

Does Interpreter-Mediated PTSD treatment for refugees' work? A comparison study in the Netherlands.

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Abstract

This study compares the outcomes of utilizing interpreters in the treatment of refugees with post-traumatic stress disorder (PTSD). The researchers compared the outcomes of posttraumatic stress disorder and general psychological distress after a treatment applied to two groups: 38 refugee patients receiving therapy with the assistance of interpreters and 38 matched refugee patients receiving the treatment without interpreters. The study found that there were no significant differences between the two groups in terms of PTSD symptoms and psychological distress at various time points throughout the treatment process. This suggests that the use of that incorporating interpreters in the treatment of refugees with PTSD does not appear to impede therapeutic progress or outcomes. The findings contribute to the growing body of literature supporting the effectiveness of utilizing interpreters in psychotherapy with diverse populations. Further research is needed to explore the specific mechanisms through which interpreters contribute to successful therapeutic outcomes and address any potential challenges that may arise in the process.

Key Words: Refugees; PTSD; interpreters; psychological distress; treatment.

Introduction

The mental health of refugees and asylum seekers has gained importance and impact on the world in recent years (Gartley & Due, 2017). The sheer number of refugees and persons internally displaced in 2022 was the most since the Second World War, with over 80 million people forcibly relocated globally (Bryant, Nickerson, Morina, & Liddell, 2022). These people come from a variety of origins and situations, but they all share a common set of struggles and experiences that, compared to the general population, greatly enhance their likelihood of developing mental health problems.

Recent methyases indicates that refugees are at a higher risk of developing mental health disorders compared to the general population (Patanè et al., 2022). The prevalence rates were 32% for major depressive disorder (MDD), 31% for posttraumatic stress disorder and 5% for bipolar disorder (BPD) and 1% for psychotic disorders. Of these, PTSD is one of the most common mental health problems experienced by refugees. Studies have found that PTSD may be present in 23% to 35% of the refugee population, with refugees with a PTSD diagnosis experiencing a lower subjective quality of life compared to other patients (Codrington et al., 2011; D'Ardenne, Ruaro, et al., 2007; Hoell et al., 2021).

Various studies have explored effective methods for cross-cultural work and working with refugee clients, particularly in the context of PTSD and MDD. However,

language difficulties can pose a significant barrier to accessing healthcare services for refugees (Aggarwal & DeSilva, 2013). Overcoming this barrier is essential to provide effectively interpreted healthcare to individuals who may have experienced extreme physical and mental violence, as it is integral to their human rights (D'Ardenne, Farmer, Ruaro & Piebe, 2007). The

use of an interpreter can be highly beneficial in closing the linguistic and cultural gap between refugees who are new to a country and mental health care providers (Aggarwal & DeSilva, 2013)The use of an interpreter could be more beneficial as it could help closing the linguistic and cultural barrier between refugees who are new to a country and mental health care the providers (Nyerges, Dajani, Kacmar, Gunathilake, & Harris, 2022).

However, little attention has been given to the implications of using interpreters in mental health settings, particularly in the treatment of PTSD among refugees.

Interpreter-mediated treatment involves the use of a professional interpreter to facilitate communication between a healthcare provider and a patient who do not share a common language. Some authors (Wenk-Ansohn & Gurriss, 2011) suggest that there are effective principles and guidelines for working with interpreters in psychotherapy. Once therapists become familiar with working with interpreters, they typically don't find it challenging or disruptive to the therapeutic process and it can also be a valuable and rewarding experience. Furthermore the study of Mirdal et al, (2012) explained that certain aspects of therapy, such as care, support, involvement, and empathy, which may initially seem less significant, are actually essential components of the treatment approach when working with refugee patients who require the assistance of translators. In other words, these elements are not merely add-ons or optional, but integral and fundamental to the therapeutic process for refugees in need of language interpretation (Mirdal et al., 2012)

The guidelines of the National Institute for Clinical Excellence in England (NICE, 2005) recommend the use of interpreters as an integral part of the treatment with refugees. The guideline affirm that interpreters can assist in conveying important safety information and ensuring effective communication during the stabilization and safety phase, which may be challenging for asylum seekers facing possible deportation. In trauma-focused interventions, interpreters also play a vital

role in providing refugees with PTSD comprehensive information about treatment options and incorporating their treatment preferences.

Despite this evidence, there is still a lack of knowledge on how this process of including interpreters in the treatment of refugees should be done. There are no guidelines to interpret trauma-focused CBT as well as the ethical and practice issues associated with interpreting in mental health. (D'Ardenne, Farmer, et al., 2007).

Additionally, some authors (Patel, 2003) have suggested that therapy involving an interpreter can disempower individuals from non-Western backgrounds and may hinder effective outcomes. Additionally, the presence of a third-party during therapy can impact the development of trust and confidentiality. Interpreters may also lack adequate training in mental health, leading to communication difficulties (Westermeyer, 1990).

Sander et al (2019) reported that that using interpreters during psychotherapy was associated with less improvement during treatment on most of the secondary outcome measures, that included depression and anxiety symptoms, quality of life and functioning, as well as the primary outcome measure, that included posttraumatic stress disorder symptoms compared to the group that did not use interpreters. (Sander et al., 2019).

Studies such as Carlsson, Mortensen, Kastrup (2005) did not find any changes after treatment using translations in a group of traumatized refugees, and it remains unclear whether this approach is effective for treating mental health issues, specifically PTSD, among refugees.

Studies have shown mixed results regarding the impact of using interpreters during therapy, with some indicating less improvement in treatment outcomes (Sander et al., 2019; Carlsson, Mortensen, Kastrup, 2005) also, there is a lack of knowledge regarding the process of including

interpreters in the treatment of refugees, including the interpretation of trauma-focused cognitive-behavioral therapy and the associated ethical and practice issues (D'Ardenne, Farmer, et al., 2007).

Therefore, this study aims to compare the outcomes of psychological distress and PTSD utilizing interpreters in the treatment of refugees with those who received treatment without interpreter. The research question addresses whether the use of interpreters has an influence on PTSD treatment for refugees. The hypothesis proposes that including interpreters in therapy for the treatment of PTSD in refugees will not have difference in the results of psychological distress and PTSD compared to those patients who no required a translator. Through investigating these factors, this study seeks to shed light on the potential benefits of incorporating interpreters in the treatment of refugees.

The mental health and general wellbeing of refugees are significantly affected by our understanding of the effectiveness of interpreter-mediated treatment. If this strategy is successful, it may make it easier for refugees with low Dutch proficiency or who speak a different language from their providers to communicate and get mental health care. To guarantee that the mental processes are suitable and effective, it is crucial to understand this information barrier.

Method

Participants

The study included refugee patients who entered treatment at the psycho-trauma treatment center “Centrum’45” in Diemen, the Netherlands. The facility focuses on helping refugees who have experienced trauma. All participants were formally diagnosed with PTSD using the CAPS-5. All participants were provided with a specialized PTSD treatment according to their needs such as Eye Movement Desensitization and Reprocessing (EMDR) or Narrative Exposure Therapy. The final sample for this study included 76 refugee patients divided in two matched groups: the interpreter group (n=38) and the non-interpreter group (n=38). The participants in each group were carefully matched based on age, gender, region of origin, and refugee status. This matching process ensured that the groups were comparable in terms of these demographic characteristics, minimizing potential confounding factors related to these variables. The sociodemographic characteristics are presented in table 1.

Table 1.*Sociodemographic characteristics of the sample.*

	Group with Translator (n=38)	Control Group (n=38)
Age		
\bar{x}	18.52	20.18
SD	11.16	11.14
Gender	(%)	(%)
Male	68.4	68.4
Female	31.6	31.6
Region of Origin	(%)	(%)
Africa	34.2	34.2
South-East Asia	2.6	2.6
Europe	5.3	10.5
Eastern Mediterranean	52.3	52.6
Asylum Status	(%)	(%)
With Refugee status	44.7	44.7
Asylum seeker	7.9	13.2
Undocumented	47.4	42.1

Interpreters

All interpreters were certified, and it was ensured that they came from the same country as the participants. Each participant used the same interpreter throughout the whole treatment.

Procedure

After signing the informed consent all participants were assessed using the CAPS-5, PCL-5, and BSI measures prior to the start of treatment. Each patient received specialized treatment for post-traumatic stress disorder (PTSD), either EMDR or Narrative Exposure Therapy, depending

on their specific needs. Following the completion of treatment, some individuals with interpreters and others without, the participants were reevaluated using the same measures at 6 months and 12 months after treatment administration.

Instruments

CAPS. The CAPS-5 (Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane, 2013). Is a structured interview consisting of 30 items that serves the following purposes: Diagnose current PTSD (within the past month, Diagnose lifetime PTSD, Assess PTSD symptoms experienced over the past week In addition to evaluating the 20 PTSD symptoms outlined in the DSM-5, the interview includes questions about symptom onset, duration, subjective distress, impact on social and occupational functioning, improvement since the previous CAPS administration, overall response validity, overall severity of PTSD, and specifications for the dissociative subtype (depersonalization and derealization). The administration process involves identifying a significant traumatic event as the basis for symptom assessment. It is recommended to use the Life Events Checklist for DSM-5 (LEC-5) alongside the CAPS-5 to inquire about Criterion A.

PCL-5. The PTSD Checklist for DSM-5 (PCL-5) (Weathers, Litz, Keane, Palmieri, Marx, & Schnurr, 2013). The PTSD Checklist for DSM-5 (PCL-5). National Center for PTSD.is used to evaluate the frequency and intensity of symptoms associated with posttraumatic stress disorder (PTSD). This assessment scale comprises 17 items that measure symptoms of reexperiencing, avoidance, and hyperactivation. Respondents use a Likert-type format, ranging from 0 to 3, to indicate the frequency and intensity of their symptoms, with higher scores indicating a higher

frequency and intensity of symptoms. The PCL-5 has good internal reliability, as indicated by a Cronbach's alpha coefficient of 0.70. (Sveen, Bondjers, & Willebrand, 2016)

BSI. The Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1993) is a widely used measure for assessing psychological distress and psychiatric disorders. It is a shortened version of the Symptom Checklist 90, consisting of 53 self-report items. Participants rate each item on a 5-point Likert scale, ranging from "not at all" to "extremely," and the BSI assesses nine dimensions of psychological symptomatology, including somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The BSI also measures the intensity and number of reported symptoms. The reliability of the nine dimensions ranges from .71 to .85, indicating good internal consistency, and test-retest reliability ranges from .68 to .91. The subscale of interest in this study is the one that assesses symptoms of depression, which has a good internal consistency with a Cronbach's alpha of .85 (De Beurs and Zitman, 2005).

Data Analysis

Descriptive analyses were utilized to analyze the demographic and background information of the patients. The aim of this study was to compare the outcomes of general psychological distress and general PTSD in refugees receiving treatment with interpreters versus those without interpreters. Repeated measures ANOVA analysis was employed to examine the interaction of time and group, comparing the two groups at three different time periods. It is important to note that not all patients completed all questionnaires at each time point. Specifically, 14 patients were included in the analysis for the outcome of general psychological distress, as measured by the BSI.

Additionally, 10 patients were included in the analysis for the outcome of PTSD, as measured by the PCL-5, at all-time points.

Additionally, to analyze contrast between groups for each separate assessment moments paired t-test was used to investigate if the difference was significant. The data analysis was performed using the Statistical Package for the Social Sciences (SPSS, version 27).

Results

Table 1 shows the results from the CAPS-5. Patients from the group with translator showed and average total level of 39.67 and from the Control Group and average total level of 42.52. Showing no differences between them $P=0.39$.

To address the aim of this study repeated measures ANOVA analysis was used, according to the results no statistically significant differences were found between the levels of general psychopathology (BSI) measures in the two groups at the three measurement moments of assessment with a small effect size $F_{(2)} = 0.157, p = 0.855, \eta p^2 = 0.013$. Furthermore, the different between groups at different assessment moments analyzed separately was also not statistically significant. The means and standard deviations of the variables at different assessment moments are presented in Table 2.

Table 2

Levels of general psychopathology (BSI) pretreatment and at 6 and 12 months after treatment.

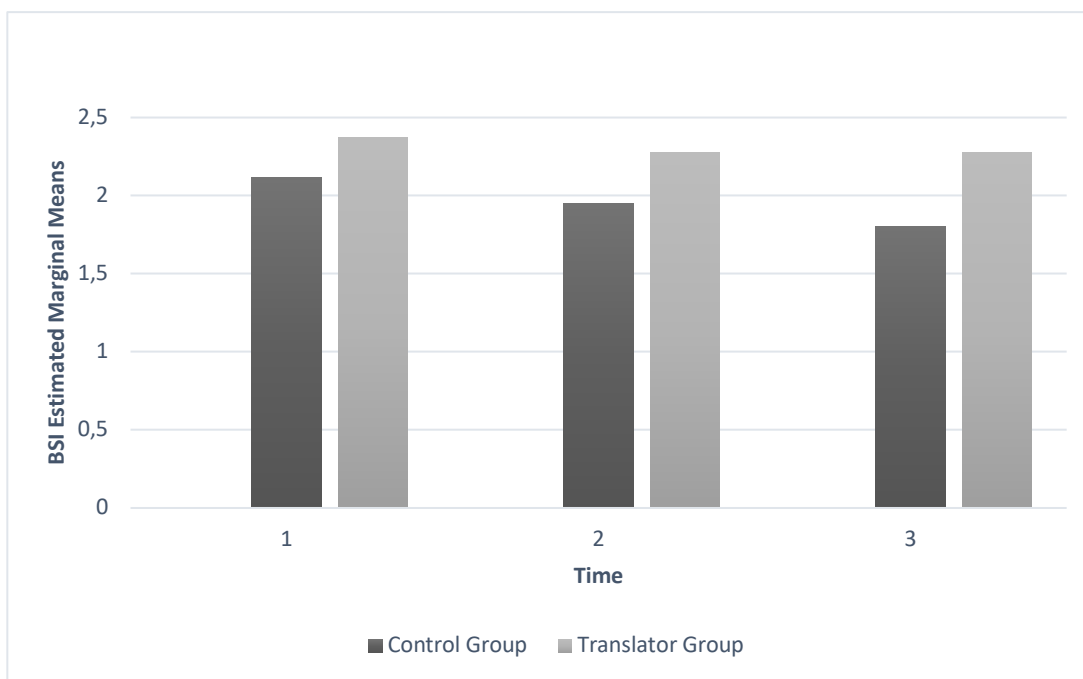
	Group with Translator		Control Group		Contrast
	\bar{x}	DE	\bar{x}	DE	p
BSI pre-treatment	2,37	0,56	2.11	0.70	0.313
BSI after 6 months	2,27	0,82	1.95	0.72	0.088
BSI after 12 months	2,27	0,69	1.80	0.80	0.584

Note: Total N =14

The comparison between the two groups at the three assessment moments in general psychopathology are presented in Figure 1.

Figure 1.

Group with translator and control group at three assessment moments in BSI.



Note: Total n=14

Furthermore, no significant differences were found between PTSD (PCL-5) measures in the two groups at the three measurement moments of assessment with a small size effect, $F_{(2)} = 0.648$, $p = 0.538$ $\eta^2 = 0.085$. The means and standard deviations of the variables at different assessment moments are presented in Table 3.

Table 3

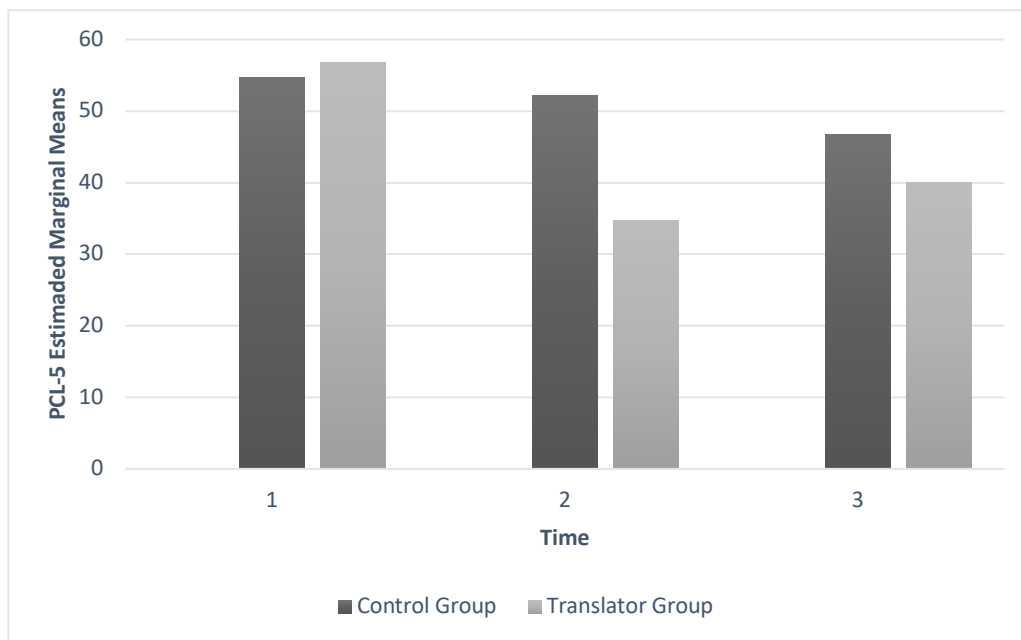
Levels of PTSD (PCL-5) pretreatment and at 6 and 12 months after treatment.

	Group with Translator		Control Group		Contrast
	\bar{x}	DE	\bar{x}	DE	p
PCL-5 pre-treatment	52.67	11.06	54.57	10.05	0.703
PCL-5 after 6 months	34.75	25.22	52.17	12.05	0.342
PCL after 12 months	40.00	34.22	46.67	12.62	0.043

Note: Total N =10

Finally, comparison between the two groups at the three assessment moments in PTSD are presented in Figure 2

Figure 2 *Group with translator and control group at three assessment moments in PCL-5.*



Note: Total N =10

Discussion

The aim of this study was to compare study aims to compare the outcomes of psychological distress and PTSD utilizing interpreters in the treatment of refugees with those who received treatment without interpreter. The results showed that not statistically differences were found between the levels of general psychopathology between the two groups at no significant difference was observed at 6- and 12-months post-treatment. These findings are consistent with previous studies, such as the one of D'Ardenne, P., Ruaro, L., Cestari, L., Fakhoury, W., & Priebe, S. (2007) that indicated that employing interpreters in the treatment of individuals with PTSD using Cognitive Behavioral Therapy (CBT) can yield favorable outcomes. Also is consistent with Brune, Eiroa-Orosa, Fischer-Ortman, Delijaj, & Haasen (2011) who found that psychotherapy with the assistance of interpreters can be equally effective as therapy conducted without interpreters for refugees with post-traumatic disorders. Therefore, the use of interpreters in psychotherapy should not be viewed as a lesser alternative but rather a valuable and effective approach.

Furthermore, the results also showed when comparing the severity of PTSD between the group with interpreters and the control group, no significant difference was observed at 6-months post-treatment. However, it was observed that at 12-months post treatment there was a significant difference between groups ($P=0.043$), with the interpreter group showing lower levels of PTSD symptoms after 12 months post treatments. These results suggest that the use of interpreters in therapy may have a positive long-term effect on reducing PTSD symptoms. This finding implies that the presence of an interpreter during treatment may contribute to better therapeutic outcomes and potentially enhance the effectiveness of interventions for PTSD in this population. However Further research is needed to explore the specific mechanisms by which the use of interpreters

contributes to improved outcomes and to investigate potential confounding variables that may have influenced the observed difference.

Overall, these results suggests that the use of interpreters may not act as a barrier to therapeutic outcomes, at least in the treatment of PTSD. These findings differ from those reported by Sander, Laugesen, Skammeritz, Mortensen, and Carlsson (2019), where the use of interpreters in psychotherapy was associated with less improvement in PTSD treatment for refugees. These differences in the results may be due to variations in the use of diagnostic instruments and the types of treatment employed. In the case of the study cited, a flexible CBT approach with elements of TF-CBT (Trauma-Focused Cognitive Behavioral Therapy), stress management (SM), acceptance and commitment therapy (ACT), and mindfulness was utilized. Future research should consider different validated treatment approaches for PTSD and conduct comparisons among them.

It could be suggested that the use of interpreters does not appear to play a significant role in the administration of post-traumatic stress disorder (PTSD) treatment for refugees, and there also does not seem to be an interaction. However, despite these, it is important to acknowledge some limitations. Firstly, it is important to note that the study was conducted under routine clinical conditions, without selecting patients specifically for research purposes. Therefore, the sample reflects the diversity and complexity of everyday practice. Secondly, Due to the longitudinal nature of the study, it is expected that many individuals may drop out of the experiment. Some studies indicate that the dropout in longitudinal experiments can be high (Guo, Logan, Glueck, & Muller, K. 2013) that is why the study ends up with a small sample. However, the analyses were still conducted as planned as several studies recommend their use, while acknowledging that this comparison may lose effect size, future studies should take this into account. Finally, it was not

considered that all patients received the same type of treatment for PTSD, but rather individualized treatment based on each patient's needs. Future studies should consider specific treatments and analyze the effects of each of them with the use of interpreters.

In conclusion, the findings of this study indicate that the utilization of interpreters in the treatment of refugees does not appear to impede therapeutic progress or outcomes. Furthermore, to the best of our knowledge, this is the first study that examines the results over time, suggesting that the use of interpreters could be an important element in the long-term effects for participants. These results add to the growing body of literature supporting the effectiveness of utilizing interpreters in psychotherapy with diverse populations. Future research should delve into the specific mechanisms by which interpreters contribute to successful therapeutic outcomes and address any potential challenges that may arise in the process.

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