

## Interpreter-Mediated Therapy for Refugees: A Need for Awareness and Training

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This brief report discusses the challenges arising from interpreter-mediated therapy in the treatment of refugees with Post Traumatic Stress Disorder (PTSD). Although the refugee population continues to grow in the United States, the treatment competency of mental health professionals working with this population has not adequately responded to this growth. As a result of the trauma often experienced by refugees many present with PTSD symptomatology and require trauma-focused mental health care. Language disparities between clinical psychologists and refugees often result in the need for interpreter-mediated therapy, yet psychologists lack awareness and relevant training in working collaboratively with interpreters to provide competent care. The complex reality of interpreter-mediated therapy can involve substantial deviations from the refugee's original message and deprive refugees from receiving adequate treatment.

Of the estimated 16 million refugees globally, over 2.5 million have been relocated to the United States (United Nations High Commissioner for Refugees; UNHCR, 2009). In addition to not speaking English (United States Department of State, Bureau of Population, Refugees, and Migration, 2001), many refugees experience forced separation from loved ones, a lack of formal education, restricted employment and housing opportunities, and discrimination from both the general population and other ethnic minorities (Iwamasa, Hsia, & Hinton, 2006). According to The United Nations High Commissioner for Refugees (1951):

A refugee is defined as anyone fearing of being persecuted for reasons of race, religion, nationality, or political opinion who is outside of the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail him- or herself of the protection of that country; or who, not having a nationality and being outside the country of his or her former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (p. 16)

Given their traumatic history and the hardships they face upon arrival in the U.S., many refugees suffer extreme distress and require trauma-focused mental health care. However, the reality is that the refugee population continues to grow in the U.S., and the psychological community has not adapted to meet the needs of this community.

### **A Rationale for Interpreter-Mediated Therapy**

There is currently a gap in the implementation of culturally relevant psychotherapy interventions for ethnic minorities. Although approximately 25% of the U.S.

population is an ethnic minority, only 7% of clinical psychologists fall into this category (Norcross, Karpiak, & Santoro, 2005). Due to this disparity, non-English speaking clients may face several challenges in their communication with English-speaking therapists, who may misperceive cultural influences. Even more, much of the language used in psychology, as well as in case conceptualization, is rooted in a Western world view and can often lead to imposing Western ideals of social convention and role expectation onto refugees (Tribe, 2007).

For refugees in particular, the inability to speak English and communicate fluently can be both frightening and disempowering (Tribe, 2008). Few refugees speak English and relatively few psychologists speak multiple languages. As such, therapists must rely on the use of interpreters to facilitate the therapeutic process (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Using interpreters, many of whom are insufficiently trained in the field of psychology, contributes to an already complex endeavor (Farooq, Fear, & Oyebode, 1997), including the erroneous interpretation of psychological symptoms and subsequent misdiagnoses. Psychologists have rigorous standards that include an ethics code, state laws, and institutional mandates, yet none of these appear to sufficiently address how to work collaboratively with an interpreter to provide competent care.

In addition to our ethical obligation to provide treatment to this population, the absence of interpreter-mediated treatment for refugees violates the standards put forth by the Office of Minority Health (OMH) for Culturally and Linguistically Appropriate Services (CLAS; OMH, 2001). In an effort to improve the health of minority populations, the OMH adopted 14 CLAS standards to address culturally competent care, language access services, and organizational support for cultural competence. While the CLAS standards have signaled an appropriate first step towards addressing the inequities of health care, the standards regarding access to language services are largely directed at policy makers and

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have, unfortunately, circumvented awareness in the field of psychology. This lack of awareness coupled with the substantial refugee population in the U.S. highlights our ethical responsibility to gain training and experience with this population.

We believe that training standards for collaboration between psychologists and interpreters have yet to be established. This absence of training is a direct result of a lack of awareness and a gap in the literature, all of which deprive a large population of refugees from receiving adequate treatment. Culturally competent treatment of refugees requires the training of both psychologists and interpreters in collaborative care. In order to generate greater awareness of this subject matter, and thereby influence the psychological community to take action, the current paper presents a brief report on interpreter-mediated therapy as it exists today. First, we seek to establish the need to provide competent care to the refugee population by illustrating their unique experiences of trauma. Second, we will address the complex reality of interpreter-mediated therapy as it relates directly to the refugee population. Finally, we provide suggestions for areas of future research and growth.

### **Understanding PTSD Experiences Among Refugees**

Although the symptom presentation of PTSD is largely cultural and dependent on race, gender, and the type of trauma experienced, many refugees exhibit enough symptoms to meet diagnostic criteria of PTSD as outlined in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [DSM-IV-TR], 2000; Keller, et al., 2006; Regel & Berliner, 2007). In addition to experiencing the intrusive, avoidant, and arousal symptoms characteristic of PTSD, other often multiculturally influenced characteristics include feelings of self-blame, guilt, shame (Drozdek, 1997), poor coping strategies, negative self-concept, and hyper-vigilance (Silove, Sinnerbrink, Field, & Manicavasagar, 1997).

Despite the universality of PTSD clinical features, the traumatic experiences of refugees are qualitatively different from the traumatic experiences of non-refugee clients (Kinzie, 2001), even those from ethnic minority backgrounds. The traumatic experiences of refugees are typically extreme (i.e., torture), prolonged, and persistent (Kinzie, 2001; Nicholl & Thompson, 2004). Literature is abundant in describing the traumatic events experienced by refugees. One Cambodian woman recounted the time she was forced to witness her husband being slaughtered while a knife was held to her throat and her life threatened if she spoke a word (Kinzie, 2001). An Iraqi Kurdish man detained by Iraq security forces was subjected to prolonged interrogations, frequent beatings, cold water dousing, suspensions off the floor for hours with his arms bent backwards, and genital mutilation for three months; he was taken to the hospital twice when his body gave way to the torment, only to be returned to the prison when he was revived (Regel & Berliner, 2007). A Rwandan woman was raped by her son as soldiers held a knife to his neck. Her

husband was forced to watch and their young children were forced to hold open her legs (Landesman, 2002). Examples such as these illustrate the extreme, prolonged, and persistent traumas refugees experience, and unlike non-refugees, the environmental realities from which they seek asylum. For refugees, everyday life equates to a continuous threat to safety; trauma is a perpetual state of existence.

As a result of severe trauma experienced by refugees, up to 86% of this population displays PTSD symptomatology (Thulesius & Hakansson, 1999). Currently, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is recognized as a first line treatment for individuals who manifest symptoms of PTSD (Bisson & Andrew, 2005). TF-CBT is an adapted model of CBT that specifically addresses PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic stress (Cohen & Mannarino, 2008; for a review, see Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004). TF-CBT has been found to be efficacious in diverse cultural backgrounds and multiple languages, as well as in the treatment of multiple traumas, sexual abuse, and traumatic grief. Despite the effectiveness of this treatment (Cohen & Mannarino, 2008; Mendes, Mello, Ventura, de Medeiros Passarella, & de Jesus Mari, 2008), TF-CBT remains unutilized with refugees.

### **The Complex Reality of Interpreter-Mediated Therapy**

Therapy would not be possible for many refugees without interpreters. The use of an interpreter allows the refugee to communicate in his or her native tongue and utilize culturally relevant linguistics to facilitate accurate communication and a comfortable working pace. Yet, the presence of an interpreter adds new dimensions to the therapeutic process, including additional factors that need to be considered in therapy. Interpreters imbue translations with corrected cultural meaning and may not interpret verbatim (Farooq, Fear, & Oyeboode, 1997). Farooq and Fear (2003) identify common interpretation errors while using an interpreter: (a) omission (a portion of the therapist's question or the client's answer is left out of the interpretation); (b) addition (the interpreter adds his or her own information into the client's response); (c) condensation (the interpreter paraphrases a client's response); (d) substitution (an interpreter replaces a concept that the therapist uses with another similar, but abstractly different concept); (e) role exchange (the interpreter asks his or her own question instead of the therapist's); (f) closed-ended questioning (the interpreter tries to shorten or simplify the questioning process by shifting the questions to a closed format); and (g) normalization (the interpreter is unsure of how to interpret information from a client and thus will attempt to provide a rationalized version of the client's response).

In addition to interpretation errors, other factors may play a role in confounding the therapeutic process. Interpreters often play multiple roles when working with clients; they are translators for language and culture, client advocates, co-workers, neighbors, social workers, and family

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members (Farooq & Fear, 2003; Raval & Smith, 2003). Multiple roles can create complications for both the client and the interpreter. If the refugee and the interpreter share the same culture, the interpreter may feel that the client's disclosure will bring shame to his or her country of origin. As a result, this is likely to lead to errors in interpretation. An additional complication arises when the interpreter has a close relationship with the client outside of therapy (i.e., family member, neighbor), which can contribute to the client withholding information for fear of embarrassment or lack of privacy. Moreover, if the interpreter has experienced a trauma, the interpretation process may lead to a re-experiencing of trauma for the interpreter.

Regardless of the interpreter's role, the task of translating communication from the refugee to the psychologist involves an unconscious act of gatekeeping (Davidson, 2000; Wadensjö, 1993). As a function of gatekeeping or coordinating communication, the message between the refugee and psychologist is altered, albeit unconsciously, by the interpreter. Though the reasons for altering the message remain unconscious, this creates an unavoidable bias in communication that is beyond the purview of the psychologist. There appears to be intrinsic and extrinsic forms of gatekeeping. Intrinsic gatekeeping reflects the interpreter's personal belief system and may reflect attempts to "communicate more clearly, avoid conflict, or present a cultural perspective different from what is given in the intended message" (Hwa-Froelich & Westby, 2003, p. 82). Extrinsic gatekeeping reflects differences in linguistic systems and variations in comprehending socio-cultural differences embedded within the context of communication (Davidson, 2000).

Though interpretation errors, multiple roles, and gatekeeping are inevitabilities of interpreter-mediated therapy, many interpreters have little or no training in these areas. While these problems may always exist to some extent, it is likely that awareness and training in these areas may limit deviations in the original communication. Hwa-Froelich and Westby (2003) acknowledge an overall lack of available educational opportunities for professional interpreters, highlighting that certification requirements are also not established. In fact, the role of the interpreter first came into play when translators were needed to facilitate political and diplomatic work. With over 300 languages spoken in the U.S. today, the role of the interpreter has since shifted to include providing services in education, medical, and community settings (Avery, 2001). Certainly, the training required for translating in a psychological setting differs from the skills required for translating in a diplomatic setting. Unfortunately, training interpreters to work in psychological settings has not caught up with the growing demand for their service.

### **Gaining Greater Awareness and Experience**

Refugees face several problems when relocating to the United States. While they face normative problems of acculturation (i.e., cultural differences and language barriers),

these problems are further exacerbated by the traumatic experiences that precipitated their relocation. The inability to meet the language and cultural demands of refugees leaves them with scant resources for treatment after relocation. The reality is that while a large refugee population suffers from PTSD, most do not receive adequate treatment.

The role of the interpreter has only recently shifted to include providing services in professional arenas outside of diplomacy. Currently, there are two forms of interpretation that appear to be consistently used in most settings: simultaneous interpretation and conservative interpretation (Hwa-Froelich & Westby, 2003). Simultaneous interpretation occurs when the interpreter translates at the same time as the client is speaking; this type of interpreting is often used for political or diplomatic work and is most common at the United Nations (Ohtake, Santos, & Fowler, 2000). Consecutive interpretation occurs when the interpreter waits to translate until the client pauses, indicating to the interpreter that it is the appropriate time to translate; this method of translation is often used in medical and educational settings. At this time, no research has examined the effect of simultaneous versus consecutive interpretation in health care settings. Research in this area could provide a strong foundation from which to develop guidelines for psychologists working with interpreters. Psychologists as well as interpreters would certainly benefit from a standard and consistent approach to interpretation. Outcome studies comparing the efficacy of TF-CBT to other trauma-focused therapies among refugee populations would also contribute to the implementation of adequate care for this population. If a best practice can be established for treating refugees, interpreter training can be tailored more effectively.

Although guidelines have been suggested for working with interpreters (see Tribe, 2007 for a review), too often these suggestions represent conceptual considerations (e.g., creating a good atmosphere to ask for clarification), rather than concrete practices (e.g., allocating time to meet with the interpreter prior to meeting with the client), for managing the relations of the psychologist-interpreter-client triad (Tribe, 2007). Yet, there remains an absence of awareness, literature, and training to target the dyadic relationship between psychologist and interpreter. Such guidelines might offer suggestions on how to effectively address issues of multiple roles, interpretation errors, and gatekeeping with the interpreter.

Awareness and advocacy serve as the foundation for new research and ultimately the clinical application of that research into training opportunities. As a new generation of emerging psychologists, we must hold ourselves to higher standards when providing treatment to refugees by bringing awareness to professionals in our field and through advocacy efforts. Graduate students interested in developing clinical experience and competency in working with interpreters to treat refugees may want to first begin by becoming involved in local community outreach and advocacy efforts and by demanding training opportunities from professors, leaders in the field, American Psychological Association (APA)

division representatives, and the American Psychological Association of Graduate Students (APAGS). While a seemingly daunting task, APA divisions have historically been formed in the same manner. It is our hope that this paper will inspire small efforts in each of its readers that, in turn, will launch future efforts in research and clinical training.

### References

- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV TR (4th, text revision ed.)*. Washington, D.C.: American Psychiatric Association .
- Avery, M. B. (2001). *The role of the health care interpreter: An evolving dialogue*. The National Council on Interpretation in Health Care Working Paper Series, April 2001.
- Bisson, J., & Andrew, M. (2005). Psychological treatment of post-traumatic stress disorder (PTSD) (Review). The Cochrane Collaboration. John Wiley & Sons, Ltd.
- Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). *How to Implement Trauma-Focused Cognitive Behavioral Therapy*. Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.
- Cohen, J., & Mannarino, A. (2008). Trauma-Focused Cognitive Behavioural Therapy for Children and Parents. *Child and Adolescent Mental Health, 13*, 158–162. doi: 10.1111/j.1475-3588.2008.00502.x
- Davidson, B. (2000). The interpreter as institutional gatekeeper: The social- linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics, 4*, 379–405.
- Drozdek, B. (1997). Follow-up study of concentration camp survivors from Bosnia-Herzegovina: Three years later. *Journal of Nervous and Mental Disease, 185*, 690-694. doi: 10.1097/00005053-199711000-00007
- Farooq, S., & Fear, C. (2003). Working through interpreters. *Advances in Psychiatric Treatment, 9*, 104-109.
- Farooq, S., Fear, C., & Oyeboode, F. (1997). An investigation of the adequacy of psychiatric interviews conducted through an interpreter. *Psychiatric Bulletin, 21*, 209-213. doi:10.1192/pb.21.4.209
- Hwa-Froelich, D. A., & Westby, C. E. (2003). Considerations When Working with Interpreters. *Communication Disorders Quarterly, 24*, 78-85.
- Iwamasa, G. Y., Hsia, C., & Hinton, D. (2006). Cognitive-behavioral therapy with Asian Americans. In G. Y. Iwamasa (Ed.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. (117-140). Washington, DC US: American Psychological Association.
- Keller, A., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., Porterfield, K. (2006). Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *The Journal of Nervous and Mental Disease, 194*, 188-194. doi:10.1097/01.nmd.0000202494.75723.83
- Kinzie, D. (2001). Psychotherapy for massively traumatized refugees: the therapist variable. *American Journal of Psychotherapy, 55*(4), 475-490.
- Landesman, P. (2002, September 15). A woman’s work. *New York Times*, 82-131.
- Mendes, D., Mello, M., Ventura, P., de Medeiros Passarella, C., & de Jesus Mari, J. (2008). A systematic review on the effectiveness of cognitive behavioral therapy for posttraumatic stress disorder. *International Journal of Psychiatry in Medicine, 38*, 241-259. doi:10.2190/PM.38.3.b
- Miller, E., Martell, Z., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The Role of Interpreters in Psychotherapy With Refugees: An Exploratory Study. *American Journal of Orthopsychiatry, 75*, 27-39. doi: 10.1037/0002-9432.75.1.27
- Nicholl, C., & Thompson, A. (2004). The psychological treatment of post traumatic stress disorder (PTSD) in adult refugees: a review of the current state of psychological therapies. *Journal of Mental Health, 13*(4), 351-362. doi:10.1080/09638230410001729807
- Norcross, J., Karpiak, C., & Santoro, S. (2005). Clinical psychologists across the years: The division of clinical psychology from 1960 to 2003. *Journal of Clinical Psychology, 61*(12), 1467-1483. doi:10.1002/jclp.20135
- Office of Minority Health. (2001) *National standards on culturally and linguistically appropriate services (CLAS) in health care final report*. Retrieved March 7, 2011, from <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>.
- Ohtake, Y., Santos, R. M., & Fowler, S. A. (2000). It’s a three-way conversation: Families, service providers, and interpreters working together. *Young Exceptional Children, 4*(1), 12–18.
- Raval, H., & Smith, J. (2003). Therapists' experiences of working with language interpreters. *International Journal of Mental Health, 32*(2), 6-31.
- Regel, S., & Berliner, P. (2007). Current perspectives on assessment and therapy with survivors of torture: the use of a cognitive behavioral approach. *European Journal of Psychotherapy and Counseling, 9*, 289-299. doi:10.1080/13642530701496906
- Silove, D., Sinnerbrink, I., Field, A., & Manicavasagar, V. (1997). Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry, 170*, 351-357. doi:10.1192/bjp.170.4.351
- Thulesius, H., & Hakansson, A. (1999). Screening for posttraumatic stress disorder symptoms among Bosnian refugees. *Journal of Traumatic Stress, 12*, 167-174. doi:10.1023/A:1024758718971
- Tribe, R. (2007). Working with interpreters. *The Psychologist, 20*(3), 159–161.

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- Tribe, R., & Thompson, K. (2008). Working with Interpreters in Health Settings: Guidelines for Psychologists. *British Psychological Society*, October, 2008.
- United Nations High Commissioner for Refugees. (2009). *UNHCR annual reports shows 42 million people unrooted worldwide*. Retrieved from <http://www.unhcr.org/4a2fd52412d.html>.
- United Nations High Commissioner for Refugees. (1951). *Convention and protocol relating to the status of refugees*. Geneva, United Nations.
- United States Department of State, Bureau of Population, Refugees, and Migration. (2001, October 17th). *Fact Sheet: U.S. Refugee Admissions and Resettlement Program*. Retrieved November 9th, 2008, from <http://www.state.gov/g/prm/rls/fs/2001/5412pf.htm>.
- Wadensjö, C. (1993). The double role of a dialogue interpreter. *Perspectives: Studies in Translatology*, 1, 105–121.