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Secondary Traumatic Stress in Interpreters for Refugees: Why Training and Supervision Matter

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Abstract

Interpreters who translate for refugees are regularly confronted with traumatic content. Listening regularly to and translating potentially traumatizing stories make interpreters vulnerable to secondary traumatization. The current study aimed to investigate secondary traumatic stress (STS) in interpreters working with refugees and to identify potential risk and protective factors. In this cross-sectional study, 64 interpreters from Austria, Germany, and Switzerland participated. STS, compassion satisfaction, burnout, and resilience were assessed using the Secondary Traumatic Stress Scale, Professional Quality of Life Scale, and Connor–Davidson Resilience Scale. Sociodemographic data were collected (e.g., experiences with translation in psychotherapy, personal backgrounds of forced displacement, and personal experiences with psychotherapy as a client). Subgroup comparisons were conducted to identify risk factors for STS. A total of 43 participants (67%) showed at least mild STS. STS was significantly associated with burnout. Personal experiences of forced displacement, gender, and working context had no impact on STS. Interpreters with personal experiences of psychotherapy showed a higher level of STS as well as higher resilience than those without personal experiences of psychotherapy. Independent of personal experiences of forced displacement, gender, and working context, interpreters who work with refugees are at high risk of STS. Regular training and supervision for interpreters who work with refugees should thus be offered as standard practice.

Keywords: secondary traumatic stress; post-traumatic stress disorder; interpreter; refugee; psychotherapy; mental health

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1. Introduction

The number of forcibly displaced people has risen continuously in recent years to approximately 122.6 million people worldwide in mid-2024, accounting for 5% of the global population [1]. In Germany alone, more than three million people applied for asylum from 2014 to the end of 2024 [2]. Increased numbers of asylum applications after 2014 were also recorded in Austria [3] and Switzerland [4]. This trend highlights the necessity for structural and societal measures that promote integration and address intercultural discrepancies. The need for psychotherapy for refugees must also be met.

Compared to the general population of host countries, refugees show high rates of psychological distress, particularly symptoms of post-traumatic stress disorder (PTSD), depression, and anxiety disorders [5]. A study of refugees in Germany revealed that around 85% had been exposed to at least one traumatic event; on average, participants reported more than four traumatic experiences [6]. The high demand for psychotherapy is at odds with a lack of therapy services. In Germany, for example, the demand for psychotherapy for refugees with mental health problems cannot be met [7]. To make matters worse, therapy is often not available in refugees' native languages [8]. For this reason, interpreters are often involved in psychotherapeutic processes to overcome the language barrier.

Interpreting involves not only translating words, but also translating non-verbal cues and intercultural differences to facilitate understanding between parties who speak different languages and have different cultural backgrounds [9]. This requires interpreters to manage not only their own emotions but also those of others involved in a conversation. This responsibility can lead to frustration and helplessness among interpreters as they strive to maintain professional neutrality [10]. However, working with refugees in counseling or therapeutic settings presents its own set of unique challenges for interpreters because they are regularly confronted with traumatic content [11]. Individuals who work in therapeutic settings and repeatedly hear details of others' traumatic experiences are at risk of secondary traumatic stress (STS) [12]. In addition to the volume and frequency of a trauma caseload, personal trauma histories and a lack of social support are risk factors for developing STS [12]. Many interpreters feel intense negative emotions such as helplessness and fear while translating traumatic content [13].

The mental health of interpreters who work with refugees has been explored in previous studies. A systematic review from 2021 pointed out that between 12% and 17% of interpreters suffered from moderate STS and up to 50% of interpreters experienced severe STS [14]. Female interpreters reported higher levels of general stress, anxiety, and depression than did male interpreters, but there was no significant gender difference regarding STS [15]. Compared to the general population, the prevalence of PTSD was higher in interpreters [14]. A study from 2017 revealed that 21% of examined interpreters suffered from secondary traumatization, 33% showed subclinical PTSD symptoms, and a further 9% of interpreters fulfilled the criteria for PTSD [15]. The number of personal traumatic experiences seems to be a crucial risk factor for developing STS and PTSD symptoms [16]. On the other hand, interpreting for refugees with similar traumatic experiences can induce a protective sense of shared victimization which may foster post-traumatic growth [17].

Geiling and colleagues proposed a theoretical model of interpreters' distress including several potential risk and protective factors [14]. According to this model, traumatic content, a high workload, low professional experience, and the felt experience of role limitations being too strict within the triad are all work-related risk factors for psychological distress. Specific training, supervision, collegial exchange, social support, compassion satisfaction, and adaptive coping strategies are some of the protective factors. Interpreters themselves having a personal history of forced displacement is considered both a risk and a protective factor in this model [14].

Earlier studies indicate that interpreters who work with refugees are at high risk of mental health problems, and especially at risk of STS. Nevertheless, too little is known about protective and risk factors related to the mental health of interpreters because there is a lack of quantitative data and findings in the literature mostly rely on qualitative studies with small sample sizes [14].

The current study aimed to investigate STS in interpreters and to identify potential risk and protective factors. Therefore, personal histories of forced displacement and work experience in psychotherapeutic settings were assessed. We also addressed, for the first

time, the personal experience of psychotherapy as a client. In addition, professional quality of life and resilience were assessed. The latter had been neglected in earlier studies. Based on the existing literature, it was expected that (a) interpreters with personal histories of forced displacement would show higher levels of STS, but also higher levels of compassion satisfaction and resilience in comparison to individuals without personal backgrounds of forced displacement; (b) female interpreters would report higher levels of STS and burnout than would male interpreters; and (c) interpreters translating in psychotherapeutic settings would show higher levels of STS and burnout than interpreters without work experience in psychotherapeutic settings. The experience of psychotherapy as a client requires a diagnosed mental disorder. As the development of many mental illnesses is fostered by distress and, on the other hand, many mental disorders make those affected vulnerable to increased stress experience, it was hypothesized that individuals with personal experiences of psychotherapy as a client would show higher levels of STS than interpreters without such experiences.

2. Materials and Methods

2.1. Participants

Individuals working professionally as interpreters for refugees in the German language were entitled to participate in this study. The minimum age for participation was 18 years (legal age). Interpreters were recruited from the German-speaking countries of Austria, Germany, and Switzerland.

2.2. Procedure

This cross-sectional study was carried out in accordance with the ethical principles for medical research involving human subjects (Declaration of Helsinki) upon receiving a positive vote from the responsible ethics committee of Ärztekammer Nordrhein, Germany, in November of 2022 (number 2022331). The interpreters were recruited from December 2022 to December 2024 through several facilities in Austria, Germany, and Switzerland, namely the "AG Healthbuddies for Refugees" of the medical student association at the University of Cologne, through "AidHoc", a Swiss NGO, through the "Verein Ute Bock" in Vienna, through a counselling and therapy facility for refugees (PSZ Duesseldorf, Düsseldorf, Germany), a youth welfare facility for young refugees (Diakonie Duesseldorf, JUMP, Düsseldorf, Germany), and through a child and adolescent psychiatric outpatient clinic specialized in the treatment of refugees. Participants were provided with written information about the study and data privacy. Interpreters who were interested in participating in the study were asked to call a designated contact person at the study center and were informed verbally about the study in that telephone conversation. After providing informed consent to participate in the study, the interpreters who met the inclusion criteria of being of legal age and working professionally as interpreters for refugees in the German language received the questionnaires by post, including a stamped envelope for submission of the anonymously answered questionnaire. The following sociodemographic data were collected: age, gender, place of residence, country of origin, mother tongue, spoken languages, experiences with translation in psychotherapy, personal backgrounds of forced displacement, and personal experiences with psychotherapy as a client.

2.3. Measures

2.3.1. Secondary Traumatic Stress Scale (STSS)

The STSS [18] is a self-report measure designed to assess the extent of possible secondary traumatization. Therefore, it measures the frequency of intrusion, avoidance, and anger connected with indirect exposure to traumatic events through professional relation-

ships with traumatized persons. Respondents specify how often they experienced each of the 17 items in the past seven days on a 5-point Likert scale (1 = never, 5 = very often), resulting in a possible total score ranging from 17 to 85. According to Bride's suggestion [19], the total score indicates whether the respondent has severe (total score $\geq$ 49), high (44–48), moderate (38–43), mild STS (28–37) or no STS (total score < 28). Total values of at least 38 points falling within the moderate to severe range indicate relevant secondary traumatic stress [20]. The original version of the STSS had excellent reliability (α = 0.93) and minimal to moderate convergent validity, as indicated by significant correlations with the extent of client population traumatization (r = 0.26), the frequency of traumatic stress in client work (r = 0.23), severity of depression symptoms (r = 0.50), and anxiety symptoms (r = 0.55) [18]. Internal consistency of the measurement in this study was also excellent (α = 0.92).

2.3.2. Professional Quality of Life Scale (ProQOL)

The ProQOL [21] is a measure of professional quality of life, which assesses both the negative and positive effects of working with traumatized people. It comprises three subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Since the latter one overlaps with STSS, only the first two subscales were evaluated in this study. Compassion satisfaction assesses the gratification one derives from accomplishing their work successfully. Burnout is connected to feelings of despair and struggles with work management or effective job performance. Each subscale has 10 items that reflect the frequency of specific experiences within the last 30 days, scored on a 5-point Likert scale (1 = never, 5 = very often), resulting in a possible total score ranging from 10 to 50 for each subscale. The reliability estimate for the subscale Compassion Satisfaction (α = 0.88) was considered good, while the estimate for the Burnout subscale (α = 0.75) was deemed acceptable [21]. Convergent validity is supported by strong correlations with scales of well-being at work (r = 0.69) and with psychological distress at work (r = $-$0.67) [22]. In the current study, internal consistency was acceptable (α = 0.79) for Compassion Satisfaction and questionable (α = 0.66) for the Burnout subscale.

2.3.3. Connor-Davidson Resilience Scale (CD-RISC)

The CD-RISC [23] is a self-report measure of resilience. The 25 items specify the extent to which the statements align with the respondents' experiences over the past month on a 5-point Likert scale (0 = not at all true, 4 = almost always true), resulting in a possible total score ranging from 0 to 100. The German version had excellent internal consistency (α = 0.90), satisfactory test–retest reliability (rtt = 0.86), and good convergent validity (rtc = 0.60) [23]. Internal consistency of the measurement in this study was good (α = 0.89).

2.4. Data Analysis

All analyses were performed using the open-source statistical software RStudio 2024.09.1+394.pro7. Information about gender as well as personal experiences of psychotherapy and personal experiences with forced displacement were coded as dichotomous variables (sex: male, female; experiences with translation in psychotherapy: yes, no; experiences with forced displacement: yes, no; personal experiences with psychotherapy: yes, no). In the analyses of gender differences, one participant who reported non-binary for gender was excluded. Out of a total of 4608 values, there were 33 missing data (0.72%). There was at least one missing value for 13 out of 64 participants. Missing values were imputed using the unconditional mean across individuals for each variable. Given the small subgroup sample sizes, Mann–Whitney U Tests were calculated to assess group differences. To control for potential confounding variables (e.g., age, number of spoken languages), post-hoc moderated regression analyses were conducted.

3. Results

3.1. Sample Characteristics

A total of 64 individuals participated in the study. Of these, 34 (53.1%) were female, 29 (46.3%) were male, and one participant identified as non-binary. Participants' ages ranged from 21 to 83 years of age (M = 45.27, SD = 14.05). Fifty-three interpreters were resident in Germany, seven lived in Austria, and four participants lived in Switzerland. The participants hailed from 25 different birth countries. The most common countries of birth were Afghanistan (n = 10; 15.6%), Germany (n = 10; 15.6%), Iran (n = 8; 12.5%), and Ukraine (n = 4; 6.3%). Of the 64 interpreters, 53 (82.8%) were able to translate into more than one language. The most frequently translated languages were Arabic (n = 19; 29.7%), Persian (n = 18; 28.1%), Russian (n = 13; 20.3%), and French (n = 11; 17.2%).

Fifty-two interpreters (81.3%) reported prior experience translating in the context of psychotherapy, 11 (17.2%) indicated no such experience, and one interpreter did not provide information regarding experience translating in psychotherapy. Twenty-one participants (32.8%) reported having personal experiences with forced displacement, while 43 (67.2%) did not. Sixteen (25.0%) interpreters had personal experiences with psychotherapy, whereas 48 (75.0%) had no such experience.

3.2. Secondary Traumatization and Secondary Traumatic Stress

A total of 43 participants (67.2%) reached a total score in the STSS that indicated at least mild STS. Twenty-eight interpreters (44.8%) showed mild STS, six interpreters (9.4%) showed moderate STS, one participant (1.6%) showed high STS, and eight individuals (12.5%) showed severe STS. Fifteen participants (23.4%) reached at least 38 points in the STSS and therefore met the criteria for relevant STS.

As Table 1 shows, interpreters with personal experiences of psychotherapy reported a significantly higher total score in STSS (M = 38.98, SD = 13.07) compared to those without psychotherapy experiences as client (M = 31.16, SD = 10.99; U = 241, p = 0.027, r = 0.276). Post-hoc moderated regression analyses revealed no significant moderator effects based on age (β = 0.30, p = 0.219) or the number of languages spoken (β = –3.98, p = 0.278).

Table 1. Secondary traumatization, positive and negative effects of working with traumatized individuals, and resilience among interpreters with and without personal histories of forced displacement, and with and without personal psychotherapy experiences as client.

	Experiences of Forced Displacement					**Personal Experiences of Psychotherapy**				
	Yes (n = 21)	**No (n = 43)**	**Subgroup Comparison**			**Yes (n = 16)**	**No (n = 48)**	**Subgroup Comparison**		
	$M \pm SD$	$M \pm SD$	U	p	r	$M \pm SD$	$M \pm SD$	U	p	r
STSS	36.95 ± 15.95	31.24 ± 9.02	387.5	0.363	0.114	38.98 ± 13.07	31.15 ± 10.98	241.0	0.027	0.276
CS	43.04 ± 4.47	39.91 ± 5.34	297.5	0.028	0.275	38.56 ± 5.82	41.73 ± 4.85	503.0	0.065	0.231
BO	20.42 ± 6.57	20.90 ± 4.39	522.5	0.312	0.126	23.31 ± 6.00	19.89 ± 4.60	243.5	0.030	0.271
CD-RISC	68.60 ± 14.72	71.92 ± 12.47	494.0	0.548	0.075	73.44 ± 11.60	63.00 ± 15.03	546.5	0.012	0.314

Note. STSS: Secondary Traumatic Stress Scale, CS: subscale Compassion Satisfaction from Professional Quality of Life Scale, BO: subscale Burnout from Professional Quality of Life Scale, CD-RISC: Connor–Davidson Resilience Scale; N = 64.

However, no significant differences in STSS score were found between interpreters with (M = 36.95, SD = 15.95) and without personal experiences with forced displacement (M = 31.24, SD = 9.02; U = 388, p = 0.363, r = 0.114), between male (M = 31.75, SD = 10.22) and female interpreters (M = 33.37, SD = 12.36; U = 47, p = 0.809, r = 0.030), nor between interpreters who translate in psychotherapeutic settings (M = 36.18, SD = 14.28) and those who do not (M = 32.66, SD = 11.48; U = 266, p = 0.724, r = 0.044).

3.3. Burnout

No significant subgroup differences were observed in the level of burnout, regardless of whether the interpreters had personal experiences with forced displacement refugee backgrounds or personal psychotherapy experiences (see Table 1).

3.4. Compassion Satisfaction

As Table 1 shows, interpreters with personal histories of forced displacement reported higher compassion satisfaction at work ($M = 43.04$, $SD = 4.47$; $U = 297.05$, $p = 0.028$, $r = 0.275$) compared to those without such experiences ($M = 39.91$, $SD = 5.34$). This indicates a high level of compassion satisfaction among interpreters with histories of forced displacement, as opposed to a moderate level observed in interpreters without such experiences. There were no significant moderator effects of age ($\beta = 0.02$, $p = 0.864$) or number of languages spoken ($\beta = -1.02$, $p = 0.485$). Interpreters with personal experiences of psychotherapy and those without such experiences did not differ in their compassion satisfaction (see Table 1).

3.5. Resilience

Interpreters with personal experiences of psychotherapy exhibited a higher level of resilience ($M = 73.44$, $SD = 11.60$, $U = 546.5$, $p = 0.012$, $r = 0.314$) compared to those without psychotherapy experiences ($M = 63.00$, $SD = 15.03$). Post-hoc moderation analyses revealed no significant effects based on age ($\beta = -0.51$, $p = 0.060$) or the number of languages spoken ($\beta = 6.71$, $p = 0.100$). Interpreters with personal history as refugees and those without personal histories of forced displacement did not differ in the extent of resilience (see Table 1).

3.6. Associations Between STS, Compassion Satisfaction, and Burnout

There was a large correlation between total scores in STSS and the burnout scale ($r = 0.59$; $p < 0.001$). No significant correlation was found between STSS scores and compassion satisfaction ($r = -0.19$; $p = 0.128$).

4. Discussion

More than two-thirds of interpreters who translated for refugees showed at least mild STS. In the current study, 23% of interpreters met the criteria for at least moderate STS. Hence, the proportion of relevant STS in interpreters in this study was below the pooled prevalence of STS (45.7%) in professionals and volunteers who work directly with forcibly displaced people which was revealed in a systematic review [20]. Nevertheless, the proportion of interpreters with severe STS (12.5%) is comparable to the proportion of severe STS in trauma therapists [24]. The results of the current study are therefore consistent with previous findings, according to which interpreters who work with refugees are at high risk of secondary traumatization and PTSD [15].

Contrary to the first hypothesis of this study, interpreters with and without a personal history of forced displacement showed no significant difference in the level of STS and burnout. While personal trauma history and trauma caseload increase susceptibility for STS [12], the current results do not support the assumption that a personal background of forced displacement per se is a risk factor for secondary traumatization in interpreters [14]. The results of this study are thus in line with other study results from Germany [15]. One possible explanation could be the influence of compassion satisfaction. In this respect, interpreters with personal experiences of forced displacement showed a higher level of compassion satisfaction than those without such experiences. It is possible that interpreters with personal experiences of forced displacement view their work helping others with shared traumatizing experiences as especially meaningful and satisfying. As a result of their

own experiences of forced displacement, these interpreters might see themselves as being particularly well positioned to understand and empathize with the cognitions and emotions of other refugees. This ability may then enable them to build bridges between refugees and contracting authorities that go beyond overcoming the language barrier. Precisely these skills might foster a felt sense of making an important contribution to supporting refugees through their work. This hypothesis is therefore in line with the assumption that personal experiences of forced displacement can have a protective effect [14], in relation to the current study results, in the form of high compassion satisfaction. However, the findings of a systematic literature review suggest that high compassion satisfaction and high levels of STS can coexist, indicating that people can simultaneously experience STS and derive satisfaction from their work [25]. Future studies should therefore systematically examine the factors contributing to high compassion satisfaction in interpreters, particularly in those with personal experiences of forced displacement.

Among mental health professionals who work with traumatized clients, female clinicians seem to have a higher susceptibility for secondary traumatization compared to males [26]. However, contrary to the second hypothesis, the current study did not reveal a significant gender difference in STS. This may be due to the special setting in which interpreters work. The greater female propensity to STS was explained by greater fear and greater empathy in women compared to men. It was assumed that female health professionals are more reactive and experience traumatic content more intensely due to higher levels of empathy. Due to higher levels of fear, women may lose their sense of safety more easily, fostering the development of PTSD symptoms [26]. Unlike mental health professionals, interpreters are never alone when in contact with traumatized people. Interpreters also bear no responsibility for the content of the interview or the mental health of the traumatized person. These structural differences may explain why earlier findings on gender differences cannot be confirmed in studies on interpreters.

In contrast to previous findings [12] and contrary to the third hypothesis, this study does not confirm that interpreters experience higher STS in a psychotherapeutic context than interpreters who do not translate in context of psychotherapy. In the current study, this may be because refugees in German-speaking countries also describe traumas they have experienced in great detail outside psychotherapy and interpreters support them in doing so. For example, refugees are asked very detailed questions about their biography during their asylum application interview. If people cite trauma as a reason for fleeing or as the cause of a mental illness, they must provide very detailed information to assess the credibility of their presentation during the interview. Such hearings with refugees are often practiced in advance with the help system, for example, refugee aid organizations. Here, too, interpreters support refugees.

According to the hypothesis, interpreters with personal experiences of psychotherapy showed a higher level of STS than those without personal experiences of psychotherapy. This may also be due to a previous or ongoing mental illness. In German-speaking countries, psychotherapy is only covered by health insurance if a psychiatric disorder has been diagnosed. The current study did not assess whether participants had undergone psychotherapy in the past or were still undergoing psychotherapy, and for which diagnosis they were being treated. This represents a limitation of the study. For example, no statement can be made as to whether the interpreters concerned have dealt with their own traumas in the past or are currently seeking support in psychotherapy due to the stresses and strains of their work. It is therefore conceivable that those interpreters with higher levels of STS may have sought psychotherapeutic treatment.

However, personal experience of psychotherapy is not only associated with a higher level of STS, but also has a positive effect. Interpreters with personal psychotherapy experi-

ences have significantly higher resilience than those without such experiences. Therefore, psychotherapy might be a suitable measure for increasing resilience. On the other hand, it is also possible that people with a high level of self-reflection and therefore higher resilience may have taken advantage of psychotherapy. Self-reflection is known to be an important part of resilience. It is assumed to strengthen a person's resilience by developing insights into already-present capacities for coping with stressors, the limitations of these capacities, and by stimulating the search for alternative coping strategies [27]. The study results could therefore reflect an effect of self-selection.

A previous study revealed a substantial likelihood that exposure to secondary trauma is associated with job burnout [28]. Another study showed a significant relation between STS and burnout in sign language interpreters working in trauma-related fields [29]. These findings are in line with the current study results, which show that STS is significantly associated with burnout. Interpreters should therefore be informed about their vulnerability when working with traumatized refugees to symptoms of STS and risk factors. Regular trainings and supervision for interpreters working with refugees should be offered as standard practice.

Based on previous studies and general recommendations for training and supervision for interpreters in the psychotherapeutic setting [30], the following organizational frameworks appears to be useful: Before working in the psychotherapeutic setting, interpreters should receive specific training to better handle emotional and psychological stress and to get information about typical psychotherapeutic processes. Ideally, such training sessions should be jointly led by psychotherapists and experienced interpreters and last at least two days. In addition, pre-session briefings by psychotherapists were useful for preparing interpreters for the concrete psychotherapeutic context. Supervision should take place at least once a month for 1.5 h. This should be accompanied by peer support groups that are led by psychotherapists. Such groups offer the opportunity to share experiences and receive mutual support. A current study pointed out that also weekly training with interpreter–clinician dyads are helpful [31]. Training for interpreters working with refugees in psychotherapeutic contexts should include education about symptoms of PTSD, especially flashbacks and dissociations, and their treatment, especially exposure therapy. Ideally, role-playing can be used to practice translating for highly affected people. In addition, interpreters should be informed about typical types of traumatization among refugees. As interpreters are bound to confidentiality, they should have the opportunity to talk about issues that they have experienced as very stressful as part of a supervision. Thereby, emotional stress can not only be validated, but also linked to one's own biography in order to promote understanding of the experienced distress. Functional interventions to reduce stress such as skills, relaxation exercises and motivation to regular sport exercises, as well as warnings against dysfunctional coping mechanisms such as substance use, should also be included. There is a lack of studies investigating treatment of STS. A current study is examining EMDR intervention for interpreters with STS [32].

Regarding dysfunctional coping mechanisms, the extent of media consumption, especially smartphone use, should also be addressed in training and supervision. Especially during times of crisis, individuals tend to increase their media consumption due to the need for detailed and updated information [33]. For example, interpreters who have fled their country due to war or civil war may feel the need to regularly inform themselves about the current situation in their country of origin by consuming videos online. Such media exposure might increase levels of anxiety and affect working memory performance [33]. In addition, there is evidence that intensive smartphone use is associated with increased sensory processing difficulties [34]. Media consumption could therefore have an impact on the development or persistence of STS. In addition, decreased auditory sensory processing

as well as affected working memory because of media consumption could increase the feeling of burnout, as the activity of translating requires particularly low auditory sensory thresholds and very high working memory performance. Future studies on STS should therefore systematically investigate media exposure and, if applicable, expand explanatory models to include this factor.

This study has several limitations. The cross-sectional nature of the study design prevents any causal inference, meaning all results should be interpreted with caution. Compared to other studies with interpreters for refugees [14], the current study has a large sample size. However, the sample includes only a small number of subgroups, in particular interpreters with personal experiences of psychotherapy and interpreters without work experiences in psychotherapy. This limits the interpretability of the results and restricts the generalizability of our findings. The impact of personal experiences of psychotherapy on STS in interpreters were investigated for the first time. However, the treatment diagnoses and possible pre-existing conditions of the mental illnesses were not recorded. No distinction was made between ongoing and terminated therapeutic processes. The results therefore do not allow any conclusion to be drawn as to whether participants' mental disorders were due to their work as interpreters, or rather linked to pre-existing psychological vulnerability. Future large-scale studies should address these factors and collect longitudinal or follow-up data to investigate possible developments and changes over time. In addition, the study did not assess other relevant risk factors for STS, namely personal histories of traumatization, caseloads and frequencies of translating in trauma therapy, or general workloads. Therefore, based on the study results, only risk factors can be identified, but no comprehensive explanatory model for STS in interpreters can be presented. Regarding burnout, potential influencing factors such as weekly working hours, shift work and the frequency of translating traumatic content were not taken into account. Future studies on this topic should consider these factors.

5. Conclusions

Independent of personal experiences with forced displacement, gender, and working context, interpreters who work with refugees are at high risk of STS. Interpreters' level of STS is significantly associated with burnout. Therefore, regular training and supervision for interpreters who work with refugees should be offered as standard practice.

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Abbreviations

The following abbreviations are used in this manuscript:

STS	Secondary Traumatic Stress
PTSD	Post-Traumatic Stress Disorder
STSS	Secondary Traumatic Stress Scale
ProQOL	Professional Quality of Life Scale
CD-RISC	Connor–Davidson Resilience Scale
CS	subscale Compassion Satisfaction from Professional Quality of Life Scale
BO	subscale Burnout from Professional Quality of Life Scale
EMDR	Eye Movement Desensitization and Reprocessing

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