Community interpreting

Community or social service interpreting takes place in a great variety of settings and demands good interpersonal skills as well as linguistic and cultural knowledge.

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"The community interpreter has a very different role and responsibilities from a commercial or conference interpreter. She is responsible for enabling professional and client, with very different backgrounds and perceptions and in an unequal relationship of power and knowledge, to communicate to their mutual satisfaction." (1)

This definition still applies today. The clients it refers to are mainly immigrants, refugees of all age groups, migrant workers and their children. Even if they have been living in their host country for years, their community, like New York's "Little Italy" or the Polish area of Chicago, has protected them from the need to learn English until they need social security or health care. The settings are hospitals and doctors' offices, schools, the various offices dealing with immigrant matters, housing and social security, and police stations. Compared to conference interpreting, the range of languages needed is enormous, even when compared to what is in store for the European Union. Moreover, the language level may be quite different from that of a diplomatic conference: regional variations and dialects can be a problem. Previously, the difficulties of dealing with this population have only been described by psychologists in the literature on the questioning of suspects or victims of accidents. The clients are worried, afraid, and sometimes illiterate. They find themselves in strange surroundings. Add to these difficulties the fact that the professionals -- the doctors, nurses, police officers, social workers etc. -- are usually in a hurry. They have a given case load to take care of and are disinclined to let the interpreter do "a beautiful consecutive." In a nutshell, community interpreters need people skills as well as language and cultural knowledge -- and interpreting know-how.

Some languages dominate: Spanish in the US, Turkish in Germany and Austria, Italian and Greek in Australia. But the Health Care Interpreting Services office of the Heartland Alliance in Chicago at present has demand for 28 languages. It is also obvious that it is not only the clients of community interpreters who are usually immigrants, but that the interpreters themselves are foreign-born. Their backgrounds vary accordingly. Hardly any of these interpreters have proper training in interpretation. Even where some efforts in this direction are made, the most common length of training is 40 hours. (2) "Most interpretation in health care settings, unfortunately, is still provided by a variety of other people who have been neither screened, nor trained, and who do not self-identify as being interpreters." (3)

Interest in this kind of interpreting, however, has grown by leaps and bounds. Last year the International Conference on University Institutes for Translation and Interpretation (CIUTI) decided that institutes do not have to teach conference interpreting exclusively in order to become a member.
They may offer any of a range of interpreter specialisations, including community interpreting.

There is not sufficient space to include a comprehensive bibliography on community interpreting here. The best sources would be the proceedings of the Canadian conferences on "interpreters in the community" -- the next one is planned for 2001 in Montreal -- and of the Babelea conference (Vienna, November 1999).


2 Cynthia E. Roat, ATA Chronicle, March 2000)

3 Ibid.

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