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Intermediated communication by interpreters in psychotherapy with traumatized refugees

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Abstract

Immigrants in need of psychotherapy are often confronted with the fact, that there is no psychotherapist available, with whom they can proceed in a common language understood well by both. In some cases psychotherapy with communication intermediated by interpreters is offered. This study compares the outcome of 190 individual psychotherapies with refugees with posttraumatic disorders, half of them with the help of interpreters, the other half without. The results show, that psychotherapies with the help of interpreters were as effective as those without, even though the psychosocial conditions (such as employment, training, foreign language proficiency and social network) for those patients who needed interpreters were tougher. Psychotherapy with the help of an interpreter should not be considered the poorer alternative.

Key words

Interpreters, Immigrants, Psychotherapy, Refugees

Introduction

Immigrants in the Western world in need of psychotherapy often do not speak the language of the host country well enough to benefit from psychotherapy in the national language. Moreover, although language acculturation may enhance effective functioning in the host culture, it may be a less socially inclusive way of communication with respect to associated problems (Ng, 2007). If no psychotherapist is available who speaks the native language, psychotherapy with help of an interpreter can be offered. Even though effective therapy with the help of interpreters has been found to be possible (Haenel, 2001), due to limited systematic research, however, doubts remain whether psychotherapy and, in general, psychiatric care with interpreters is effective (Bauer & Alegria, 2010).

Therapists often see psychotherapy with an intermediated communication as a less-than-ideal solution (Baxter & Cheng, 1996), as a second hand alternative to a possible direct communication between psychotherapist and patient. According to these authors, the potential of psychotherapy is presumed to be limited or at least less efficient, as the process of interpretation can distort transference, complicate group dynamics, and lead to cultural incongruencies.

The issue of intercultural understanding between persons with different cultural background should also be mentioned (Tseng, 1999). There is an ongoing discussion on how essential it is that psychotherapist and patient have similar cultural backgrounds for the outcome of psychotherapy.

Intermediated communication in psychotherapy

Psychotherapy with an intermediated communication by an interpreter means that individual psychotherapy becomes 'therapy in a triangle'. The triadic situation in therapy leads to difficulties but also to some interesting and sometimes even useful changes of the psychodynamics of the usual dyadic setting in psychotherapy (Bolton, 2002; Lindbom-Jakobson, 1995; Tribe & Thompson, 2009).

In psychotherapy with intermediated communication the triad of the interpreter, patient and therapist should always be the same persons, as changing the interpreter from one session to the next would interfere with the therapeutic process. The interpreters learn some of the formal therapist behaviours such as punctuality, professional distance and neutrality. The therapist and the interpreter should see themselves as doing teamwork, where both have different and clearly defined roles. Mutual respect for the other's profession and person, especially as the team psychotherapist/interpreter generally will work together for several months, is of particular importance (Brune & Akbayir, 2008).

Several colleagues (Bauer & Alegria, 2010; Dhawan, 2004; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005) point out that specific training and experience are very important in order to avoid possible biases. Apart from the previously cited cultural and psychodynamic problems, using inexperienced interpreters can also lead to clinically relevant misunderstandings (Vasquez & Javier, 1991).

The role of the interpreter in intercultural psychotherapy

There are different views on the role of the interpreter in psychotherapy, ranging from a objective translator with no capacity of processing feelings (Acosta & Cristo, 1981; Englund-Dimitrova, 1997; Musser-Granski & Carrillo, 1997) to a culturally competent co-therapist (Brune & Akbayir, 2008; Mudarikiri, 2003; Tribe, 1999). Baxter and Cheng (1996) point out the phenomenon of "pairing" as a possible problem when the interpreter gets too involved in the process of psychotherapy. It has also been pointed out that patients can have problems when answering through an interpreter due to a possible influence on the contents of the narratives (Englund-Dimitrova, 1997). Moreover, the research on the "reliability" of interpretation shows how bias can affect renditions (Bot, 2005; Carr, Roberts, Dufour, & Steyn, 1997; Gile, 1995; Yahyaoui, 1988). In practice, the limited availability of culturally competent co-therapist interpreters leads to the fact that generally interpreters tend to be

neutral, with no initiative to participate with their own observations in the therapy. Nonetheless, this third person should be able to transmit empathy.

Research on the effectiveness of psychotherapy with refugees mediated by an interpreter is insufficient. We found only one trial which compared refugees who required interpreters; refugees who did not and a control group of non refugees, which concluded that interpreters are effective in this special population (d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007). The aim of this study is to analyze the differences in therapy outcome when using an interpreter. The study includes refugees with traumatic experiences.

Method

Sample,

A total of 190 patients were selected for the present study. Patients make up a convenience sample of those treated during the years 1990 and 2004 in Sweden and Germany by two of the authors. There were 8 interpreters involved in the psychotherapies. The two therapists had 5 and 20 years of experience working with traumatized refugees, the interpreters had been working between 3 and 10 years as interpreters in psychotherapy and also had specialized training. Three of the interpreters had a formalized education to work as an interpreter in mental health (in Sweden they had specific training for psychotherapy and in Germany they had formal education in medical, psychosocial and juridical interpretation), the rest had a long practical experience of working as interpreters. The interpreters had to have access to and supervision from the therapist, as well as training on psychotherapy interpretation and were provided with literature on the topic. All the interpreters had a migration background.

All patients experienced organized violence in their countries of origin (torture, imprisonment, war and other forms of persecution), and then sought refuge in Sweden or

Germany. The main regions of origin were Iran, Ex-Yugoslavia, Latin America, Turkey, Africa, Iraq and Russia. Table 1 show the countries of origin of the patients by use of interpreter.

PLEASE INSERT TABLE 1 ABOUT HERE.

All patients were treated with individual psychotherapy which included elements of psychodynamic, cognitive and supportive psychotherapies using a therapeutic program as defined by Van Der Veer (1992) and Basoglu (1992). Due to the different origin of the patients, cultural influences in treatment response were taken into consideration suiting treatment approaches as outlined by Morris and Silove (1992) and psychotherapist's opinions about the specific situation of each patient. Some of the patients (36.3%) also received psychopharmacological treatment, mainly antidepressant, anxiolytic or hypnotic medication. All patients were treated once a week. The average duration of the therapies was 22.05 months (range 3-72, S.D. =14.70). Further details of this study have been published elsewhere (Brune, et al., 2002; Eiroá-Orosa, Brune, Huter, Fischer-Ortman, & Haasen, in press).

All patients had experienced traumatic experiences. 76.8% of the patients were diagnosed with Posttraumatic Stress Disorder (F43.1), 9.6% with dysthymic disorder (F 34.1), 4.2% with somatoform disorders (F 45), 2.6% with anxiety disorders (F 41), 2.1% with adjustment disorder (F 43.2), 3.1% with recurrent depressive disorders (F 33), 1.1% with enduring personality change after catastrophic experience (F62.0) and one patient (0.5%) with paranoid schizophrenia (F20).

93 patients (48.9%) were treated using an interpreter in psychotherapy. The rest of the patients needed no interpreter, of which 23 (12.1% of the whole sample, 23.7% of those treated without interpreter) were treated using their mother tongue (in this case the therapist

was speaking a foreign language, Spanish), 67 were treated in the language of the country of exile (German or Swedish, 35.3% of the whole sample, 69.1% of those treated without interpreter) and 7 were treated in a foreign language both for the therapist and for the patient (English or French, 3.7% of the whole sample, 7.2% of those treated without interpreter).

Measures.

To measure the outcome of psychotherapy, HAM-D (Hamilton, 1967) and CGI (National Institute of Mental Health, 1996) were used. As all the included persons in this sample were traumatized refugees, they all were confronted with severe losses, in turn leading to reactive depressive symptomatology. HAM-D was therefore considered an appropriate measure of mental health improvement. CGI is an adequate general measure for treatment outcome. The combination of these two instruments was considered sufficient to measure a differential effect of interpreters on therapy.

Results

Patient characteristics.

Table 2 shows the sociodemographic and treatment characteristics of the two subsamples. 135 patients (71.1%) were men and 55 (28.9%) women. The mean age of the patients was 35.93 (range 15-68, S.D.=9.151). 121 (63.7%) had secure residence status, 123 (64.7%) stable housing, 61 (32.1%) were employed or retired, 72 (37.9%) had completed a vocational training (university or professional education). Significant differences were found in four characteristics: A greater proportion from the group of those treated without an interpreter were employed, had completed a vocational training, judged as good their social network and had a higher proficiency in the language of the country of asylum. Duration of therapy without an interpreter did not significantly differ from those with interpreter.

PLEASE INSERT TABLE 2 ABOUT HERE.

Treatment outcome.

The average HAM-D score at treatment initiation was 16.54 (range 6-45, S.D.=6.07) and 8.06 at the end (range 0-27, S.D.= 5.06). The average reduction was 8.47 (range -6-28, S.D.=5.33), which corresponds to a 50.7% reduction. CGI ranged from 3 to 6 at treatment initiation (mean=5.32, S.D.=6.40) and from 1 to 6 at the end (mean=2.65, S.D.=1.25). The average reduction was 2.67 (range 0-5, S.D.=1.34), or 24.0%. Reduction of HAM-D and CGI had a high correlation ($r=.53$, $p<.0001$).

Initial mean HAMD scores showed no significant difference between groups with and without interpreter ($t=-.958$, $p=.339$), but initial CGI scores were significantly higher for the group treated without interpreter ($t=2.47$, $p=.013$). Repeated measures analyses of variance (RM ANOVA) were carried out to check time effect and compare between those who underwent therapy with and without interpreter. Time effect was found to be significant for both measures and group interaction effect was found to be significant in CGI, showing a higher decrease in the group without interpreter, but not in HAMD. Initial and end scores and significance of comparisons between groups can be seen in table 3.

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To control for possible interference of other factors, further RM ANOVAs were carried out using as dependent variables CGI and HAM-D scores, use of interpreter as independent factor and social integration characteristics (secure residence status, employment, vocational training, quality of social network and language competence) and additional pharmacological treatment as covariates. In the reduction of HAM-D, two covariates showed a significant effect: secure residence status (Pillai's Trace= .114, $F=23.434$, $p<.0001$) and additional pharmacological treatment (Pillai's Trace= .038, $F=7.112$, $p<.05$). In this model the use of interpreter showed no significant effect (Pillai's Trace= .001, $F=.152$, $p=.697$). When

controlling for these factors in CGI reduction, no significant effect was found for use of interpreter (Pillai's Trace= 0.12, $F=2.259$, $p=.135$), yet it was influenced by vocational training (Pillai's Trace= .027, $F=4.960$, $p<.05$) and the quality of social network (Pillai's Trace= .021, $F=3.990$, $p<.05$).

Discussion

Regarding the fact, that the sample included mostly persons with severe trauma disorders, the overall psychotherapy outcome can be considered to be good. Therefore one conclusion is that it makes sense to offer psychotherapy with or without interpreters to severely affected individuals, such as traumatized refugees, who quite often find themselves in difficult psychosocial situations. The main result of the study is that the outcome of psychotherapy with intermediated communication by an interpreter is as effective as psychotherapy with direct communication, thereby confirming earlier findings (d'Ardenne, et al., 2007). As duration of the therapy did not differ between groups, the treatment effects cannot be explained by the length of treatment.

Refugees treated without interpreter were more likely to be employed, to have finished vocational training and to have a good social network. They have a higher level of language competency of the country of exile due to a successful integration process, which would be expected to be predictors for positive treatment outcome. The group needing an interpreter during psychotherapy had a poorer initial level of functioning and could be considered the harder to treat, which would be expected to correlate with poorer outcome.

The results of the analysis of variance show how, when controlling for social and treatment factors, there is no significant difference in outcome when an interpreter is used in psychotherapy or not. One explanation for this finding could be the role model of the interpreters for the patient. All of the interpreters have an immigrant background, are all well integrated in society, have a good and mutually respectful relationship to an academically educated national person - the therapist - and may be seen as compatriots. Therefore, the

interpreters may represent a positive example, that it is possible to establish oneself in the new country, which often has a stimulating effect, in the integration and hence also in the therapeutic process.

It needs to be stressed that in this study all the interpreters were professionals with extensive experience in their work, some had special training for working within psychotherapy, and they all had a special interest in this work. They all had at least some access to supervision of their work. Also the therapists had a long experience in working with the help of interpreters and they appreciated this triadic work within intercultural psychotherapy. These conditions are not self-evident. Quite often the reality in clinical contexts is that the therapist is unwilling to put in this extra effort and the interpreters are inexperienced. Under these circumstances psychotherapy with help of interpreters probably would be less effective.

Assuming that therapists are motivated to work with professional interpreters, psychotherapy with intermediated communication seems to work as well as psychotherapy with direct communication. There is also no evidence that these results should be different for non-traumatized immigrants. Considering that patients needing psychotherapy with interpreters are often the harder-to-treat group, the higher cost of using interpreters seems to be cost effective in light of similar treatment outcome. Therefore the use of an interpreter within psychotherapy definitely should be taken into consideration and should not necessarily be considered the poorer alternative.

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Table 1. *Distribution of those treated with and without interpreters by countries of origin.*

| | Treatment without interpreter (n=97) | Treatment with interpreter (n=93) | Total (n=190) |
|-----------------|-----------------------------------------|--------------------------------------|---------------|
| Iran | 29 | 29 | 58 |
| Ex-Yugoslavia | 9 | 18 | 27 |
| Latin America | 26 | 0 | 26 |
| Turkey | 3 | 18 | 21 |
| Africa | 12 | 4 | 16 |
| Iraq | 6 | 9 | 15 |
| Russia | 5 | 4 | 9 |
| Other countries | 7 | 11 | 18 |

Table 2. *Sociodemographic characteristics of the sample*

| | Treatment without interpreter (n=97) | Treatment with interpreter (n=93) | Significance* |
|-----------------------------------------------------------------------------------|--------------------------------------|-----------------------------------|---------------------------------------------------|
| Female gender (n, %) | 26, 26.8 | 29, 31.2 | $\chi^2=.443$, p=.506 |
| Age at beginning of treatment (Mean, SD) | 36.43, 9.93 | 35.41, 8.29 | t=.771, p=.442 |
| Duration of treatment (Mean, SD) | 20.6, 12.7 | 23.6, 16.5 | t=-1.402, p=.163 |
| Secure residence permit status (n, %) | 59, 60.8 | 62, 66.7 | $\chi^2=.701$, p=.403 |
| Living with partner (n, %) | 38, 40.4 | 47, 53.4 | $\chi^2=3.078$, p=.079 |
| Stable housing (n, %) | 69, 71.1 | 54, 58.1 | $\chi^2=3.553$, p=.059 |
| Employed (n, %) | 51, 52.6 | 10, 10.8 | $\chi^2=38.102$, p<.0001 |
| Completed vocational training (n, %) | 51, 52.6 | 21, 22.8 | $\chi^2=18.153$, p<.0001 |
| Foreign language proficiency in a range from 1 to 5 (Mean, SD) | 3.44, 0.90 | 2.14, .65 | t=11.455 , p<.0001 |
| Good social network (n, %) | 58, 59.8 | 18, 19.4 | $\chi^2=32.351$, p<.0001 |
| Fulfilled expectations in the country of asylum in a range from 1 to 4 (Mean, SD) | 2.14, .78 | 2.12, .61 | t=.796, p=.796 |

*Significant differences are marked in bold.

Table 3. *Treatment outcome measured by reduction of CGI and HAM-D scores.*

| Measure | Treatment without interpreter (n=97) | Treatment with interpreter (n=93) | Significance |
|----------------------------|--------------------------------------|-----------------------------------|----------------------------------------------------------------------------------|
| HAM-D beginning (mean, SD) | 16.12, 6.12 | 16.97, 6.02 | Time effect: Pillai's Trace=0.718, F=478.20 df=1, p=0.000 |
| HAM-D end (mean, SD) | 7.45, 5.09 | 8.70, 4.99 | |
| | | | Between-group interaction: Pillai's Trace=0.001, F=,268, df=1, p=0.605 |
| CGI beginning (mean, SD) | 5.43, 0.59 | 5.20, 0.67 | Time effect: Pillai's Trace=0.816, F=779.52 df=1, p=0.000 |
| CGI end (mean, SD) | 2.51, 1.25 | 2.81, 1.24 | |
| | | | Between-group interaction: Pillai's Trace=0.039, F=7.72, df=1, p=0.006* |

HAM-D: Hamilton Rating Scale for Depression.

CGI: Clinical Global Impression.