Therapeutic Alliance with Traumatized Refugees and Asylum Seekers in relation to Treatment Change

Background: No consensus has been reached about what leads to meaningful treatment change in traumatized refugees and asylum seekers. It is reasonable that the quality of the therapeutic alliance with refugees and asylum seekers in trauma treatment is related to treatment change. **Aims:** The first part of this study compared the evaluations of the therapeutic alliance by refugees and asylum seekers with the evaluations by other groups of patients. The second part of this study examined if the quality of the therapeutic alliance predicts change in psychological well-being. **Methods:** Seventy-three patients (19 refugees and asylum seekers, 19 Dutch veterans, and 34 patients of the post-war generation) of the day clinic of Foundation Centrum '45 evaluated their state of psychological well-being and the therapeutic alliance every week by completing the Outcome Rating Scale and the Session Rating Scale. **Results:** The results suggest that the therapeutic alliance in therapy with refugees and asylum seekers is of poorer quality compared to the other treatment groups. Furthermore, this study provides some evidence that a weak alliance predicts a worsening in psychological well-being. **Conclusion:** The results of the study underline the importance of therapeutic alliance when working with traumatized refugees and asylum seekers. There is a need for further studies, with larger samples sizes and a longer follow-up period, to the therapeutic alliance in relation to treatment change in this group of patients.

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Introduction

Worldwide, the number of forcibly displaced people is estimated to be about 45,2 million (United Nations High Commission on Refugees, 2013). Many refugees have a prolonged and repeated history of traumatic experiences, like forced migration, torture, and the killing of family and friends, which often result in mental health problems (Palic & Elklit, 2010). Posttraumatic stress disorder (PTSD) is one of the most frequently reported mental health problems in refugees and asylum seekers: The meta-analysis of Fazel, Wheeler, and Danesh (2005) shows that one in ten of adult refugees in Western countries is diagnosed with PTSD.

Many refugees and asylum seekers are referred to mental health services (Gerritsen et al., 2006). Longitudinal studies of treatment outcomes in refugees and asylum seekers show different results. Some studies demonstrate a decrease in PTSD symptoms (e.g. Boehnlein et al., 2004; Neuner et al., 2010). However, numerous studies report a chronicity in mental health problems in this group of patients despite intensive treatment and time lapse (Boehnlein, et al., 2004; Carlsson, Mortensen, & Kastrup, 2005; Carlsson, Olsen, Kastrup, Mortensen, 2010). In addition, Drožđek (1997) reports a considerable relapse in PTSD after three years of treatment. These results point to the fact that it is still unclear what constitutes meaningful treatment change in chronically traumatized refugees and asylum seekers (Palic & Elklit, 2010).

Many practitioners and theorists believe that the development of a positive therapeutic alliance predicts positive treatment outcomes (Martin, Garske, & Davis, 2000). Empirical research supports this belief (Orlinsky, Rønnestad, & Willutski, 2004). The therapeutic alliance, also known as the working alliance, is defined as "a positive, collaborative relationship based on trust and a shared commitment to the client's growth and healing" (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005, p. 29). The therapeutic alliance is developed from various understandings of the relationship between therapist and patient, and is generally divided in three themes: (a) the development of an affective bond between patient and therapist, (b) the collaborative nature of the relationship, and (c) the patient and therapist's ability to agree on treatment goals and tasks (Martin et al., 2000). Findings suggest that improving the therapeutic alliance during treatment leads to better treatment outcomes (Anker, Owen, Duncan, & Sparks, 2010). It is reasonable that differences in quality of the therapeutic alliance explain the various treatment outcomes in refugees and asylum seekers described above.

Therapeutic alliance with refugees and asylum seekers

The literature broadly discusses the therapeutic alliance with refugees and asylum seekers in psychological treatment, including the affective therapist-patient bond, the collaborative nature of the relationship, and the agreement on goals (e.g. Blom, 1999; Fabri, 2001; Van der Veer & Van Waning, 2004).

Affective bond. Trust, cultural, and language barriers can hinder the development of a strong therapist-patient relationship. Firstly, with respect to trust and the feeling of safety, the "core responsibility" in therapy with refugees and asylum seekers is the reconstruction of trust in another person (Fabri, 2001). Many refugees and asylum seekers are survivors of torture, which results in an "ongoing vulnerability within the survivor to feel disempowered or controlled by others" (Fabri, 2001, p. 453). In therapy, this vulnerability becomes visible when the therapist is negatively viewed as an imposing authority figure (Fabri, 2001). Besides, many refugees and asylum seekers foster distrust against authorities due to their experiences during the asylum procedure (Rohlof, 1999). Secondly, cultural barriers form a challenge for the therapist-patient relationship. It can be assumed that many refugees and asylum seekers are unfamiliar with Western psychotherapy and do not know how psychotherapy can help (Sue, 2006). Especially when they are from traditional cultures where it is common to seek assistance within the family or one's religious community, talking to a stranger about problems might be difficult (Fabri, 2001). Thirdly, language barriers influence the relationship. Miller et al. (2005) describe the alternation of the dyadic therapy to a triadic relationship, due to the addition of an interpreter. In this study, Miller and colleagues illustrate a common experience of therapists, when the client initially forms a stronger bond with the interpreter.

Collaboration. With respect to the collaborative nature of the relationship between the therapist and his/her refugee patient, (cultural) ideas about the typical roles in therapy are important. In Western psychological treatment, a therapist tries to equalize the relationship by encouraging the patient to be an active collaborator. In intercultural treatment, this encouragement may clash with the deeply held norms of a refugee or asylum seeker, who is from a hierarchical and traditional culture where the therapist is typically viewed as an authority (Shonfeld-Ringel, 2001).

Goals. Trauma-focused psychotherapy is currently recommended as the treatment of choice for PTSD. However, for most refugees and asylum seekers, the diagnosis of PTSD does not encompass the whole range of posttraumatic reactions; post migratory living conditions should be considered as well (Palic & Elklit, 2010). Their problems can be defined as "psychological", but at the same time as "medical", "social", "political" or "multidimensional" (Drožđek, 2007, p. 12). The pitfall of trauma-focused therapy is emphasizing the experienced traumatized events and ignoring the more urgent needs of refugees, like financial or family problems (Knipscheer, van Middendorp, & Kleber, 2011). Drožđek (2007) suggests that when planning interventions in trauma treatment with refugees and asylum seekers, the mental health professional has to rank the priority areas of change. This means when "mental engineering" of individual problems is the main concern; the role of the (psycho)therapist is the integration of fragmented traumatic experiences. For others, a necessary precondition for further healing might be "social engineering" or practical aid at the familial and societal levels, in combination with aiming for the stabilization of the client (Drožđek, 2007).

All these issues described above can create a difficult uphill struggle for the development of a strong therapeutic alliance with refugees and asylum seekers. Given that the quality of the therapeutic alliance is one of the most important factors for treatment change in general (Orlinsky et al., 2004), one could imagine that the therapeutic alliance in therapy with refugees and asylum seekers, characterized by low levels of trust and a wide range of problems, is an important predictor for treatment change in this group of patients. To the author's knowledge, no quantitative study has focused specifically on the therapeutic alliance in therapy with refugees and asylum seekers. Therefore, it is of considerable importance to identify the role of the therapeutic alliance for treatment change in this group of patients.

Aims of study

The present study has two primary aims. The first goal of this study is to compare the evaluations of the therapeutic alliance by traumatized refugees and asylum seekers with the evaluations of the therapeutic alliance by Dutch veterans and the post-war generation. It is hypothesized that the therapeutic alliance with refugees and asylum seekers is of poorer quality than with the other treatment groups. The second goal of this study is to identify the extent to which the therapeutic alliance predicts treatment effect (i.e. change in psychological well-being) in

refugees and asylum seekers. It is hypothesized that a positive therapeutic alliance predicts a positive change in psychological well-being.

Methods

Sample

Twenty therapists, working at Foundation Centrum '45, invited their patients to participate in a pilot study about the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). Foundation Centrum '45 is a Dutch national institute for specialist diagnostics and treatment of psychotrauma complaints resulting from persecution, war, and violence.

In this study, data from 104 patients were used on the basis that they all referred to the day clinic and completed five or more ORS forms. A minimum of five ORS administrations was considered as the minimal period to see any treatment change. Of the 105 patients, 32 had to be excluded from analysis because they had not completed the SRS at the end of the day, as was instructed (Crouzen, 2010).

Of the remaining 72 patients, 22 were female, the mean age was 50,74 (*SD* = 8.66) years, and the following treatment groups were included: (Dutch speaking) refugees and asylum seekers (*N* = 19), post-war generation (*N* = 34), and Dutch veterans (*N* = 19). The refugees and asylum seekers came from different countries: Croatia (*N* = 1), Bosnia-Herzegovina (*N* = 3), former Yugoslavia (*N* = 1), Chechenia (*N* = 1), Turkey (*N* = 1), Egypt (*N* = 1), Iraq (*N* = 5), Iran (*N* = 3), (Belgian) Congo (*N* = 2), and Burundi (*N* = 1). Most of the post-war generation and veterans were born in the Netherlands (*N* = 46*)*. Others were born in Germany (*N* = 1), Indonesia (*N* = 2), Dutch East India (*N* = 3), and Russia (*N* = 1).

All patients in this sample, followed a day treatment program one day in the week. This program contained several group sessions and individual treatment sessions. Different types of therapies were offered throughout the day, namely: trauma-focused group therapy, sociotherapy, non-verbal therapy, and if necessary psycho-pharmaceutical therapy and social work.

The number of ORS forms completed by patients of this group ranged from 6 to 22, with an average of 11 administrations per patient. The number of completed SRS forms ranged from 4 to 22, with an average of 10 administrations per patient.

For the second part of this study, the (Dutch speaking) refugees and asylum seekers (*N* = 19) were analyzed. The mean age was 51,32 years (*SD* = 8.15), and 3 were female. The number of ORS forms completed by these patients ranged from 6 to 14, with an average of 10 administrations per patient. The number of completed SRS forms ranged from 4 to 12, with an average of 8 administrations per patient.

Measures

The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) are a Routine Outcome Measurement (ROM) method. The ORS and SRS measure psychological well-being and the therapeutic alliance, respectively. In this study, a group-SRS is used, which is adapted to the group setting (Quirk, Miller, Duncan, & Owen, 2012). The ORS and the SRS each consist of four items. The ORS covers three areas of patient functioning: individually (personal well-being), interpersonally (family and close relationships), and socially (work, school, friendships). Three of the four SRS-items cover the main elements of the therapeutic alliance: the relationship (i.e. *I felt heard, understood, and respected by the therapist and the group*), goals and topics (i.e. *We worked on or talked about what I wanted to work on or talk about*), and approach or method (i.e. *The leader and/or the group's approach are/is a good fit for me*). The fourth item of the ORS and SRS requires the patient to evaluate his/her daily functioning and the treatment day program in general (Hafkenscheid, Duncan, & Miller, 2010).

A patient was instructed to place a mark on a 10-cm line: The more the mark is placed to the right, the more positive the person feels. For the group of refugees and asylum seekers, a sad smiley face on the left and a happy smiley face on the right were added to clarify the dimensional line. Overall scores of psychological well-being and therapeutic alliance were computed by summing the scores on the four subscales of the ORS and SRS.

The ORS and the SRS were available in different languages: Dutch, English, French, German, Arabic, Farsi, Dari, Pashto, Russian and Servo-Croatian. The validity and the reliability are adequate for the ORS (Hafkenscheid et al., 2010; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the Group-SRS (Quirk et al., 2012).

Procedure

The therapists invited their patients to participate in a pilot study about the ORS and SRS. At the start of treatment, patients provided written informed consent. At the start of the pilot study, patients received an information letter about the ORS and SRS from their therapist. From then on, patients received the ORS form at the beginning of the day

program and evaluated their psychological well-being over the last week. At the end of the day, patients received the SRS form and evaluated the therapeutic alliance.

When the forms were completed, each mark on each line was measured to the nearest millimeter. The subscores on the ORS and SRS were filled in an Excel spreadsheet that was specially created for the pilot study. As a result, a graph showed changes in ORS and SRS (sub)scores over time.

Design & analysis

For the first part of this study, a one-way ANOVA was used to test differences between treatment groups (i.e. refugees and asylum seekers, Dutch veterans, post-war generation) on the evaluation of the therapeutic alliance. Overall scores and subscores on the SRS were used for analysis. A Pearson correlation analysis was performed to assess the relationship between the number of administrations of the SRS and the evaluation of the therapeutic alliance. No statistically significant correlation was found between the two variables ($r(71) = .185$, $p = .185$).

For the second part of this study, a repeated measures ANOVA was carried out to test if the quality of the therapeutic alliance predicts change in psychological well-being. Overall ORS scores at three time points were used for analysis: the first, the middle, and the last administration. The mean of the overall SRS scores was calculated for every patient. Subsequently, patients were divided into two groups by the median: patients with a mean below the median were placed into the low alliance group, and patients with a mean above the median into the high alliance group. The high alliance group represents the patients with better evaluations of the therapeutic alliance than the low alliance group. Overall ORS scores at three time points were used as dependent variables, and the alliance group as the predictor variable.

Results

For the first part of the study, a one-way ANOVA revealed that the evaluation of the therapeutic alliance differed statistically significantly between refugees and asylum seekers, Dutch veterans, and the post-war generation ($F(2,69) = 22.703$, $p = .000$). To test whether the evaluations of the therapeutic alliance by refugees and asylum seekers differed from the evaluations of the therapeutic alliance by other treatment groups, a planned contrast test was conducted. This revealed that refugees and asylum seekers evaluated the therapeutic alliance in therapy statistically significantly lower than the other treatment groups ($t(69) = -6.459$, $p = .000$). Table 1 represents the means of the overall SRS scores for every treatment group.

Furthermore, a one-way ANOVA showed that the ratings on all elements of the therapeutic alliance (i.e. relationship with therapists and group, goals and topics, approach and method, overall feeling) differed statistically significantly between refugees and asylum seekers, Dutch veterans, and the post-war generation: relationship, $F(2,69) = 22.190$, $p = .000$, goals and topics, $F(2,69) = 20.507$, $p = .000$, approach and method, $F(2,69) = 18.968$, $p = .000$, and overall feeling, $F(2,69) = 18.062$, $p = .000$. To test whether the ratings on the subscales by refugees and asylum seekers differed from the ratings by patients of the other treatment groups, a planned contrast test was conducted. This revealed that the evaluations by refugees and asylum seekers were statistically significantly lower, with regard to all four elements of the therapeutic alliance, than evaluations by the other treatment groups: relationship ($t(69) = -$

Table 1

Therapeutic Alliance Scores by Treatment Groups

Elements Therapeutic Alliance	*n*	*M*	*SD*
Therapeutic alliance			
Refugees and asylum seekers	19	16.98	8.07
Post-war generation	34	28.86	5.09
Dutch veterans	19	27.18	6.35
Relationship			
Refugees and asylum seekers	19	4.20	2.08
Post-war generation	34	7.20	1.33
Dutch veterans	19	6.77	1.53
Goals and topics			
Refugees and asylum seekers	19	4.18	2.05
Post-war generation	34	7.06	1.22
Dutch veterans	19	6.42	1.62
Approach and method			
Refugees and asylum seekers	19	4.33	2.17
Post-war generation	34	7.24	1.38
Dutch veterans	19	6.69	1.57
Overall feeling			
Refugees and asylum seekers	19	4.31	1.9
Post-war generation	34	7.37	1.38
Dutch veterans	19	7.28	2.49

6.383, p = .000), goals and topics (t(69) = -5.963, p = .000), agreement on approach and method (t(69) = -5.815, p = .000), and the overall feeling about the therapeutic alliance (t(69) = -5.917, p = .000). Table 1 represents the means of the SRS subscores for every treatment group.

For the second part of the study, a repeated measures ANOVA was performed to examine if the quality of the therapeutic alliance predicts change in psychological well-being. Mauchly's test indicated that the assumption of sphericity had been violated, $\chi^2(2) = 7.081$, p = .29, therefore degrees of freedom were corrected using the Greenhouse-Geisser estimation of sphericity (ε = .727). The main effect of time was non-significant (F(1.453,23.251) = 1.985, p = .168), which suggests that a patient's psychological well-being did not change over time. The interaction between time and the quality of the therapeutic alliance was marginally significant (F(1.453,23.251) = 3.153, p = .075). Figure 1 indicates that patients with lower alliance scores decreased in psychological well-being over time, and patients with higher alliance improved between the first and middle administration, but then fall back to almost the same state of well-being as at the beginning.

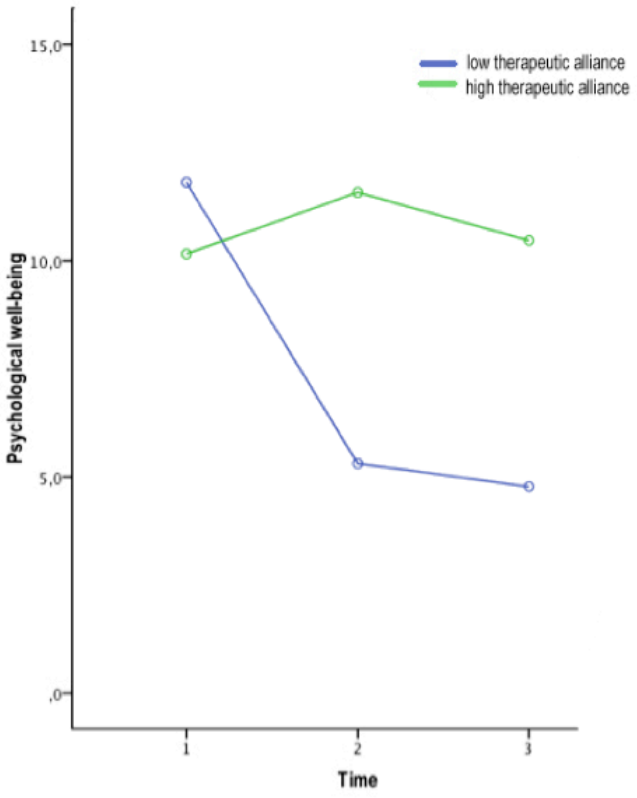

Figure 1. Change in psychological well-being in patients with lower alliance scores and higher alliance evaluations.

Discussion

To gain more knowledge about what constitutes meaningful treatment change in chronically traumatized refugees and asylum seekers, this study identified the role of the therapeutic alliance in treatment change in this group of patients.

The first part of this study compared the therapeutic alliance in therapy with refugees and asylum seekers with the therapeutic alliance in therapy with other groups of patients (i.e. Dutch veterans and post-war generation). As hypothesized, the therapeutic alliance, from a patient's point of view, was statistically significantly lower in refugees and asylum seekers compared to the other groups of patients. On all elements of the therapeutic alliance, refugees and asylum seekers scored statistically significantly lower compared to the Dutch veterans and the post-war generation. The second part of this study examined the role of the therapeutic alliance in treatment change (i.e. change in psychological well-being) in refugees and asylum seekers. In contrast to what was hypothesized, no statistically significant change in psychological well-being over time for the whole group was found. The interaction effect was marginally significant; which suggests that patients with lower alliance scores decreased in psychological well-being, and patients with higher alliance scores did not change remarkably.

The results of this study imply that the therapeutic alliance in therapy with refugees and asylum seekers is of poorer quality compared to other groups of patients. This is in line with the literature, which describes many challenges for the development of a strong affective and collaborative relationship between a therapist and his/her refugee patient. For instance, trust issues can hinder the development of a strong therapist-patient bond (Fabri, 2001). Furthermore, a weak therapeutic alliance could be a consequence of a clash between the norms of the therapists and his/her refugee patient: when, for instance, the encouragements of a Western therapist to make the patient an active collaborator collides with the traditional norms of the patient, who beliefs the therapist is an authority (Shonfeld-Ringel, 2001). In addition, the complexity of social and psychological problems in refugees and asylum seekers can further complicate the collaboration between therapist and patient (Drožđek, 2007).

Previous studies show that the therapeutic alliance is an important factor for treatment change (Orlinsky et al., 2004). Therefore, the low evaluation of the therapeutic alliance by refugees and asylum seekers is worrying. To the author's knowledge, no other study has compared the quality of the therapeutic alliance

in therapy with refugees and asylum seekers with other treatment groups. That is why this study must be regarded as a stepping-stone to further research to the therapeutic alliance with refugees and asylum seekers.

The second part of this study indicates that patient's state of psychological well-being did not change over time. A lack of significant change has been observed in more studies of treatment effects in refugees and asylum seekers (e.g. Boehnlein et al., 2004; Carlsson et al., 2010). The reality is that, for most refugees and asylum seekers, mental health problems lasted many years at the time of the start of treatment (Carlsson et al., 2010). Post-migration factors, which are specific for refugees and asylum seekers, may possibly underlie the unchanged psychological well-being in this group of patients as well. Post-migration factors, like identity loss and acculturation are connected to social problems like unemployment, social isolation, and discrimination (Palic & Elklit, 2010). Studies show that post-migration factors might play a role in the maintenance of refugees' mental health problems (Carlsson, et al., 2006; Lie, 2002).

The marginal interaction effect found in this study still suggests that the therapeutic alliance is related to treatment change in refugees and asylum seekers. The slight improvement in psychological well-being in patients with high alliance scores between the first and second measurement is of interest. More follow-up measurements should provide evidence that patients with higher alliance scores improve in psychological well-being over a longer period of time. It should be kept in mind that a gradual response to treatment should be expected for this group of patients, due the complexity of the trauma (Silove, Steel, McGorry, Miles, & Drobny, 2002).

The finding that psychological well-being decreased in patients with lower alliance scores is alarming. This finding suggests the possibility that treatment may be harmful when the therapeutic alliance is weak. To the author's knowledge, no other studies showed worsening in symptoms in traumatized refugees and asylum seekers; even untreated patients in the study of Drožđek (1997) showed some improvement at a three-year follow up. The decrease in psychological well-being in patients with weak alliance scores, could be a consequence of losing hope: Some patients show a sharp rise in psychological well-being in the early phase of treatment, but constantly worsen again when treatment is not what they hoped it would be (Crouzen, 2010). It should be noticed that a decline in psychological well-being in refugees and asylum seekers might be caused by post-migrational stress as well. Uncertainties like status, finances, conflict situation in their country of origin, and being separated from family of friends could possibly influence their state of well-being.

Strengths and limitations

This study is unique for different reasons. Firstly, no other quantitative study has examined the therapeutic alliance in therapy with refugees and asylum seekers. This is remarkable because low levels of trust, language, and cultural barriers make the therapeutic alliance for refugees and asylum seekers of great concern. Secondly, instead of measuring symptom change, this study measured well-being on three areas of patients functioning (i.e. individually, interpersonally, and socially). This different approach is important, because aspects like 'self-efficacy' and 'competency' affects psychological well-being as well (Bandura, 1994; Warr, 1990). For instance, when a person is competent, he/she has adequate psychological resources to deal with the experienced difficulties in life (Warr, 1990). In other words, it is reasonable that a patient still reports trauma symptoms, but psychological well-being improved due to more experienced competency and/or self-efficacy.

This study has several limitations. The validity and reliability of the ORS and SRS have not (yet) been specifically tested in the population of the present study. Nevertheless, it could be assumed that the brief visual measures, used in this study, are easy to understand for (Dutch speaking) refugees and asylum seekers. Furthermore, the number of refugees and asylum seekers included for analysis was small and therefore differences in scores could affect conclusions that are drawn from the data. Therefore, the study results cannot be generalized to the population of refugees and asylum seekers in general. Further research with a longer follow-up period and larger sample sizes should provide more information about the quality and the role of the therapeutic alliance in therapy with refugees and asylum seekers in general.

Practical and theoretical implications

The results of this study underline the importance of including therapeutic alliance measures in studies of treatment outcome in refugees and asylum seekers.

Furthermore, the low evaluations of the therapeutic alliance in refugees and asylum seekers suggests that more time is needed in the early phase of treatment with refugees and asylum seekers. Treatment protocols should adapt to the situation of

refugees and asylum seekers by providing more time for the development of a strong therapist-patient relationship. Even before the start of treatment, "pretherapy" for non-Western patients could be a helpful intervention. This aims at familiarizing non-Western patients with Western psychotherapy by explaining what psychotherapy is, how psychotherapy can help, what the typical roles of therapists and clients are, and what confidentiality is (Sue, 2006). This sounds especially helpful for traumatized refugees and asylum seekers to inspire confidence, and because for many refugees the roles in therapy are unclear (Shonfeld-Ringel, 2001).

A cultural sensitive attitude in intercultural treatment is important to deliver effective interventions to patients from other cultures (Drožđek, 2007; Sue, 2006). In brief, this holds a specific attitude wherein the therapist "combines his knowledge on healing with authentic curiosity about his/her own and the patient's cultural background" (Drožđek, 2007, p. 16). According to Drožđek, this means being aware of your own identity, and at the same time being open-minded for cultural explanations of illness, disease, and healing that the patient brings into treatment.

Last but not least, a more holistic perspective in trauma treatment with refugees and asylum seekers might be helpful. This means that psychological work should not take place in isolation, but rather be a part of broader rehabilitation process (Lie, 2002). According to Watters (2001), this holds a blurring and overlapping of professional roles. Watters states that a worker who helps, for example, a refugee family to gain access to accommodation, is more likely to engage the refugee in counseling and psychotherapeutic work through the trust that is built up in the relationship.

Conclusion

To the author's knowledge, this is the first quantitative study that examined the quality of the therapeutic alliance in therapy with refugees and asylum seekers, and its relation to treatment change. The low evaluations of the therapeutic alliance by refugees and asylum seekers in contrast to the other groups of patients, together with the decrease in psychological well-being for refugee patients with weak alliance scores, is worrying. These results emphasize the need to find ways to improve the therapeutic alliance, to effectively treat traumatized refugees and asylum seekers. Therefore, in practice and theory, the therapeutic alliance in therapy with refugees and asylum seekers deserves more attention.

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