services very helpful and felt that the medical encounter would be much more difficult without it. They stated they understood all the information that the physician communicated, and 96% wanted the telephone interpreting services for subsequent visits. Interestingly, only 33% of physicians in the study believed their patients would opt to use telephonic interpreting services in the future. In a 2017 study, a number of healthcare providers acknowledged that they underutilized interpreters and used heuristics to evaluate if an interpreter is really needed [113].

OVERVIEW OF CHALLENGES AND UNIQUE DYNAMICS INVOLVED IN USING INTERPRETERS

CONFUSION OF ROLES AND BOUNDARIES

Confusion stemming from blurred role boundaries on the part of the practitioner and/or interpreter can affect the clinical encounter. Interpreters may experience tension between being advocates for the patient and working on behalf of their employer [19]. The interpreter is often viewed by the patient as a listener, interpreter, gatekeeper, interviewer, and advocate for change, which can cause stress and confusion for all involved parties [25].

As discussed, if an interpreter is viewed as a conduit, then the practitioner will expect that he or she will only interpret the spoken word. If this is the case, the interpreter will most likely be expected to avoid acting as an advocate or cultural broker [37]. Many interpreters report feeling as though they should be invisible; all of their experience and intelligence are expected to be omitted from their work [146]. However, because a new set of dynamics is introduced when a third party is involved in the clinical process, it is not always feasible for the interpreter to remain completely neutral. Interpreters can form powerful therapeutic connections with patients, particularly if they are from the same racial/ethnic background or the same community [19; 54]. This can then lead to role exchange, whereby the interpreter becomes the counselor in the eyes of the patient and the practitioner is relegated to the role of an outsider. Because the practitioner is not familiar with the patient's language and culture, it is also possible for the practitioner to become overly dependent on the interpreter [19]. The interpreter also has to negotiate professional and ethical boundaries. If interpreters are from the patient's community, the ethical mandates of confidentiality and privacy can be compromised. Interpreters may be confused by organizational policies and may not always feel sup-

ported as they encounter blurred boundaries [147]. In one study, practitioners described being wary of interpreters providing emotional support to patients because it can cloud roles. Often, as one relationship (e.g., patient and interpreter) grows, the other relationship (e.g., patient and practitioner) becomes weaker. So, while practitioners acknowledge that the emotional support offered by interpreters can be beneficial to patients, they are simultaneously concerned about the rapport between the practitioner and patient being threatened [30]. This is further exacerbated if the practitioner and interpreter do not discuss role exchange and confusion prior to meeting with the patient [54].

This theme of power was reinforced in a 2015 study with interpreters and clinicians who worked in a multicultural setting [83]. When an interpreter and clinician had no prior working relationship and rapport, the power struggle was more obvious. In these cases, interpreters experienced the clinician's authority and their control for this authority in the session, and clinicians tended to feel threatened when interpreters took the initiative in expanding their role and tasks. Interpreters often report feeling that practitioners do not understand their work and its emotional toll [148]. If they feel caught between the patient and the practitioner, tension results [146]. This is particularly the case when the practitioner is a novice, as they may have limited experience working with interpreters [146].

The opposite can also transpire, with the patient rejecting the interpreter due to fears regarding privacy and confidentiality, particularly if the interpreter is known or is from the same community. The patient and interpreter may also be from different ethnic groups, in which case historical and political differences may result in tension [19].

The issue of accountability is a factor in role confusion. Before beginning work, it is important to resolve questions such as: Who does the interpreter work for? Who does the patient believe the interpreter works for? What is the practitioner's position on the role of the interpreter in the clinical encounter? If interpreters do not assume that they work for the agency, then they may step out of the bounds of what the agency can offer in terms of services. The patient or the provider may also assume that the interpreter will perform additional tasks that are not within their professional purview [37]. For example, if the provider requests the interpreter obtain informed consent, this could compromise patient safety, ethical validity, and professional roles [101]. These roles should be clarified before problems arise.

Cultural values and norms can also result in role confusion. Norms about gender roles, for example, are extremely powerful in some cultures [48]. If an elderly Korean male patient is not very acculturated, he may be uncomfortable and embarrassed disclosing information to a young Korean female interpreter, because in many Asian cultures, social hierarchy and etiquette are based on age and gender. Cultural taboos may also impede an interpreter from adequately optimally performing their job because a particular topic may be viewed as unacceptable or inappropriate [114]. Cultural values regarding disclosing bad news can impact roles as well. A practitioner who adheres to the Western biomedical model and the associated tenets of individualism and autonomy will feel ethically obligated to disclose bad news or a poor prognosis, but the interpreter may know that it is not culturally sensitive to do so. How and where does the interpreter draw the boundaries [55]? Again, these questions should be discussed before interacting with the patient.

INTERPRETER COMPETENCIES AND SKILLS

There are few nationally certified programs for interpreters in the medical and mental health fields, and not all states certify or license language interpreters [9]. In part, the lack of professionally trained and qualified interpreters stems from this lack of standardized, locally and federally recognized training and certification interpreting programs, particularly in the area of mental health [56; 144].

However, even if not certified, there are basic competencies that all interpreters should possess. Professionally trained interpreters should be skilled and competent in six main areas: the field in which they are interpreting, communication and interpersonal skills, content interpretation, interviewing, cultural background(s), and the expectations of the employing organization. Interpreters who limit their practice to a specific content area should have knowledge of specific technical terms and how to facilitate the flow of communication [115].

Issues Related to Health and Mental Health

Healthcare interpreters should be familiar with health issues and health terminology, including any technical information that might arise [25; 115]. If working in mental health, interpreters should be proficient with terminology associated with mental health and psychiatric issues, such as depression, suicide, and mental illness, as well as interventions that counselors might use [9]. However, it is not merely finding the literal words and communicating the terminology. In some cases, literal terminology is difficult to interpret and communicated in a manner that can be meaningfully understood by the patient [149]. Interpreting in health and mental health also entails processing affective and nonverbal cues [150]. Ultimately, collaboration between interpreters and practitioners is required to accurately communicate the meanings of complex terms and ideas. Finally, all interpreters should have a clear understanding of ethical issues and ethical standards when it comes to interpreting within their chosen field [25].

Interpretation Methods

Interpreters should have a firm grasp of the different interpreting methods and their merits and limitations. Good interpreters are able to interpret accurately while facilitating and monitoring conversations [25].

Communication and Interpersonal Skills

Interpretation requires good, active listening skills and message conversion skills. Conveying respect and professionalism to all parties involved is also vital [22]. In a study with eight therapists regarding their experiences with interpreters, the clinicians stated that while accurate interpreting is vital, interpreters' personality attributes (e.g., the ability to be empathic, develop good interpersonal relationships, be psychological minded, collaborate, be open to learning, problem solve, be attentive to nuances) were also important [9; 56].

Interviewing Skills

Interpreters should have proficient interviewing skills. This includes knowing when to use closed- versus open-ended questions and being able to facilitate, clarify, confront, observe, and probe in a sensitive manner [21].

Cultural Background(s)

Cultural competence and cultural awareness are also crucial competencies for interpreters [22; 25]. Interpreters should be able to navigate between the belief and value systems of American language and culture and the patient's native language and culture [9]. In a study with Arabic-speaking refugees, participants expressed concern using professional interpreters who were nationally or culturally different. Political and cultural conflicts resulted in participants being unsure if they could trust interpreters with different backgrounds [92].

Organization/Agency Context

Interpreters should be familiar with the mission and philosophy of the organization/agency in which they are operating. It is important to keep in mind that interpreting work does not exist in a vacuum but operates within an agency context.

ISSUES OF TRUST

The issue of trust is at the heart of therapeutic process. There are several layers of trust when a third party is introduced in the clinical encounter—trust between the practitioner and the patient, trust between the interpreter and the patient, and trust between the practitioner and the interpreter. Few studies have examined how the presence of an interpreter affects the therapeutic alliance. In a 2016 study with 458 Spanish-speaking patients in Arkansas, there did not appear to be any differences in participants' self-reported therapeutic alliance whether there was a trained interpreter or a bilingual clinician in the session [93]. However, interviews revealed that patients preferred a bilingual clinician, feeling it was more efficient and confidential [93].

Patients are often asked to share their stories as part of any health or mental health care. If their trust has already been violated through traumatization, such as rape or victimization, then their story may have components of shame and humiliation. When an interpreter is necessary, the patient must retell the traumatic events with two different people [57]. If the patient perceives anyone in the clinical process as being cold and/or judgmental, then the trust is adversely affected and the therapeutic alliance and the healing process are also negatively impacted [57]. So, it is vital that the patient trusts his/her interpreter and feels as comfortable as possible.

There should also be trust established between the practitioner and the interpreter. The practitioner must entrust his/her voice to the interpreter with confidence that concrete information, identity, and emotions are conveyed accurately [29; 151]. Four components have been identified as vital to building trust between the practitioner and interpreter. First is the interpreter's competence, as practitioners should be certain information will be relayed to and from patients accurately. Second are shared goals between the practitioner and interpreter. Trust is enhanced when everyone knows they share a common goal and are part of a team. This is reinforced when interpreters feel they are respected as professionals. The third component involves professional boundaries. When interpreters remain within their professional boundaries and these boundaries are clearly defined, the relationship is strengthened. Finally, trust is increased when practitioners and interpreters build a collaborative relationship, becoming accustomed to each other's communication style and anticipating each other's needs [29]. The patient is embedded in the triadic relationship, and when patients feel tension emanating from power differentials, they may feel fearful and powerless if trust has not been established [151].

INTERPRETATION ERRORS

Studies indicate that untrained interpreters have inaccuracies 23% to 52% of the time [35]. In a study conducted by Flores, even trained interpreters, in this case Spanish interpreters in a pediatric emergency department, made an average of 31 errors per clinical encounter [58]. An estimated 63% of these errors subsequently affected diagnosis and treatment. The error rates are highest when dealing with untrained interpreters compared to full-time hospital interpreters (77% vs. 53%) [59]. In a 2019 study involving 10 clinical encounters that were audiotaped with ad hoc interpreters and emergency room physicians, there were 704 ad hoc interpreter speech turns [152]. Accurate interpretation occurred in as few of 19% of these speech turns. The most frequent types of errors were answering for the patient and omitting information [152]. In a 2018 study, some providers relayed feeling that interpreters were not attentive listeners or skipped words [116]. For example, an open-ended question might be translated to a closed-ended question [114]. According to Luk, there are three common errors made during the interpreting process: omission, addition, and inaccuracy [19]. With omission of or minimizing information, content is purposely or inadvertently deleted or skipped. In some cases, this is unconscious, but in others, it is intentional in order to save time, minimize perceived embarrassment, or eliminate information that is perceived to be irrelevant or unimportant. Some interpreters omit information to help control the flow of conversation in order to keep the conversation on

track or because they believe the information was not important [153]. Some interpreters will act to protect patients from shame or embarrassment they have not adhered to instructions. In a 2017 study examining transcripts of interpreted health consultations, 25% of healthcare providers' affective utterances (i.e., words that give emotional expression) and 21.5% of all instrumental utterances (i.e., explicit, directive, or factual information) were actually interpreted [117]. Another study found that about 20% of patients' emotional and informational cues were interpreted [118]. Interpreters may minimize issues such as child abuse, family violence, or sexual dysfunction because they want to "protect" the patient, but this can result in delays in diagnosis, missed services, and improper care [60].

The opposite of this error is adding or exaggerating information. In these cases, the interpreter, again either unconsciously or purposely, adds or expands on information based on their value systems, experiences, and/or worldviews. This can inject bias into the diagnosis and treatment planning processes.

Problematic condensation and substitution are also possible and can lead to problems with diagnosis. Condensation is basically defined as paraphrasing and simplifying patients' lengthy and/or complicated responses. For example, in mental health, failing to convey a patients' disordered thought process can result in missed or delayed diagnosis [94].

The last type of error stems from inaccurate translation of words. For example, certain terms may have multiple meanings. In Chinese, the word for "noise" and "voices" is the same. A patient might answer "yes" to a question about hearing voices, but the question might have actually been interpreted as about hearing noises. This becomes even more difficult when regional and dialect differences are present, as a term may have a completely different meaning in another dialect or region [54]. The complexities of language will affect the accurate translation of terms.

TRANSFERENCE/COUNTER-TRANSFERENCE AND VICARIOUS TRAUMATIZATION ISSUES

Interjecting a third person into a counseling dyad introduces a new set of dynamics. Even suggesting use of an interpreter can have significant meaning for the patient. For example, a patient who feels extremely vulnerable may feel rejected by the practitioner, which can negatively affect rapport and the therapeutic alliance [119]. Practitioners should also be aware of transference issues that may emerge between the interpreter and the patient. For example, a patient may project feelings of insecurity and inadequacy to the interpreter, or a patient and interpreter may direct transference reactions toward the practitioner, further distancing themselves [120; 121]. Some even argue that the terms transference and countertransference as used in therapy have different meanings in a triadic encounter. Instead, numerous interactions are occurring and should be addressed [119].

Because some interpreters work with patients who have experienced trauma, victimization, and/or abuse, it is possible that interpreters may experience secondary traumatization, secondary victimization, vicarious traumatization, or compassion fatigue. These terms all refer to the psychologic trauma experienced by those in close contact with trauma victims [61]. Secondary traumatic stress is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" [61]. Secondary trauma can affect practitioners' beliefs about the world, others, and self, including concepts of safety, trust, control, and intimacy [62]. It has been argued that trauma caused by another person (e.g., abuse) may be more difficult for practitioners to deal with because it brings up the issue of human evilness. This may affect existing beliefs and ideals more than trauma caused by natural events (e.g., natural disasters) [62].

Seven psychologic areas are negatively affected by trauma or secondary trauma [63]:

- Frame of reference: one's perspective for understanding the world and one's experiences
- Trust: the need to depend on others and their ability to care
- Esteem: the need to be validated by others
- Safety: the need to feel secure
- Independence: the need to feel in control of one's life and choices
- Power: the need to exert control over others
- Intimacy: the need to feel connected to others

Much empirical work has been conducted regarding secondary or vicarious trauma in health and mental health professionals but less is available on interpreters. Interpreters listen to emotionally charged stories and must repeat this information back to the practitioner, so it is inevitable that stories of trauma, loss, victimization, and separation will affect interpreters [57; 131]. At times, interpreters can overidentify with patients' stories (particularly those who share cultural or ethnic histories) and become overwhelmed with the pain and distress [64; 114]. In a 2019 study, interpreters who worked with patients with emotionally charged stories frequently reported feeling mentally exhausted [122]. In a 2021 systematic review, interpreters reported negative emotions related to their work, including distress, hyperarousal, anxiety, mental exhaustion, and sadness [148]. Interpreters' use of first person in the interpreting process can add to the risk of vicarious traumatization. For example, an interpreter who interprets "I have been sexually abused" or "I have been raped" may feel and experience the devastation, sense of helplessness, and horror [95; 120]. It is important to remember that interpreters are not necessarily trained to recognize or address vicarious traumatization and countertransference issues [131].

Interpreters should debrief with the practitioner after every session to resolve any issues that came up [85]. Other strategies for avoiding vicarious trauma and burnout include distracting oneself with other tasks after work, focusing on the importance of the work, and seeking and obtaining emotional support from family and friends [57].

In a qualitative study with eight interpreters regarding vicarious traumatization, interpreters discussed how the process of interpreting can impede one's ability to ensure emotional distance from a patient's story [65]. When translating patients' emotionally distressing and traumatic stories verbatim, there is increased involvement and identification. To cope with the intense emotions related to their work, the interpreters noted the importance of having a good social support network, peer supervision, opportunities to debrief, and other personal coping methods like exercising, meditating, watching movies, using avoidance strategies, and general life balance [65]. One interpreter who worked with rape victims described her personal strategy of coping: "If I have something that really bothers me, I write it on a piece of paper after the session and then throw it away before I go home" [66]. Organizational infrastructure that promotes incorporating supervision as a part of the workflow is crucial. Systems and administrators should consider how interpreters' value is conveyed. For example, consider if interpreters are reimbursed for travel time or overtime [122]. Ultimately, vicarious traumatization can lead to existential growth and resilience [122].

BEST PRACTICE GUIDELINES FOR PRACTITIONERS WORKING WITH INTERPRETERS

CHOICE OF LANGUAGE AND SERVICES

Although it may seem basic, practitioners should not automatically assume a patient wants an interpreter. Some may decline the use of an interpreter because they feel that it is important for them to converse in English, or they may perceive having an interpreter as a sign that their English is not good enough, which can be embarrassing [21]. Keep in mind that the patient can also change his/her mind during the clinical encounter. Therefore, practitioners should always be mindful of signs that indicate discomfort or difficulties conversing in English and offer services when appropriate.

COLLABORATION WITH INTERPRETERS

It is very important that interpreters are treated as part of the healthcare team. Unfortunately, in many cases tension between providers and interpreters results in a misalignment and miscommunication of professional roles, goals, working styles, and interpersonal dynamics [137]. Providers fear losing control of the therapeutic alliance between themselves and patients. Simultaneously, interpreters feel that providers hold institutional control over their jobs. These tensions in the power dynamics have resulted in a mistrust and misalignment [137].

It is highly recommended for the practitioner and interpreter to meet prior to the clinical encounter to discuss the case (e.g., background of the patient, presenting problem), objectives of the meeting, how interpretation will affect the clinical process, and the logistics of working together [37; 83; 131]. Roles and tasks should be clarified [123]. In general, the patient's role is to seek and accept help; interpreters should not assume this role even if there is a common shared experience. The interpreter's role is to provide his/her interpreting expertise and to help empower the client. Finally, the provider's role is to provide a framework for the session and to facilitate it in such a manner that recognizes the difference between the therapeutic and interpreter roles. This is particularly important when there are sensitive or difficult topics that need to be addressed (e.g., bad news) to avoid either party being caught by surprise [67]. When working with an interpreter, it is important for practitioners to discuss whether they expect strict interpreting or whether the interpreter can take on other roles, like being a cultural broker [67]. The practitioner and interpreter should discuss and agree on communication logistics (including type of communication style, the mode of interpreting to be used, and frequency of communication) before the start of the therapeutic encounter [95; 131; 149].

It is also important to meet with the interpreter after the session to debrief [9]. The practitioner may simply ask the interpreter his/her thoughts and observations about the session and the patient. This is a good time for the practitioner and interpreter to discuss any cultural issues that may have affected the clinical process [9]. Furthermore, the practitioner should check in with the interpreter about how he/she is feeling and responding to emotionally difficult topics that may have been raised [131; 149]. When possible, the agency and practitioner should provide on-going support for interpreters after working with difficult patients or patients who are grappling with emotionally difficult issues [37].

SEATING ARRANGEMENTS

Consider seating arrangements prior to the session. Seating arrangements can implicitly convey power and position between the practitioner and interpreter and affect the ability to establish rapport [68]. Should the interpreter be seated a bit off to the side? Or should the patient and interpreter sit side-by-side facing the practitioner? The practitioner and the interpreter should determine which arrangement is most conducive for the clinical encounter; there are no definitive rules. If the interpreter sits beside but slightly behind the patient, he or she may not catch all of the nonverbal cues. However, this type of arrangement conveys the message that the practitioner-patient relationship is the center of focus [9; 124]. A triangular seating arrangement, whereby every party can maintain eye contact, may be necessary and is most recommended [124]. With this approach, the practitioner and patient can look at each other directly and the interpreter is then perceived as being objective and neutral [39; 68]. In a 2015 study, the interpreters conveyed the importance of the sitting position in order to promote eye contact to facilitate trust with the patient and the practitioner [84]. Triangular seating implies that the patient is the focal point and conveys equality of all parties [9; 125].

USE OF FIRST AND THIRD PERSON

Before beginning a session, the interpreter must decide whether to use first or third person. Some argue for the use of first person, because this allows for more accurate (literal) translation of words and emotions being conveyed [37]. However, others have differed. Using first person may be distressing for some patients if it is too personal [57]. In some languages, verb conjugation depends on the gender

of the subject of the sentence, which can be confused in interpretation [78]. Consequently, it is crucial that the practitioner and interpreter discuss the merits and limitations of using first or third person prior to meeting with the patient.

INTERVIEWING STYLE

The practitioner should talk directly to the patient (e.g., "Mrs. L, how are you feeling today?") rather than asking the interpreter to inquire with the patient (e.g., "Please ask Mrs. L how she feels.") [9; 39; 154]. By speaking through the interpreter rather than to the patient, the practitioner may jeopardize establishing rapport and trust [19]. The practitioner should continually check whether the patient comprehends the information being conveyed [39]. Furthermore, the practitioner should be attentive and respond to non-verbal cues, pause frequently, and be in control of the clinical encounter [39]. Again, it is vital that the practitioner and interpreter meet prior to the session to review how reflections or affirmations should be handled [126].

MATCHING OF PATIENTS AND INTERPRETERS

When possible, the gender of the patient and the interpreter should be matched. There are often cultural norms regarding gender roles, and some patients will feel uncomfortable disclosing embarrassing or sensitive information to an interpreter of the opposite sex [41]. It is also important to take into account any spiritual, sociopolitical, and regional nuances between the ethnicity of the patient and the interpreter [85]. Careful consideration to whether it is prudent to have an interpreter from the same community as the patient is necessary. A shared community experience could promote rapport, or it could make the patient feel that his/her confidentiality and privacy are compromised. However, it is important not to assume that a same or similar racial/ethnic background equates to shared cultural experiences [85].

USE THE SAME INTERPRETER

When possible, practitioners should attempt to use the same interpreter with the same patient. The connections between interpreters and patients are strong, particularly if the relationship is given time to develop. If a new interpreter is used with each clinical contact, this discounts the importance of having the same trained interpreter develop rapport and a safe therapeutic environment for the patient [56].

AVOID USING TECHNICAL JARGON, PROVERBS, AND HUMOR

Language is complex; however, when cultural differences are added, it can be even more complicated, with layers of nuances. As a result, practitioners should avoid using proverbs or colloquialisms that are confusing or nonsensical when translated literally [37; 102; 154]. Practitioners should also realize that not all concepts common in a health or mental health setting can be easily translated [95]. Humor and jokes should be carefully considered, as they can be easily misunderstood in a different cultural context [67; 102]. Finally, technical jargon is difficult to interpret and should be avoided whenever possible.

AVOID COMPOUND QUESTIONS

Practitioner should avoid asking compound questions that may require more than one answer. In addition, it is important to wait for a response before proceeding to the next question [96]. Speaking in long sentences and digressing can result in a confusing session [126]. Skilled interpreters may be able to convey to the practitioner that slowing or pausing is necessary. As much as practitioners can, they should attempt to unpack the information and speak in a simplified manner [154].

NONVERBAL CUES

Hand gestures and nonverbal communication are culturally bound. A hand gesture, for example, may be benign in one culture but interpreted as insulting or sexually suggestive in another [69]. A smile can also have different cultural connotations. In Chinese culture, a smile does not always mean happiness, but can convey disagreement or even lack of understand-

ing [127]. Therefore, practitioners should be careful with their physical expressiveness. The practitioner should focus on maintaining eye contact with the patient rather than the interpreter [95].

LOOK FOR INCONGRUENCE

Practitioners should keep attuned to any incongruence. For example, if the patient provides a lengthy response but the interpreter conveys a brief response, this may be an indication that the interpreter is condensing the information [96]. Alternatively, if the patient's body language appears to be dissonant with the message being communicated back, it is best to pause and check in with the patient [96].

INTERPRETING WITH CHILDREN

It is important to recognize that every subpopulation has different needs, and interpreters working with children require a different set of competencies. Skills necessary for interpreters working with children and their families include [60]:

- Knowledge of child development
- Understanding of verbal and nonverbal cues of children
- Knowledge of the impact of cultural values and belief systems on families and children's roles
- Ability to navigate the complex dynamics of having four parties involved—the practitioner, interpreter, family member, and child

CONTINUING CULTURAL COMPETENCE

Practitioners should keep in mind that using an interpreter does not mean that they may abandon their responsibility of cultural competence. The practitioner cannot rely solely on the interpreter to be the cultural broker and expert [19]. Because cultural competence is an ongoing process, practitioners should seek out education on cultural and racial issues in health and mental health care. If a clinician's patient population is predominantly one culture/ethnicity, this should be a focus of additional research.

TRAINING PRACTITIONERS AND INTERPRETERS

As discussed, collaboration between practitioners and interpreters is crucial. It is not enough for interpreters to be well trained; practitioners also require training on how to best work with interpreters. Research indicates that practitioners' educational and professional training are not adequate in preparing them to work with interpreters [56]. Most often, providers learn from on-the-spot training, usually by trial and error.

To address this deficit, staff training can be offered to instruct practitioners on how to work with interpreters in a variety of clinical situations. The training can include a discussion of roles interpreters assume; how these roles affect the clinical process; different interpreting methods; shared goals and challenges; types of cross-cultural conflicts that can ensue when working with patients, interpreters, and practitioners from different cultural backgrounds; how to resolve these conflicts; and common errors made by interpreters. Even points that may seem like common sense should be reinforced. Interpreters have indicated that practitioners often do not remember that interpreting is difficult and that it is important to speak slowly, using brief sentences and pausing frequently [52; 146].

It is also important to discuss with practitioners that patients may first develop a stronger rapport and level of trust with interpreters and not to feel threatened by this [57]. As always, meetings before and after clinical encounters should be encouraged. Little research has been conducted exploring collaboration between practitioners and interpreters. However, some have recommended that training and supervision of practitioners and interpreters should be done conjointly and collaborative standards of care should be established [148]. For example, best practice guidelines can be developed about turn-taking in conversation and when the practitioner might step in to assist [155]. Respectful turn-taking in the conversation acknowledges that the interpreter is more than just a conduit [155]. In addition, both the practitioner and interpreter can work together to design the structure of clinical sessions [137].

Practitioners should focus on the cultural relational dynamics, inviting both the patient and interpreter for feedback and clarification. Interpreters can then focus on the process of interpreting the content and not determining when to intervene over clinical issues [137].

ETHICAL ISSUES

CONSIDERATIONS FOR PRACTITIONERS

Beneficence

As discussed, practitioners often decide to "get by" without interpreting services due to time constraints, even if interpretation could improve the quality of patient care. This conflicts with the ethical principle of beneficence (or "doing no harm") [70]. If the services delivered are compromised, patients can feel disempowered, ashamed, and vulnerable. Even if inconvenient, interpretation may be an ethical necessity.

Autonomy

Practitioners are obligated to ensure that their patients have all the information needed in order to comprehend their situation and to make an informed decision about how to proceed with their care. When patients are not proficient in English and a translator is not used, their autonomy can be compromised [71]. But even working with interpreters and patients, practitioners may need to ensure that patients' self-determination is not further compromised. More time may be needed to allow the patient's story to be told to two parties, particularly if the history has components that are stressful [37]. Alternatively, the practitioner should be sure that the patient wishes to use an interpreter and that the interpreter chosen will not hinder the process (for cultural reasons).

Autonomy, individualism, and self-determination are highly important in Western societies, especially in the United States. But autonomy may be organized into two categories: first-order and second-order [72]. First-order autonomy refers to self-determination and autonomy in decision making, and this is the concept valued in Western medicine. Second-order autonomy is prevalent in collectivistic societies in which decision making is group-oriented. In these cultures, another decision maker is accorded authority and respect, and it may be necessary to involve this designated decision maker in the process. He or she may also need interpreting services. Four parties are then involved, which obviously has a higher risk of complicating the communication process, and enough time should be allotted for everyone involved. If being used, a copy of the consent form should be given to the interpreter so he/she can familiarize him/herself with it before the clinical encounter.

The patient should also be informed about the role of the interpreter and how confidentiality will be ensured. This should be explicitly stated on the consent form [97]. If the interpreter is not employed by the same agency as the practitioner, a release of information will be necessary. This is a written document indicating that the patient understands that the practitioner and interpreter will be communicating about what has transpired in the sessions [97].

Competence

Practitioners' obligation to practice within the boundaries of their competence applies to working with patients with limited English proficiency and interpreters. It is key that practitioners understand how the therapeutic dynamics are altered by bringing in an interpreter and how to establish and maintain a relationship and rapport with the patient in this environment [97]. Research indicates that the practitioner-patient relationship can be compromised if the practitioner has not established a strong relationship with the interpreter [97]. In the health and mental health professions, most codes of ethics address delegating professional activities to third parties. It is therefore the responsibility of practitioners to find the balance between finding interpreting services for patients with limited English proficiency and locating interpreters who are competent [9].

Confidentiality and Privacy

As discussed, practitioners should meet with interpreters prior to the session to set clear rules regarding patient confidentiality. If an interpreter is from the same community as the patient, the clinical implications of being acquainted or familiar with patients in other social arenas outside the clinical encounter should be reviewed [9]. For example, it is possible that an emotional dependence could arise on the part of the patient to the interpreter [73]. In such cases, the practitioner should decide whether he or she can conduct professional and ethical work in such a situation.

An open discussion should also be held with patients to explore expectations of confidentiality [9; 73]. Patients should be assured that interpreters are bound by confidentiality just as practitioners are and that their role is to remain neutral [68]. If a patient knows his or her interpreter, the practitioner should also address whether he or she is comfortable and, if not, whether another interpreter is necessary. In a 2018 study with women in Guam, some participants reported feeling uncomfortable disclosing reproductive health information to interpreters from the same community, feeling confidentiality could be compromised [128].

Dual Relationships

A racial and ethnic community may be small, with interpreters living in the same community as the patient. In some cases, the interpreter may have experienced similar traumas as the patient [97; 131]. In some cases, a bond is developed between patients and interpreters due to a shared ethnic background. As such, practitioners should assess if an interpreter has any previous relationship with the patient and if this relationship will negatively impact the therapeutic process and the patient's ability to access care [97].

CONSIDERATIONS FOR INTERPRETERS

Interpreters are bound to a code of professional conduct and ethical principles as well. Similar to the codes of ethics that practitioners operate under, interpreters have a responsibility to maintain confidentiality, accuracy (in order to promote beneficence), and impartiality and objectivity. They are also required to promote the patient's welfare and dignity [74]. A sense of self-awareness is extremely crucial when it comes to professional conduct and ethics. Interpreters should be continually cognizant of their role and the limitations of the process of interpreting [67]. The National Council on Interpreting in Health Care Code of Ethics may be accessed online at https://www.ncihc.org/ethics-and-standards-of-practice.

RESOURCES

The following resources may be helpful for practitioners working with interpreters. Although it is far from a comprehensive list, it is a good start when beginning to gather additional information.

California Federation of Interpreters
https://www.calinterpreters.org

California Healthcare Interpreting Association
https://chia.wildapricot.org

The Cross Cultural Health Care Program Medical Interpreter Training
https://xculture.org/medical-interpreter-training

Health Care Interpreter Network
https://www.hcin.org

International Medical Interpreters Association
https://www.imiaweb.org

Federal Interagency Website Working Group on Limited English Proficiency (LEP)
https://www.lep.gov

National Association for Interpretation
http://www.interpnet.com

The National Board of Certification for Medical Interpreters
https://www.certifiedmedicalinterpreters.org

National Council on Interpreting in Health Care
https://www.ncihc.org

Refugee Health Technical Assistance Center
https://refugeehealthta.org

CONCLUSION

The United States is more racially and ethnically heterogeneous than ever before, and practitioners often interact with patients for whom English is not their first language. In these cases, interpreters may assist with language, communication, and even cultural gaps between patients and practitioners [30]. Professional interpreters are more than passive agents who translate and transmit information back and forth. When enlisted and treated as part of the interdisciplinary team, interpreters can enhance cultural competence and the clinical encounter. However, the involvement of a third party in the clinical process will result in unique dynamics. Practitioners have a professional obligation to respect interpreters' psychological and emotional well-being and the unique professional skills they bring into the clinical process. Similarly, interpreters hold a tremendous amount of responsibility for adequately communicating not only the content but also the voice, tone, and identity of the practitioner to the patient [56]. The practitioner-interpreter relationship is truly a collaborative professional relationship.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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