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Does Interpreter-Mediated CBT with Traumatized Refugee People Work? A Comparison of Patient Outcomes in East London

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Abstract. There is controversy about the value of psychological interventions offered to refugee people through an interpreter, but little empirical evidence in this field. This study compared routine clinical outcomes of three groups of PTSD patients receiving CBT: refugees who required interpreters; refugees who did not require an interpreter; and English-speaking non-refugees. The aim of the study was to ascertain whether interpreted CBT is feasible. All three groups attended a similar number of sessions and showed significant improvements after treatment. Refugees receiving treatment with and without interpreting did not differ in treatment outcomes. The findings suggest that interpreters can be used with positive outcome in treating PTSD patients with CBT. This study supports NICE (2005) recommendations that CBT should be offered regardless of language need.

Keywords: CBT, interpreters, refugees, posttraumatic stress disorder.

Introduction

This retrospective study compares routine clinical outcome of interpreter-mediated cognitive behaviour therapy (CBT) for refugees with those of monolingual therapy for refugees and non-refugees in a tertiary NHS clinic. CBT has a strong evidence base and is the treatment of choice for posttraumatic stress disorder (NICE guidelines, 2005). CBT is used in the treatment of traumatized refugees (Jankovic-Gavrilovic, d'Ardenne, Bogic, Capuzzo and Priebe, 2005, Paunovic and Ost, 2001), who often require an interpreter. The guidelines of the National Institute for Clinical Excellence in England (NICE, 2005) recommend the use of interpreters with non-English speakers. However, some authors have proposed different approaches. For example, Summerfield (1999) argues that refugees need political and social justice rather than psychotherapy. Patel (2003) posits that interpreted therapy disempowers people from non-Western backgrounds. Interpreting could be a hindrance to effective outcome. For example, the presence of a third party changes the therapeutic relationship from dyad to triad and can affect the establishment of trust and confidentiality. Interpreters are often not trained in mental health work and this can lead to poor communication (Westermeyer, 1990). Publications on the subject tend to be summaries of general clinical observations (e.g. Tribe 1999; Bischoff et al., 2003) and there appears to be no published study on the use of interpreters and their

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effect on the outcome of psychotherapy, including CBT. Many services, however, have a duty to provide care for traumatized patients of all backgrounds, and therefore it is important to establish whether the use of interpreters in CBT is both feasible and associated with improved outcomes.

Methods

Sample

The sample consisted of patients referred to an East London mental health service specializing in the psychological treatment of posttraumatic stress disorder (PTSD) between 2000 and 2004 (d'Ardenne, Capuzzo, Ruaro and Priebe, 2005). All had been referred from community mental health teams and had received a full mental health assessment from them. Their social, legal and advocacy needs were addressed by these secondary mental health services and referral was made for the alleviation of psychological distress and included those who were fully embedded in secondary mental health care. Patients facing imminent dispersal or deportation are not referred to this service; neither are patients already in psychotherapy or counselling elsewhere. Two hundred and thirty-nine patients have been seen and assessed for treatment in this clinic, of whom 98 required an interpreter. All consecutive patients who completed two or more of the three routine psychological measures pre and post treatment were included in this study ($n = 128$). All were formally diagnosed with PTSD using the CAPS (Blake et al., 1996) based on the DSM IV (APA, 1994). Refugees who had been in war or tortured were referred with multiple traumas, which were difficult to quantify. They were asked to select an index trauma on the basis of severity and accessibility. Forty-four refugee patients requiring interpreters, 36 refugee patients not requiring interpreters, and 48 non-refugee patients were included in this study. All patients in the latter two groups received all treatment sessions in English.

The term "refugee people" refers to both asylum seekers and those who have obtained *indefinite leave to remain* (refugeecouncil.org.uk). In both cases people have had to flee their country and seek refuge, which may or may not have been granted. Our use of the term "refugee people" is an inclusive term and is not limited to their legal status.

Therapists

Two BABCP accredited CBT therapists conducted the therapy throughout the 4-year study. Both were chartered clinical psychologists specialized in trauma, and trained in how to use interpreters. Each used a final year trainee clinical psychologist, who changed 6-monthly, i.e. eight trainees conducted therapy under supervision. This is a standard arrangement for the treatment of PTSD patients in an NHS setting.

Interpreters

Interpreters were resourced and accredited with the local authority and had at least one year experience in health interpreting. A total of 22 interpreters were used throughout the study period. The clinicians addressed gender, ethnicity and political sensitivities as part of interpreter allocation. The same interpreter was used throughout treatment, unless the patient requested another, which happened in four cases during their assessments. These cases,

however, are included in the study as the treatment was carried out with the same interpreter. Interpreters were provided with basic briefing in cognitive behavioural techniques and trauma focused work, specifically reliving and cognitive restructuring. They were given a copy of *Understanding your Reactions to Trauma* by Claudia Herbert (1995) and the department's *Interpreters' Protocols* (d'Ardenne, Farmer, Ruaro and Priebe, 2007).

Treatment

Standard cognitive behavioural interventions were provided (see Foa et al., 1999 and Ehlers and Clarke, 2000). The first two appointments focused on diagnosis and assessment and the following sessions on trauma-focused CBT, which included reliving and exposure to traumatic memory for all patients. They were seen weekly or fortnightly, for at least one hour, with additional time allocated for interpreted sessions.

Measures

Routine pre and post treatment measures were used to determine symptom severity and treatment outcome. The primary outcome measure was the Impact of Events Scale (IES) (Horowitz, Wilner and Alvarez, 1979), which assesses the severity of PTSD symptoms. Other measures were the Beck Depression Inventory (BDI) (Beck and Steer, 1987) and the Manchester Short Assessment of Quality of Life (MANSA) (Priebe, Huxley, Knight and Evans, 1999). One hundred and four patients completed the IES: 36 were refugees requiring interpreters, 30 were refugees without interpreters, and 38 were non-refugees. One hundred and twelve patients completed the BDI: 36 were refugees requiring interpreters, 31 were refugees without interpreters, and 45 were non-refugees. Ninety patients completed the MANSA: 31 were refugees requiring interpreters, 25 were refugees without interpreters, and 34 were non-refugees. Data on trauma history and number of treatment sessions were taken from the medical records. Although there are occasional translations of our routine psychometric tools, none has been validated for use across the communities living in East London. Therefore, in the group requiring interpretation, all measures were routinely administered orally by interpreters prior to the clinical sessions.

Data analysis

The statistical analysis was conducted on the Statistical Package for Social Sciences (SPSS.13). Percentages and number counts were used to describe categorical data while means and standard deviations described continuous variables. Paired sample *t*-tests were used for comparison between the pre and post scores on the different measures for the three patient groups. To assess the interaction effect between group and outcome, we used the General Linear Model for Repeated Measures (GLM). However, there were no significant statistical differences and they were, therefore, not reported. Throughout the paper, statistical significance is set at 95% probability level.

Results

Table 1 shows the primary source of trauma reported by each of the three patient groups. For the purposes of the statistical analysis, they were amalgamated into two categories: war/torture and crime/accident, as some of the cells have a value lower than five, but are reported in

Table 1. Primary source of trauma for each patient group

	Refugees with interpreters	Refugees without interpreters	Non-refugees	Chi-square	*df*	*p*
Accident	0	0	8	80.3	2	<.001
Crime	3	7	32			
War	17	19	1			
Torture	21	11	0			
Other	0	1	2			
Rape	3	0	1			
Terrorism	0	0	8			

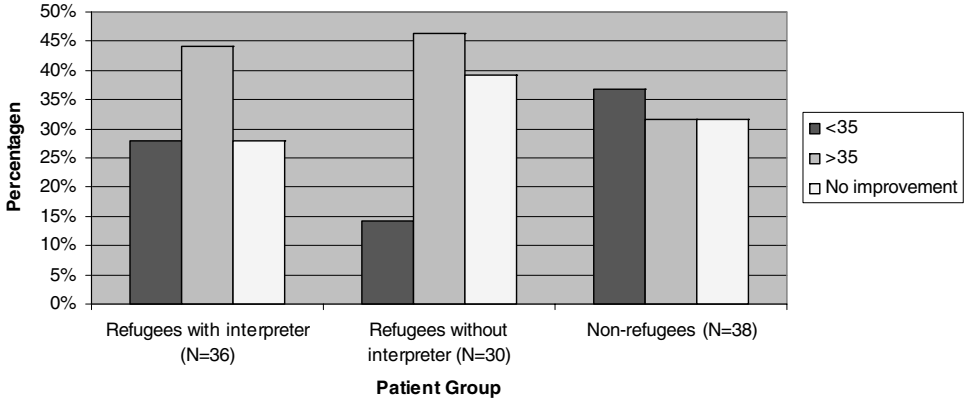

Figure 1. Improvement categories for each patient group on the IES

Table 1 in full. Refugee patients are more likely to have experienced war and torture, whilst non-refugee patients were more often the victims of crime, including terrorism and accidents. This difference is statistically significant (chi-square = 80.3; $p<.001$). However, the primary source of trauma did not significantly differ between the two refugee groups.

The mean number of sessions was 9.1 ($SD = 5.8$) for refugees with interpreters, 9.0 ($SD = 5.5$) for English speaking refugees, and 8.9 ($SD = 5.0$) for non-refugees. The difference was not statistically significant. Table 2 shows the treatment outcome for all three groups. All groups showed significant improvements on the IES, and BDI. They also improved on subjective quality of life, but the changes failed to reach statistical significance for the group of refugees requiring interpreters. The GLM revealed no significant interaction effect, indicating that there was no significant difference in the extent to which the three groups benefited from treatment.

Figure 1 shows the improvement categories for all three patient groups on the IES. All three groups show patients who improve, outnumber patients who do not, whether or not they are above or below the clinical cut-off point of 35 for PTSD diagnosis on the IES. The non-refugee group, however, has a greater proportion of patients who have improved, who are below the clinical threshold and could be regarded as being within a non-clinical population. Refugees with interpreters have proportionally more improvement than refugees without interpreters.

Table 2. Treatment outcomes for each group and all patients

	Refugees with interpreters						Refugees without interpreters						Non-refugees						All patient groups					
Measure	*N*	Mean	*SD*	*t*	*df*	*p*	*N*	Mean	*SD*	*t*	*df*	*p*	*N*	Mean	*SD*	*t*	*df*	*p*	*N*	Mean	*SD*	*t*	*df*	*p*
Pre IES	36	46.5	14.7	2	35	.024	30	51.5	14.3	2.46	29	.02	38	51.3	14.7	3.86	37	.00	104	49.7	14.6	5.1	103	<.0001
Post IES	36	40.5	15.2				30	45.2	12.9				38	39.8	18.6				104	41.6	16.0			
Pre BDI	36	38.2	9.5	4	35	.001	31	34.1	8.9	3.29	30	.00	45	32.5	13.5	5.83	44	<.0001	112	34.8	11.3	7.54	111	<.0001
Post BDI	36	32.2	9.3				31	28.0	11.3				45	22.7	12.9				112	27.2	12.0			
Pre MANSA	31	3.04	0.6	1	30	.179	25	3.18	0.9	2.8	24	.01	34	3.26	0.8	3.68	33	.001	90	3.16	0.8	4.26	89	<.0001
Post MANSA	31	3.25	0.7				25	3.50	0.7				34	3.67	0.9				90	3.48	0.8			

Discussion

This study compared outcomes for refugees who received CBT through interpreters with those of refugees and non-refugees who received monolingual CBT. Results show a significant improvement for all groups, which confirms the effectiveness of CBT in the treatment of PTSD (Ehlers and Clarke, 2000; Foa et al., 1999, 2005; Tarrier et al., 1999).

The therapeutic gains, however, are modest. These patients have severe and complex disorders and are seen in a tertiary service, serving a population with high levels of social deprivation and with a significant history of imprisonment, torture and violent crime. The outcomes may therefore be seen as encouraging, particularly as some studies with traumatized refugees have shown no improvement in treatment (Carlsson, Mortensen and Kastrup, 2005). At discharge, many of our patients are still within a clinical population, as can be seen in Figure 1, but the proportion of patients who have improved across all patient groups is similar. Interestingly, the refugee group *with* an interpreter had a higher proportion of patients who had improved than the group of refugees without, suggesting that the use of interpreters is no barrier to therapeutic outcome.

All groups had high initial scores, indicating severe symptomatology, and improved significantly on all outcome measures. The only exception was on the subjective quality of life (SQoL) measures (MANSA), where refugees with interpreters do make an improvement that does not reach statistical significance. The low SQoL for refugee people has been described extensively elsewhere (d'Ardenne et al., 2005).

The brief number of sessions for all the groups was limited by: therapeutic progress, practical access to the service, and the level of support provided by secondary mental health services after discharge. There is no evidence of an optimum number of sessions, although it would be interesting in future research to establish this for both interpreted and non-interpreted treatments.

All three groups improved and the difference of therapeutic gains between groups was not significant. Yet, non-refugees tended to improve more on all measures. The relatively small sample size limited the power of the study to detect significant differences. A larger study might reveal a statistically significant difference in treatment outcomes between refugees and non-refugees. In the interpretation of such potential differences the various primary sources of trauma would have to be taken into account. However, the main question of the paper was not to compare refugees and non-refugees, but to compare refugee patients with and without language support. These two groups had similar trauma histories and show similar treatment gains, which are each significant.

Interpreting generates additional costs. In this study the costs for interpreters were approximately €100 per therapy session, together with therapists spending 50% more of their time on each session, as well as other organizational costs (d'Ardenne et al., 2005). Interpreting is challenging; there remain issues of trust, confidentiality, disempowerment and minimal mental health training for interpreters (Westermeyer, 1990; Dearnley, 2000; Stedman, 2003; Patel, 2003).

The study was conducted under routine clinical conditions that did not select patients for the purpose of the research, and the sample reflects the diversity and complexity of everyday practice in East London. Like most trauma services (Jankovic-Gavrilovic et al., 2005) the clinic used external interpreters who were trained neither in mental health nor in CBT. These results are therefore relevant for any other services working within similar limitations. The use of

interpreters for the administration of the psychometric measures may affect their reliability and validity. There is no easy solution to remedy this problem as such measures are not validated in the many diverse communities that this clinic serves: either this practice is continued, or refugee patients are excluded from any routine psychological assessment.

Limitations

The sample is partially self-selective in as much as it represents only about a half of the entire clientele seen at the service over the study period. The range of languages seen and the ethnic origins of the clients were dynamic and diverse. The five most common languages provided by the interpreting service were Turkish, Arabic, French, Farsi and Bengali, although more than 20 other languages were used in the study period. Some patients requested interpreting in their second or third language and choice was based on the availability of interpreters and the preference of the patient. There is as yet insufficient data that one particular community do particularly well or badly; this paper addressed the general principle of interpreted work. Similarly there are insufficient data on the number of traumas per person and its impact on therapeutic outcome. All the patients in this study undertook reliving of their traumatic memory but there is no breakdown about the exact numbers of reliving sessions done within and between the groups, which might have affected outcome.

It could be argued that the quality of interpreting might have affected outcome but this has always been variable in a busy NHS clinic that employs an external agency. The authors are currently applying protocols for interpreting CBT in an attempt to standardize quality and interpreter effects. The therapist effects are less variable, as the clinicians were both accredited cognitive behaviour therapists and adhered to NICE guidelines for the treatment of PTSD.

Last but not least, the questionnaires were administered via interpreters in the group requiring interpretation, possibly undermining their reliability and validity. This is a methodological problem that affects all outcome research with refugee populations for which there is no current solution.

Conclusions

The findings suggest that the interpreting process is not a hindrance to positive outcome and that interpreter-mediated CBT with traumatized refugee people works. These findings should be taken as support for the recommendations of the NICE guidelines that, "Where language or culture differences present challenges to the use of trauma-focused psychological interventions in PTSD, healthcare professionals should consider the use of interpreters and bicultural therapists" (NICE, 2005, 1.7.2/3 p. 13).

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