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Effects of Language Concordance and Interpreter Use on Therapeutic Alliance in Spanish-Speaking Integrated Behavioral Health Care Patients

Abstract

The discrepancy between the growing number of Spanish speakers in the U.S. and the availability of bilingual providers creates a barrier to accessing quality mental health care. Use of interpreters provides one strategy for overcoming this linguistic barrier; however, concerns about whether sessions with interpreters, versus bilingual providers, impede therapeutic alliance remain. The current study explored associations between the use of interpreters and therapeutic alliance in a sample of 452 Spanish-speaking patients seen for integrated behavioral health visits at primary care clinics. Patients completed a brief (4 item) therapeutic alliance scale at their behavioral health appointment. In addition, to supplement the quantitative study data, a pilot study of 30 qualitative interviews was conducted with a new sample of 10 Spanish-speaking patients, 10 behavioral health consultants (BHCs), and 10 trained interpreters. Quantitative results showed that interpreter use did not relate to therapeutic alliance, even when controlling for relevant demographic variables. However, qualitative interviews suggested major themes regarding the relative benefits and challenges of using interpreters for patients, interpreters, and BHCs. In interviews, patients expressed a strong preference for bilingual providers. Benefits included greater privacy, sense of trust, and accuracy of communication. However, in their absence, interpreters were seen as increasing access to services and facilitating communication with providers, thereby addressing the behavioral health needs of patients with limited English proficiency. BHCs and interpreters emphasized the importance of interpreter training and a good collaborative relationship with interpreters to minimize negative effects on the quality of care.

Key words: therapeutic alliance, limited English proficiency, interpreters, language concordance, integrated behavioral health care

Effects of Language Concordance and Interpreter Use on Therapeutic Alliance in Spanish-Speaking Integrated Behavioral Health Care Patients

Recently, one of us (AUTHOR) had a behavioral health session with a primary care patient. The patient, a 49-year-old Hispanic woman from Chile, had been previously seen by another behavioral health consultant (BHC) in the clinic. Because the patient was fairly fluent in English, she and the previous BHC, a monolingual English speaker, were able to communicate without the use of an interpreter. However, when she learned that her new BHC, a bilingual male from Mexico, spoke Spanish, she stated effusively how excited she was that she could use her native language for her sessions. She stated that talking in Spanish with her BHC was like being “en casa” [at home] and that she could express herself more freely. While the patient praised her prior BHC, she noted readily that “we need more bilingual providers” and that she could “connect” more easily with someone who spoke her own language. In this two-part study, we explore further language concordance between BHCs and Spanish speaking patients.

As of 2010, the Hispanic population comprised one of the largest ethnic minority groups in the U.S. (Ennis, Rios-Vargas, & Albert, 2011). Spanish is the second most spoken language in the U.S. (Shin & Kominski, 2010). This growth places an increasing demand for language-responsive mental health services. Indeed, language incompatibility is a structural barrier to accessing mental health treatment for many Hispanic Spanish-speaking people (Bridges, Andrews, & Deen, 2012). Nationwide, there is a shortage of bilingual, trained mental health providers (Annapolis Coalition on the Behavioral Health Workforce, 2007). Although precise figures are not available, a search on the American Psychological Association’s “Find a Psychologist” link revealed 6,083 therapists with a specialization in depression but only 226 therapists nationwide could work with primarily Spanish speaking patients needing treatment for

depression (or 3.7% of the original 6,083 therapists) (APA, 2015).

Trained interpreters can help bridge the gap between patients' need for Spanish speaking services and provider availability; however, the scientific literature provides conflicting reports regarding the value of interpreters. Positive reports note interpreters may help patients feel understood by their therapists (Kline, Acosta, Austin, & Johnson, 1980). Patients have indeed reported the presence of interpreters and other staff members who speak their language is an important component of their health care (Alvarez, Marroquin, Sandoval, & Carlson, 2014).

On the other hand, negative reports of interpreter use reveal numerous concerns. One issue involves choosing the best interpreting model. The U.S. recognizes four models of interpreting with varying perspectives about the roles of interpreters in the provider-patient relationship (e.g., as strictly invisible messengers; as responsible for the accuracy of information; as cultural-linguistic ambassadors; and as cultural brokers and advocates; Beltran Avery, 2001). Another concern is interpreter training. Currently, there is no national or legal certification for interpreting. Instead, major advocacy groups have developed standards of practice and ethical codes of conduct for the development of professional interpreters (for a list of advocacy groups, see Dysart-Gale, 2007). Based on terms defined by the National Council on Interpreting in Health Care (2001), *trained interpreters* are those individuals who are qualified to interpret through appropriate training and experience and who demonstrate high proficiency in at least two languages. *Untrained interpreters*, or ad-hoc interpreters, are family members, bilingual staff, or volunteers with limited to no training in interpreting. Most research on interpreters in mental health care, reviewed below, focuses on the issue of trained versus untrained interpreters. Finally, potential problems may arise between the interpreter and clinician. For example, the clinician may feel uncomfortable with or lack trust in the interpreter (Raval & Smith, 2003).

Use of Interpreters in Primary Care and Traditional Mental Health Settings

The primary care setting is often the entry point of an individual patient into the health delivery system. Primary care visits are typically aimed at alleviating acute symptoms, managing chronic conditions, and providing preventative care. Primary care teams typically consist of a number of individuals who work collaboratively to coordinate patient care, including medical assistants, nurses, physician assistants, general physicians, medical interpreters and, increasingly, psychologists and other behavioral health specialists.

Given their benefit in the primary care setting (Karliner, Jacobs, Chen, & Mutha, 2007), medical interpreters are essential members of the health care team. On the whole, studies in the medical field suggest visits facilitated by trained interpreters are just as satisfactory as visits with bilingual providers, and both are better than using untrained interpreters (Lee, Batal, Maselli, & Kutner, 2002; Moreno & Morales, 2010; Ngo-Metzger et al., 2007). Studies also suggest diagnostic conclusions are similar when physicians and patients are language concordant or discordant (e.g., Dodd, 1984; Farooq, Fear, & Oyeboode, 1997).

When examining psychotherapeutic, versus medical, outcomes, studies again suggest the use of trained interpreters results in similar benefits to clients as what is obtained by seeing a bilingual therapist. Numerous examples of the benefits of trained interpreters for clients with posttraumatic stress disorder (PTSD) have been reported (e.g., Brune, Eiroá-Orosa, Fischer-Ortman, Delijaj, & Haasen, 2011; Schulz, Resick, Huber, & Griffin, 2006). On the other hand, interpreter use may impact assessment and diagnosis. Price and Cuellar (1981) found bilingual Mexican American patients diagnosed with schizophrenia were more likely to disclose psychopathology symptomatology when interviewed in Spanish than English, but

Marcos, Alpert, Urcuyo, and Kesselman (1973) found bilingual patients with schizophrenia disclosed more psychopathology in English than Spanish interviews.

Several researchers discuss possible detriments to interpreter use in therapy, primarily in terms of perceived threats to therapeutic alliance (Bolton, 2002; Tribe & Tunariu, 2009).

Therapeutic alliance is the degree of involvement between the client and therapist, as evidenced by their mutual collaboration on treatment processes and personal rapport (Orlinsky, Ronnestad, & Willutzki, 2004). Developing treatment alliance with clients who prefer to receive clinical services in Spanish presents unique challenges. For instance, it is possible that a Spanish-speaking client may feel unsatisfied with a language-matched clinician who does not understand particular linguistic expressions or culturally bound behaviors that are specific to a region.

Very few studies have explored therapist, interpreter, and/or client perspectives on how interpreters relate to therapeutic alliance in traditional care. Kline and colleagues (1980) found twice as many clients who used interpreters in session reported being pleased with the services provided by mental health providers as compared to clients who did not use interpreters. Raval and Smith (2003) conducted semi-structured interviews with nine mental health professionals regarding their experiences providing mental health services to children and adolescents with the assistance of an interpreter. Therapists expressed concern that interpreters tend to filter out emotional content provided by clients, hampering the therapist's ability to share in the intensity of the client's experience and develop a therapeutic bond with the client. Additionally, mental health professionals perceived that techniques intended to foster rapport with clients, such as reflective listening, were less effective when mediated through an interpreter. Some participants discussed experiences in which interpreters' responses to information shared by clients delayed the development of therapeutic alliance or even damaged existing rapport (for instance, by

having an interpreter laugh at the disclosure of a client's sexual dysfunction). Mental health professionals also indicated challenges related to forming a working alliance with the interpreter. Professionals reported doubting that interpreters were accurately communicating their statements to clients and feeling disempowered when providing therapy with the assistance of an interpreter.

Miller, Martell, Pazdirek, Caruth, and Lopez (2005) conducted semi-structured interviews with 15 therapists and 15 interpreters in the U.S. The authors did not specify if interpreters had formal training. Most therapists and interpreters ascribed value to the alliance an interpreter forms with both therapist and client. Most therapists reported interpreter use during sessions prolonged the process of developing rapport with the client. Some therapists indicated clients developed rapport more rapidly with the interpreter than with the therapist; a few therapists felt excluded or competitive with the interpreter in obtaining therapeutic alliance with the client. Several therapists reported experiences of interpreters showing resistance to interpreting certain statements for the client (e.g., too upsetting, unnecessary information).

Ebersole (2011) conducted an empirical study to compare development of therapeutic alliance with an interpreter or a language concordant mental health practitioner. Social workers conducted psychosocial interviews with parents of children who were being evaluated for special education services in a public school district. Results showed parents, social workers, and interpreters reported strong therapeutic alliance in nearly every case; these findings were consistent with qualitative information obtained from focus groups with social workers.

In contrast to traditional therapy settings, integrated care settings allow primary care patients with behavioral health needs opportunities to be seen by mental health care professionals in the primary care clinic, oftentimes the same day as a behavioral health need is identified (Robinson & Reiter, 2007). Sessions with mental health professionals who are integrated into

primary care clinics tend to be much briefer than sessions conducting in traditional mental health care settings, both in terms of session duration (typically 15-20 minute sessions) and frequency (oftentimes visits are spaced 2 or more weeks apart, with most patients receiving only 1-4 sessions) (Corso et al., 2012). This model has been shown to be efficacious at improving the behavioral health of primary care patients (Bryan, Morrow, & Appolonio, 2009), even in clinics where the majority of patients are of LEP (Bridges et al., 2014).

To date, no study has examined how therapeutic alliance or patient outcomes are affected by the use of bilingual interpreters for primary care patients receiving behavioral health care services. While the research on use of interpreters in traditional mental health care settings is instructive, the significantly compressed time of behavioral health care visits in primary care makes generalization from traditional mental health care difficult. In addition, while research on alliance and patient outcomes in primary care settings suggests trained interpreters are useful to patients, the content of medical visits and of behavioral health visits may be quite different.

Study Aims

The primary purpose of this study, therefore, was to explore how the use of trained interpreters related to therapeutic alliance in integrated behavioral health care patients with LEP (in particular, with a group of Spanish speaking patients). A second purpose of this study was to contextualize the quantitative data by providing pilot qualitative data on how patients, behavioral health care providers, and interpreters viewed behavioral health care services delivered through interpreters versus language-concordant providers. We expected these exploratory qualitative data would provide a richer context for the interpretation of our quantitative analyses.

Method

Participants

Quantitative data collection. Participants were 458 Spanish-speaking patients seen for behavioral health services at two primary care clinics, both part of a local federally qualified health center (FQHC) in northwest Arkansas. This region has experienced significant growth in its Hispanic population over the past decade (US Census Bureau, 2015). The two primary care clinics were located in cities with populations of approximately 75,000 and 60,000. The Hispanic population comprises approximately 30-35% of all city residents (US Census Bureau, 2015). Patients of the primary care clinics are more diverse than those of the cities in which they are situated: over half of patients are Hispanic and prefer to speak a language other than English. Most patients (over 90%) are of lower socioeconomic status, earning 200% or less of the Federal Poverty Level (ACHI, 2015; see also <http://www.communityclinicnwa.org/>). For more details about the clinics and patients, please refer to AUTHORS (2014).

Data were taken from consecutive patients seen over a 43-month period (September 2010 to April 2014) who met inclusionary criteria. Inclusionary criteria were: (a) adult patient (age > 17 years); (b) never received behavioral health sessions before; (c) spoke Spanish during the behavioral health session; and (d) completed self-report questionnaires at the conclusion of session that included a measure of therapeutic alliance. A total of 56.6% of sessions were conducted by bilingual BHCs, while 43.4% of sessions were conducted with the aid of a professional interpreter (a medical assistant trained in behavioral health interpretation). Training for interpreters takes place during an in-depth orientation to clinic services in addition to shadowing experienced medical assistants during medical and behavioral health visits. The length of time spent shadowing varies and depends on the medical assistants comfort in their ability to function independently. Currently, the FQHC designates the use of specific interpreters for BHCs. These BHC-specific interpreters undergo the same training, with a special focus on

ensuring confidentiality, accuracy to facilitate diagnoses and treatment interventions, and establishing the role of the interpreter as a channel between the patient and clinician.

Demographic data for the sample are summarized in Table 1. In terms of race/ethnicity, 94.1% of the participants were Hispanic and 4.4% were non-Hispanic White. A majority (84.1%) of patients were women and 55.2% were married. In terms of socioeconomic variables, most (64.0%) patients were unemployed, only 23.1% were employed full-time, and 65.7% were uninsured. Patients ranged in age from 18 to 73 years, with a mean age of 41.35 ($SD = 10.71$).

Patients presented for behavioral health services with a variety of complaints, most commonly depressive symptoms (33.8%), anxiety symptoms (17.0%), internalizing symptoms relevant to recent stressors (adjustment disorder; 12.7%), or other behavioral health concerns (e.g., insomnia, sexual dysfunction; 6.8%). Over one-fourth of patients (29.7%) were seen for behavioral health concerns that did not merit a psychiatric diagnosis, including behavioral health consultations (e.g., diet/exercise counseling, medication noncompliance) or relational problems (e.g., difficulties with romantic relationships or with parenting). Comorbidity with chronic medical problems was common. For instance, 19.0% of patients had diabetes, 24.5% had high cholesterol, and 21.0% had hypertension. Most patients (91.5%) received at least one prescription medication. On average, patients were prescribed 4.00 medications ($SD = 3.38$, range 0 to 18), although this included oral or injectable contraceptives, vitamins and nutritional supplements, antibiotics, allergy medications, and over-the-counter pain relievers. A total of 27.7% of patients were prescribed a psychotropic medication.

Qualitative data collection. Following the analyses of our quantitative data, we opted to conduct an exploratory pilot qualitative study that would permit richer context for our quantitative study. Ten new Spanish-speaking Hispanic patients who had not participated in the

quantitative study (70% female; $M_{age} = 38.30$ years, $SD = 6.77$, range = 29 – 50), 10 behavioral health care providers (60% female; 40% Hispanic; $M_{age} = 29.20$ years, $SD = 5.60$, range = 25 – 44), and 10 medical assistants (80% female; 100% Hispanic; $M_{age} = 25.80$ years, $SD = 4.61$, range = 22 – 36) who had served as trained interpreters in behavioral health appointments were recruited to provide qualitative information about their experiences with therapeutic alliance. Of the Spanish-speaking patients, half ($n = 5$) reported on a session in which they had used an interpreter and half ($n = 5$) reported on a session in which they had seen a bilingual BHC. Of the BHCs, 1 was a native Spanish speaker, 5 spoke Spanish fluently as a second language, and 4 used an interpreter when working with Spanish-speaking patients. BHCs had an average of 5.90 years of general clinical experience ($SD = 5.62$, range = 2 – 21) and 1.94 years of experience in integrated behavioral health care ($SD = 1.66$, range = 5 weeks – 6 years). Of the trained interpreters, all were native Spanish speakers. Interpreters had an average of 4.42 years working as interpreters ($SD = 2.57$, range = 8 months – 7 years).

Measures

Demographic data. We culled pre-existing information from patient electronic medical records, including demographic variables (age, ethnicity, race, marital status, employment status, insurance status, and primary language). We also obtained dates of BHC appointments, global assessment of functioning (GAF) scores given at each BHC appointment, and medical and psychiatric diagnoses from electronic records.

Psychiatric distress. To assess patient symptoms and functional impairment, the A Collaborative Outcomes Resource Network (ACORN) questionnaire was utilized (Brown, 2011). The 18-item ACORN assesses global levels of psychiatric symptoms. The adult version (for people 18 years or older) asks questions about mood, anxiety, sleep, alcohol and drug use, and

functional impairment. Items inquire about how often the person has experienced each of the symptoms in the past two weeks. Responses are scored on a 5-point Likert scale, from 0 (*never*) to 4 (*very often*). Items are then averaged to form a global score. According to the ACORN manual, Cronbach alpha for the global distress items is .92 in clinical samples. Concurrent validity was demonstrated with a significant relation between ACORN global distress scores and the Beck Depression Inventory ($r = .78$).

Therapeutic alliance. In the ACORN, there are four questions assessing therapeutic alliance, also scored on a 5 point Likert scale (from 0 = *do not agree* to 4 = *agree*). Items assess the relevance of the information discussed during the behavioral health visit for the patient and the patient's perceptions of the working relationship with the behavioral health consultant. These four items are averaged to form a session alliance score, with higher scores indicating higher alliance. In the current study, internal consistency reliability was good, Cronbach $\alpha = .80$.

In qualitative interviews conducted by the study authors, Spanish-speaking patients, behavioral health care providers, and medical assistants who had served as interpreters were asked a few open-ended questions about their perceptions of the influence of using an interpreter or receiving services from a bilingual behavioral health care provider on therapeutic alliance. Table 2 provides a list of questions asked of each participant group.

Procedures

A sequential exploratory mixed-methods design was used, such that after quantitative data were collected and analyzed, qualitative data were collected to facilitate a more enriched interpretation of the results (Hanson, Creswell, Clark, Petska, & Creswell, 2005). The qualitative pilot study, in particular, was designed to enrich our understanding of the topic by providing an initial exploration into categories that represent the myriad benefits and challenges

of utilizing interpreters in behavioral health sessions conducted in primary care settings. All procedures were approved by the executive director of the FQHC and the university's Institutional Review Board.

Quantitative data collection. Patients presented to their primary care provider for a variety of reasons, including annual physical examinations, infections, pain, diabetes management, and asthma. During their visit, the primary care provider identified a behavioral health issue and referred the patient to a behavioral health consultant for a same-day appointment. Behavioral health consultants were licensed clinical social workers ($n = 5$), a licensed psychologist ($n = 1$), or psychology doctoral students in training ($n = 6$). At that visit and all subsequent behavioral health appointments, patients were instructed to complete the ACORN questionnaire. Patients were seen for an average of 1.53 visits ($SD = 1.00$, range 1-8). Each visit lasted between 15 and 30 minutes and visits were spaced approximately 2-4 weeks apart. Sessions were problem-focused and generally employed brief cognitive-behavioral interventions such as behavioral activation, motivational enhancement, exposure therapy, psychoeducation, and parent management training. As part of standard operating procedures, patients of the FQHC sign a consent form that specifies information in their medical chart may be used for research purposes. Therefore, additional consent to access pre-existing data from electronic medical records for this part of the study was not requested from patients.

Qualitative data collection. Qualitative data collection took place over a two-month span (mid-September through mid-November 2014). During times when research assistants were present at the primary care sites, behavioral health care providers having sessions with Spanish-speaking patients would request the patient's permission to allow a researcher to ask them a few open-ended questions at the end of their appointment. Patients were not selected by any other

criteria. In addition, during that span of time researchers arranged in-person or telephone interviews with behavioral health care providers and medical assistants. We interviewed all BHCs who were currently employed by the clinic ($n = 4$) and all BHCs who were or had completed an externship at the clinic as part of their doctoral training ($n = 6$). We also solicited interviews with medical assistants who were currently employed by the clinic, frequently provided interpretation services for BHCs, and could schedule an interview.

All participants provided verbal consent and received a copy of a consent form describing the purpose of the study, procedures, and how data would be utilized. Interviews were conducted in Spanish by bilingual clinical psychology doctoral students and a licensed psychologist (all study authors). Interviews lasted between five and ten minutes each. Interview responses were typed out verbatim by the interviewer. Qualitative interview responses were then content analyzed by the researchers for identification of emerging themes. The process of identifying thematic categories involved reading through interview transcripts, identifying as a group the themes reflected in the responses, and then detailing these themes into a codebook. Because of the exploratory nature of the study, we avoided collapsing categories and opted instead to create independent categories for *all* identified themes. Following creation of the codebook, the first two authors independently coded each interview. We assessed inter-coder reliability separately for each sample, using percent agreement (total agreements/total coding instances). Inter-rater reliabilities were 97% (patient data), 86% (behavioral health provider data), and 92% (medical assistant data). Disagreements were resolved via consensus by the two coders.

Results

Quantitative Results

A one-way between subjects analysis of variance (ANOVA) was conducted to determine whether the use of an interpreter in the behavioral health session (yes/no) was related to patients' self-reported therapeutic alliance with the behavioral health consultant. No significant main effect of interpreter use was found, $F(1, 456) = 1.81, p = .179$. Patients who had an interpreter in the room ($M = 3.89, SD = 0.32, N = 199$) had alliance ratings comparable to those of patients who received services from a bilingual BHC ($M = 3.85, SD = 0.32, N = 259$). Even when controlling for relevant demographic covariates in a multiple regression (see Table 3 for all variables), the use of an interpreter remained unassociated with therapeutic alliance and the set of variables, as a whole, did not predict alliance, $F(10, 445) = 1.85, p = .051, R^2 = .040$.

Qualitative Results

Table 4 presents all thematic categories and relative frequencies of endorsement by participant group: patient, BHC, and interpreter. Below is a more detailed description of some of the thematic categories that emerged, along with exemplar responses. Themes are generally presented in order of relative frequency of endorsement.

Patient reports. All patients interviewed (100%) reported they had a good relationship with their BHC, regardless of whether the BHC was bilingual or monolingual and the patient had used an interpreter. In addition, all patients (100%) reported the Spanish spoken by the BHC or interpreter was very good. On the whole, patients expressed a preference for bilingual BHCs (80%), but felt interpreters were an excellent alternative to not receiving services at all. Specific benefits to seeing a bilingual BHC included enhanced privacy (40%), increased therapeutic alliance (increased trust and understanding; 30%), and enhanced communication (30%). One patient also noted that session length was a benefit to seeing a bilingual BHC compared to using an interpreter (10%). As one patient stated:

The session might have gone just as well, but it would have lasted longer. (29 y.o. Hispanic female, seen by a Hispanic BHC without the use of an interpreter)

Another patient noted:

It is better to talk directly to [providers] so you do not waste time with the translation. (29 y.o. Hispanic female, seen by a Hispanic BHC without the use of an interpreter)

One patient, who was asked how the session would have differed had the BHC spoken Spanish rather than requiring the use of an interpreter, noted:

My experience would be much better if the psychologist spoke Spanish. All the ones I have had speak English and it gets complicated. (43 y.o. Hispanic female, seen by a non-Hispanic White BHC with the use of an interpreter)

Another patient stated:

The session would have been much better. It would deepen the communication. [Interviewer: Can you tell me what you mean by deeper communication?] More clear, more direct. (34 y.o. Hispanic female, seen by a non-Hispanic White BHC with the use of an interpreter)

On the other hand, patients felt interpreters were critical to enhancing access to services (40%).

For example, one patient recalled being referred to a clinic without Spanish speaking personnel:

I was sent to an English clinic for arthritis and pain in my neck. I do not understand English. How am I going to go if I do not speak English? (47 y.o. Hispanic female, seen by Hispanic BHC without the use of an interpreter)

One patient noted:

I think there are enough interpreters at this clinic. I feel at ease. At other places I have to wait two hours for an interpreter while other patients who speak English and arrived after me are seen. Other clinics don't have interpreters. It is important that they have interpreters. (32 y.o. Hispanic female, seen by a non-Hispanic White BHC with the use of an interpreter)

In one case, the patient stated it was not the spoken language but the ethnicity of the BHC that mattered. In this case, the interpreter could act as a cultural broker.

Maybe if she [the BHC] had the same culture, we would understand each other more. Hispanics understand each other. I was talking about my husband that, during his childhood, had paranormal experiences... people from the United States do not believe in

these things. It is because of the culture. (32 y.o. Hispanic female, seen by a non-Hispanic White BHC with the use of an interpreter)

Behavioral health consultant (BHC) reports. Bilingual BHCs reported numerous benefits to being able to use their Spanish language skills in therapy with LEP patients. The most common benefits reported by bilingual BHCs included enhanced accuracy of communication (90%), enhanced rapport and increased sense of collaboration with the patient (50%), greater sense of confidentiality (40%), greater sense of control over the session (40%), and feeling gratified at being able to provide needed services (30%). Both bilingual and non-bilingual BHCs noted one benefit of bilingual services was that they are more efficient compared to using an interpreter (10% noted efficiency of bilingual sessions and 30% noted problems with long wait times for interpreters). For instance, one BHC noted:

Sometimes they [the patients] have to wait longer because there is a lack of translators when it is busy. (32 y.o. non-Hispanic White female who is not bilingual)

Another BHC noted:

I felt that there was more openness and more time to discuss their [the patient's] difficulties because there wasn't someone else that then had to take what I said, interpret it based on their own understanding, and then send that message back to the patient. (25 y.o. bilingual Hispanic female)

In addition to helping increase access to services and to making patients feel welcome, BHCs noted benefits to their own professional development. One bilingual BHC noted:

My experience so far has been wonderful to be able to offer services to a community that is in need that sometimes has difficulty or is unable to receive adequate care. It's important to me that the Latino community is receiving evidence-based interventions in practice. I think as much as the experience details . . . they also help me as a trainee clinician/student in my efforts to provide the best services possible in English or in Spanish. It's been a wonderful life-changing experience. (26 y.o. bilingual Hispanic male)

Forty percent of BHCs struggled with finding words or learning the technical vocabulary associated with behavioral health interventions. However, one bilingual BHC noted this was

beneficial to her, because she would simplify her language and avoid psychobabble in her delivery of specific interventions:

It made me slow down and think about the processes of what I was describing because I had to use smaller words and not use vocabulary that patients didn't understand, such as behavioral activation or mindfulness that do not have direct translations. (26 y.o. bilingual non-Hispanic White female)

When asking about their experiences with using interpreters in sessions with LEP patients, monolingual BHCs reported numerous benefits, especially when they came to trust the interpreter and his skills. A notable benefit was that interpreters could serve as cultural brokers, educating BHCs by providing context to understand word meanings (30%). When the BHC and the interpreter had developed a good working relationship, the interpreter was often seen as enhancing to service delivery (20%). One BHC noted:

The rapport I build with each translator, I thought, is what did it for me. Once I worked for a bit with each of them they kind of already knew what I was going to say so sometimes, with minor revisions, they knew exactly what I was going to do with someone with sleep difficulties or anxiety difficulties, which made the whole process that much smoother. (30 y.o. non-Hispanic White male who is not bilingual)

On the other hand, experiences with the use of interpreters resulted in some cautionary tales. In particular, BHCs noted concerns with the accuracy of interpretation (30%). This was both a concern for loss of information and for occasions where an interpreter was seen as “overstepping” her role. One BHC stated:

I have to be careful that the interpreter doesn't get carried away. Sometimes I can watch by their tone or body language how they are relaying information and sometimes it might not be in the same manner that I am. I think at times they might be more forceful, more punitive, like with a diabetic patient not being compliant. (42 y.o. bilingual non-Hispanic White female, referring to sessions she has conducted with Marshallese patients facilitated by interpreters)

Another noted:

The interpreters would intervene and provide a lot of commentary and I would have to wrangle the translator as much as I was providing services. (28 y.o. bilingual non-

Hispanic White male, referring to sessions he has conducted with Marshallese patients facilitated by interpreters)

Barriers to rapport and alliance were also noted by some BHCs (30%).

I feel as though the patients are sometimes uncomfortable with another person present in the room. I've also found that sometimes the interpreters seem to be uncomfortable with the content of session and that in turn affects the patient and they [the patients] start speaking less about their problem (27 y.o. Hispanic female who is not bilingual)

Finally, some BHCs noted sessions required additional effort on their part, especially attending to the emotions of both the patients and the interpreters. A BHC stated in her interview:

I have to try harder [with personal interactions] and find I am more focused on non-verbals: tone, posture...all non-verbals. I am more expressive and use more non-verbal facial expressions and hand motions. (44 y.o. bilingual non-Hispanic White female)

Interpreter reports. Interpreters had insightful observations regarding the benefits and challenges they face providing interpretation services for BHCs and patients. Many of the same benefits noted by BHCs were noted by interpreters, including making patients feel welcome (50%), helping enhance access to services (40%), and feeling enriched professionally (30%). Interpreters noted some professional obstacles to their work, including navigating differences among diverse Spanish dialects or acquiring the specific technical language of mental health providers (60%) and becoming more comfortable with the more sensitive material of mental health, versus medical, sessions (20%). This was true despite having received additional training in interpretation for behavioral health sessions, in particular. As one interpreter noted:

At times it was hard because I learned there is not just one type of Spanish. One word can have different meanings. (22 y.o. Hispanic female)

When asked about her experiences interpreting for medical visits compared to BHC visits, one interpreter noted:

I would have to say there is a slight difference between the both. In a medical visit, things are interpreted in a faster pace than in behavioral health, which goes more into depth. In a behavioral health visit emotions get more involved than in a regular medical visit,

which could make it hard for an interpreter if they're [the interpreter] an emotional person. (24 y.o. Hispanic female)

Comparisons among reporters. Several similarities and differences among the three participant groups emerged. Across all groups, there was a strong sense that interpreter services were vital to increasing access to needed care. There was also an appreciation for the benefit of bilingual providers for both enhanced rapport between provider and patient and enhanced communication. Bilingual services were also seen as more efficient compared to interpreter services. However, differences among the groups also emerged. Providers and interpreters saw benefits to their professional development from providing services in Spanish or through the use of interpreters, but also noted challenges of navigating diverse dialects and technical vocabulary. They also focused more on the importance of the relationship between provider and interpreter for a smooth session. BHCs and interpreters were somewhat agnostic about the relative benefits of bilingual providers versus interpreters, seeing both as quite similar in efficacy. Patients were more likely to express a strong preference for direct communication with providers.

Discussion

In this study, we asked how therapeutic alliance between primary care patients with limited English proficiency (LEP) and their behavioral health care providers (BHCs) was impacted by language concordance between the BHC and the patient, versus when a trained interpreter was present. Quantitative data from 452 patients revealed comparable satisfaction with the BHC and the session in LEP patients who saw bilingual BHCs versus those who saw an English speaking BHC with the aid of a trained interpreter. Importantly, therapeutic alliance was very high in both groups, suggesting the use of bilingual BHCs and trained interpreters are equally effective at addressing the behavioral health care needs of LEP patients. Our finding is

consistent with a growing body of research suggesting health care services can be effectively delivered with trained interpreters (Brune et al., 2011; Karliner et al., 2007; Schulz et al., 2006).

Content analyses of interviews conducted with LEP patients, BHCs, and trained interpreters revealed a richer and more complex picture. With almost no exception, patients revealed a preference for language concordance between the BHC and the patient. In particular, language concordant services were thought to be more efficient, more effective in terms of communication of content, easier for the establishment of trust and rapport, and more confidential. Multiple patients reported an increased willingness to disclose sensitive information when it was just the patient and the BHC, versus when a third party was present.

However, the use of trained interpreters was also seen positively by nearly all patients, providers, and interpreters. Sessions with interpreters were valued for numerous reasons, including increasing access to needed services for LEP patients and enhancing professional development in BHCs and interpreters. The common refrain across multiple informants was that interpreters were valued members of the health care team and critical for receiving timely care. Most participants recognized the disparity between need for bilingual professionals and workforce skills; in this context, trained interpreters were seen as essential to bridging the gap.

Similar to cautions articulated by Raval and Smith (2003) and Tribe and Tunariu (2009), we found patients, BHCs, and interpreters expressed caveats to the benefits of interpreter services. Some of these were not unique to interpreter services per se. For example, both bilingual BHCs and interpreters noted concerns regarding navigating the different Spanish dialects, regionalisms, and nuances in expression. On the other hand, working with diverse Spanish speaking populations provided opportunities for professional growth in both BHCs and

trained interpreters—both noted the benefits of enhancing their technical language skills and valued additional training specific to mental health interpretation.

Other caveats to the benefits of providing services to LEP patients through the use of trained interpreters were more specific to that situation. Patients, BHCs, and interpreters all noted the challenges of establishing rapport and navigating the reactions of all persons in the room when an interpreter was present—the material revealed during behavioral health sessions was often personal, sometimes stigmatizing, and frequently emotional. While mental health professionals have specific training in managing such content with a high degree of openness, compassion, and empathy, some trained interpreters found the difference between medical and behavioral health interpretation to be challenging. Some interpreters also noted they felt like a “third wheel” in session, a sentiment echoed by a few BHCs and patients.

Limitations and Future Directions

While we are encouraged by our results, readers should consider the limitations to our study. First and foremost, the current study examined therapeutic alliance when *trained* interpreters were used in behavioral health care sessions. We do not know how patients would have felt about sessions that included *ad hoc* interpretation by untrained individuals; however, a robust body of research suggests untrained interpreters can be problematic for patient satisfaction and outcomes (see Karliner et al., 2007). A second but related concern is that the interpreters used in the current study were not specifically trained for mental health care interpretation. Although all were provided with some training in behavioral health interpretation, the training was limited to one presentation and additional shadowing experiences of varying duration. It is possible that additional in-depth training specific to mental health care would alleviate many of the potential concerns raised by patients, BHCs, and interpreters. d'Ardenne, Farmer, Ruaro, and

Priebe developed an interpreting protocol for trauma-focused cognitive behavioral therapy that provides specific recommendations for clinic services, therapists, and interpreters. In addition, the National Latino Behavioral Health Association and the National Asian American Pacific Islander Mental Health Association provide an interpreter training program for mental health interpreter certification.

Third, the unique structure of integrated care sessions (brief, problem-focused, few visits) limits the generalizability of our findings. It is unclear if similar benefits and caveats to interpreter services would be present for more traditional mental health settings. It is possible that some concerns would be amplified in traditional care, including the need to manage emotional responses of people in the room or concerns regarding disclosure of confidential information; on the other hand, it may be that the longer duration and greater intensity of traditional mental health services give patients and therapists opportunities to acclimate to the presence of the interpreter, rendering many concerns moot. Future studies examining interpreter service satisfaction in more traditional mental health care settings are therefore sorely needed.

Fourth, the quantitative and qualitative portions of the study were complementary, but not redundant. In particular the quantitative portion of the study had a limited measure of therapeutic alliance (four questions), none of which assessed satisfaction with the linguistic abilities of the BHC or the relative preference of a bilingual BHC versus a trained interpreter. It is possible that more pointed and specific questions regarding alliance and satisfaction with linguistically competent services would have revealed differences between LEP patients seen by language concordant providers versus those seen by interpreters. Future studies may wish to expand the quantitative measurement of alliance and satisfaction. Relatedly, although the qualitative portion of the study specifically asked patients to consider how the session might have differed if they

had used an interpreter (for those who saw a bilingual BHC) or had seen a bilingual BHC (for those who used an interpreter), patients were not directly asked to compare and contrast sessions with bilingual BHCs and interpreters, nor did patients necessarily have experiences with both types of sessions. Responses that indicate relative comparisons, therefore, should be interpreted with some degree of caution and future studies could select patients who have experienced both types of sessions in order to compare the two more directly. The qualitative portion of the study included interviews with essentially all BHCs the clinic employed, but only a limited number of interpreters and patients. In addition, we did not specifically select patients who were representative of the original sample, nor did we have an independent auditor for coding of interview responses. It is unclear if additional themes would have emerged had more people participated, or if themes were reflective of the original sample. Future researchers may continue enrolling participants until themes are saturated. Relatedly, the interviews were designed to be brief so as to minimally disrupt clinic flow. A more detailed and in-depth interview may have revealed additional complexities and preferences that did not emerge in this briefer format. Finally, even the bilingual BHCs frequently had experience using interpreters for patients who spoke languages other than English and Spanish; therefore, the emerging themes may have not been unique to interpretation for Hispanic patients, but may be reflective of more general challenges when providing services to patients of LEP.

Conclusion

Taken together, our results suggest enhancing culturally and linguistically responsive services to behavioral health care patients can be done in the two ways explored in this study: either by increasing bilingual providers or utilizing trained behavioral health interpreters. Other reasonable alternatives that were not utilized in the current study may also enhance services (e.g.,

technology-driven services like those provided by translating programs or tele-health services provided by telephone or live video). Ideally, clinics will hire bilingual providers who can conduct sessions in the patient's preferred language. This appears to be important for both willingness of patients to disclose information and for efficiency of operations. On the other hand, given the need for bilingual providers outpaces the availability of a bilingual workforce, the use of trained interpreters is an effective means of addressing behavioral health care needs of LEP patients. Patients report high satisfaction with services when trained interpreters are used and, when a good working relationship is established between the BHC and the interpreter, the interpreter may in fact enhance service delivery. As one BHC noted:

Overall the quality of [patient] care is enhanced because interpreters provide the means for providers to be able to communicate with their patients. I believe that the quality of services is likely to be notably affected primarily if the therapist does not carefully employ non-specific therapeutic factors in the presence of a translator. (30 y.o. non-Hispanic White male)

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Table 1
Patient Demographic Information

Variable	M	SD	N	%
Gender				
Male			73	15.9%
Female			385	84.1%
Age, in years	41.35	10.71		
Marital status				
Single			122	26.6%
Married			253	55.2%
Divorced or separated			30	6.5%
Widowed			7	1.5%
Other			46	10.0%
Employment status				
Employed full-time			106	23.1%
Employed part-time			40	8.7%
Unemployed			293	64.0%
Retired			2	0.4%
Other			17	3.7%
Race/ethnicity				
Hispanic			431	94.1%
Non-Hispanic White			20	4.4%
Insurance coverage				
Public insurance			75	16.4%
Private insurance			53	11.6%
Other insurance			29	6.3%
Uninsured			301	65.7%
Chronic health condition				
Diabetes			87	19.0%
High cholesterol			112	24.5%
Hypertension			96	21.0%
Mental health condition				
Depressive disorder			155	33.8%
Anxiety disorder			78	17.0%
Adjustment disorder			58	12.7%
Other			31	6.8%
Patient is prescribed medication			419	91.5%
Number of prescription medications	4.00	3.38		
Patient is prescribed psychotropic medication			127	27.7%
Prior year clinic encounters	5.40	4.07		
ACORN Global Distress	1.98	0.84		
Interpreter used during behavioral health session			199	43.4%
ACORN therapeutic alliance	3.87	0.32		

Table 2

Qualitative Interview Questions

Group	Questions
Patients	<ol style="list-style-type: none"> 1. How was your visit with [name of BHC]? 2. What did you think of the Spanish speaking abilities of [name of bilingual BHC <i>or</i> name of interpreter]? Was it easy to understand his/her Spanish? 3. How well do you think [name of bilingual BHC <i>or</i> name of interpreter] understood your Spanish? 4. Do you think you had a good relationship with [name of BHC]? 5. Do you think it made that a difference that [name of BHC] could/could not speak Spanish? 6. Had you used an interpreter before? 7. <i>For sessions with bilingual BHCs:</i> Would it have been preferable to have an interpreter in your visit with [name of bilingual BHC]? Why or why not? 8. <i>For sessions with interpreters:</i> Would it have been preferable if [name of BHC] spoke Spanish? Why or why not? 9. We want to improve our services for Spanish speaking patients. What could we do to make our services better?
Interpreters	<ol style="list-style-type: none"> 1. What is your experience like providing interpreter services for Spanish speaking patients of the clinic? 2. Are these experiences similar for medical visits and behavioral health visits? If not, what is different? 3. How do you think the quality of patient care is affected by interpreter services?
BHCs	<ol style="list-style-type: none"> 1. What is your experience like providing bilingual services for Spanish speaking patients of the clinic? 2. What about using interpreter services (if applicable)—how have you found that to be? 3. How do you think the quality of patient care is affected by interpreter services?

Table 3

Multiple Regression Predicting Therapeutic Alliance from Demographic Variables and Interpreter Use

Predictor variable	B	SE	β	T	p
Age, in year	-.002	.002	-.065	-1.18	.237
Female gender	.081	.042	.093	1.93	.054
Chronic health condition (diabetes, high cholesterol, or hypertension)	.022	.037	.035	0.61	.542
Uninsured	.016	.032	.023	0.50	.621
Unemployed	-.025	.032	-.038	-0.78	.435
Married	.070	.031	.109	2.26	.024
ACORN Global Distress	-.016	.018	-.042	-0.87	.387
Number of prescription medications	.009	.005	.100	1.75	.080
Past year clinic service utilization	.004	.004	.052	1.03	.306
Interpreter used during behavioral health session	.047	.030	.073	1.55	.122

Table 4

Frequency of Qualitative Interview Themes

Theme	% Patients	% BHCs	% Interpreters
Bilingual services...			
...Benefit the patient			
1. Increases access to services	0%	20%	0%
2. Enhanced rapport, sense of collaboration (<i>or</i> interpreter services may present barriers to rapport between BHC and patient, such as having a third person in the room, or having the interpreter's reactions)	30%	50%	10%
3. Enhanced trust, understanding, privacy, willingness to self-disclose (<i>or</i> interpreter services may compromise confidentiality and trust)	40%	40%	0%
4. Better communication (increased accuracy of communication, including avoiding use of psychobabble)	30%	90%	20%
5. Are more efficient (shorter sessions than if you have to have everything interpreted)	10%	10%	20%
...Benefit the BHC			
6. Improves BHC's Spanish speaking abilities	0%	10%	0%
7. Enhances clinical skills and knowledge	0%	10%	0%
8. Satisfaction with providing a needed service	0%	30%	0%
9. BHC maintains more control over the session, session less effort (e.g., making sure the message is understood as intended, rather than communicating indirectly; managing self and patient reactions to session content, without worrying about interpreter reactions)	0%	40%	0%
...Are challenging to provide			
10. Trouble with word finding, dialects, phrasing, or technical vocabulary	0%	40%	0%

Theme	% Patients	% BHCs	% Interpreters
Interpreter services...			
...Benefit the patient			
11. Increased access to services	40%	70%	40%
12. Interpreter (or BHC) can be a “cultural broker” in the room (<i>or</i> the shared culture matters)	10%	30%	10%
13. Helps make patients feel welcome and comfortable	10%	10%	50%
14. Facilitates intervention (can go very smoothly)	0%	20%	20%
... Benefits the interpreter			
15. Enhances Spanish speaking abilities/vocabulary	0%	0%	20%
16. Is an enriching professional experience	0%	0%	30%
... Are challenging to provide			
17. Resources intensive	0%	10%	0%
18. Interpreters not always available	20%	30%	0%
19. Trouble with word finding, dialects, phrasing, or technical vocabulary	0%	0%	60%
...Can be helpful or harmful, depending on the interpreter			
20. Good working relationship with the BHC	0%	20%	0%
21. Comfort with psychological material	0%	30%	20%
22. Degree of professionalism, training, and experience	0%	30%	30%
Interpreter < Bilingual BHC	80%	30%	10%