The Cognitive Behaviour Therapist (2025), vol. 18, e45, page 1 of 18
doi:10.1017/S1754470X25100238

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ORIGINAL RESEARCH

Cognitive behavioural therapists' experiences of working remotely with language interpreters

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(Received 4 August 2024; revised 30 April 2025; accepted 4 July 2025)

Abstract

In the United Kingdom (UK), approximately one million people cannot speak English well enough to access therapy in English. If there is no shared language used by both the client and therapist, then individuals require access to an interpreter so that they receive an equitable service. Research highlights the anxiety and pressures that working with an interpreter can bring for professionals. In light of the Coronavirus pandemic and increased remote working, this research aimed to explore the experience and perspectives of cognitive behavioural therapists working with language interpreters remotely. Semi-structured interviews were conducted with 18 participants who were asked about their experience of working with interpreters remotely. Data were analysed using Braun and Clarke's six phases of thematic analysis. The analysis resulted in four main themes being constructed: the system doesn't make it easier; working in a culturally sensitive way; the powerful role of the interpreter; and remote therapy – different landscape, different journey. Findings offer an understanding of how working with an interpreter impacts ways of working in cognitive behavioural therapy. The findings draw attention to the impact of the organisational context where therapists work.

Key learning aims

After reading this paper, it is hoped that readers will be able to:

(1) Consider cognitive behavioural therapists' experiences of challenges and barriers when working remotely with interpreters.
(2) Look at the experience and perspectives of cognitive behavioural therapists working with interpreters remotely (in light of the COVID-19 pandemic and increased remote working practices).
(3) Consider the support needed to enable therapists, healthcare services and broader healthcare structures to provide services to clients through working with interpreters and adapting therapy for diverse cultural groups.

Keywords: cognitive behaviour therapy; interpreters; interpreter-mediated therapy; mental health; qualitative; remote therapy

Introduction

In most mental health services, language is fundamental as it is the primary way in which clients are able to articulate their inner experiences and share these with those offering them support. If

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https://doi.org/10.1017/S1754470X25100238 Published online by Cambridge University Press

there is no shared language used by both the patient and therapist, then a trained spoken language interpreter will be needed to enable the therapist to work with their client (Costa, 2022a).

Inequalities in accessing healthcare for refugees and people from diverse ethnic backgrounds is an ongoing concern regarding mental healthcare services, including access to therapy (Beck *et al.*, 2019; Naz *et al.*, 2019). In the 2021 Census, 1.8% of people (1,041,000) could not speak English well or at all. Working with interpreters is therefore essential to attend to the needs of people who are not fluent in English. Working effectively with interpreters is integral to anti-oppressive and anti-racist practice, involving intentional efforts to ensure equal opportunities both at the individual and systemic levels (Williams *et al.*, 2022).

A spoken language interpreter translates the spoken word, whereas a translator converts written words between two languages. The task of an interpreter in the therapeutic context is to support communicative autonomy. This is defined as 'the capacity of each party in an encounter to be responsible for and in control of his or her own communication' (García-Beyaert, 2015; p. 4). There are different approaches to interpreting: 'proximate' interpreting refers to when the interpreter is physically present, whereas 'remote' interpreting refers to the interpreter working at a distance (such as via video or by telephone). 'Simultaneous' interpreting refers to when an interpreter translates during the conversation, thus a word or two behind, whereas in 'sequential' interpreting, the interpreter waits for a pause and then interprets what has been spoken. There are also different models of interpreting including the linguistic model, the psychotherapeutic model, the cultural broker role, and the advocate (Tribe and Morrissey, 2004). The linguistic model emphasises the role of the interpreter as providing strictly verbatim translation. The psychotherapeutic or constructivist model emphasises the importance of conveying the meaning of words. The cultural broker or cultural mediation model emphasises the interpreter's role in offering relevant cultural information. It suggests that communication goes beyond language skills and often requires more, such as knowledge about the cultural background. The cultural broker role can also involve interpreters normalising therapy which may be particularly useful for people from cultures in which therapy is unfamiliar or stigmatised. It is important to highlight the ethical issues of working with interpreters as cultural mediators. For example, an interpreter may not always be the expert in a culture and if the interpreter adopts this role, it may change the dynamics and information may get missed. Finally, the advocate model is when the interpreter serves as an advocate for a client. As can be seen from this range of interpreting approaches, the process of interpretation is not a straightforward or unified process, and different approaches will impact communication between clients and service providers in different ways.

Qualitative research has explored the experience of working with interpreters in mental health services. Therapists often find this work anxiety provoking and challenging (Gerskowitch, 2018; Raval and Smith, 2003; Scott, 2014; Tutani *et al.*, 2018). Anecdotally, there have been reports of therapists avoiding working with patients requiring an interpreter (Costa, 2022b). Costa (2022b) highlighted that people requiring a spoken language interpreter often face barriers to accessing equitable support. Subsequently, an implementation paper was published providing detailed guidance for cognitive behavioural therapists (Costa, 2022a). The guidance draws attention to the benefits of working with an interpreter, highlighting how it can enhance the therapeutic experience, provide a greater sense of containment, enable a collaborative relationship and provide time to reflect while an interpreter renders translations. The guidance highlights six areas to consider: preparation; meta-communication; boundaries; managing three-way relationships; working with interpreters remotely; and offering support to interpreters. In recent changes to their 'Minimum Training Standards', BABCP (2021) now recommends that clinicians should be able to demonstrate skills in working with interpreters.

Due to the COVID-19 pandemic, remote delivery of CBT became essential (Cromarty *et al.*, 2020). Research suggests that remote CBT results in equivalent outcomes compared with traditional face-to-face treatment across a number of common mental health disorders such as generalised anxiety disorder (Théberge-Lapointe *et al.*, 2015; Trenoska Basile *et al.*, 2022); obsessive compulsive disorder (Wootton, 2016); panic disorder (Efron and Wootton, 2021) and post-traumatic stress

https://doi.org/10.1017/S1754470X25100238 Published online by Cambridge University Press

disorder (PTSD) (Sijbrandij *et al.*, 2016). Remote interpreting in therapy introduces a significant shift in how therapy is experienced. When therapy is conducted remotely, either through phone or video platforms like Zoom, therapists and clients are physically separated, which alters the dynamics of the therapeutic relationship. Previous research has explored themes such as how boundaries and relationships are experienced differently in remote settings. For example, the physical separation may create a perceived loss of direct connection, which can impact the therapist–client alliance and the management of boundaries (James *et al.*, 2022). The change of space – where clients may feel more comfortable in their own homes, but therapists may face challenges in controlling the environment – can either enhance or challenge CBT working. The advantages of remote therapy include greater accessibility and convenience. However, therapists may find it harder to read body language, gauge emotional states, or address non-verbal cues. Additionally, the responsibilities around boundaries can shift, with both therapists and clients needing to adapt to new virtual settings.

The British Psychological Society (BPS) offers guidelines for working with interpreters remotely (British Psychological Society, 2020; Tribe and Thompson, 2022). Although telephone interpreting has its benefits, such as confidentiality and practicality, BPS guidelines recommend using video rather than telephone interpreting where possible. Video allows for visual cues which may help determine meaning. Preparation is key and it is recommended that guidance is provided for clients before a video appointment. The Royal College of Speech and Language Therapists (2020) also produced guidelines for working with interpreters remotely. They provide a checklist of issues to consider before, during and after a session.

Study aims and objectives

There appears to be only one study that has explicitly investigated the experiences of cognitive behavioural therapists working with interpreters (Tutani *et al.*, 2018). However, this study did not explore the remote aspect of therapeutic work.

The research aim for this study was to explore CBT therapists' experiences of working with interpreters remotely (including telephone and video formats). It is hoped that the research findings will inform services about how to improve efficacy and equity. The research questions are 'How do CBT therapists experience working with interpreters remotely?', 'What are the barriers and facilitators when working with interpreters remotely?' and 'How do therapists adapt CBT and the process of therapy when working with an interpreter remotely?'.

Method

Design

An interpreter-facilitated therapy process is complex, as are the dynamics that arise in the triadic therapy relationship. Therefore, using a qualitative method allows for preservation of this complexity and richness of data. This study used Braun and Clarke's (2022) approach to thematic analysis which is suitable for examining the experiences of therapists embedded in context and fits appropriately with a critical realist approach.

Inclusion criteria

The inclusion criteria for this study were that therapists were accredited with the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and had at least one experience of working with an interpreter remotely either by telephone, video or both.

Recruitment

An overview of the study was posted on social media accounts (Twitter, LinkedIn, Facebook) and the researcher shared the study through word of mouth. Recruitment also took place via a poster

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at the BABCP Annual Conference in July 2022. As part of the recruitment strategy, participants were offered the chance to be entered into a lottery whereby one participant would win a £25 Amazon voucher. This strategy was adopted to encourage participants to come forward and to express gratitude to participants.

Procedure

Once an individual expressed interest, participant information sheets were provided via email. The information sheet outlined the study, what was involved, information concerning storage of data, confidentiality and what would happen to the data once analysed. If the potential participants were still interested, they were sent some basic questions to screen for suitability. Participants signed and returned the consent form prior to the interview. All interviews took place online via Zoom. Semi-structured interviews were used to explore therapists' experiences. This semi-structured approach allows for consistency between interviews as well as flexibility to tailor the questions. Semi-structured interviews were conducted with 18 participants between November 2021 and September 2022.

Data analysis

Interviews were audio-recorded and transcribed. Identifying material was removed or disguised. Transcript notations included all words, long pauses and laughter as suggested by Braun and Clarke (2013). Data were managed using NVivo version 12 which is a software package that helps organise qualitative data.

Process of coding and developing themes

The dataset was analysed using thematic analysis and Braun and Clarke's (2006, 2022) six stage process was used as a guide to analysis. The six phases are reported here in sequential order; however, the analysis was not a linear process and the researcher moved backwards and forwards through the phases (Braun and Clarke, 2021).

The first phase involved initial engagement with the data, and recordings were read and listened to by the first author to allow the researcher to become familiarised and immersed with the data. Secondly, initial codes were generated and grouped which involved labelling data that was relevant or of interest related to the research question. Each transcript was coded line-by-line systematically before moving onto the next transcript. Initially, the majority of coding was semantic and stayed close to the participants' own experience. As the process developed, latent coding also took place. At a semantic level, themes are identified within the explicit meanings of what has been said, whereas at a latent level, themes are identified by examining underlying meanings, assumptions or ideas (Braun and Clarke, 2006; Braun and Clarke, 2022).

To ensure this process was comprehensive, the researcher revisited interviews over time, and codes were added to and refined. The second author also independently coded one interview and the codes generated were cross-referenced to note any differences in perspectives. The aim of this was not to reach a consensus but to explore multiple assumptions and interpretations of the data. The third phase allowed for codes to be collated into potential themes. Codes were grouped to develop initial themes that reflected the data. Themes were produced by organising codes around commonalities or central ideas. In the fourth stage, themes were reviewed after a break from data analysis. This stage involved ensuring that themes supported the coded data across the dataset. During this phase, there was a constant revisiting of the transcripts and initial codes. The fifth phase of conducting thematic analysis was to refine, define and name the themes which involved all authors. The themes were sent to participants who were invited to comment on the findings. Finally, in the last phase, the final results section was produced using quotes from the transcripts.

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Reflexivity

Reflexive research requires researchers to be self-aware and reflect on the ways their own history, training, values, experiences, beliefs and feelings are implicated in research (Willig, 2013). Findings from the research are inevitably impacted by these factors and it is important to consider how these various factors have influenced the research. The first author has worked as a CBT therapist in an NHS Talking Therapies (NHSTT) service and has clinical experience working with interpreters to deliver in-person CBT and experience of non-interpreted remote CBT. The second author is a psychotherapy researcher with no experience of delivering therapy. The third author is a qualified clinical psychologist with experience of delivering psychological therapies in adult mental health services, including working with refugees through interpreters in-person and by telephone. The authors were curious about how we apply models and concepts with individuals who may hold different worldviews to the ones held by services.

Results

Participants

In total, 18 participants were interviewed. Research participants' ages ranged from 29 to 56 years with a mean age of 41 years. There were 12 females and six males. To ensure anonymity, participants' ethnicity has been grouped into White (including 'White other') and people from minoritised ethnic groups. There were 10 White participants and eight participants from minoritised ethnic groups. The length of time participants had worked as a cognitive behavioural therapist ranged from 8 months to 20 years with an average length of 5 years and 4 months. Participants' experience of interpreter-mediated CBT ranged from one case to over 320 cases. There were five participants who had only worked with an interpreter over the telephone and not via video, whereas two participants had only worked with an interpreter via video and not the telephone (see Table 1 for a summary of participants' experience).

During the time of the research, the majority of participants (11) were currently working in an NHSTT, four were working in other National Health Service (NHS) contexts such as refugee-specific services or secondary care services, and three were working in private practice. Although seven participants were not working in NHSTT at the time of interview, four of them reflected on previous experience working in NHSTT during the interviews. In total, 15 participants had some experience working in NHSTT as a CBT therapist. In addition, some of those who were currently working in NHSTT, mentioned that they had previously worked in other services such as specific trauma services or services for refugees and asylum seekers. Table 2 shows an overview of the four themes and 12 corresponding subthemes.

Theme 1: The system doesn't make things easier

Anxiety about meeting demands of the system

Working with an interpreter generated additional work and participants were concerned that they did not have sufficient time to explore the client's issues in enough depth. Josh explained, 'It is just making all of the adjustments to make it somewhat meaningful. When it is more difficult, it is often down to time pressures and practical challenges which is really unfortunate'. Furthermore, Mo stated, 'If I had an extra ten sessions, I could explore that, and build on that with them, but we have targets to meet. So again, there is that therapist desire to speed things along'. The impact of the time-limited context seemed to have an impact on doing the work 'properly'. Erica states, 'You don't actually have the time, you don't get given the time for what you need in order to do those appointments and to do them properly'. This pressure was particularly evident for participants working in the NHS within Talking Therapy services who were subject to changing and competing demands. For example, Mark stated, 'Now, it's all recovery rates, a little while ago it was the

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Table 1. Summary of participants' characteristics

Pseudonym	Years/months experience as a CBT therapist	Total number of interpreter-mediated clients (face-to-face or remote)	Total number of interpreter-mediated clients remotely (via video or telephone)
Mo	2 years	5	3
Ross	8 months	1	1
Mia	3 years	50+	12
Reuben	6 years	25	2
Kim	3.5 years	1	1
Ellie	1.5 years	15	5
Grace	4 years	20	4
Ciara	3 years	5	1
Ali	4 years	10	5
Mark	2 years	1	1
Lily	3 years	100+	32+
Josh	5 years	10	3
Maxine	10 years	20+	1
Carol	9 years	5	3
Stephen	20 years	320+	160+
Maeve	9 years	100+	50
Erica	1.5 years	2	2
Nina	10 years	25	25

Table 2. Themes and subthemes developed from thematic analysis

Main themes	Subthemes
The system doesn't make things easier	Anxiety about meeting demands of the system
	Mismatch between service provision and the needs of the client
Working in a culturally sensitive way	Where are the boundaries of CBT?
	A willingness to learn and reflect
	Working with interpreters remotely widens access to communities
	Offering choice can be empowering
The powerful role of the interpreter	The interpreter as a source of cultural knowledge
	Uncertainty about what was being communicated
	Shifting control
	The dynamics of interaction
Remote working: different landscape, different journey	Anxiety about creating a safe environment
	Reduced interpersonal cues

waiting list, so, it's whatever the commissioners are not happy with, that's kind of getting filtered down'. Participants spoke about how working with an interpreter remotely added elements to their work that felt more of an emotional strain or tiring. Josh stated, 'Personally, I find it a bit more stressful almost, I kind of feel it in my body a bit more with a telephone interpreter session'.

Some of the reflections and language used highlighted the sense that working with interpreters and immigrant communities was perceived as a burden by some therapists some of the time. Mia commented:

> they [client] may show up late or they may not just show up. And the NHS still needs to pay for the very expensive interpreter sessions ... Just makes you feel you know "why don't you appreciate this kind of opportunities when the whole country you know, when other people are still starving and you're not using that" ... it happens quite a lot especially with let's see, refugee, asylum seeker groups and they really make you have a bitter taste in your mouth when you think about how these resources can be used somewhere else.

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This quote reveals a tension between the therapist's responsibilities, the system they work within, and their attitudes towards the clients. This highlights the complex emotional landscape that therapists may experience when they feel burdened by service pressures and also provides insights into biases or frustrations that can emerge in these contexts.

Mismatch between service provision and the needs of the client

Participants expressed their desire to prioritise the needs of their clients, but this often felt unachievable. Participants highlighted that clients not suited to NHSTT may not have access to a provision of care within the NHS. Josh reported, 'Often, if you have had experience as a refugee, you are getting told no all the time. You are not welcome, we cannot work with you, you are not right for us, we cannot give you this'. Erica explains how referring on could be distressing and potentially lead to moral distress:

> It never feels that comfortable saying to someone, I know you've just spoken to me for an hour, but actually we are not the right service and you need to go over here. That never feels comfortable, and I think that feels more difficult, particularly because if you know that someone's got to work with an interpreter in order to access a service, there's that issue about they can't necessarily access all of the same services that other people can.

This mismatch between service provision and client needs was often due to ongoing systemic issues. Mo stated:

> If they are going through poverty, or they are not sure they will be sent back soon, or they are incredibly isolated at the moment or they have no money. All these things where all you can do is refer on and hope for the best

There was a sense of frustration towards service provision that appears ineffectual in reaching out and enabling non-English speaking clients to actively engage with services. Nina reported how outreach work 'needs to be embedded within the organisation'.

Theme 2: Working in a culturally sensitive way

Where are the boundaries of CBT?

For some participants they felt that the principles underpinning CBT were broad enough to embrace a range of approaches to meet the needs of clients. Other participants felt that the CBT model was compromised. For Grace, a space for the client to share their story was felt to be most helpful, 'Sometimes it felt a bit more like counselling in a way. It was just listening to someone, which I think was helpful in some ways, but it was not CBT. It was hard to be more structured with it'. There was a sense that fitting clients into models would neglect the individual needs of the client and so adaption and flexibility was often seen as essential. Stephen commented, 'I think we get slightly stuck in our Western frameworks. CBT has the capacity to adapt but if we apply it in a formulaic way according to the books, we often miss the context'. Interestingly, Stephen commented on his perception of CBT which was broad and constantly evolving, 'If you're using cognitions in its broadest context and behaviours to change emotions, then it's CBT'. There was recognition that the CBT model lends itself well to asking about culture. Josh spoke about what he would ask during assessment and formulation sessions and how the CBT model is flexible enough to work across cultures:

> thoughts about themselves, the world the future, or you are thinking about people's rules for life and core beliefs. That is all essentially people's culture. How you have learned to make

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> sense of the world as a young person, what was your family like? What was your school like? What was your local area? What were the messages you were getting? These are things that we should all be making space for and thinking about.

An idiosyncratic approach to therapy was described by some therapists. Carol explained, 'I'm not afraid to do idiosyncratic formulations with people to follow what they bring in the session. I find it can be quite helpful because it's really geared to the difficulties a person has'. Reuben highlighted how he works to address and respond to the client's individual needs, 'taking the same protocols that we would use with the majority service users, but it's about those more case-by-case changes and arguably there is some literature saying that is what CBT was originally envisaged as'. This indicates that participants held differing perspectives as to what constitutes CBT, perhaps shaped by their initial training and subsequent clinical practice. The quote from Lily captures some of the reflections about the boundaries of CBT and how the system can impact the model, 'there's a big difference between what is cognitive behavioural psychotherapy and [NHS Talking Therapies] CBT. Sometimes I do one, sometimes I have to do the other [[laughs]]'. This quote highlights a difference between CBT as a protocol driven approach, and a more flexible, tailored or integrative approach. The fact that therapists sometimes 'have to' switch approaches hints at the pressures from the system. This may create tension between the ideal therapy and what is practically required by the service.

A willingness to learn and reflect

Due to the nature of the work with interpreters and at times cultural differences, participants spoke about how they valued the importance of being curious in their work. Maeve spoke about treating the client as the expert and the importance of asking questions:

> I might have a generalised idea about kind of, you know, models of mental health in Iraq, but actually, what about you, in particular, like, what did your family really think about someone who's having flashbacks or, you know, hearing voices.

Some participants spoke about how working with interpreters often brought up feelings and thoughts of their own which they wanted to reflect and learn from. However, sometimes the time and space for this was not provided. There was also a recognition that making mistakes was inevitable, but this was also a vehicle for personal and professional growth which they valued. Reuben states:

> almost a self-supervisor who comes up on my shoulder and sort of says well hang on that's a bit of an assumption there or that sounds like a bias activating there and I can sort of check what I'm doing and what I'm thinking and in a very sort of CBT way, do some self-practice, self-reflection. And I guess the other bit that's important is there's also something about, I don't know, accepting that I will make mistakes.

A 'self supervisor' or 'internal supervisor' is a concept used to describe the way in which the supervisory process and relationship is internalised and utilised by the supervisee as a means of self-support. A self or internal supervisor therefore can act to provide space for reflection and awareness. Some participants felt that their training on issues relating to difference was superficial and did not provide sufficient grounding for critical self-reflection. Lily stated:

> It's lip service. It doesn't get to the root of it. It doesn't give you any skill. It doesn't get you to reflect on your own biases. We go, you have your own biases. That's nice. What are they? How do they affect you in your therapy room and how are you going to overcome them?

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Although this theme would also apply to working in face-to-face settings, it is relevant to this study because it highlights how CBT interfaces with non-English speaking clients who might be refugees or asylum seekers and may have faced trauma and have current adversities.

Working with interpreters remotely widens access to communities

Participants spoke about the importance of improving community engagement and providing equal access to psychological services to individuals who might otherwise be excluded or marginalised. Maeve spoke about how her service helped people set up with internet access during the pandemic to improve inclusivity of access to support: 'we've been buying dongles and sending them and then like, talking through the patient, how do we help them sort of get connected when they didn't have that connectivity'. Mark also spoke about how remote working allowed for clients to have access to an interpreter which they otherwise may not have had access to. Mark worked face-to-face with the client, and the interpreter joined the session remotely from another country, 'there was no chance of us actually getting somebody in the room with us. It would have to be some form of remote'. Reuben stated, 'I guess remote delivery has sort of really highlighted is it can be done, it can be safe, ethical and effective, but it improves access'.

Offering choice can be empowering

Grace spoke about offering choice of the mode of therapy, 'I just feel like in an ideal world, we give people the choice as to whether they are face-to-face or remote'. Ellie spoke about offering a choice of interpreter, 'choice in who their interpreter is. I always try to check in with them, is that interpreter, do you feel comfortable with them?'. Reuben spoke about respecting the client's decision about which language to speak in:

> I would always leave the preference down to the client. I would always be wary about making an assumption because it can go either way in my experience. I've had some people make an explicit request to work with someone who speaks their language and that then can be facilitated, but I've also had explicit requests not to when there's concerns about confidentiality or stigma.

Nina also highlighted how therapists cannot assume that clients want to be matched with a therapist who speaks the same language or from a similar cultural background. Nina gave an example of this: 'not all Sikh women, for example, want a therapist that is of their own culture. That presumption needs to be tackled because where there's been domestic violence or where they're in the same culture everybody knows one another'.

Theme 3: The powerful role of the interpreter

The interpreter as a source of cultural knowledge

Participants spoke of ways that interpreters provided cultural knowledge and could offer suggestions for cultural metaphors to help convey an idea, as Ellie explained, 'they [interpreter] helped come up with metaphors that were appropriate for her culture'. Despite the usefulness of cultural information from the interpreter, at times this could feel inappropriate if it was felt that translation was inaccurate or inappropriate:

> I was asking the patient through the interpreter what their beliefs were about the fact that this other person that they knew had passed away and the interpreter said I'm really sorry can't ask that. I went, yes, you can. I need to know that because it's really important and she says in our culture, we really don't talk about death. And I'm going okay, but I need the patient to tell me that not you [Lily]

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It might be that this cultural information was useful, but the therapist indicates that this information remains a guide rather than an absolute and therefore the therapist has a responsibility to check understanding with the client. In addition to this, interpreters are also bringing their own culture and beliefs into the therapy space as Maxine explains, 'interpreters are human as well and they are not therapists. They are coming from a particular viewpoint when you ask them a general question that is not about interpreting, you are getting what their views are from their family experience'.

Uncertainty about what was being communicated

Some therapists had poor expectations of interpreters. Ali stated, 'interpreters are people who just translate information. So, I suppose, they don't know how to keep boundaries, they don't know how to communicate things properly'. Grace highlighted, 'sometimes you can tell that they are interpreting everything, other times, the client would talk for minutes, and the interpreter would talk for maybe ten seconds, so you knew not everything was being translated'. In line with guidelines, some participants spoke about the importance of a pre-briefing with the interpreter to discuss expectations. As Stephen explained, 'I would normally do twenty minutes preparation prior to seeing somebody, especially for the first time, even if the interpreter doesn't want to do that. Simply because you can iron out these sorts of things a little more'. Some participants spoke about how the meaning or idea was more important than the verbatim translation of words. Maeve explained, 'we really rely on our interpreters to help translate ideas where maybe the idea does exist in that culture, but the language around it is quite different'. Carol reported that she informs the interpreter that she wants to 'understand the gist of it, and don't translate verbatim, so not word-for-word, but give the context of what I'm asking in their language'. Stephen commented on how 'meaning' felt particularly central to the CBT way of working, 'in CBT, the words are really important, meaning is really important. There's enough different meanings for "depressed" in UK language'.

Shifting control

The therapist was reliant on the interpreter and therefore the interpreter was seen as powerful. The therapist was competing for this power as Maeve explained:

> there are some patients who develop a really strong rapport with the interpreters and will kind of turn and look only at the interpreter for the whole session, and you're there kind of craning your neck around going, "I'm in charge here" [laughs], I promise

The therapist can sometimes feel like they have lost control of the session and want to remind the client and interpreter that they are in charge or ask to be invited back into the conversation, Ellie reported 'I have interrupted to say, "I'm noticing this is going on for a long time, would you be able to kind of let me back in"'. Ali spoke about how she may need to be more active to keep control of the session, 'I usually say can I just interrupt you here, kindly, and make sure that you are telling me what they're saying. I find I have to be a bit more firmer in sessions with the interpreters'. Therapists spoke about feelings of exclusion:

> and loss of power when there was a close relationship between the interpreter and the client. You find an interpreter and the patient talking like a tennis ball and it gets a bit nervous . . . anxious for me, because I don't want to interrupt them, but at the same time, I need to interrupt them because I don't know what they're saying [Ali]

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This image of a 'tennis ball' going back and forth highlights the centrality of the interpreter and the client in the therapeutic exchange. This can generate anxiety for the therapist who may experience reluctance to interrupt whilst appreciating the necessity to be an active central participant in the triad whilst also holding clinical responsibility. Some participants also reflected on how the remote element of the work impacted their sense of control in the session as Maeve said 'I can't tell you what to do, because you're in your own home but you are also in my clinic'.

The interpreter had a powerful presence even when they were not in the virtual room. Mia explained that the 'interpreter just dropped out and left me and the patient staring at each other for five to ten minutes and the whole time you don't really know … we can't talk anyway'.

The dynamics of interaction

A third person in the virtual room can make the relationship feel different, Ross reflected, 'I feel like our relationship is slowly coming along. I get the sense that it is slower than my English-speaking clients because of the language barrier and because of the technical problems we have had'. Sometimes participants relied on the interpreter for warmth and empathy. Lily stated, 'when it comes to the empathy and the tone and the unconditional attention, the interpreter should be able to or one would hope the interpreter should be able to deliver that as well'. However, Grace felt that this could be lacking from the interpreter, 'when they [interpreter] would say things back, you lose a lot of empathy in the room sometimes. Some interpreters seemed a bit rough. It just did not feel like a very safe environment sometimes'. Some therapists commented on how the interpreter matched their tone. Subsequently, this meant the therapist felt more optimistic about forming a relationship. Maxine stated 'she even tried to copy the tone of how things were said, which I really liked'.

The alliance and trust in the three-way relationship was particularly important for sensitive work around trauma. Therefore, having a consistent interpreter was seen as vital for the alliance as Maeve highlights:

> some stranger in the room and carry on talking about your rape. So we do tend to kind of go to quite a lot of lengths to make sure that we can get the interpreter that can consistently, you know, be with the patient for the whole of that journey

Theme 4: Remote working: different landscape, different journey

Anxiety about creating a safe environment

Most participants commented on technological difficulties. Reuben explained, 'poor connection and access to technology can present as difficulties for therapists and clients, I've had one or two instances where we had poor connection and that was, yeah tricky'. Confidentiality and a confidential space were important for therapists. Stephen highlights:

> if the interpreter's in the room, I do feel a bit more in control of the contextual element. I'm happier protecting the client, whereas if I don't quite know where the interpreter is … I just want to know what they're doing, who else is there.

Working remotely with an interpreter added anxiety about creating a safe environment particularly around trauma work. Maeve stated 'the majority of our patients are very dissociative and we just felt we couldn't keep them clinically safe on the end of the phone not being able to see if they were dissociating while they were doing reliving'. The anxiety about a safe environment included the therapist's own sense of containment. Due to the impact of the pandemic and increased time working from home, adaptions to supporting each other changed.

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> Ordinarily, in the office, you sort of stumble out of a heavy session with the patient and just go into the staff room and whoever was there, you'd go, Oh, can I just tell you? Can I just tell you how that session, like, I just have to offload this that was so upsetting and you almost just process it quickly, again, with your colleague [Maeve]

Reduced interpersonal cues

Participants touched on the lack of body language when working remotely. Maeve explained, 'you have to work a bit harder, the three of you to find your kind of your cadence, like to find your kind of rhythm'. Participants commented on how it is difficult not knowing how questions are landing with the client. Erica said, 'you can't rely on any sort of body language or anything to sort of get some sense of how the person's receiving what you're saying'. Some spoke about the usefulness of seeing someone on video compared with lost visual cues via the telephone. As Ellie states, 'there's social cues of, "I'm about to speak", in some way, and it's easier to get everyone on board with that'. Participants spoke about how they would pay attention to other cues: 'I got an idea of how they're speaking and how their tones were . . . sometimes the client would start speeding up a little bit, and I knew that was coming up in an area that would be tough, so I would ask in those moments to slow down, or to just check in with her emotional scale' (Ellie). The participants reflected on not being in the same physical space together. Reuben explains, 'If we're in a room together there are subtle cues and things you can do sort of show the person you are there, even if it's as simple as passing over a box of tissues'.

Discussion

The researchers believe that this is the first research study to qualitatively explore the experience of CBT therapists working with interpreters, specifically via remote access. The findings identified that the experience of working with an interpreter was perceived as valuable but was also associated with some difficulties and frustrations. This echoes the existing literature on working with interpreters. Although the remote aspect of this work does lead to some additional challenges, this study highlights that the greater challenge is working with interpreters. Although not specific to remote working, the findings of this current study offer a novel insight into how the modality of CBT is impacted when working with an interpreter.

Many of the findings from this study mirror those from previous studies, including mixed views about the role of an interpreter (Becher and Wieling, 2015; Miller *et al.*, 2005; Tutani *et al.*, 2018); issues relating to power (Becher and Wieling, 2015; Gerskowitch and Tribe, 2021; Raval and Smith, 2003); changes to the therapeutic relationship (Becher and Wieling, 2015; Gerskowitch and Tribe, 2021; Gryesten *et al.*, 2021; Kuay *et al.*, 2015; Miller *et al.*, 2005; Tutani *et al.*, 2018); challenges to communication (Hagan *et al.*, 2020; Pugh and Vetere, 2009; Raval and Smith, 2003; Tutani *et al.*, 2018); and the pressures to meet the demands of the system therapists work within, particularly in NHS settings (Erbil, 2015; Gerskowitch and Tribe, 2021). Findings also echo conclusions in previous studies about working remotely, such as challenges of reduced interpersonal cues (James *et al.*, 2022; McBeath *et al.*, 2020) and navigating the virtual environment (James *et al.*, 2022).

The findings of this study highlighted how participants held differing perspectives on how CBT was conceptualised and delivered. For some therapists working in NHSTT, this meant adherence to diagnosis specific protocols. The research findings also draw attention to the pressured, target-driven environments in which therapists worked. This was often characterised by stress, anxiety and frustration. This pressure meant that therapists had to make pragmatic decisions on how best to manage their workload, which sometimes meant prioritising organisational protocols and expectations. Protocol adherence is often prioritised in NHS settings (Sreenan, 2013), which could cause conflict for participants who felt that they needed to deviate from protocol or structure. It

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appears evident that participants did not always feel they had the time or emotional energy to engage in a reflective process to examine their therapeutic work in depth or to reflect on how they might be impacted.

This may account for aspects of the data in which it appears that some therapists seemed inflexible at times and seemed to feel that aspects of client diversity could be an impediment to following a manualised form of CBT. This tendency to find fault in the client rather than the manual is more likely to occur when working in systems under stress without adequate support or supervision.

Participants identified that many non-English-speaking clients had presenting problems that centred on practical concerns, such as gaining refugee status and/or how to access a range of resources. CBT can be shaped and adapted to meet client needs, for example by selecting interventions focusing on behavioural techniques such as problem-solving strategies. Naeem *et al.* (2019) highlight that the CBT therapist's challenge is to work with cultural awareness and sensitivity, adapting the delivery of the therapy and the interventions used whilst maintaining CBT's core theoretical principles.

Findings show that moving from the traditional dyadic to a triadic relationship changed the dynamics of the therapeutic encounter. Research consistently suggests that therapy of any orientation is an interpersonal endeavour in which the therapeutic relationship is of central importance (Messer and Wampold, 2002). The CBT therapeutic relationship has traditionally been seen as 'necessary but not sufficient' (Beck *et al.*, 1979). However, in recent years, interest in the role of the therapeutic relationship within CBT has increased. The focus has been on establishing an empathically attuned co-operative therapeutic relationship that is traditionally nurtured within a face-to-face encounter that helps to create a sense of psychological intimacy. This absence of physical proximity and care can potentially reinforce feelings of isolation, alienation and disconnection for the client. This is particularly relevant for clients who may already feel isolated by language barriers and lack of opportunities for social integration. Understanding the context of the client's life highlights the importance of forging a collaborative working alliance between the therapist and interpreter to provide a psychologically safe and productive therapeutic space.

Findings also highlighted how therapists can feel anxious about working with traumatic experiences or issues in a virtual space, given the potential difficulties in ensuring client safety and emotional containment. Remote therapy means working with a limited physical image of the client and as such is unlikely to provide the necessary opportunities for the therapist or interpreter to accurately observe or read a client's non-verbal communication. This has the possibility for misunderstanding between all members of the triad. Zoumpouli (2020) draws attention to the importance of establishing a consistent, emotionally attuned presence in remote practice where difficulties in connection with clients, whether technological or interpersonal communication, are acknowledged and discussed.

Therapists are often aware of the inherent power dynamics in working with an interpreter in triad work and are mindful that they hold clinical accountability. It is interesting to note that although participants in this study recognised their responsibilities for managing the therapeutic process, participants tended to articulate how the session would be organised in general rather than specific terms. This may have signified a lack of relevant training or a reluctance to move into what could be perceived as a managerial rather than a collegial role. Although participants spoke about power dynamics inherent in the interaction with the interpreter, some may have found this differential uncomfortable. Indeed, wider issues relating to power imbalances and social inequalities and how these might impact on each member of the triad were often not acknowledged. This echoes Gerskowitch (2018) who suggests that this avoidance may be due to discomfort, fear of causing offence, or lack of confidence in addressing the situation.

Patel (2003) identifies that several differences exist between the client, interpreter and therapist, for example social economic status, ethnicity, age, gender, political and religious beliefs. These differences will impact upon the triadic relationship and are likely to unconsciously play out in the

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therapeutic process. It is interesting to note that participants predominantly focused on technical or organisational pressures. Whilst it is easy to recognise how these immediate concerns took priority, it may also suggest a reluctance to address sensitive issues around inequality and difference.

It is important to acknowledge that working with people who do not speak English and may require an interpreter increases the likelihood of working with asylum seekers and refugees who may have complex histories and presenting difficulties. Furthermore, mental health services that offer CBT are often pressured services. In light of this, it can be difficult to disentangle these interwoven elements.

Clinical implications

Findings suggest that ensuring high quality training in working with interpreters continues to be a clinical priority. This is particularly relevant in the context of rapid changes to service delivery since the pandemic. In addition to identifying the benefits of professional study, the research also offers implications for individual learning and development via personal reflexivity, peer and individual supervision and activities to promote self-awareness.

Service level change

Findings indicate that CBT therapists tend to experience conflicting emotions in relation to working with interpreters. This points to the importance of support systems such as ongoing training, supervision and reflective practice being embedded into good practice guidelines. During the interviews, some participants reflected on the systemic and social changes needed to support non-English-speaking communities to address barriers that clients' face. These changes ranged from revising referral processes to enable non-English speakers to access therapy more easily to assessing how CBT could be tailored to suit individual needs. Therapists would benefit from a deeper understanding of the stigma and discrimination that clients with limited spoken English may experience and how these factors impact upon their engagement with professional services.

Wider implications

Successive UK Governments have committed to providing universal health care to all, including migrants and refugees. How this translates into practice and policy is often a contested field. Some literature suggests that non-English speaking individuals who might be refugees have a greater need for political and social justice rather than psychological therapies (Summerfield, 1999; Turner *et al.*, 2003). This includes improving the asylum and immigration system, access to legal advice and strategies to support social inclusion. However, providing psychological services that enable non-English speaking refugees and migrants to feel supported and empowered to cope with the issues they face is also valuable. The research indicates this can be achieved via culturally and linguistically informed therapeutic service provision. Sometimes, people with limited spoken English are considered marginalised, disadvantaged or 'hard to reach' groups. These terms may suggest that there is an inherent reluctance of these groups to be reached. Although there may be reasons that certain people do not engage with services, it could also be reframed as a reluctance of service providers to seek ways to understand and work with diverse groups in a meaningful way.

Strengths and limitations

The study explored is a worthy topic, mainly due to its relevance and timeliness given increased remote working since the COVID-19 pandemic and increasing number of people seeking asylum

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in the UK. The sample size is a noteworthy strength. There was diversity in ethnicity, age, gender, length of time working as a therapist and level of experience with interpreters. The participants in this study were all BABCP accredited therapists, and those who did not hold accreditation were excluded. Although this exclusion criterion was applied to ensure that only therapists with sufficient training and experience of CBT were recruited, the exclusion may have inadvertently limited the transferability of the findings to those practising CBT without BABCP accreditation. Purposeful sampling meant that the sample was self-selected. Some participants had only worked with one interpreter remotely and others had a lot of experience which increases the diversity in the sample but also means it is not possible to know the extent to which level of experience might influence some of the findings. The sampling method could lead to a selection bias, with therapists who either struggled to work with interpreters or had a particular passion for this area. Furthermore, the project included all remote ways of working (both video and telephone) which impact differently on therapist-client encounters. Further study may be useful to look at video and telephone consultations separately. Finally, the study did not collect detailed information about participants' prior training or support in relation to use of interpreters and remote therapy. Many participants had attended workshops and training, done self-directed study or attended in-house team meetings or discussions on the topic but without systematic data on this it is not possible to know how much influence this had.

Directions for future research

This study has only explored the experiences of therapists, and future research could give attention to the experiences of clients and interpreters working within different therapeutic modalities and settings. Further research could be undertaken to explore help-seeking in non-English-speaking individuals who may have additional barriers to accessing help.

Conclusion

Working with interpreters is integral to the work of CBT therapists and is a regular part of their workload. The research offers important insight into how the system therapists work in can impact their confidence and willingness to work with an interpreter, and how working with clients through interpreters can impact the therapeutic process.

Key practice points

(1) Emphasise the need for cognitive behavioural therapists to develop skills when working with interpreters and embody cultural humility.
(2) Emphasise the need for flexible services that offer regular supervision and spaces for reflection.

Further reading

British Psychological Society Guidance – Working with interpreters online or via the telephone. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Working%20with%20interpreters%20online%20or%20via%20the%20telephone.pdf Google Scholar

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Data availability statement. The data that support the findings of this study are available on request from the lead author (J.W.-B.). Documents that may be available are: interview schedule, participant information, consent form, recruitment poster.

Acknowledgements. The authors wish to thank the participants for their involvement and valuable contribution to the study.

Author contributions. Primary author, Dr Jenny Wardman-Browne led in designing and implementing the research, including data collection and analysis, and took the lead in writing the manuscript. The second and third authors guided and monitored the research process, confirmed the data interpretation, themes generated and verified the research findings. All authors contributed to the review and revision of the manuscript and approved the final version for publication. **Jenny Wardman-Browne:** Data curation (lead), Formal analysis (lead), Methodology (lead), Project administration (lead), Resources (lead), Writing (lead); **Susan McPherson:** Data curation (supporting), Formal analysis (supporting), Methodology (supporting), Supervision (lead), Writing – review & editing (supporting); **Caitlin Phillips:** Data curation (supporting), Methodology (supporting), Supervision (supporting), Writing – review & editing (supporting).

Financial support. This research was completed in 2023 as part of a Doctoral thesis for Clinical Psychology training in the UK at University of Essex. Training is funded by the National Health Service (NHS) and Higher Education England (HEE). Otherwise, this research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Competing interests. The authors declare none.

Ethical standards. This study received ethical approval from the University of Essex Ethics Committee. Participants gave consent to take part and publish data; all data remains anonymous. Participants' personal information such as names and contact details along with the audio-recordings and transcripts were stored confidentially on the University's secure online cloud storage and a password protected laptop accessible only to the researcher and research supervisors. Participants were allocated ID numbers throughout data analysis and then pseudonyms throughout the write-up of the research. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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Cite this article: Wardman-Browne J, McPherson S, and Phillips C (2025). Cognitive behavioural therapists' experiences of working remotely with language interpreters. *The Cognitive Behaviour Therapist* 1–18. https://doi.org/10.1017/S1754470X25100238

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