Effects of Interpreter Use on Quality of Mental Health Encounters: An Updated Preliminary Systematic Review

Lucille Miao, MS4
Caring for Newcomers in Charlottesville Rotation
University of Virginia School of Medicine
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Abstract

Context: The most recent systematic review examining the effect of interpreter use on mental health care concluded that there was insufficient evidence to inform evidence-based guidelines. However, this systematic review was published in 2010 and therefore, only included publications from inception of each database to 2009.

Objective: To synthesize the updated evidence on the effects of interpreter use on patient outcomes in mental health care.

Data sources: Literature searches of PubMed from 2009 to 2025, and empirical studies that were included in Bauer and Alegria's systematic review.

Study selection: Inclusion criteria were peer-reviewed, English-language papers that evaluated interpreter use in mental health encounters and reported data about patient outcomes. The search strategy identified 370 publications, and 40 articles met inclusion criteria for full-text screening.

Data extraction and synthesis: Given that this is a preliminary systematic review, only one person reviewed studies and abstracted data. A quality assessment was deferred at this time.

Results: A total of 17 studies was included. Untrained interpreters often made interpretation errors, some of which were clinically significant. When compared to no interpreters or family members as interpreters, trained interpreters were associated with increased patient reports of psychological symptoms and traumatic events. Interpreter use was associated with improved self-reported therapeutic alliance ratings. The implementation of threshold language access programming across California, which required access to interpreters if a certain percentage of the population spoke a certain language, was associated with increased mental health utilization among Russian and Vietnamese speakers but not Spanish speakers. Finally, one study found that when compared to no interpreter use, trained interpreter use was associated with less improvement on pre-post mental health rating scales; interpretation service need was determined by patients' linguistic proficiency.

Conclusion: Overall, trained interpreter use, but not necessarily ad hoc interpreter use, was generally associated with higher quality mental health care encounters.

Introduction

As interactions between patients and clinicians with different linguistic and cultural backgrounds become more common in our increasingly pluralistic societies, the need for interpreters in health care and mental health care encounters will increase. For example, between 1980 and 2019, the number of Americans who use a language other than English as their primary language had tripled from 23.1 million people to 67.8 million people.[1] Based on the Title VI of the Civil Rights Act of 1964, there is also a legal requirement for all

healthcare entities receiving federal funding to provide professional interpretation services to individuals requiring assistance.[2] However, it is unclear how interpreter use affects mental health encounters, where excellent communication is required to provide good mental health care. Further elucidation could inform future practice guidelines for clinicians and interpreters.

Bauer and Alegria's systematic review[3] provided a comprehensive review of the literature about the effect of interpreter use on mental health encounters, but was published in 2010, thus it only included studies prior to April 2009. The goal of this paper is to update our understanding with more current evidence of how interpreter use affects patient outcomes in the setting of psychiatric assessment and management.

Methods

Search Strategy and Selection Process

A comprehensive search of the literature in PubMed between April 2009 to July 2025 was performed using the search terms from Bauer and Alegria's systematic review.[3] Table 1 provides a description of the search terms. Given that this is a preliminary updated systematic review, PsycINFO and CINAHL were not searched at this time. PubMed, PsycINFO, and CINAHL were searched in Bauer and Alegria's systematic review.[3]

Articles were included if they contained patient outcome data related to the use of interpreters in mental health encounters. Non-peer reviewed and non-English articles were excluded. Publications of abstracts only, case reports, letters, and comments were also excluded. Of note, this paper's eligibility criteria were narrower than those of Bauer and Alegria's systematic review.[3] Specifically, in addition to this paper's inclusion criteria, Bauer and Algeria's systematic review[3] also included articles that assessed the effects of language proficiency on mental health care, which were not included in this paper. Therefore, the fourteen empirical studies from their systematic review were rescreened based on these eligibility criteria.

Data Collection

This author (LM) reviewed the titles, abstracts, and full-text articles. She then extracted the following data: study characteristics (i.e., location, year of data collection, study design), participant characteristics (i.e., sample size, patient characteristics, and interpreter type), and study results. A quality assessment was deferred at this time.

Results

Data Retrieval

The search strategy identified 370 citations. A total of 17 studies were included. Figure 2 provides a flow diagram outlining the results of the systematic search. Table 2 provides a description of the included studies' characteristics and results. Studies that had been described in table 1 of Bauer and Alegria's systematic review[3] were excluded from this paper's Table 2. However, they are included in the data synthesis section below.

Data Synthesis

Quality of interpretation

Key question 1a: How accurate is interpretation in mental health encounters?

Key question 1b: What is the clinical significance of interpreter errors?

Six studies[4-90]examined the quality of interpretation in mental health encounters. Four studies[4,5,8,9] described several types of interpretation errors, including omissions, substitutions, condensations, and additions. Examples of some of these interpretation errors are provided in Table 3.

Table 1: Search strategy based on Bauer and Alegria's (2010) systematic review

Database	Search terms
PubMed	("Translating"[Mesh] OR "interpreter" OR "language proficiency") AND ("Mental Health Services"[Mesh] OR "Community Mental Health Services"[Mesh] OR "Mental Disorders"[Mesh] OR "Psychopathology"[Mesh] OR "Psychotherapy"[Mesh] OR "Interview, Psychological"[Mesh] OR "Hospitals, Psychiatric"[Mesh]) NOT ("Psychometrics"[Mesh] OR "Questionnaires"[Mesh] OR "Psychological Tests"[Mesh])

Figure 1: Flowchart of literature search

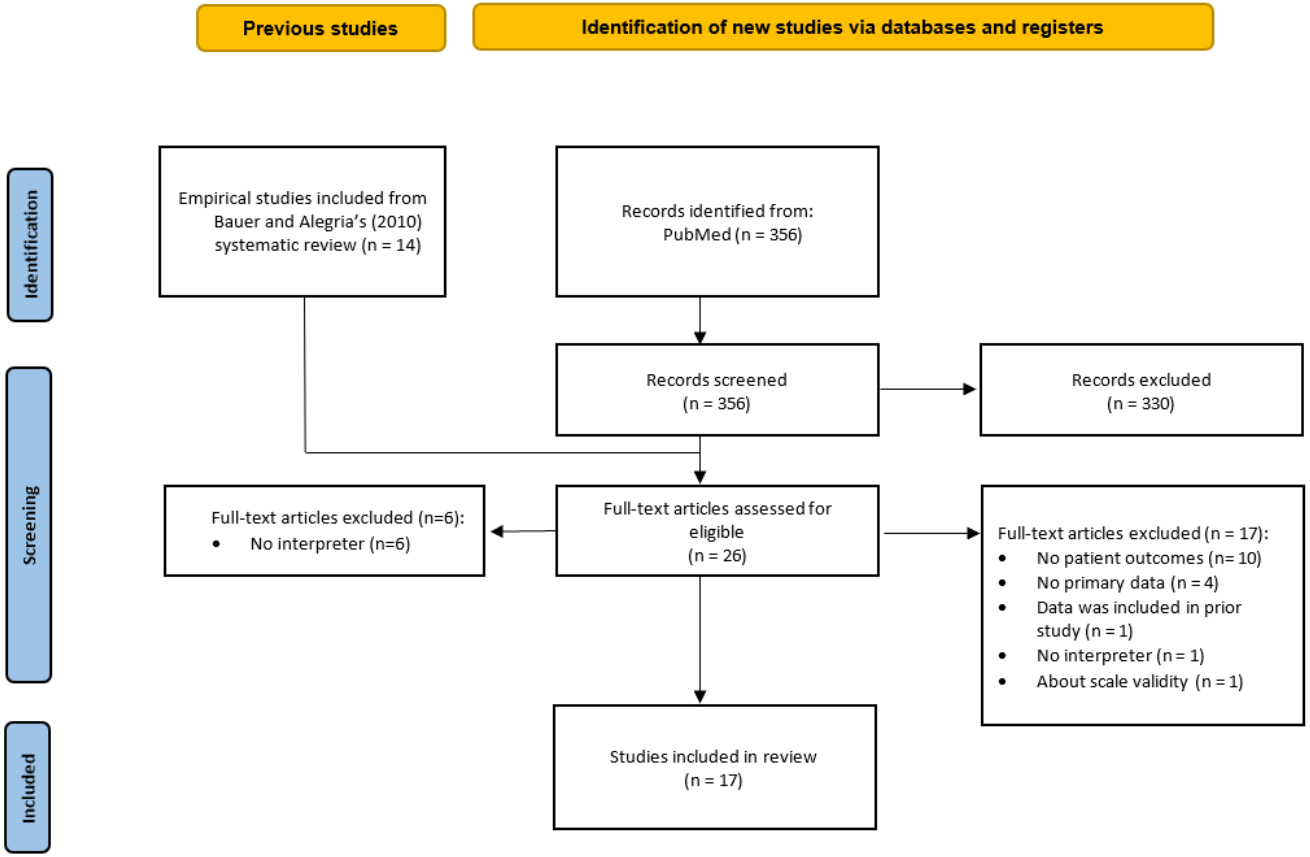

Table 2: Summary of studies on the effects of interpreter use on patient outcomes related to psychiatric assessment and management

Reference	Location	Years of Data Collection	N and sample	Interpreter type	Psychiatric disorder type	Methods	Results	Comments
Chang et al. (2021)[12]	United States	Unspecified	n = 14 Mandarin-speaking outpatients and n = 11 Spanish-speaking outpatients	Bilingual/ bicultural clinicians	Unspecified	Quasi-analog study in which interpreters were encouraged to play an active role during the clinician-patient encounter. Clinicians and patients were interviewed after their interpreter-facilitated encounter	Most common interpreter intervention was clarification. Patients appreciated 'emotion work,' that is when the interpreter represented the speakers' tone and affect	
Flynn et al. (2013)[17]	United States	10/2009 - 9/2010	Study group: n = 1,566 adult patients requiring interpreter services Comparison group: n = 61,959 adult patients not requiring	Unspecified	Any mental health diagnoses or somatic diagnoses	Retrospective cohort study that compared visits to primary care, express care, or emergency department between patients requiring interpreter services and	Lower rates of mental disorder diagnoses (13.9% v. 16.7%, $p<0.01$) but higher rates of somatic diagnoses (including disorders of nervous system, digestive system, musculoskeletal system, and ill-defined	

			interpreter services. This group included patients with preferred language of English and preferred language other than English (n = 1,592)			those not requiring interpreter services	conditions) in patients requiring interpreter services	
Kilian et al. (2010)[6]	South Africa	5/2006 - 7/2006	Not applicable	Ad hoc interpreters (e.g., administrative clerk, security guards, nurses)	Unspecified	Participants were asked to translate commonly used psychiatric diagnostic questions from English into Xhosa, which were subsequently back-translated	Incorrect translations of common psychiatric diagnostic questions were often made	
Kilian et al. (2014)[7]	Western Cape, South Africa	2010	n = 13 psychiatric evaluations	Ad hoc interpreters, who were employed as health care workers and household aides. Household	Unspecified	Audiotaped encounters of psychiatric evaluations that were transcribed verbatim and rated by a psychiatrist and psychologist	There were 57 total interpreter errors: 14 addition errors (9 errors that were clinically significant), 24 omissions (11 that were clinically significant), and 19	

				aides had 4-16 years of experiences acting as ad hoc interpreters.			substitutions (6 that were clinically significant). All clinically significant errors made the patient appear more ill.	
McClellan et al. (2012)[19]	California, United States	7/1996 - 1/2006	n = 390 Russian speakers, n = 1,326 Spanish speakers, n = 663 Vietnamese speakers.	Unspecified	Unspecified	Time-series study that compared county-by-quarter data prior to and after implementing threshold language access programming. For counties without data prior to threshold language access programming, non-equivalent control groups were used, including counties not implementing threshold language access programming or	Significantly increased mean penetration rates of mental health services for Russian speakers (+ 8.2 points, $p<0.01$) and Vietnamese speakers (+3.3 points, $p<0.01$) after implementation of all four language access programing elements. No significant effect for Spanish speakers	

						for only some languages		
McClellan et al. (2015)[20]	California, United States	7/1996 - 1/2006	n = 697 county-quarter observations of adult Spanish-speaking clients with limited English proficiency	Unspecified	Schizophrenia, major depression, and bipolar disorder	Same as above	Implementation of language access programing had no significant effect on rates of having at least two follow-medication visits within 90 days or at least three visits within 180 days for Spanish speaking clients	
Muntigl et al. (2025)[9]	Belgium	Unspecified	n = 1 Syrian-speaking refugee	Professional interpreter	Trauma	Conversation analysis of video-recorded session of interpreter-mediated psychotherapy	Interpreter was found to take a more active role, including adding instructions, rather than merely transcribing the words	
Sander et al. (2019)[18]	Denmark	6/2009 - 10/2015	n = 436 - 598 adult refugees or member of a family who was reunited with a refugee	Professional interpreters, who were experienced in translating psychotherapy sessions. However, health care interpreters in Denmark do not require	PTSD	Retrospective cohort study that compared treatment outcomes of psychotherapy sessions with interpreters v. no interpreters via pre-post score differences in self-report	Use of interpreter in psychotherapy sessions was associated with significantly less improvement in PTSD scale HTQ, depression and anxiety symptoms scale HSCL-25, somatization scale SI-SCL-90,	Need for interpreter was determined by patient's linguistic proficiency, as assessed by a medical doctor

				formal education or authorization		and observer scales	functioning scale SDS, quality of life scale WHO-5, and depression and anxiety scale HAM-A. No significant difference between groups in global assessment of functioning scales GAF-F and GAF-S, or HAM-D scale.	
Villalobos et al. (2016)[15]	Arkansas, United States	9/2010 - 4/2014	n = 458 adult Spanish-speaking patients, who had previously never received behavioral health sessions	Medical assistants trained in behavioral health interpretation	Depressive symptoms (33.8%), behavioral health concerns that did not merit a psychiatric diagnosis such as relationship difficulties (29.7%), anxiety symptoms (17%), adjustment disorder (12.7%), other (6.8%)	Retrospective cohort study that compared patients who used interpreter services v. patients who had bilingual providers	No significant difference in self-reported therapeutic alliance between interpreter group (M=3.89, SD=0.32, n=199) and bilingual provider group (M=3.85, SD=0.32, n=259)	

Table 3: Examples from the literature of interpretation errors

Interpretation Error Type	**Definition**	**Example**
Omission	Partially or completely deleted message	*Clinician*: 'Does she have any other illnesses beside high blood pressure?' *Interpreter to patient*: 'She is asking if you have ever had other sickness other than the high blood pressure?' *Patient*: 'It's insanity and this high blood pressure they say I have, I don't know how a person is when she has it.' *Interpreter to clinician*: 'No'[7] *Clinician*: 'What kind of moods have you been in recently?' *Interpreter to patient*: 'How have you been feeling?' *Patient's response*: 'No, I don't have any more pain, my stomach is now fine, and I can eat much better since I take the medication.' *Interpreter to clinician*: 'He says that he feels fine, no problems.'[8]
Substitution	A concept is replaced by another	*Clinician to patient*: 'Do you ever feel that you would like to go to sleep and not wake up?' This was interpreted as a question about sleep rather than suicidal ideation.[5]
Similar phonetic sounds	Similar-sounding word is misconstrued as another similar-sounding word	A clinician asked a Punjabi-speaking patient if she felt guilty. The interpreter did not translate the word 'guilty' into Punjabi and instead used the English word, 'guilty' when speaking to the patient. *Of note, the English word 'guilty' sounds similar to the Punjabi word 'swelling.'* The patient stated that she did not feel a swelling.[5]

Two studies[6,8] attributed interpretation errors to interpreters' insufficient language competence, translation skills, and psychiatric knowledge, and one study[10] attributed interpretation errors to patient characteristics, including actively psychotic patients and patients who gave long answers. In all three studies,[6,8,10] the interpreters were not trained interpreters.

One study[7] explored the clinical significance of interpretation errors. This study[7] found that 46% of the interpretation errors were clinically significant, all of which made the patient appear more mentally ill. The interpreters in this study were ad hoc hospital staff interpreters.

Therapeutic alliance

Key question 2a: How does interpreter use affect therapeutic alliance?
Key question 2b: If there is an effect, what is the clinical significance?
Five studies[11-15] directly or indirectly investigated the effect of interpreter use on therapeutic alliance. Three studies[12,14,15] directly examined self-reported therapeutic alliance. One study[14] found that when compared to no interpreter use, interpreter use had a positive effect on therapeutic alliance. Another study[12] found that in qualitative interviews, many patients appreciated the interpreter's role, although there was no comparison group in this study. Finally, one study[15] found no significant difference in therapeutic alliance between the trained interpreter group and bilingual provider group (F (1,456) =1.81, p=0.179).

Of the two studies[11,13] that indirectly examined therapeutic alliance, both found that trained interpreter use was significantly associated with increased detection of psychological symptoms. In Eytan and colleagues' study,[13] when a trained interpreter was present, significantly more psychological symptoms (trained interpreter 33%, family member as interpreter 14%, and no interpreter 12%, p=0.001) and history of traumatic events (trained interpreter 77%, family member as interpreter 46%, and no interpreter 55%, p=0.003) were reported. In Bischoff and colleagues' study,[11] when a trained interpreter was present, significantly more psychological symptoms were reported (trained interpreter 32%, ad hoc interpreter 16%, and no interpreter 18%, p=0.029).

Diagnostic formulation

Two studies[16,17] indirectly evaluated the effect of interpreter use on diagnostic formulation. In Dodd's retrospective medical record review,[16] physicians who spoke the same language as their patients and physicians who used interpreters diagnosed mental disorders at similar rates. In Flynn and colleagues' study,[17] there were significantly lower rates of mental disorder diagnoses (13.9% v. 16.7%, p<0.01) but significantly higher rates of somatic diagnoses in patients requiring interpreter services, compared to patients who did not require interpreter services.

Treatment and Intention to seek care

Only one study[18] explored the effect of interpreter use on treatment outcomes. It found that when compared to no interpreter use, the use of trained interpreters in psychotherapy sessions was associated with significantly less improvement in several mental health rating scales. Patients were allocated interpreters versus no interpreters based on their linguistic proficiency, as assessed by a clinician.

Three studies[14,19,20] examined the effect of interpreter use on the intention to seek care. One study[13] found that 76% of patients who had an interpreter-facilitated encounter intended to attend their follow-up visit, compared to 73% of those who did not use an interpreter. In this study, statistical significance for this outcome was not reported, although it was reported for other outcomes. Two studies[19,20] investigated the impact of the implementation of language access programming in the United States, which included access to interpreter services. They found that access to interpreter services was associated with significantly increased mental health service utilization in Russian and Vietnamese speakers but not in Spanish speakers.

Discussion

This present paper builds on an older systematic review[3] that examined the effects of interpreter use and language proficiency on psychiatric diagnostic evaluation and management.

Quality of interpretation

When synthesizing the data, it is important to note that most studies appeared to subscribe to a passive interpreter model, where interpreters were expected to make one-to-one translations of the clinicians and patients' speech, rather than an active interpreter model, where interpreters were encouraged to broaden their scope and take on additional roles, such as that of a cultural broker. Therefore, any deviations from a one-to-one translation were likely categorized as errors.

With this caveat, all the studies[4-10] that evaluated the accuracy of interpretations in mental health encounters found translation errors. All the studies[3-9] examined untrained interpreters. The clinical significance of these errors, such as whether they lead to diagnostic and management errors, is unclear. One study[7] found that about half of the errors were clinically significant and made the patient appear more ill. However, there was not a sufficient number of studies that analyzed the clinical significance of translation errors to draw a definitive conclusion.

Given the data, it may be unreasonable to expect flawless translations, at least with untrained interpreters. There are not enough data to conclude that trained interpreters also make similar amounts of translational errors. However, it would not be an unreasonable hypothesis, as even foreign language films' subtitles have translation errors, some of which lead to audience misunderstandings.[21,22] One may speculate that the task of creating subtitles post hoc for foreign language films may be less error-prone than live interpretation.

Future studies could consider exploring the clinical significance of various types of translation errors, as it may be more feasible to target possible interventions toward minimizing certain types of translation errors that tend to be clinically significant rather than all errors. In addition, although some studies have investigated possible mediating factors, like interpreter and patient characteristics, it may also be clinically valuable for future studies to also investigate the role of clinician characteristics. This may also inform future interventions, such as training programs for clinicians and interpreters that aim to reduce the number of clinically significant misinterpretations.

Given the present technology, it would also be fruitful to understand how in-person interpretation versus virtual with audio only interpretation versus virtual with video and audio interpretation may mediate the number of translation errors and their clinical significance. If virtual interpretation is found to be inferior to in-person interpretation, then it may support funding for in-person interpretation services, or at least this information would be able to inform clinical thinking.

Finally, it may also be clinically useful to understand whether there is an association between patients' language proficiency and number of translation errors and their clinical significance. For example, if it is found that there are less clinically significant misinterpretations when patients with medium proficiency of the clinician's language forgo interpretation services, then it may make sense to recommend no interpretation services for patients above a certain language proficiency threshold.

Effect on diagnostic assessment

In addition to understanding how translational errors may affect diagnostic assessment, this paper also aims to elucidate how the presence of an interpreter, a third-party participant, may influence diagnostic evaluation. There were two studies[16,17] that assessed the prevalence of mental disorder diagnoses in patients requiring interpretation services versus those who did not. One study[17] found lower rates of mental disorder diagnoses but higher rates of somatic disorder diagnoses in patients requiring interpretation services. The authors[17] of this study speculated that when a language barrier is present, it may be more difficult to communicate about psychological symptoms, as opposed to somatic symptoms, even if interpretation services are available.

In terms of the empirical evidence for this hypothesis, two studies[3,7] explored the effect of interpreter use on disclosure of psychological symptoms. They[3,7] both found that trained interpreter use, but not family member as interpreter use, was associated with increased detection of psychological symptoms and traumatic events. The mechanism of action has not been empirically studied, but several possible mechanisms of actions have been proposed, including hypotheses about language concordance and the use of interpreters as cultural mediators.[12]

Returning to the Flynn and colleagues' study,[17] the paper did not clarify whether the interpreters were trained. Therefore, their findings may be mediated by the training level of the interpreters. However, even if trained interpreters were used, the evidence does not necessarily contradict the authors' hypothesis. A reasonable hypothesis would be that although trained interpreters increase disclosure of psychological symptoms when compared to untrained interpreters, the rates of disclosure may still be lower than those from psychiatric evaluations conducted in the patient's native language. To better evaluate this hypothesis, future studies could consider comparing the outcomes of psychiatric evaluations that are conducted in the patient's native language versus those that are mediated by a trained interpreter. Alternatively, it is also possible that in some cultures, mental illnesses manifest with more somatic symptoms than psychological symptoms.[23]

Future studies could also consider exploring how passive versus active interpretation models may affect disclosure of psychological symptoms, as the various proposed mechanisms of action seem to correspond to different interpretation models. For example, theories about language concordance subscribe to a passive interpretation model, whereas hypotheses about the use of interpreters as cultural mediators follow an active interpretation model. If active interpretation models are found to be superior to passive models, then this could lead to a significant shift in how clinicians and interpreters work together. It would also be clinically valuable to understand the effect of in-person versus virtual interpretation services on disclosure of psychological symptoms.

Effect on treatment

In terms of the effect of interpreter use on treatment and treatment-related outcomes, it is encouraging that all studies[12,14,15] found that interpreter use was associated with increased therapeutic alliance, or at least therapeutic alliance levels that were similar to those of bilingual providers.

It is interesting that the implementation of the threshold language access programming improved mental health care utilization among Russian and Vietnamese speakers but not Spanish speakers.[19,20] It would be informative to understand the prevalence of Spanish-speaking interpreters and clinicians in California prior to the implementation of the threshold language access programming, as perhaps there was sufficient access to Spanish-speaking interpreters and clinicians prior the implementation of threshold language access programming. It is also possible other factors, such as stigma, have a stronger impact in Spanish speakers in the United States.

The results of Sander and colleagues' study[18] may again point to the utility of understanding whether there is a threshold language proficiency effect. In the threshold language proficiency effect, which this paper hypothesizes, language proficiency may mediate the relationship between interpreter use and patient outcomes–that is, if a patient has a certain level of language proficiency, would interpreter use lead to worse outcomes? It could be speculated that if the patient's language proficiency is within one standard deviation of the interpreter's language proficiency, then the risks of interpreter use, such as risk of translation errors, may outweigh the benefits.

Limitations

As this paper was intended to be a preliminary update of the literature, a comprehensive search of PsycINFO and CINAHL, which would have yielded more articles, was deferred at this point. A quality assessment of the included studies was also deferred. Additionally, only one reviewer performed the title and abstract screening, full-text screening, and data extraction. Typically, there are multiple reviewers independently performing the screening and data extraction, as this tends to improve the accuracy and reliability of the screening and data extraction processes.

Aside from these caveats, this paper also presents other limitations. First, the search strategy did not find randomized controlled trials, which may be more methodologically robust than retrospective cohort studies. Second, the majority of the papers tended

to focus on English-speaking countries, possibly because non-English language articles were excluded or possibly because of less research on this topic in non-English-speaking countries. This paper's findings, therefore, may not necessarily be generalizable to countries, whose primary language is not English. Third, this paper did not consider non-peer-reviewed data sources, which may be subject to less publication bias.

Conclusions and Practical Tips

Please note that this paper was focused more on how interpreter use affects patient outcomes in mental health care settings. This paper was not a review of the literature about best practices of how to work with interpreters in mental health care settings. Therefore, these practical tips are simply points to keep in mind when working with interpreters in mental health encounters. This is not intended to be prescriptive or a description of best practices.

- All papers which explored the accuracy of interpreters' translations found that untrained interpreters made interpretation errors, some of which were clinically significant. It is unknown whether trained interpreters also make similar amounts of errors and their clinical significance. Clinicians, who work with interpreters, may need to consider that the data collected via untrained interpreters may be of lower quality than that of their typical clinician-patient interviews.
- The University of Virginia uses Globo virtual interpretation services. Globo interpreters are considered trained after completing the Bridging the Gap 40-hour basic training program, which is available nationally.[24] Its corresponding textbook does not appear to have a chapter dedicated to mental health encounters or psychiatric terminology.[25] A Bridging the Gap: Training for Mental Health Interpreters course is available.[26] However, interpreters are not required to complete this course. The health system may benefit from recommending more robust mental health training, especially if future studies re-demonstrate the finding from Marco's study[7] showing that some interpreter translation errors are clinically significant. Although this may decrease the supply of medical interpreters, it would ensure that interpretation for mental health encounters is high quality, which of paramount clinical importance.
- Trained interpreters, but not family members as interpreters or untrained interpreters, were associated with increased disclosure of psychological symptoms and traumatic events. One may consider establishing a policy stating that if an interpreter is needed in a mental health encounter, the clinician must use a trained interpreter. This may improve the quality of the clinical encounter, while also reducing the friction that may occur with declining a request for a family member to act as the interpreter.
    - In the University of Virginia, the policy recommends trained interpreter use. However, adult family members may be used as interpreters, if the patient insists. The use of untrained volunteer interpreters and

staff as untrained interpreters is discouraged.

- Interpreter use has been associated with improved therapeutic alliance, or therapeutic alliance levels similar to those of bilingual clinicians.
- One paper[18] found that the interpreter use in psychotherapy was associated with less improvement in several mental health rating scales, when compared to no interpreter use. Interpretation service need was determined by patients' language proficiency. Given that this was only one paper, it is difficult to draw a definitive conclusion. However, it may be prudent for clinicians to consider this when treatment planning.
- If a future paper would like to synthesize the best practices for interpretation in healthcare settings, it may be worthwhile exploring the best practices for translating foreign language films. Subtitle creation for foreign language films is an established industry, whereas interpretation in healthcare settings seems to be a burgeoning industry. Therefore, there may be opportunities for cross-pollination.

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