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REVIEW PAPER

Bridging the language gap: a review of cognitive behavioural therapy with spoken language interpreters

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Abstract

Cognitive behavioural therapy (CBT) is a frontline treatment for a range of mental health problems and is increasingly offered as the psychological therapy of choice across the globe. Access to or benefit from this psychological therapy relies on proficiency in the dominant language of the area. However, to meet our clients' needs in an increasingly mobile, multicultural, and diverse society, it may require adaptation through the use of spoken language interpreters. The benefits of interpreter-mediated CBT for mental health problems remains uncertain. The objective of this review is to systematically identify, evaluate, and integrate the existing empirical literature on interpreter-mediated CBT for mental health problems. A comprehensive search was conducted in July 2024 across CINAHL, MEDLINE, PsycINFO and Scopus. Studies meeting the inclusion criteria resulted in a total of eleven articles being included in the review. The included research shows promise in terms of feasibility and efficacy, but not conclusively. The narrative review enabled the synthesis of recommendations, which have been conceptualised as being at individual, service, and organisational levels. There is limited research and a need for further studies into the influence of other factors such as therapist proficiency, interpreter proficiency, complexity/co-morbidity and service context. Further evaluation should consider controlled trials of interpreter-mediated CBT, while also establishing its efficacy more robustly in regular practice. It should also further explore the experiences and perspectives of the client, interpreter, and therapist regarding the suggested recommendations.

Key learning aims

(1) Gain an understanding of the existing evidence on the effectiveness of interpreter-mediated CBT for various mental health problems across diverse populations.
(2) Learn about key recommendations emerging from empirical research on the implementation of interpreter-mediated CBT.
(3) Acquire clear, practical guidance that can inform the work of interpreters, practitioners, services, and healthcare systems to improve the delivery of interpreter-mediated CBT.

Keywords: cognitive behavioural therapy; culturally adapted; interpreter-mediated CBT; language interpreter; mental health therapy; spoken language interpreter

Introduction

Cognitive behavioural therapy (CBT) is a widely endorsed psychological therapy, recognised for its efficacy in treating a variety of mental health disorders across a range of groups, from young to elderly adults (Fordham *et al.*, 2021; Hofmann *et al.*, 2012). Whilst we might refer to it in the

singular, it is important to note is not a monolithic approach but better understood as a family of therapies that share similarities but also have distinct differences.

With an array of research, highlighting its efficacy and numerous meta-analyses and systematic reviews confirming its efficacy in treating depressive disorders (Angelakis *et al.*, 2022; Cuijpers *et al.*, 2013; Cuijpers *et al.*, 2023; Santoft *et al.*, 2019; Sockol, 2015; Werson *et al.*, 2022), anxiety disorders (Bhattacharya *et al.*, 2023; Carpenter *et al.*, 2018; Hofmann and Smits, 2008; Otte, 2011; Öst *et al.*, 2023), eating disorders (Keegan *et al.*, 2022; Linardon *et al.*, 2017; Linardon, 2018; Waller and Beard, 2024), substance misuse disorders (Magill *et al.*, 2019; Magill *et al.*, 2023; McHugh *et al.*, 2010) and many other presenting problems.

A growing body of research demonstrates its successful cultural adaptations while maintaining effectiveness (Jankowska, 2019; Kunorubwe, 2023; Naeem *et al.*, 2019; Phiri *et al.*, 2023; Praptomojati *et al.*, 2024; Rathod *et al.*, 2019; Silveus *et al.*, 2023).

CBT delivered across languages

CBT has demonstrated efficacy when delivered in a range of languages. To fully appreciate this, it is important to recognise that there are over 7000 spoken languages globally (Leben, 2018). Languages are classified into families and branches based on their historical and structural relationships (Trask and Stockwell, 2007), illustrating that linguistic diversity extends far beyond a simple distinction between English and non-English languages. Families such as Indo-European, Sino-Tibetan, Niger-Congo, Austronesian, and Afro-Asiatic encompass numerous languages shaped by distinct cultural, sociological, historical, and geographical influences.

CBT's effectiveness across different linguistic families has important implications for its acceptability, appropriateness, and efficacy when culturally and linguistically adapted. Many studies have demonstrated the efficacy of CBT in languages closely related to English within the Indo-European family, such as German (Linde *et al.*, 2005), Frisian (van Apeldoorn *et al.*, 2010), Danish (Nielsen, 2015), and Icelandic (Egilsdóttir, 2018).

Evidence also supports the efficacy of CBT in Indo-European languages that are more distant from English, including Russian (Pchelina *et al.*, 2024), Farsi (Kananian *et al.*, 2017), Urdu (Amin *et al.*, 2020), and Kurdish (Zemestani et al., 2022). Beyond Indo-European languages, research demonstrates CBT's adaptability across diverse linguistic families, including Arabic (Afro-Asiatic; Lindegaard *et al.*, 2021), Igbo (Niger-Congo; Ede *et al.*, 2020), Chinese dialects (Sino-Tibetan; Fan, 2022), and Māori (Austronesian; Bennett *et al.*, 2014).

Whilst this summary cannot capture all studies across language families, it demonstrates that CBT's efficacy extends across a broad range of linguistic contexts when adapted appropriately. Figure 1 presents a visual taxonomy of the languages and language families represented in these studies.

These findings demonstrate the adaptability and robustness of CBT as a therapeutic approach when delivered in the client's language by someone who also speaks that language. When it is not possible to deliver CBT in the client's language, the use of interpreters offers an alternative. Effective use of interpreters in CBT requires specific strategies to adapt typical practices, ensuring accurate communication, fostering therapeutic rapport, and preserving the core aspects of CBT. Therapists must work effectively with interpreters to promote accessible psychological therapies, ensure good clinical practice, and achieve equal outcomes and service delivery (Tribe and Lane, 2009).

Rationale for current research

There is limited empirical research on interpreter-mediated CBT, and to the researcher's knowledge, no systematic reviews have been conducted. Therefore, a systematic review of interpreter-mediated CBT is crucial for considering its effectiveness in treating mental health conditions, identifying best practices, and highlighting research gaps.

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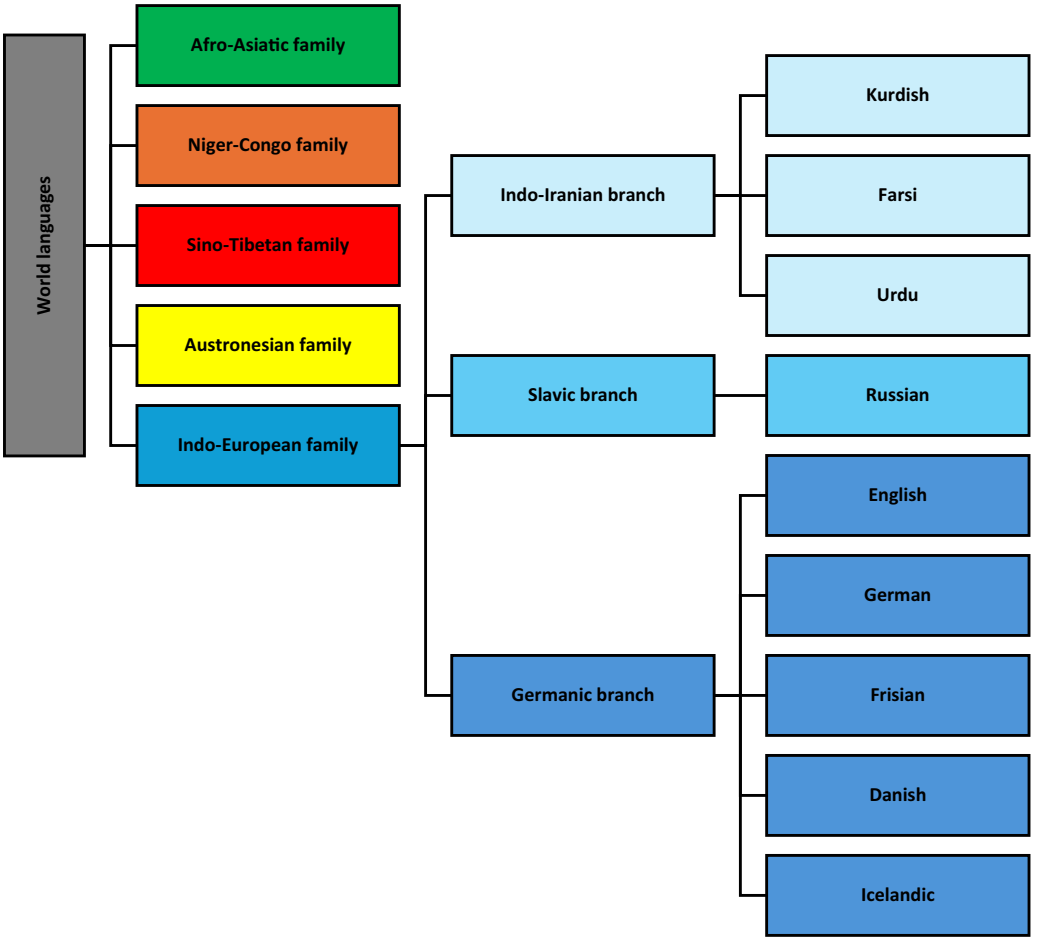

Figure 1. Illustration of taxonomy of the languages.

This review aims to systematically identify, evaluate, and integrate the findings of the existing empirical literature on interpreter-mediated CBT. It attempts to answer the following research questions:

Is interpreter-mediated CBT a beneficial treatment for mental health problems?

What are the best practices for conducting interpreter-mediated CBT for mental health issues?

Method

Database search

An electronic literature search was conducted in July 2024. Due to the lack of research on this specific topic, searches were completed in four databases:

- CINAHL
- MEDLINE
- PsycINFO
- Scopus

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Table 1. Search terms, truncations and Boolean operators

	Search terms and truncations	Boolean operators
CBT-related terms	• 'CBT' • 'cognitive behavioural therapy' • 'cognitive behavioral therapy' • 'cognitive therapy' • 'behavioural therapy' • 'behavioral therapy'	OR
		AND
Spoken language interpreting-related terms	• 'interpreter' • 'interpreters' • 'interpret*' • 'language interpreter' • 'language interpreters' • 'translators' • 'language translation' • 'mother tongue'	OR

Search terms

The search terms, truncations and Boolean operators (Table 1) were utilised as they represented the main concepts for the research topic and are words used in practice.

Due to limited research on interpreter-mediated CBT, it was decided not to use search terms that would limit the potential results to specific populations, outcomes, or countries. Although the approach may be more time-consuming and require additional effort in the screening process, it aims to provide a broad range of results.

Inclusion and exclusion criteria

Empirical studies on interpreter-mediated CBT for mental health problems published in the past 20 years were included. A 20-year timeframe was selected to maximise the inclusion of relevant studies, given the limited and emerging nature of research in this area. All studies related to the involvement of a professional interpreter to facilitate communication between the therapist and client in the delivery of CBT.

The initial search resulted in 5490 studies being identified, of which 2563 duplicates were removed, giving a total of 2927 studies to be considered for initial screening. Exclusion criteria included research that was not specific to psychotherapy, not specific to CBT, not empirical, not related to interpreters or where the primary problem was not a mental health problem. As part of the initial screening, the titles and abstracts were assessed utilising the inclusion/exclusion criteria (Table 2), with a total of 2888 being excluded.

The remaining 39 were full-text screened, using the inclusion and exclusion criteria mentioned above, resulting in 28 being excluded.

One study (Emmelkamp and van Schaik, 2010) was excluded as an English full-text version could not be sourced. Non-English papers were not automatically excluded to ensure comprehensive coverage of global research contributions and minimise the risk of assuming CBT is only for English speakers. Rather, English translations of journals and articles were sourced, which was possible for most, except for this one.

Another study (König, 2013) was excluded after careful consideration and supervision, as it related to sign language interpreting. Including this could lead to the homogenisation of the distinct challenges and techniques unique to each field, thereby obscuring the specialised training, considerations, and communication dynamics inherent in both. Sign language interpretation involves unique cognitive, linguistic, and cultural competencies and considerations of language deprivation that may differ from those required for spoken language interpretation; see Glickman

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Table 2. Inclusion/exclusion criteria

Domain	Inclusion criteria	Exclusion criteria
Diagnosis	• Primary problem is mental health problem	• Mental health problem is not the primary problem • Physical health diagnosis is main presenting problem
Interventions	• CBT or CBT-based psychological interventions	• Not related to psychotherapy • Main intervention is any other psychological intervention
Modifier	• The psychological intervention is delivered with an interpreter	• Intervention delivered in English • Intervention delivered in the client's preferred language without use of interpreter
Timeframe	• 2004–2024	• Outside of this range
Study type	• Empirical	• Non-empirical study • Review/meta-analysis • Book/book chapter • Guidance documents

and Harvey (1996), Glickman and Gulati (2003), Glickman (2013), Glickman (2016), and Glickman and Hall (2018).

This resulted in nine studies that met the criteria.

Hand searching of references was utilised to identify any relevant studies, with 22 studies identified; titles and abstracts were assessed utilising the inclusion/exclusion criteria (Table 2), with 20 being disregarded, leaving two deemed acceptable.

A total of 11 studies were included for quality assessment.

Systematic search results *(PRISMA chart)*

The procedure used for selecting articles follows the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher *et al.*, 2009). Please refer to Fig. 2.

Quality assessment *(risk of bias)*

This was conducted independently by the primary researcher and another researcher for all the papers; this was important to reduce the risk of bias and subjective judgements.

The Mixed Methods Appraisal Tool (MMAT; Hong *et al.*, 2018) was utilised. This review included a range of study types, such as qualitative research, randomised controlled trials, non-randomised studies, quantitative descriptive studies, and mixed methods studies, making the MMAT an appropriate choice for critical appraisal.

With the MMAT, each paper is initially screened based on two questions:

(1) Are there clear research questions?
(2) Does the collected data address these questions?

If either answer was 'No' or 'Cannot tell', the paper was deemed unsuitable for further evaluation, but no papers in this review fell into that category. Subsequent questions varied by study methodology, addressing aspects such as the appropriateness of the research approach, sample representativeness, data collection methods, and methodological integration. Each item was rated as 'Yes' if the study fully met the criteria, 'Unclear' if it partially met the criteria, and 'No' if it did not meet the criteria at all. See Table 3 for the MMAT rating from two raters.

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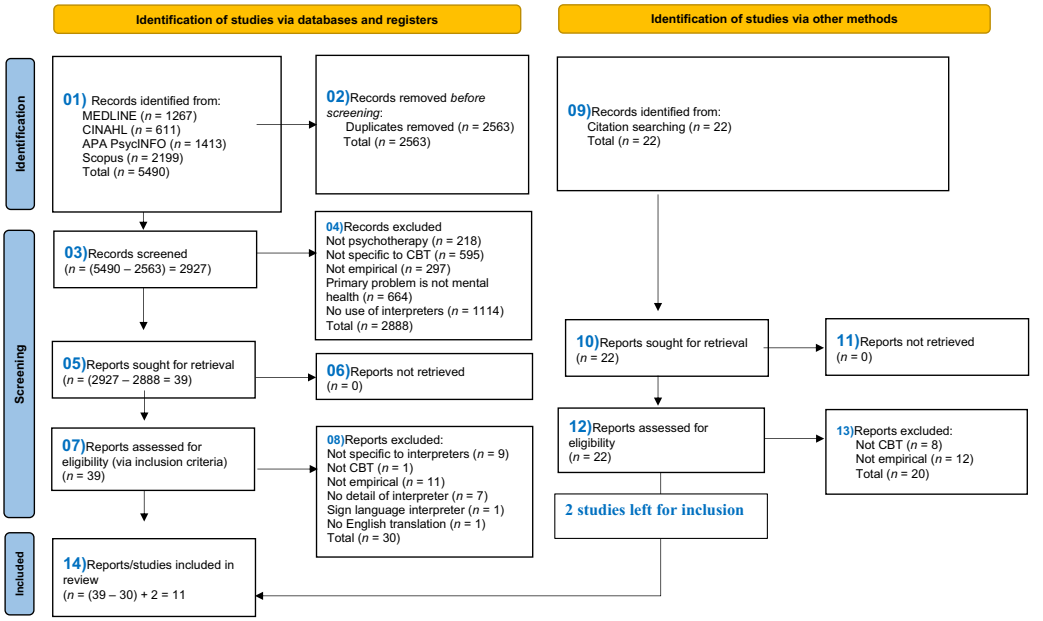

Figure 2. Search results: PRISMA flow diagram of study selection procedure. From Page *et al.* (2021).

Hong *et al.* (2018) discouraged calculating an overall score from the ratings of each criterion and typically advised against excluding studies based on low methodological quality. The MMAT does not have cut-off values, as such categories can be arbitrary (Hong *et al.*, 2019); therefore, they have not been used in this review. Consequently, papers were not excluded based solely on these categories. Instead, the author has provided a more detailed representation of the papers' quality by including a quality rating in Table 3.

In relation to inter-rater reliability, Cohen's kappa (κ) was initially calculated for each paper. However, for several papers, there was no variability in ratings because both raters consistently chose the same rating ('Yes', fully met criteria). As a result, Cohen's κ was deemed unsuitable for evaluating agreement, as it can be unreliable when there is no variation in ratings or when agreement is perfect. Therefore, raw agreement was calculated for each paper, as shown in Table 4. The overall inter-rater agreement for all studies was 98.79%.

Results

Characteristics of the studies

Three out of the 11 included studies were quantitative, exploring the feasibility and outcomes of interpreter-mediated CBT for trauma-affected refugees (d'Ardenne *et al.*, 2007a; Sander *et al.*, 2019; Schulz *et al.*, 2006). One study was a case study on interpreter-mediated CBT for phobia and depression (Mofrad and Webster, 2012). Another was a quantitative study evaluating a training program for interpreters in the field of interpreter-mediated CBT (Müller *et al.*, 2023). One study employed mixed methods aimed at developing good practice guidelines for interpreter-mediated CBT (d'Ardenne *et al.*, 2007b). One study focused on clients' experiences of interpreter-mediated CBT (Costa and Briggs, 2014), another explored interpreters' perspective on interpreting within psychotherapy (Villalobos *et al.*, 2021), and three studies were qualitative, exploring therapist experiences of interpreter-mediated CBT (Gerskowitch and Tribe, 2021; Tutani *et al.*, 2018; Wardman-Browne, 2023).

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Seven of the studies were conducted in England, two in the USA, one in Denmark, and one in Germany. Sample sizes varied considerably, ranging from 1 to 646 participants. Three studies did not specify participants' gender; however, among those that did, there was a slight predominance of females (464 females compared with 405 males). While the level of detail provided about the languages used in interpreter-mediated CBT varied, 44 specific client languages were reported. The dominant languages used by therapists, which reflected the predominant language of the healthcare settings, included English in nine studies, Danish in one study, and German in one study.

Notably, there is a lack of detailed information on race, ethnicity, nationality, or cultural background in many of the studies, with a few studies conflating some of these categories. In several studies, data on gender, age, and language is either missing or unspecified. This lack of detailed demographic information could limit the depth of analysis or interpretation of the results.

To enable the systematic data analysis, key features of each study were synthesised and organised using a data extraction tool created by the researcher (Table 5).

Summary of results

Studies on interpreter-mediated CBT reveal interesting findings regarding its feasibility and outcomes. On one hand, quantitative studies suggest that while interpreter-mediated CBT can be effective, the results are not conclusive. Some studies show significant improvements in symptoms related to PTSD (d'Ardenne *et al.*, 2007a; Schulz *et al.*, 2006), and a case study reported improvements in a client with phobia and depression (Mofrad and Webster, 2012). However, Sander *et al.* (2019) reported less benefit from interpreter-mediated CBT compared with sessions without interpreters. Additionally, training for interpreters has been found to positively impact their knowledge and attitudes towards treatment (Müller *et al.*, 2023).

On the other hand, qualitative studies highlight varied experiences from different perspectives. Clients who have received interpreter-mediated CBT often find the presence of interpreters essential, acting as a conduit for therapy. However, clients also report challenges related to disruptions in the typical flow of communication and struggle with conveying meaning (Costa and Briggs, 2014). Interpreters themselves face difficulties such as vicarious trauma and limited time to process the emotional load of therapy sessions (Villalobos *et al.*, 2021). Therapists delivering CBT with interpreters report both benefits, such as reaching clients who might otherwise be excluded, and challenges, including changes to the traditional therapeutic dynamic, potential disruptions to the flow of therapy, and friction with service delivery (Gerskowitch and Tribe, 2021; Tutani *et al.*, 2018; Wardman-Browne, 2023).

A mixed-method study developed good practice guidelines for interpreter-mediated CBT based on telephone polls, focus groups, and team reflections (d'Ardenne *et al.*, 2007b).

Is interpreter-mediated CBT beneficial?

d'Ardenne *et al.* (2007a) and Schulz *et al.* (2006) reported a statistically significant reduction in PTSD symptoms and some improvement in other areas, such as symptoms related to depression or quality of life. Mofrad and Webster (2012) conducted a single-case design study and reported some improvement but did not provide statistical tests.

In contrast, Sander *et al.* (2019) found that the use of an interpreter in psychotherapy was associated with less improvement in outcome measures compared with when no interpreter was used because the client and therapist were able to communicate without a spoken word interpreter. However, the discrepancies may not only be due to the use of an interpreter but could also involve other factors, and the impact of therapist/interpreter proficiency on outcomes was not explored. It is essential to consider other variables that may affect the results, and further research is needed to understand the role of such proficiency in outcomes. All of these studies were related

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Table 3. MMAT rating from two raters

	Costa and Briggs (2014)		d' Ardenne *et al.* (2007a)		d' Ardenne *et al.* (2007b)		Gerskowitch and Tribe (2021)		Mofrad and Webster (2012)		Müller *et al.* (2023)		Sander *et al.* (2019)		Schulz *et al.* (2006)		Tutani *et al.* (2018)		Villalobos *et al.* (2021)		Wardman-Browne (2023)	
	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE	TK	SE
S1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
S2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
1.1	Y	Y					Y	Y									Y	Y	Y	Y	Y	Y
1.2	Y	Y					Y	Y									Y	Y	Y	Y	Y	Y
1.3	Y	Y					Y	Y									Y	Y	Y	Y	Y	Y
1.4	Y	Y					Y	Y									Y	Y	Y	Y	Y	Y
1.5	Y	Y					Y	Y									Y	Y	Y	Y	Y	Y
2.1																						
2.2																						
2.3																						
2.4																						
2.5																						
3.1			Y	Y							Y	Y	Y	Y	Y	Y						
3.2			Y	Y							Y	Y	Y	Y	Y	Y						
3.3			Y	Y							Y	Y	Y	Y	Y	Y						
3.4			N	N							N	Y	Y	Y	Y	Y						
3.5			Y	Y							Y	Y	Y	Y	Y	Y						
4.1									Y	Y												
4.2									N	N												
4.3									Y	Y												
4.4									N	N												
4.5									Y	Y												
5.1					N	N																
5.2					Y	Y																
5.3					N	N																
5.4					C	N																
5.5					N	N																
	*****	*****	****	****	*	*	*****	*****	***	***	****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****

Y, yes; N, no; C, can't tell. A 5-star rating (*****), signifies that the study meets 100% of the quality criteria; a 4-star rating (****) indicates it meets 80% of the criteria; a 3-star rating (***) reflects 60% adherence to the criteria; a 2-star rating (**) represents 40%; and a 1-star rating (*) means it meets only 20% of the criteria.

Table 4. Inter-rater agreement for all studies

	Percentage agreement
Costa and Briggs (2014)	100%
d'Ardenne *et al.* (2007a)	100%
d'Ardenne *et al.* (2007b)	85.71%
Gerskowitch and Tribe (2021)	100%
Mofrad and Webster (2012)	100%
Müller *et al.* (2023)	85.71%
Sander *et al.* (2019)	100%
Schulz *et al.* (2006)	100%
Tutani *et al.* (2018)	100%
Villalobos *et al.* (2021)	100%
Wardman-Browne (2023)	100%
Mean agreement = 98.79%	

to individual interpreter-mediated CBT with adults, rather than group or family work. Overall, based on the reviewed studies, interpreter-mediated CBT shows potential, although further research is needed.

Consideration was given to conducting a meta-analysis focused on the outcomes or feasibility of interpreter-mediated CBT or performing a statistical analysis to combine the results of multiple studies. Only four studies were identified; as such, the researcher decided against this approach due to the limited number of available studies.

Typically, a meta-analysis requires a larger number of studies to ensure that the results are robust and reliable (Macaskill *et al.*, 2022). With such a small sample size, the results of a meta-analysis would likely be inconclusive and would not provide a meaningful or comprehensive understanding of the efficacy of interpreter-mediated CBT. Therefore, this section provides a narrative description of the results instead.

There is a clear need for more research into the efficacy or feasibility of interpreter-mediated CBT. To support future empirical research, a second data extraction tool (Table 6) was developed to summarise outcomes for the research exploring whether interpreter-mediated CBT was effective, including whether the intervention was statistically significant and the effect size.

What are the practice points for interpreter-mediated CBT for mental health issues?

Across the included studies, a range of practice points for interpreter-mediated CBT were identified. These were summarised and synthesised to provide a narrative description of best practices as reported in the literature. An inductive narrative synthesis process was used to develop these findings. Following familiarisation with all included studies, a data extraction tool was employed to generate initial recommendations, which were then iteratively refined. This process was supported by ongoing reflection, regular reference to the original papers, and discussion in supervision to ensure fidelity to the source material. Conceptually, the recommendations are organised according to their relevance within the therapeutic journey and the individuals responsible for implementing them in practice. This structure was informed by the authors' professional experience as a CBT therapist previously working within the NHS and now within private practice.

These recommendations were across three interconnected levels: Individual, service, and organisational (see Fig. 3). While each level addresses distinct areas, they are interdependent, reflecting the need for a cohesive approach to interpreter-mediated therapy.

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Table 5. Table of characteristics of studies

Author, date, country of origin, and kappa (κ)	Research aims	Methodology	Participant details (gender, age, ethnicity, language)	Intervention (either received, delivered or interpreted)	Summary of results
Costa and Briggs (2014) England Agreement between MMAT rater = 100%	Explore clients' experiences of working with interpreters in psychological therapy	Qualitative study using semi-structured interviews Opportunity sampling Panel method for qualitative analysis No exclusion criteria noted	Clients ($N = 7$) No specific information on the gender of clients No specific information on the age of the clients Doesn't offer detail on race, ethnicity or nationality Languages spoken by clients: Punjabi ($n = 3$) Polish ($n = 2$) Portuguese ($n = 1$) Dari ($n = 1$)	Clients received psychological therapies within IAPT Completed therapy ($n = 1$) Ongoing therapy ($n = 6$) *Limited detail on which therapy	Three main patterns of response were identified from the clients' responses: • Negative impacts on the therapy • Interpreter as conduit for therapy • Therapist and interpreter jointly demonstrating a shared enterprise
d'Ardenne *et al.* (2007a) England Agreement between MMAT rater = 100%	Explore whether interpreter-mediated CBT is feasible and associated with improved outcomes	Retrospective study Retrospective sample between 2000 and 2004 Quantitative analysis No exclusion criteria noted	Clients ($N = 128$) No specific information on the gender of clients No specific information on the age of the clients Doesn't offer details on race, ethnicity or nationality Languages spoken by clients: More than 20 languages, notes Turkish, Arabic, French, Farsi and Bengali were most common	Clients received TF-CBT within specialist trauma mental health service Group 1: Refugee clients with interpreters ($n = 44$) Group 2: Refugee clients without interpreters ($n = 36$) Group 3: Monolingual non-refugee clients ($n = 44$)	All groups showed significant improvement Refugees with interpreters have proportionally more improvement than refugees without interpreters
d'Ardenne *et al.* (2007b) England Agreement between MMAT rater = 85.71%	Describe the interpreting processes for TF-CBT	Mixed methods Purposive sampling Part 1: telephone poll Part 2: focus group of interpreters Part 3: reflective session with service staff Unclear on approach to analysis No exclusion criteria	Part 1: Specialist trauma services ($n = 17$) Part 2: Experienced staff from interpreting service ($n = 4$) Part 3: Refers to team reflective session but doesn't specify who participated For parts 2 and 3 – no specific information on the gender of the participants For parts 2 and 3 – no specific information on the age of the participants	Part 1 Services delivered trauma-focused psychotherapy Part 2 Interpreters working within trauma-focused psychotherapy Part 3 Team of therapists delivering trauma-focused psychotherapy with interpreters	Generated guidance on interpreter-mediated CBT, with recommendations for the service, the therapist and the interpreter

(*Continued*)

Table 5. (*Continued*)

Author, date, country of origin, and kappa (κ)	Research aims	Methodology	Participant details (gender, age, ethnicity, language)	Intervention (either received, delivered or interpreted)	Summary of results
			Doesn't offer details on race, ethnicity or nationality Doesn't offer any details of languages interpreted		
Gerskowitch and Tribe (2021) England Agreement between MMAT rater = 100%	Aimed to gain an understanding of the impact the context of therapy has on the experiences of therapists in the NHS of working with interpreters	Interpretative phenomenological analysis (IPA) Semi-structured interviews Opportunity sampling from one mental health trust in London No exclusion criteria	Psychotherapist ($N = 10$) Male ($n = 4$) Female ($n = 6$) Doesn't offer details on age or ethnicity of the therapists or the clients seen within these services Doesn't offer any details of languages interpreted	Therapists who deliver psychotherapies in IAPT/secondary care Therapies included CBT, cognitive analytic therapy, eye movement desensitization and reprocessing (EMDR) and psychodynamically informed therapy	The analysis resulted in the development of three super-ordinate themes: • 'The most powerful thing is the system' • 'The knotty question of power' • 'Dyadic and triadic alliances'
Mofrad and Webster (2012) England Agreement between MMAT rater = 100%	Outline the use of an interpreter in the treatment of clients with phobia and depression	Single case study Opportunity sample No exclusion criteria	Client ($N = 1$) Female 35-year-old Mentions she is Middle Eastern but doesn't offer specific in terms of ethnicity, nationality or culture Languages spoken by client: Arabic	Received CBT within IAPT service	The client reported subjective positive outcomes and some reduction in routine outcome measures Positive learning for the therapist related to working with interpreters
Müller *et al.* (2023) Germany Agreement between MMAT rater = 85.71%	Develop and evaluate a training program for interpreters in the field of trauma-focused CBT	Pre and post design Opportunity sample Quantitative analysis No exclusion criteria	Interpreters ($N = 129$) Male ($n = 43$) Female ($n = 77$) Diverse ($n = 2$) Age ($M = 43.9$, $SD = 13.2$) Doesn't offer details on race, ethnicity or nationality Languages spoken by interpreters: Arabic ($n = 44$), Dari ($n = 21$), French ($n = 17$), Farsi ($n = 15$), English ($n = 14$), Kurdish	An interpreter working within trauma-focused CBT service for minors and attended one-day training on interpreting within TF-CBT	Positive feedback, change in levels of knowledge and a positive shift in attitudes considered beneficial for working as an interpreter with traumatised minors

(*Continued*)

Table 5. (*Continued*)

Author, date, country of origin, and kappa (κ)	Research aims	Methodology	Participant details (gender, age, ethnicity, language)	Intervention (either received, delivered or interpreted)	Summary of results
			($n = 14$), Turkish ($n = 12$), Other* ($n = 62$) which included Pashto, Russian, Tigrinya, Sorani, Spanish, Amharic, Somali, Italian, Hindi, Croatian, Mandinka, Portuguese, Vietnamese, Armenian, Bulgarian, Chinese, Greek, Oromiffa, Polish, Slovak, Tajik, Tamil, Telugu, Czech, Chechen, Hungarian, Urdu, Wolof		
Sander *et al.* (2019) Denmark Agreement between MMAT rater = 100%	Examine if interpreter-mediated CBT with trauma-affected refugees affected the outcome	Retrospective cohort Retrospective sample Quantitative analysis Main problem PTSD and completed a minimum 8 sessions of trauma-focused CBT	Clients ($N = 646$) Male ($n = 338$) Female ($n = 308$) Age ($M = 45.2$, $SD = 9.1$) Doesn't offer details on race, ethnicity or culture Country of origin: Iraq ($n = 215$) Afghanistan ($n = 88$) Ex-Yugoslavia ($n = 84$) Iran ($n = 78$) Lebanon ($n = 74$) Doesn't offer details on race, ethnicity or culture Languages spoken by clients Arabic, Farsi, Bosnian, Danish and English *Doesn't specify numbers	Received trauma-focused CBT at a specialist trauma service between 2009 and 2015 Group 1: Treatment with interpreters ($n = 375$) Group 2: Treatment without interpreters ($n = 271$)	The use of an interpreter (Group 1) was associated with less improvement in the outcome measures in comparison to no use of an interpreter (Group 2)
Schulz *et al.* (2006) USA Agreement between MMAT rater = 100%	Testing the effectiveness of CBT for PTSD With refugees in a community setting	Retrospective cohort Retrospective sampling between 1993 and 2004 Quantitative analysis No exclusion criteria	Clients $N = 53$ Male ($n = 7$) Female ($n = 48$) Age ($M = 45.8$, $SD = 12.1$) Country of origin: Afghanistan ($n = 9$) Former Yugoslavia ($n = 44$)	Received trauma-focused CBT at a community-based mental health program for foreign-born refugees Group 1: Treatment with interpreter ($n = 25$)	Results demonstrated that treatment of PTSD was effective whether delivered through an interpreter (Group 1) or by a therapist who spoke the client's native language (Group 2)

(*Continued*)

Table 5. (*Continued*)

Author, date, country of origin, and kappa (κ)	Research aims	Methodology	Participant details (gender, age, ethnicity, language)	Intervention (either received, delivered or interpreted)	Summary of results
			Doesn't offer details on race, ethnicity or culture Languages spoken by clients: Mentions Farsi and Serbo-Croatian *Doesn't specify numbers	Group 2: Treatment without interpreters but with therapist who spoke the client native language ($n = 28$)	
Tutani *et al.* (2018) England Agreement between MMAT rater = 100%	Explore the experiences of CBT therapists and PWPs working in collaboration with an interpreter	Cross-sectional, qualitative methods design Semi-structured interviews Convenience and purposive sampling No exclusion criteria	$N = 13$ Male ($n = 2$) Female ($n = 11$) No specific information on the age of the clients Doesn't offer details on race, nationality, ethnicity *Notes 4 participants were from diverse backgrounds Doesn't offer any details of languages interpreted	Delivered evidence CBT within an IAPT/primary care mental health care High-intensity CBT therapist ($n = 6$) Low-intensity CBT practitioner ($n = 7$) Experience of working with interpreters (number of interpreted sessions $M = 40.77$; range 7–86	Four themes were identified from the practitioners' accounts: • Negotiating a three-way communication • Difficulties in expressing empathy • Establishing shared understanding • Working creatively with interpreters
Villalobos *et al.* (2021) USA Agreement between MMAT rater = 100%	Explore interpreters' perspectives on working with clients with trauma	Focus group Thematic analysis Opportunity sampling No mention of exclusion criteria	Medical interpreters $N = 10$ Male ($n = 5$) Female ($n = 1$) Did not answer ($n = 4$) Age ($M = 55.8$, $SD = 14.5$) Hispanic ($n = 3$) White Caucasians ($n = 2$) Did not answer ($n = 5$) Languages used by interpreters: Spanish ($n = 9$) ASL ($n = 1$)	Interpreting for evidence-based trauma-focused CBT	Two themes were identified: • Challenges of interpreting within trauma-focused CBT • Perceived need to improve interpreting within trauma-focused CBT

(*Continued*)

Table 5. (*Continued*)

Author, date, country of origin, and kappa (κ)	Research aims	Methodology	Participant details (gender, age, ethnicity, language)	Intervention (either received, delivered or interpreted)	Summary of results
Wardman-Browne (2023) England Agreement between MMAT rater = 100%	Explore experiences of working remotely with language interpreters	Qualitative semi-structured interviews Thematic analysis Snowball sampling via social media Exclusion criteria not accredited with BABCP CBT therapist	CBT therapists $N = 18$ Male ($n = 6$) Female ($n = 12$) Age ($M = 41$; *SD* not reported) Ethnicity White ($n = 10$) Diverse ($n = 8$) Doesn't specify the languages they have experience working with through spoken-word interpreters, but it does mention some of the languages spoken by the therapists themselves	Offering CBT within IAPT, NHS secondary care services and private practice *Some trained in other modalities	Five themes were identified: • System challenges • Therapist values • Cultural sensitivity • Interpreter's role • Remote working

Table 6. Summary of main findings for studies reported efficacy/feasibility of interpreter-mediated CBT

Reference	Aims	Was interpreter-mediated CBT effective in reducing symptoms of main presenting problem?	Effect size (*d*)	Was interpreter-mediated CBT effective in reducing symptoms of other presenting problem?	Effect size (*d*)
d'Ardenne *et al.* (2007a)	Explore whether interpreter-mediated CBT is feasible and associated with improved outcome	Group 1: Refugee patients with interpreters 6.0 reduction on the IES (PTSD symptomology) with $p<.05$ Group 2: Refugee patients without interpreters 6.3 reduction on the IES (PTSD symptomology) with $p<.05$ Group 3: Monolingual non-refugee patients 11.5 reduction on the IES (PTSD symptomology) with $p=.00$	No reported effect size	Group 1: Refugee patients with interpreters 6.0 reduction on the on BDI (Depressive symptomology) with $p<.005$ 0.17 increase on the MANSA (Quality of Life) with $p=.179$* Group 2: Refugee patients without interpreters 6.1 reduction on the on BDI (Depressive symptomology) with $p=.00$ 0.32 increase on the MANSA (Quality of Life) with $p<.05$ Group 3: Monolingual non-refugee patients 9.8 reduction on the on BDI (Depressive symptomology) with $p<.0001$ 0.41 increase on the MANSA (Quality of Life) with $p=.001$	No reported effect size
Mofrad and Webster (2012)	Outline the use of an interpreter in the treatment of client with phobia and depression	PHQ-9 (Depression) varied through treatment but had same pre and post score of 6 IAPT Phobia Q3 (specific Phobia) varied through treatment but had same pre and post score of 8 No inferential statistics completed	No reported effect size	GAD7 (Generalised Anxiety) varied through treatment but reduced from a 12 to an 8 No inferential statistics completed	No reported effect size
Sander *et al.* (2019)	Examine if interpreter-mediated CBT with trauma affected refugees affected outcome	Group 1: Treatment with interpreters 0.10 reduction on the HTQ (PTSD symptomology) with $p<0.01$ Group 2: Treatment without interpreters 0.23 reduction on the HTQ (PTSD symptomology) with $p<0.01$	No reported effect size	Group 1: Treatment with interpreters 0.10 reduction on the HTQ (PTSD symptomology) with $p<0.01$ 0.05 reduction on the HSCL-25 (depression and anxiety symptoms) with $p=0.07$* 0.05 increase on the SI-SCL-90 (somatisation) with $p=0.17$* 0.08 reduction on the SDS	No reported effect size

(*Continued*)

Table 6. (*Continued*)

Reference	Aims	Was interpreter-mediated CBT effective in reducing symptoms of main presenting problem?	Effect size (*d*)	Was interpreter-mediated CBT effective in reducing symptoms of other presenting problem?	Effect size (*d*)
				(functional impairment) with $p = 0.81$* 4.89 increase on the WHO-5 (quality of life) with $p<0.01$ Group 2: Treatment without interpreters 0.23 reduction on the HTQ (PTSD symptomology) with $p<0.01$ 0.21 reduction on the HSCL-25 (depression and anxiety symptoms) with $p<0.01$ 0.14 reduction on the SI-SCL-90 (somatisation) with $p<0.01$ 1.70 reduction on the SDS (functional impairment) with $p<0.01$ 8.47 increase on the WHO-5 (quality of life) with $p<0.01$	
Schulz *et al.* (2006)	Testing the effectiveness of CBT for PTSD with refugees in a community setting	Group 1: Treatment with interpreter 21.6 reduction on the PSS (PTSD symptomology) with $p<0.01$ Group 2: Treatment without interpreters but with therapist who spoke client native language 26.9 reduction on the PSS (PTSD symptomology) with $p<0.01$	$d = 2.0$ $d = 3.4$	n/a	n/a

An asterisk (*) indicates that the result did not meet the threshold for statistical significance ($p<0.05$).
IES, Impact of Events Scale (Horowitz et al., 1979); BDI, Beck Depression Inventory (Beck and Steer, 1987); MANSA, Manchester Short Assessment of Quality of Life (Priebe et al., 1999); PHQ-9, Patient Health Questionnaire (Kroenke et al., 2001); IAPT Phobia Q3, IAPT Phobia Scales (IAPT Toolkit, 2008); GAD-7, Generalised Anxiety Disorder Questionnaire (Spitzer et al., 2006); HTQ, Harvard Trauma Questionnaire (Mollica et al., 1992); HSCL-25, Hopkins Symptom Check List-25 (Mollica et al., 1987); SI-SCL-90, somatisation items of SCL-90 (Derogatis, 1994); SDS, Sheehan Disability Scale (Sheehan and Sheehan, 2008); WHO-5, the WHO-5 Well-being Index (Folker and Folker, 2008); PSS, PTSD Symptom Scale (Foa et al., 1993).

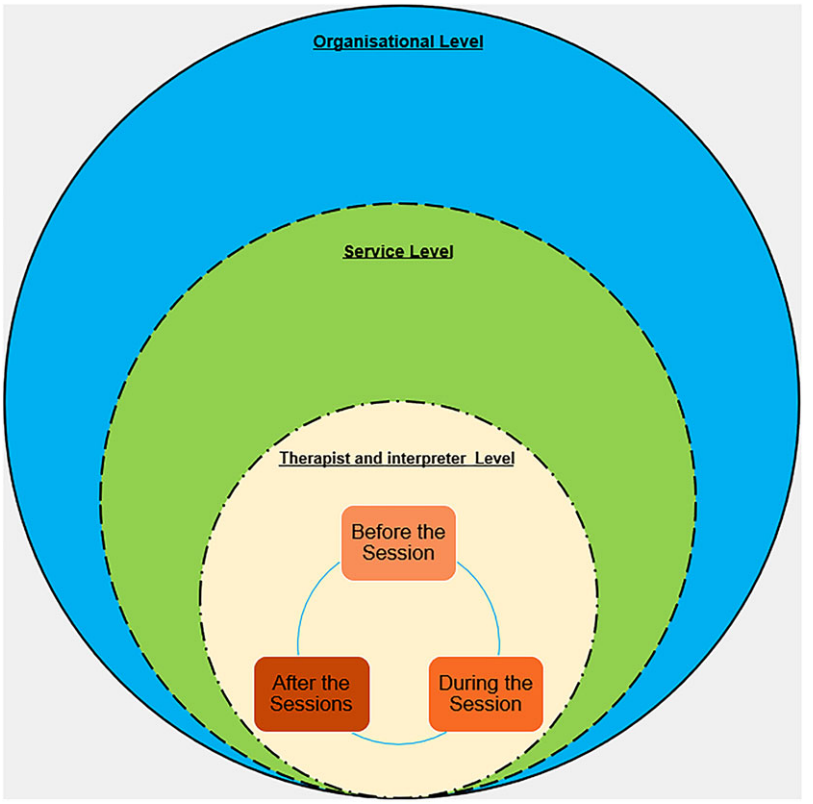

Figure 3. Illustration of how recommendations for working with interpreters align with the therapy process.

Individual level

Before the appointment

Reflective practice. Three papers referenced therapists engaging in reflective practice as an important component of their preparation. Wardman-Browne (2023) and Gerskowitch and Tribe (2021) emphasise the importance of reflective practice for therapists focused on their experiences, biases, and the dynamics of the therapeutic relationship, particularly when working with interpreters. Costa and Briggs (2014) further noted the importance of reflecting on how therapy is shaped by the triadic nature of interpreter-mediated sessions.

Existing guidance. Two papers made reference to familiarisation and the use of existing guidelines. d'Ardenne *et al.* (2007b) noted that in their survey of services, all reported that interpreters followed professional guidelines; however, these were not specific to the NHS, the service context, or CBT, highlighting a lack of standardised, context-specific practices. d'Ardenne *et al.* (2007b) recommended that both interpreters and clinicians familiarise themselves with relevant guidance to ensure they are well-prepared for the challenges that may arise during therapy sessions. Sander *et al.* (2019) further emphasised the importance of interpreters working according to guidelines tailored to interpreter-mediated CBT as these create a structured environment where both interpreters and clinicians can operate within a clear framework.

Sharing materials/resources. Two papers referred to interpreters reviewing session materials and measures beforehand. To enhance their understanding and ability to support the therapeutic process effectively (d'Ardenne *et al.*, 2007b). Ideally, these should be translated materials and other relevant resources, as this preparation can significantly improve the fluency and accuracy of interpretation (Villalobos *et al.*, 2021). This might include materials such as handouts,

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terminology lists, or therapeutic tools that allow interpreters to familiarise themselves with specialised terms and concepts, thereby reducing the risk of miscommunication. Villalobos *et al.* (2021) emphasise that such preparation makes therapy more accessible and impactful by enhancing the clarity and consistency of communication throughout the session.

Extra time. Five studies referred to allowing additional time for sessions. d'Ardenne *et al.* (2007a), Schulz *et al.* (2006), and Sander *et al.* (2019), while exploring the feasibility and efficacy of interpreter-mediated CBT, noted that sessions typically took longer because of the different pace of communication. d'Ardenne *et al.* (2007a) reported that interpreter-mediated CBT sessions required up to 50% more time compared with non-interpreter-mediated sessions.

This aligns with Tutani *et al.* (2018), who found that interpreter-mediated sessions often took longer, with guided self-help lasting up to 60 minutes and CBT lasting up to 90 minutes, due to the need for accurate interpretation, engagement, and clear communication. d'Ardenne *et al.* (2007b) further recommend that therapists should also plan for additional time for briefings with interpreters to ensure the session runs smoothly. They emphasise the importance of arriving punctually to avoid delays.

Briefing. Five studies made reference to briefing sessions between therapists and interpreters prior to a therapy session. Sander *et al.* (2019) emphasised the importance of these briefings to ensure interpreters understand the session's goals and potential challenges. Schulz *et al.* (2006) noted that using this time beforehand to discuss therapeutic techniques and client-specific concerns is beneficial. d'Ardenne *et al.* (2007b) noted that interpreters requested briefings to support emotional preparedness and potential trauma, cultural, or linguistic issues, as well as to coordinate practical aspects like seating and eye contact. Villalobos *et al.* (2021) also advocated for pre-session meetings to help interpreters prepare for difficult content and support therapist–interpreter collaboration. Tutani *et al.* (2018) and Villalobos *et al.* (2021) further recommended using the briefing to review written materials, clarify CBT-specific tools and terminology, and provide interpreters with handouts in advance – particularly those containing complex language – to support accurate and effective interpretation.

Agreeing on the interpreting model. Six studies referenced the importance of agreeing on the model of interpretation used, noting that the choice or absence of a defined model can significantly impact the therapeutic process and the clarity of expectations and roles. With some leading interpreters to act as literal translators, others convey meaning, and some also explain cultural nuances. Wardman-Browne (2023) draws attention to inconsistencies in how interpreters are perceived, with roles ranging from literal language conveyors to co-therapists or cultural mediators. Such variability underscores the need for clear agreement on the interpreting model to ensure aligned expectations and effective collaboration. Schulz *et al.* (2006) also emphasise that interpreters are not neutral conduits, but rather facilitators of the therapeutic relationship, helping to build trust and understanding. This aspect is critical in any therapeutic interaction. Similarly, d'Ardenne *et al.* (2007b) highlight the added value interpreters bring through their cultural insights, noting that they can advise clinicians when appropriate to help contextualise client experiences. d'Ardenne *et al.* (2007b) further emphasise the importance of agreeing on an appropriate interpreting model, which would be the best fit, and also ensure that both the interpreter and therapist are working in accordance with that model. However, that is not to say that it cannot change through a course of treatment, as Tutani *et al.* (2018) suggest that rigid adherence to a single model may not be suitable for all clients or contexts. Instead, this approach should be adapted based on the therapeutic setting and client needs, ensuring their involvement is supportive without being intrusive.

During the appointment

Confidentiality. Two studies highlighted the importance of confidentiality in interpreter-mediated CBT, particularly in terms of ensuring and clearly communicating it to clients to build trust.

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d'Ardenne *et al.* (2007b) emphasise that interpreters must adhere to strict confidentiality standards and avoid working with clients they know personally. They also recommend logistical measures such as providing separate waiting areas for clients and interpreters to prevent inadvertent disclosures and maintain professional boundaries. d'Ardenne *et al.* (2007a) further note that interpreter involvement can raise concerns about trust, particularly when clients are uncertain about how their information will be handled. This issue may be heightened if the interpreter shares the client's cultural or ethnic background, potentially leading to fears of judgement or breaches of privacy (Tutani *et al.*, 2018). Mofrad and Webster (2012) reinforced this point in a case study by ensuring that the interpreter and client did not share a social relationship, a step they identified as critical for maintaining trust.

Clarifying roles. Four studies noted clearly defining and communicating the roles of therapists and interpreters to clients. Before therapy begins, therapists should introduce the interpreter, agree on roles, and establish practical arrangements such as seating (d'Ardenne *et al.*, 2007b). Sander *et al.* (2019) emphasise the importance of explaining the interpreter's role and limitations to clients to set appropriate expectations and avoid confusion. Similarly, Tutani *et al.* (2018) note that clarifying roles and dynamics helps reduce misunderstandings and improves therapeutic outcomes. Ensuring both the client and interpreter understand their roles and boundaries can enhance engagement and trust in the process. Because interpreters often focus on word-for-word translation, this may limit their direct interaction with clients. To address this, therapists are encouraged to strike a balance between the interpreter's linguistic role and opportunities for meaningful client engagement (Tutani *et al.*, 2018). Role expectations may also need to be revisited throughout therapy, as mismatches between client expectations and the interpreter's actual role can lead to confusion or dissatisfaction. Costa and Briggs (2014) point out that some clients may perceive interpreters as overly rigid if their role does not align with previous experiences of interpreters providing more personal or emotional support in other contexts.

Communication. Seven studies noted adaptation to communication in interpreter-mediated CBT. Therapists should use simple, clear language and adjust their pace to support accurate interpretation (d'Ardenne *et al.*, 2007b; Wardman-Browne, 2023). Strategies such as using common codes, repeating key terms, and developing shared terminology can improve understanding (Mofrad and Webster, 2012). However, this must be carefully balanced as interpretation may interrupt the natural flow of conversation, slow the session pace, and reduce direct engagement between therapist and client (Costa and Briggs, 2014; Mofrad and Webster, 2012).

The communication of empathy can be challenging; therefore, therapists must rely more on non-verbal cues and work closely with interpreters to ensure both emotional tone and content are conveyed effectively (Tutani *et al.*, 2018). Therapists are also encouraged to observe verbal and non-verbal interactions, pause sessions when needed, and seek feedback from clients to address and refine communication issues (d'Ardenne *et al.*, 2007b). There is a risk of miscommunication when feedback lacks clarity or emotional nuance, which can potentially disrupt therapeutic rapport (Tutani *et al.*, 2018). Therefore, communication quality is essential for avoiding misunderstandings and ensuring therapeutic effectiveness (Costa and Briggs, 2014).

Interpreters are encouraged to translate in small, direct segments, remaining as close to the original language as possible – except when dealing with idioms or figures of speech, where conveying intended meaning is prioritised (d'Ardenne *et al.*, 2007b). They are also advised to pause sessions to clarify uncertainties and must accurately convey all nuances, including repetitions, pauses, ambiguities, and sensitive material (d'Ardenne *et al.*, 2007b). Psychological terminology can be particularly challenging to translate, especially when unfamiliar or inconsistent with terms used in medical contexts (Villalobos *et al.*, 2021). The interpreter's linguistic proficiency and understanding of therapeutic language can significantly influence the quality of communication (Sander *et al.*, 2019).

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Careful preparation further supports effective communication. Tutani *et al.* (2018) note that therapists who planned sessions thoughtfully seemed better able to navigate linguistic and cultural challenges. This includes preparation, such as considering terminology, avoiding idioms and jargon, and selecting words that are culturally appropriate and more easily translatable.

Therapeutic relationship. Eight of the studies made reference to the dynamics of the therapeutic relationship. The involvement of an interpreter inherently alters the traditional one-to-one therapy model, introducing a triadic structure that changes the interpersonal dynamic. Therapists often reported discomfort with this shift, describing feelings of being under pressure or scrutinised, which could hinder their ability to engage fully with clients (Schulz *et al.*, 2006; Mofrad and Webster, 2012). In contrast, clients generally appreciated the interpreter's presence and reported no issues with having a third person in the session, suggesting a more positive perception of the therapeutic environment (Costa and Briggs, 2014).

To navigate this altered dynamic, the development of relational and interpersonal skills was seen as essential for both therapists and interpreters. Strengthening the three-way relationship between therapist, interpreter, and client was viewed as crucial for fostering a collaborative and effective therapeutic environment (Tutani *et al.*, 2018; Mofrad and Webster, 2012). When interpreters were able to mirror the therapist's empathy, therapy outcomes improved, highlighting the importance of alignment in therapeutic attitudes (Tutani *et al.*, 2018). However, some therapists expressed concerns that working with interpreters might compromise their ability to build a strong therapeutic bond. In some cases, they felt marginalised when the client appeared to form a closer relationship with the interpreter, particularly if personal concerns were shared more openly with them (d'Ardenne *et al.*, 2007a; Mofrad and Webster, 2012). These experiences were linked to issues of trust, role ambiguity, and power dynamics, with some therapists reporting anxiety, feelings of powerlessness, or a loss of control, while others sought to share power more equitably within the triad (Tutani *et al.*, 2018; Gerskowitch and Tribe, 2021; Wardman-Browne, 2023). Therapists were also encouraged to reflect on how the interpreter's presence might influence transference and countertransference processes, which are important for understanding the client's experience and facilitating therapeutic progress (Costa and Briggs, 2014).

The transition to remote therapy introduced further complexity, as therapists found it more challenging to apply key interpersonal skills and maintain relational depth in online sessions (Wardman-Browne, 2023). Finally, the potential for therapeutic ruptures was noted, with one client reporting distress when an interpreter laughed at painful material – an incident that significantly disrupted the therapeutic relationship (Costa and Briggs, 2014). Addressing such ruptures was considered vital to preserving trust and ensuring clients felt respected and understood throughout the therapeutic process.

Collaboration. Four studies made reference to collaboration, with it being a key aspect within the relationship between the therapist and interpreter, as effective communication and therapy rely on their interdependence (Costa and Briggs, 2014) and shared accountability (d'Ardenne *et al.*, 2007b). Building a collaborative alliance with interpreters is crucial to support the therapeutic process (Tutani *et al.*, 2018). Client perceptions of this relationship varied; when collaboration was lacking, interpreters were often seen as interruptive; when collaboration was strong, clients appreciated the shared effort and trusted both professionals in their respective roles (Costa and Briggs, 2014). Rather than treating it as two separate collaborative relationships, it may be better viewed as a three-way partnership. Gerskowitch and Tribe (2021) advocate for a collaborative approach involving the therapist, interpreter, and client. Similarly, Costa and Briggs (2014) noted that clients valued a sense of teamwork when all three parties worked together cohesively.

Culturally adapted therapy. Five studies referred to aligning the therapeutic approach with a culturally adapted approach. Wardman-Browne (2023) stresses the importance of adapting CBT principles for diverse clients while preserving the core structure of the therapy. Therapists are encouraged to be flexible, tailoring their approach based on the client's cultural context, history,

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and current circumstances. This should be in collaboration; for example, d'Ardenne *et al.* (2007b) recommend jointly selecting metaphors and idioms that are meaningful within the client's cultural framework. Tutani *et al.* (2018) similarly advise therapists to check the cultural relevance of language and values during sessions to minimise miscommunication and enhance therapeutic impact. In cases where complex language may be a barrier, Mofrad and Webster (2012) suggest using behavioural interventions that emphasise learning through action rather than relying heavily on verbal explanation. Additionally, Costa and Briggs (2014) highlight the importance of understanding a client's culture and typical stress responses, as this insight can inform more tailored and effective interventions.

Routine outcome measures. Five studies made reference to the use of psychological outcome measures. Due to the frequent unavailability of such measures in other languages, interpreters are often asked to assist in administering psychological assessments. Tutani *et al.* (2018) reported that therapists often rely on interpreters to directly translate English-language questionnaires during sessions, which raises concerns about the consistency and validity of the measures used. Similarly, d'Ardenne *et al.* (2007a) and Mofrad and Webster (2012) emphasise that interpreter involvement in administering assessments can inadvertently influence how questions are understood and answered, potentially compromising the reliability of the results. In response to these concerns, d'Ardenne *et al.* (2007b) recommend that therapists carefully review psychometric data for accuracy and be mindful of how the interpretation process may have impacted client responses.

After the appointment

Debriefing. Four studies made reference to post-session debriefing between therapists and interpreters. Interpreters have expressed a strong need for post-session debriefings to help process the emotional and cognitive demands of the session, clarify content, and provide feedback (d'Ardenne *et al.*, 2007b). These debriefs are also viewed as a valuable opportunity for therapists to gather insights, address any misunderstandings, and assess whether the session's objectives were effectively met. Villalobos *et al.* (2021) further underscore the role of debriefing in refining the therapeutic process and enhancing collaboration between therapists and interpreters. Sander *et al.* (2019) recommend that clinicians prioritise debriefings to reinforce mutual understanding and improve communication. In addition, Schulz *et al.* (2006) found that interpreters often use these sessions to share cultural insights or perspectives, which can be invaluable for therapists navigating sensitive or unfamiliar cultural dynamics. However, despite these clear benefits, debriefings are not consistently implemented in practice. A telephone survey conducted by d'Ardenne *et al.* (2007b) found that only about half of the services allocated additional time for debriefing.

Supporting interpreters. Three studies made reference to supporting interpreters with any potential emotional reactions after the session. d'Ardenne *et al.* (2007b), Costa and Briggs (2014), and Villalobos *et al.* (2021) highlight the emotional and psychological demands placed on interpreters, particularly within trauma-focused therapy. Interpreters often report personal distress due to the content they must convey, especially when interpreting traumatic material using first-person language and non-verbal expressions (d'Ardenne *et al.*, 2007b; Villalobos *et al.*, 2021). Given these potential risks, it is crucial that, as part of the debrief, this is considered and support is offered, along with signposting as needed.

Cultural consultation. Three of the studies noted interpreters contributing culturally bound understanding. Interpreters often possess a deeper understanding of clients' cultural backgrounds and the culturally based meanings associated with them. Wardman-Browne (2023) and Tutani *et al.* (2018) emphasise that interpreters can act as important sources of cultural knowledge, enriching the therapeutic process by providing context that may not be immediately apparent to therapists. d'Ardenne *et al.* (2007b) recommend that this insight be shared during debriefing sessions, where interpreters can communicate their observations and cultural interpretations,

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allowing therapists to adjust their strategies accordingly. Therapists are encouraged to actively engage interpreters in discussions about cultural nuances that may affect therapy, as this collaboration can enhance cultural sensitivity, support rapport-building, and lead to more effective and contextually appropriate interventions, particularly when addressing culturally specific concerns.

Consistent interpreter. Six studies referred to the importance of ensuring continuity by maintaining the same interpreter throughout therapy. d'Ardenne *et al.* (2007a) and Schulz *et al.* (2006) report that this is standard practice unless a client specifically requests a change. Sander *et al.* (2019) support this approach, noting that consistent interpreter involvement across treatment sessions fosters trust and familiarity among the client, therapist, and interpreter, which can enhance therapeutic outcomes. From the therapist's perspective, continuity is essential, with d'Ardenne *et al.* (2007b) emphasising the therapist's responsibility to maintain the same interpreter or to facilitate a change if the client requests it. Clients also expressed appreciation for consistency, as it contributed to a more comfortable and trusting therapeutic environment (Costa and Briggs, 2014). From the interpreter's perspective, continuity in care was likewise seen as beneficial. Villalobos *et al.* (2021) recommend that interpreters be assigned to clients they have previously worked with whenever possible, as this familiarity improves communication and supports a more stable and effective therapeutic process.

Service level

Selecting and matching interpreter

Six studies referred to the process of selecting interpreters, with emphasis on ensuring a good fit. This was a consistent feature across studies evaluating the feasibility and outcomes of interpreter-mediated CBT (d'Ardenne *et al.*, 2007a; Schulz *et al.*, 2006; Sander *et al.*, 2019). For instance, d'Ardenne *et al.* (2007a) employed accredited interpreters with at least one year of experience in health interpreting, aiming to ensure a high standard of competence. Similarly, Schulz *et al.* (2006) worked with medically trained interpreters to effectively support the therapeutic process. To formalise standards in this area, Sander *et al.* (2019) advocated for the introduction of an accreditation scheme specifically designed for interpreters working in psychotherapy, helping to ensure consistent quality of service across contexts. Beyond professional competence, studies highlighted the importance of matching interpreters to clients in ways that respect cultural norms and foster rapport. Considerations such as gender, ethnicity, age, dialect, and political sensitivities were noted by Mofrad and Webster (2012) and d'Ardenne *et al.* (2007a) as important when assigning interpreters, as these factors may significantly influence the client's comfort and engagement. d'Ardenne *et al.* (2007b) further emphasised the therapist's role in assessing clients' specific language support needs to ensure appropriate interpreter selection. In addition, some interpreters requested detailed information about clients' linguistic and cultural backgrounds before accepting bookings, underscoring the importance of preparation and mutual fit in supporting effective therapy (d'Ardenne *et al.*, 2007b).

Supporting remote delivery

Two studies made reference to remote delivery of interpreter-mediated CBT. Wardman-Browne (2023) reported that therapists recognised the potential for remote working with interpreters to significantly expand access to therapeutic services, particularly for communities that face language-related barriers. However, this approach also introduces specific challenges, including heightened therapist anxiety, difficulties in creating a safe and confidential space, and a reduction in non-verbal interpersonal cues critical to therapeutic engagement. Despite these limitations, Wardman-Browne (2023) acknowledged the notable benefits and new possibilities that remote interpreter-mediated CBT can offer, suggesting that the flexibility and accessibility of remote

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delivery may increase its appeal to a broader client base. Similarly, Villalobos *et al.* (2021) highlighted the advantages of using live interpretation systems through videoconferencing platforms to facilitate therapy. Importantly, Wardman-Browne (2023) emphasised that remote delivery should not be imposed; instead, offering clients a choice regarding the format of their therapy is essential for maintaining a client-centred approach.

Supportive service culture

Four studies made reference to services creating the conditions that facilitate the delivery of interpreter-mediated CBT. In part, these relate to service pressures and organisational demands. Interpreter-mediated CBT requires additional time and resources, often increasing the workload for therapists and the perceived burden on the system (Schulz *et al.*, 2006; Sander *et al.*, 2019).

Therapists who felt supported by their service were more open to collaborative relationships with interpreters, more confident in addressing power dynamics and cultural differences, and better able to navigate feelings of guilt or discomfort related to power and privilege (Gerskowitch and Tribe, 2021). In contrast, therapists who did not feel supported noted that rigid systems and high organisational demands increased stress. In such contexts, working with interpreters was often perceived as a threat to their competence, resulting in heightened anxiety and a more defensive approach to collaboration (Gerskowitch and Tribe, 2021).

Moreover, this organisational stress influenced therapists' perceptions of interpreters. Under pressure, therapists were more likely to view interpreters negatively or as 'translating machines' rather than valued collaborators (Gerskowitch and Tribe, 2021). Wardman-Browne (2023) also highlights that therapists reported increased anxiety when working with interpreters due to the additional demands of meeting service expectations. Some therapists noted a mismatch between service provision and client needs, further exacerbating these challenges.

Reducing performance pressures and cultivating a more collaborative, less competitive atmosphere can enhance cooperation between therapists and interpreters, ultimately leading to better care (Gerskowitch and Tribe, 2021). Part of these recommendations includes allowing greater flexibility with service demands, time constraints, and organisational targets. This flexibility is necessary not only to accommodate the time needed for sessions and preparation but also to ensure sufficient capacity for the additional associated tasks (Wardman-Browne, 2023).

Therapist reflective practice

Three papers noted points related to the importance of reflective practice for therapists within interpreter-mediated CBT. Therapists reported the need to reflect but recognised the need for service support to facilitate reflective practice (Wardman-Browne, 2023; Gerskowitch and Tribe, 2021). Moreover, this could be facilitated by regular supervision, ongoing training, and reflective meetings between clinicians and interpreters to continuously improve the collaborative process (Wardman-Browne, 2023; d'Ardenne *et al.*, 2007b).

Address logistical issues

Five studies made reference to services addressing logistical issues that either directly obstruct interpreter-mediated CBT or create less-than-optimal conditions for its delivery. d'Ardenne *et al.* (2007b) and Villalobos *et al.* (2021) highlight problems related to the physical layout of clinics, including the lack of space for interpreters to meet with therapists for debriefings, and the absence of separate waiting areas for interpreters and clients, both of which are important for maintaining confidentiality and preventing unintended disclosures. Moreover, interpreters reported difficulties in communicating directly with clinic staff in relation to logistics, which was identified as a barrier to efficient coordination (Villalobos *et al.*, 2021).

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In addition to logistical concerns, recommendations also focus on addressing process-related challenges within services. For example, rigid and time-consuming room booking procedures were found to increase stress (Gerskowitch and Tribe, 2021). To support more effective delivery of care, organisations should establish fair policies for managing late or missed appointments and ensure that both therapists and interpreters are well informed of these procedures (Villalobos *et al.*, 2021).

Regular meetings between clinicians and interpreters are also recommended to review and refine the interpreting process (d'Ardenne *et al.*, 2007b). These meetings provide opportunities to raise concerns, discuss challenges, and strengthen alignment in approach. Finally, avoid scheduling back-to-back sessions for either therapists or interpreters and include scheduled breaks to help prevent burnout (Villalobos *et al.*, 2021; d'Ardenne *et al.*, 2007b).

Interpreters as part of the team

Four studies noted points related to sourcing interpreters from external agencies or being part of the team. In part, this was related to the cost associated with sourcing from external agencies. Wardman-Browne (2023) highlights a common perception that working with interpreters is expensive, which can act as a barrier to service provision. In a cohort study by d'Ardenne *et al.* (2007a), interpreting services were estimated to cost approximately €100 per session. These additional costs can become significant over the course of treatment, especially when multiple sessions are required for effective therapy.

As well as missed opportunities for integrating them within the team, in response to these challenges, several studies have recommended greater integration of interpreters into the team. For example, Schulz *et al.* (2006) and Sander *et al.* (2019) describe interventions in which interpreters were either employed directly by clinics or contracted regularly from trusted local agencies, supporting continuity and deeper integration. When interpreters are integrated into the clinical team, they become familiar with service procedures and therapeutic goals, thereby enhancing the effectiveness, consistency, and overall quality of therapy.

Value of interpreters

One study explicitly highlighted the importance of interpreters within therapy. Costa and Briggs (2014) reported that for clients, the ability to express themselves in their native language is particularly significant during times of emotional distress. Clients also highly valued the interpreter's contributions, which often exceeded their expectations. Importantly, the presence of a third person in the therapy room was generally not seen as problematic; rather, many clients expressed appreciation for the interpreter's involvement. This finding underscores the value of creating an inclusive therapeutic environment in which the interpreter's role is normalised and seamlessly integrated into the process. According to Costa and Briggs (2014), interpreters play a vital role not only in supporting communication but also in enhancing both the process and outcomes of therapy. Services should therefore create a culture where interpreter involvement is not simply helpful but essential in ensuring effective therapy for clients who are non-native speakers.

Developing and maintaining therapist competencies

Five of the reviewed studies noted practice related to the development and maintenance of therapist competence, in part through training for therapists to work effectively with interpreters. Sander *et al.* (2019) recommended that therapists receive specific training and gain practical experience in interpreter-mediated therapy to develop competence in this area. Similarly, Costa and Briggs (2014) emphasised the importance of training that focuses on effective collaboration with interpreters. Villalobos *et al.* (2021) advocated for training in practical strategies, such as

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conducting pre-sessions, speaking in manageable chunks, and preparing materials in advance to support smoother communication during therapy. They further recommended that such training should be ongoing, suggesting annual sessions to ensure therapists' skills remain sharp and up to date.

Mofrad and Webster (2012) suggested that therapists and interpreters build rapport and develop skills together. They even proposed seconding therapists to services with greater exposure to interpreter-mediated CBT as a way to enhance competence through experience.

Supervision was also identified as a key element in developing therapist competence. Mofrad and Webster (2012) described how clinical supervision in their case study was used to rehearse explanations and simplify language in preparation for interpreted sessions. They noted that supervision should address the specific challenges of interpreter-mediated therapy and offer guidance on communication and therapeutic techniques. Additionally, supervision could serve as a platform for formative feedback or the implementation of competency measures to monitor and support therapist development. However, they acknowledged that the slower pace of interpreter-mediated sessions can make formal competency assessments difficult, underscoring the importance of supervision in compensating for this limitation.

Finally, peer supervision and mentoring were also recommended. Villalobos *et al.* (2021) suggested pairing less experienced clinicians with seasoned practitioners to model effective use of interpreters. This approach allows new therapists to observe best practices and gradually build their own competence.

Developing and maintaining interpreter competencies

Six studies made reference to the development and maintenance of interpreter competence, primarily through training, reflection, and supervision. In relation to training, there is a necessity for further and ongoing training programs for interpreters. d'Ardenne *et al.* (2007b) emphasised the importance of interpreters having a clear understanding of mental distress, particularly in relation to the conditions commonly addressed in interpreter-mediated CBT. More in-depth training has been shown to be both feasible and effective. For instance, Müller *et al.* (2023) reported that a one-day training not only enhances interpreters' knowledge base but also positively influences their attitudes and overall effectiveness.

Moreover, competencies can be supported through supervision and reflexivity as these have also been identified as essential for supporting interpreters in navigating the complexities of mental health settings and facilitating effective communication (Tutani *et al.*, 2018; Wardman-Browne, 2023). Sander *et al.* (2019) and Tutani *et al.* (2018) further highlighted the need for clinical supervision to be extended beyond therapists to include interpreters, recognising their central role in therapeutic encounters.

Importantly, these recommendations align closely with those related to developing and maintaining therapist competence. Mofrad and Webster (2012) advocated for opportunities where interpreters and therapists can build rapport and develop their skills collaboratively. This could be achieved through joint training sessions, shared supervision, reflective practice groups, or co-facilitated skills development workshops. Such integrated approaches not only enhance individual competence but also foster a cohesive therapeutic alliance between therapists and interpreters.

Organisational level

Funding

Two studies made reference to the importance of funding decisions. Whether sourcing qualified interpreters from interpreting agencies or integrating within the team, it is dependent on adequate funding. To achieve this, organisational leadership should secure funding to hire interpreters

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dedicated solely to the service, ensuring consistency and reducing the strain on therapists (Villalobos *et al.*, 2021). In practice, sometimes interpreters are sourced from external agencies, such as local authorities or private companies, but quality assurance is required (d'Ardenne *et al.*, 2007b). While this can provide flexibility and access to a broader pool of interpreters, it is essential to ensure that external interpreters are adequately briefed on procedures and supported to maintain consistency and effectiveness in sessions.

Training interpreters

Two of the studies made reference to some interpreters lacking training in mental health, let alone training specific to interpreter-mediated CBT. d'Ardenne *et al.* (2007a) noted that although interpreters are occasionally briefed on mental health or CBT, most do not hold formal qualifications in these areas. This gap is further underscored by Müller *et al.* (2023), who found that two-thirds of interpreters in their sample lacked relevant qualifications in mental health interpreting. Clearly, training organisations and accrediting bodies have a key role to play in ensuring that mental health awareness, along with therapy-specific knowledge and skills, becomes a core component of interpreter training curricula. Additionally, there should be wider provision of continuing professional development (CPD) to upskill interpreters who are already qualified. Wardman-Browne (2023) suggests that existing training programs would benefit from regular review and updating to remain effective. In addition, other opportunities and approaches for training could be beneficial.

Training therapists

Four of the included studies made reference to training for therapists to work effectively with interpreters. Recommending therapists receive specific training and gain experience in working with interpreters to develop competence in this area (Sander *et al.*, 2019). Villalobos *et al.* (2021) recommend that therapists are trained with practical strategies to work effectively with interpreters, such as conducting pre-sessions, speaking in appropriate chunks, and preparing materials ahead of time to facilitate smoother communication during therapy. Costa and Briggs (2014) emphasise the need for training that focuses on effective collaboration with interpreters. Universities and accrediting bodies should embed training on working effectively with interpreters into core therapeutic curricula, equipping therapists with practical strategies and collaborative skills essential for interpreter-mediated therapy. Moreover, it should be continually refined. Wardman-Browne (2023) suggests that existing training programs would benefit from regular review and updating to remain effective.

Critique of studies

The studies included in the review had small sample sizes, ranging from 1 to 646, which limits the generalisability of their findings. Small sample sizes can lead to the over-estimation or under-estimation of the effectiveness of interpreter-mediated CBT, and may not accurately reflect the broader population. This limitation makes it difficult to draw robust conclusions and suggests that further research with larger sample sizes is needed to provide a more comprehensive understanding of the intervention's efficacy.

The included studies often provided limited or no information on the specific interpreter models used during therapy. This is notable because the choice of interpreter model or the lack of clarity regarding this choice may influence whether interpreters are perceived as mere word-for-word communication tools or as valued collaborators, as described by Gerskowitch and Tribe (2021). Without detailed information on the interpreter models, it is difficult to assess their impact on the quality or experience of interpreter-mediated CBT. Inadequate reporting hinders the ability

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to evaluate the effectiveness of different interpreter approaches and to make informed recommendations for best practices.

None of the studies explicitly considered the degree to which cultural factors influence the efficacy or experience of interpreter-mediated CBT, even though language and culture are intertwined but distinct. As culture plays a crucial role in shaping therapeutic experiences and outcomes, failing to account for this factor may obscure important insights into how interpreter-mediated CBT is perceived and its effectiveness. Additionally, the delivery of 'copy and paste CBT' (Kunorubwe, 2023) via an interpreter may be misconstrued as ineffective due to language barriers, when in fact the issue may be a lack of cultural adaptation, making the therapy contradictory or unacceptable to the client's cultural model (Jameel *et al.*, 2022). Therefore, understanding the interplay between language and culture is essential for optimising therapy and ensuring that interventions are both culturally sensitive and effective.

The quantitative research on the efficacy of interpreter-mediated CBT was based on standard treatment practices and did not fully report how confounding variables were controlled for. Additionally, there is no information on how closely the delivery of interpreter-mediated CBT adhered to established recommendations for working with interpreters, especially considering some of the qualitative studies highlighting how established recommendations are always implemented. This omission means that the effectiveness of interpreter-mediated CBT cannot be fully understood without knowing whether best practices for interpreter engagement were consistently followed. Consequently, this gap undermines the reliability of the findings and their applicability to real-world settings where adherence to interpreter guidelines can significantly impact therapeutic outcomes.

Another critique of the included studies is that they have predominantly focused on clients who were refugees or asylum seekers, potentially leading to the incorrect assumption that only these groups require interpreter services. This focus may overlook individuals who, although proficient in the majority language, prefer to access therapy in their first language. This narrow view may lead to gaps in understanding the broader need for interpreter-mediated CBT and how it serves various populations beyond refugees and asylum seekers.

Discussion

Summary of findings

Research on interpreter-mediated CBT shows some promise for improving access to therapy for non-native speakers, with studies reporting positive outcomes for PTSD, depression, and phobia. However, the findings are mixed and limited, highlighting the need for further research to address factors such as therapist-interpreter proficiency and client context.

This review also highlights key practice adaptations: comprehensive training and supervision for both therapists and interpreters, supportive service structures, and ongoing reflective practice to address bias and ensure clear communication. Effective interpreter-mediated CBT requires structured preparation, collaboration, role clarity, and adjustments to both communication and core CBT processes to meet clients' needs.

Relation to previous literature

The results of this review align with and further develop the existing literature on interpreter-mediated CBT. The included research indicates that interpreter-mediated CBT holds promise for improving access to psychological therapies for clients who do not speak the predominant language in a given area. These findings align with the broader literature, which suggests that interpreter-mediated therapy can be effective in bridging language barriers and facilitating psychological treatment for diverse populations. However, the review also highlights some

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inconsistencies, as one study found less improvement in PTSD symptoms when an interpreter was used compared with sessions conducted without one.

This review sheds light on potential modifications to practice when working with interpreters that align with existing guidance documents on interpreter-mediated CBT (Beck, 2016; Beck *et al.*, 2019; Costa, 2022) and broader guidance on working with interpreters in therapy (Tribe and Lane, 2009; Tribe and Thompson, 2017; Tribe and Thompson, 2022).

The review proposes a framework for interpreter-mediated CBT, which can be categorised into three interconnected levels: individual (therapist and interpreter), service, and organisational. This structured approach reflects the influence of these levels, suggesting that effective implementation or improvements in one area requires sustained effort across the levels.

Clinical implications

This review contributes to the discourse on interpreter-mediated CBT by providing a starting point for determining whether interpreter-mediated CBT can be beneficial for mental health problems. To further support best practice, we have drafted a table of recommendations for therapists/interpreters, services, and organisations. Table 7 outlines specific considerations for optimising the delivery of interpreter-mediated CBT, ensuring that the therapeutic process is both inclusive and effective.

The clinical implications of interpreter-mediated CBT are significant and multi-faceted. Effective implementation requires services and organisations to create optimum conditions and support for both therapists and interpreters. Collaboration between the therapist and interpreter, supported by structured pre-session briefings and clearly defined roles, is essential for maintaining therapeutic relationships, effective communication and a good triadic relationship. Adapting CBT practices to accommodate cultural differences enhances their relevance and engagement, while dedicated funding and improved service coordination ensure the reliability and consistency of interpreter services. Additionally, fostering a collaborative culture, actively seeking client feedback, and promoting reflective practices among therapists and interpreters contribute to better therapy outcomes and client satisfaction. Addressing these clinical implications helps create a more inclusive and effective therapeutic environment, ultimately improving access to psychological support for diverse populations.

Research recommendations

A key research recommendation is to conduct larger-scale studies with more participants, specifically examining the efficacy of interpreter-mediated CBT. This would enhance the reliability and generalisability of findings, particularly if conducted through research trials that are able to control for confounding variables that may influence outcomes. Future studies should also explore the effectiveness of interpreter-mediated CBT across a broader range of mental health disorders, beyond the current focus on PTSD, depression, and phobia, in order to develop a more comprehensive understanding of its applicability to various conditions.

In addition, there is a need to test the proposed recommendations in real-world clinical settings. This would involve implementing the suggested modifications in practice and systematically assessing their impact on therapy effectiveness and client outcomes. Studying the long-term effects of interpreter-mediated CBT on client well-being and therapeutic progress is also essential for a better understanding of the sustainability of therapeutic benefits over time.

Further research should also focus on exploring the experiences of interpreters, clients, and therapists involved in interpreter-mediated CBT. Examining the interactions among these stakeholders can help to improve communication and collaboration, while integrating their perspectives may identify common challenges and potential solutions. This comprehensive

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Table 7. Recommendations for interpreter-mediated CBT based on synthesising empirical research

Organisational level	Service level	Therapist and interpreter
1. Secure sustained funding to employ interpreters or, where external agencies are used, ensure robust quality assurance processes and regularly review agreements. 2. Training and accrediting organisations should ensure interpreters receive training in mental health and CBT as part of their core curriculum. 3. Provide ongoing CPD opportunities for interpreters to build their skills and stay current with evolving therapeutic practices. 4. CBT training and accrediting bodies should ensure that working with interpreters is part of the core training, covering fundamental strategies through to meta-competencies. 5. Offer ongoing CPD opportunities for therapists to develop competencies and remain up-to-date with evolving therapeutic practices. 6. Organisations should foster a positive culture that supports both therapists and interpreters. This includes adjusting targets, offering supervision, encouraging flexibility, and addressing poor practices that contribute to stress and burnout – such as scheduling back-to-back sessions. 7. Support the development of translated and validated psychological measures and therapy materials for use in practice.	1. Book qualified interpreters with experience in IM-CBT, ensuring appropriate matches in language, dialect, and cultural norms, and avoiding any social connections with the client. 2. Provide clients with a choice between remote and in-person sessions, supporting them through implementation and addressing any associated challenges. 3. Recognise that interpreter-mediated CBT requires additional time, and adjust service targets, time pressures, and expectations accordingly. 4. Facilitate therapist competence through ongoing training, supervision, feedback, and reflective practice. 5. Address logistical issues, including space for briefings, separate waiting areas, direct booking systems, and clear processes for missed appointments. 6. Review the pros and cons of employing interpreters versus sourcing through an agency, taking into account cost implications, collaboration opportunities, and streamlined processes. 7. Arrange joint training and feedback sessions between therapists and interpreters to build rapport, enhance skills, and improve working processes. 8. Ensure supervision supports knowledge, skill-building, and practical challenges, e.g. rehearsing explanations, simplifying language, and navigating difficult situations. 9. Consider interpreter well-being during the matching process, especially in relation to potentially shared experiences with clients. 10. Support interpreter competence through ongoing training, supervision, feedback, and reflective practice.	**Before** 1. Therapists should reflect on their own experiences, biases, and feelings about working with interpreters. 2. Therapists and interpreters should familiarise themselves with best practice guidelines. 3. Provide interpreters with translated materials and measures prior to the appointment. 4. Plan for additional time to account for extended sessions, pre-session briefings, post-session debriefings, and breaks. 5. Conduct a pre-session briefing to agree on the session plan, terminology, approaches to difficult content, and preferred ways of working. 6. During briefings, agree on the interpreting model and clarify roles – e.g. whether interpreters should convey words only or both words and meaning. **During** 7. Discuss confidentiality and its relevance to both therapist and interpreter roles. 8. Clearly explain the interpreter's role, professional boundaries, and any practical arrangements. 9. Revisit roles periodically to ensure mutual clarity and address evolving needs or misunderstandings. 10. Therapists should communicate at a slower pace, use shorter segments, and attend to both verbal and non-verbal cues. 11. Use clear language and avoid complex jargon. 12. Interpreters should convey all communication faithfully, including repetitions, ambiguities, and sensitive or uncomfortable material. 13. Adopt and maintain a three-way collaborative stance, with therapist, interpreter, and client working toward shared goals.

(*Continued*)

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Table 7. (*Continued*)

Organisational level	Service level	Therapist and interpreter
	11. Organise joint training sessions, shared supervision, reflective practice groups, and skills-based sessions to build rapport, strengthen skills, and foster therapeutic alliance.	14. Attend to the therapeutic relationship while adapting to a three-way therapeutic dynamic. 15. Ensure CBT is delivered in a culturally adapted manner that aligns with the client's cultural framework. 16. Review the use of routine outcome measures and address any challenges introduced by the interpretation process. **After** 17. Use debriefing sessions to offer support to interpreters, discuss the process, refine collaboration, and gain cultural insights. 18. Maintain consistency by using the same interpreter throughout the therapeutic process, unless the client requests a change.

approach would provide valuable insights into optimising interpreter-mediated CBT practice and improving outcomes for all parties involved.

Another important area for investigation is the influence of different service delivery models and organisational structures on the implementation and effectiveness of interpreter-mediated CBT. This includes evaluating various models, such as direct employment of interpreters and dedicated funding arrangements, to determine their impact on accessibility and quality of care. Interestingly, the use of existing guidance on interpreter-mediated CBT was not mentioned in many studies; however, it is unclear if this was not reported or if they were not followed.

Although current evidence does not yet conclusively establish the effectiveness and feasibility of interpreter-mediated CBT across all languages and dialects, existing studies have included clients and interpreters working with 44 languages from multiple language families. It would therefore be valuable to investigate whether language-specific factors influence the efficacy of interpreter-mediated CBT.

By addressing these research gaps, the field of interpreter-mediated CBT can continue to develop, ultimately leading to more effective, evidence-based practices that improve access to psychological therapies for diverse populations.

Strengths

This review offers several strengths that contribute to both the academic literature and clinical practice surrounding interpreter-mediated CBT. Firstly, it addresses an under-researched area, providing one of the few focused syntheses of empirical studies on interpreter-mediated CBT. By using a narrative synthesis approach, the review incorporates findings from both quantitative and qualitative studies, allowing for a more comprehensive understanding of the evidence base.

It develops a practical, multi-level framework that organises recommendations into individual, service, and organisational levels. This framework provides clear, actionable guidance that

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addresses both individual practice and broader systemic considerations necessary to support effective interpreter-mediated therapy.

The review highlights important research gaps, including under-reporting of interpreter models, cultural adaptations, and service delivery approaches. By identifying these gaps, a clear agenda for future research is provided, which is essential for building a stronger evidence base in this area of psychological practice.

Limitations

This review has several limitations that should be acknowledged. One of the most notable is the relatively small number of studies included ($n = 11$). This limited sample size could be a reflection of the scarcity of research on this specific topic, as highlighted earlier in the review. The small number of studies may be related to the potential risks of publication bias, where only certain studies are published, potentially skewing the overall findings of the review. These limitations underscore the need for caution when interpreting the results and highlight the importance of encouraging further research in this area to build a more comprehensive evidence base.

Another issue is the significant variation among the included studies. These studies differ widely in design, ranging from cohort studies to case studies to qualitative studies exploring experiences of interpreter-mediated CBT. Moreover, the diverse samples of therapist, client and interpreter studies, including variations in role and cultural background, can impact the generalisability of the findings.

The review also highlights the variability in the geographical contexts and the healthcare settings of the included studies. Conducted across various countries, the studies reflect differences in cultural norms, healthcare systems, and language proficiency, which can influence both the implementation and outcomes of interpreter-mediated CBT. These cultural and systemic differences complicate the ability to generalise findings across different settings, as what works well in one context may not be applicable in another.

Furthermore, although the review synthesises recommendations based on the available evidence, these have not been tested in real-world settings. Without robust testing, this raises questions about how well these recommendations would perform outside of a controlled research setting. This gap between theoretical recommendations and practical application underscores the need for further empirical testing to validate the effectiveness of interpreter-mediated CBT in diverse, real-world contexts.

The decision to exclude studies in languages other than English, whilst practical, may result in the omission of crucial findings, unintentionally reinforcing the dominance of Western, English language perspectives in the field of CBT. Reflecting a wider pattern seen across the social sciences (Hamel, 2007), science more broadly (Ammon, 2001), despite only around 18.75% of the world's population speaking English (Eberhard *et al.*, 2024).

Conclusion

This review contributes to the existing literature on interpreter-mediated CBT for mental health problems. Systematically identifying, evaluating, and integrating the findings of existing empirical literature suggests that interpreter-mediated CBT shows potential. However, further evaluation is necessary to establish its efficacy more robustly. The review has also synthesised the practice points from empirical research into recommendations.

The findings add to the evidence base and provide a rationale for further research. Within the context of practice, this will be a step towards addressing the low access and poor outcome rates for clients from diverse communities.

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Key practice points

(1) Interpreter-mediated CBT shows promise but requires further research to establish its efficacy more robustly.
(2) When delivering interpreter-mediated CBT, either as the interpreter or as a therapist, reflect on the proposed recommendations and consider how to adapt your practice to ensure safe, ethical and effective therapy.
(3) All those in positions of authority within services and organisations should reflect on the proposed recommendations and consider strategic actions and development plans to facilitate the optimum conditions for interpreter-mediated CBT.
(4) Further research is needed to fully evaluate the efficacy of interpreter-mediated CBT and to further explore the experiences of clients, interpreters and therapists.

Further reading

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