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A Comparison of Treatment Outcomes Among Pediatric Hispanic Clients Using and Not Using Language Interpretation Services

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MS, Walden University, 2019

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Dissertation Submitted in Partial Fulfillment

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Abstract

Many families immigrating to the United States come fleeing adverse conditions in their home countries. Conditions such as war, political oppression, and economic hardship frequently result in a need for mental health services. This includes not only the adults in the family but also the children. However, because of their limited English proficiency, their access to mental health services frequently requires the use of interpretive services (IS). The body of knowledge on the use of IS in counseling is limited. The use of IS must be seen from a cultural perspective, hence Ridley et al.'s process model of multicultural counseling competency supports this research where IS is seen as a cultural broker. There is a dearth of research examining the use of IS in providing counseling to children. This ex post facto study used de-identified data from clinical records (n=36) to compare the variable of treatment outcomes of pediatric and adolescent clients, ages 4-17 years, who did and did not receive IS. A two-way repeated measure analysis of variance was used to address the research question to see if there were differences in treatment outcomes between clients who used IS and those who did not over time. The dependent variable was treatment outcomes and independent variables were the presence or absence of IS and time. This study found that there were no significant differences in treatment outcomes between groups. Findings from this study confirm that IS services may help counselors in achieving beneficial outcomes even when working with children who cannot directly communicate with counselors in their languages.

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Dedication

To my parents, thank you both for supporting and encouraging me to pursue my dream.

To my dear wife and children, I know this journey was long, and it was one filled with many expectations to complete. You all continue to amaze me with your patience and support. I could not ask for a better team. Thank you for believing in me.

Acknowledgments

As I write this recognition, I want to start by identifying the leadership, guidance, and expertise of Committee Chair Dr. Arden Gale. I am deeply indebted to, and I want to share my deepest appreciation to Dr. Gale. I know that the outcome of this dissertation would not have been possible without your expertise and encouragements. You have been an exceptional educator to me both as a student in your research class and an extraordinary chair with brilliant mentorship capability during my dissertation process. My understanding of research design, statistical testing, and data analysis is directly the result of your teaching. Thank you today, tomorrow, and forever.

I cannot close this chapter without mentioning Dr. Kathy Coule, who was the committee member of this dissertation. Thank you for being patient with me, for encouraging me, and for guiding me during this work. Dr. Coule was instrumental in my counselor education training. During my journey through this program, I was fortunate to learn and benefit from Dr. Coule's expertise in clinical skills and supervision. To this day, Dr. Coule's teachings remain with me as a counselor and a clinician. Thank you!

I would like to also appreciatively acknowledge the expertise and guidance of Dr. Rebecca Cowan who was the university research reviewer for this dissertation. Thank you!

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Chapter 1: Introduction to the Study

Introduction

Due to ever-increasing movements of migration to the United States (U.S.) within the last three decades (Migration Policy Institute [MPI], n.d.), there is a growing number of families in the United States who have reported limited English proficiency (LEP). As many have fled from harrowing circumstances and crises, they often develop mental health issues resulting from economic and political crisis (Solberg et al., 2020). Not only the parents, but also the children frequently experience symptoms of mental health issues. For these children to receive treatment, it is necessary to use interpretive services (IS) in counseling. However, it is not known how the use of IS may influence treatment of children receiving mental health counseling.

Using IS provides new opportunities for counselors to conceptualize treatment issues from cultural lenses (Chang et al., 2021). When counselors lack fluencies in clients' native languages, it may restrict how information shared by clients is understood by counselors. Having an interpreter in the office provides an opportunity where counselors can understand cultural meanings of symptoms through having interpreters as allied cultural brokers. This method of application of IS services acts as a vehicle that facilitates those communications that accurately present clients' descriptions of symptoms and supports counselors' multicultural counseling skills.

Although this use of IS has a clear potential for benefits, there are also inevitable challenges with the use of any communication assistance in counseling settings (Woodward et al., 2020). With IS, the obvious concern is that communication structure is

changed from the traditional dyad to triadic communications (Raval & Smith, 2003). This change sequentially may lead to (a) inaccuracy in information sharing, (b) confusion in treatment processes that lead to client retention issues, and (c) ethical concerns (Raval & Smith, 2003).

The current body of literature on using IS in counseling has mainly focused on adults with LEP seeking mental health services (Amouyal et al., 2020, Baker et al., 2015, Gartley & Due, 2017). The research has addressed many barriers and challenges with using IS in counseling settings (Asfaw et al., 2020, Hsieh, 2015, Sander et al., 2019). Many of these barriers have been communicated in qualitative studies (Amouyal et al. 2020; Asfaw al. 2020; Floyd et al. 2016; Jidong et al, 2020; Paone & Mallot, 2008; Woodward et al. 2020) that examined counselors' and clients' perspectives on how the addition of IS has altered treatment processes. There are only a few key quantitative studies (Bischoff et al., 2003; Brune et al., 2011; d'Ardenne et al., 2007; Lambert & Alhassoon, 2015; Sander et al., 2019; Schulz et al., 2006) that examined the use of IS in counseling adults which provided mixed results as to the effectiveness of IS. Van der Rijken et al. (2016) examined quantitative data from youth receiving IS services. To date, this is the only quantitative study focused on youth available in the IS literature.

This study contributed to Van der Rijken et al.'s quantitative study examining treatment outcomes of pediatric and adolescent clients of ages 4-17 years by comparing those who were speakers of English and those with LEP who were provided IS (Van der Rijken et al., 2016). The completion of this study was important as it was the only one of its kind conducted in the U.S. to provide greater understanding on how treatments

delivered through IS compare in quality to traditional therapeutic interventions in pediatric and adolescent clients of ages 4-17 years. If IS helps increase treatment effectiveness, mental health needs of pediatric and adolescent clients of ages 4-17 years and their families would be addressed more appropriately.

This chapter focuses on creating the groundwork that supports the necessity of this study. At first, the chapter briefly reviews the body of knowledge from quantitative research examining the use of IS in mental health counseling. Within this chapter, clear determinations are made on methodology, variables of interest, and how they complement one another. Research questions as well as hypotheses that guided the direction of the study are also communicated. Other sections of this chapter include the conceptual framework, nature of the study, helpful definitions, scope, limitations, and significance.

Background

Studies focused on IS were evaluated to add supporting evidence to the need for research on the use of IS service in the mental health counseling of pediatric and adolescent clients of ages 4-17 years with LEP. Of the studies that explored IS impact on counseling treatments, those followed the arch of (a) case studies, (b) qualitative research studies, (c) quantitative research studies, and (d) literature reviews (Amouyal et al., 2020, Asfaw et al., 2020, Baker et al., 2015, Bischoff et al., 2003, Fennig & Denov, 2021, Floyd et al., 2016, Gartley & Due, 2017, Hsieh, 2015, Jidong et al., 2020, Paone & Malott, 2008, Raval & Smith, 2003, Sander et al., 2019, Searight & Armock, 2013, Woodward et al., 2020). A more thorough review of these studies was presented in the

literature review. This section focused on the quantitative studies that led to my proposed research. In these key quantitative studies (Bischoff et al., 2003; Brune et al., 2011; d'Ardenne et al., 2007; Lambert & Alhassoon, 2015; Sander et al., 2019; Schulz et al., 2006; Van der Rijken et al. 2016), data were gathered from adults who had LEP; frequently these research participants were identified as refugees.

In 2003, Bischoff et al. completed one of the first few quantitative studies that provided context into how IS facilitates treatment processes in refugee clients. Bischoff et al. examined whether IS was helpful to refugee participants who had reported trauma in Geneva, Switzerland. The use of IS was directly correlated with the amount of information participants were able to share about their symptom and treatment needs. Bischoff et al. found that IS enabled effective communication which allowed clinical providers to thoroughly evaluate needs of refugee clients.

Schulz et al. (2006) provided one of the few U.S. studies that included IS in counseling. Participants were adults who were identified as refuges from Afghanistan and Bosnia-Herzegovina who had symptoms of post-traumatic stress disorder (PTSD). The purpose of the study was to determine if cognitive processing therapy (CPT) was an effective treatment. The use of IS services in counseling was peripheral in Schultz at al.'s study but they noted that about half the clients used IS. As part of their results, they concluded clients who required IS support had equal levels of symptom reduction as those clients who directly communicated with their counselors.

In a study conducted in England, d'Ardenne et al. (2007) appeared to first directly address the effectiveness of IS services in providing cognitive behavior therapy (CBT) to

patients identified as refugees with symptoms of PTSD. Using several standardized assessment instruments, pre- and post-treatment symptom levels were compared among 44 refugee clients requiring IS, 36 refugee clients not requiring IS, and 48 nonrefugee clients. d'Ardenne et al. found the application of IS provided opportunities to support client needs using common treatment approaches even when language barriers were present.

In one unique study, Brune et al. (2011) evaluated how IS mediates mental health treatment delivery in that the quantitative study evaluated participants that were recruited from both Sweden and Germany. Like with other preceding quantitative studies examining IS services (Bischoff et al., 2003; d'Ardenne et al., 2007; Schulz et al., 2006), Brune et al. also evaluated the effectiveness of IS in clients needing treatments for PTSD symptoms. The 190 sample members were evaluated in two groups, where one group received IS while the other did not involve IS use. Findings from this study were that the application of appropriate IS allowed clients to experience similar treatment efficacies as with the group that did not require IS support.

In 2015, Lamber and Alhasson conducted a meta-analysis of 12 randomized controlled trials to estimate the effect size of trauma-focused therapies for reducing symptoms of PTSD and depression among refugees. Again, the use of IS in treatment was somewhat peripheral to their purpose, but they did find that the inclusion of IS services did not influence effect sizes, supporting that using IS services can result in equivalent outcomes experienced by clients for whom IS services are not needed.

To further add to the argument of whether IS implementation changes treatment processes in clients with language barriers, Van der Rijken et al. (2016) compared crime rates of two groups of youth where only one group required IS support in the Netherlands. Both groups were offered treatment services by therapists with multisystemic therapy (MST) trainings. Van der Rijken et al. reported that, because outcomes in crime rates for both groups were similar at posttreatments, IS must have been effective enough to result in those comparable outcomes.

Sander et al. (2019) focused specifically on the use of IS among adults in psychotherapy. They compared the patient records of refuges in Demark who received CBT for symptoms of PTSD, depression, anxiety, and somatization. They also looked at quality of life and general functioning. Of these, 217 did not use IS services while 375 used IS. Sander et al. found that those using IS had less improvement in mental health than those who did not need IS. They noted using IS delayed communication processes, thereby delaying treatment processes.

This dissertation added a new insight to the body of literature in that it examined treatment outcomes in mental health work with pediatric and adolescent population between ages 4-17 years. Unlike findings shared in the above-mentioned quantitative studies that shared perspectives on how IS facilitates treatment work in mental health treatments with adults, work with the pediatric and adolescent population involved more complex therapeutic considerations that have not been explored. For example, treatment processes and outcomes were contingent on parents of those pediatric and adolescent clients maintaining full participations by bringing clients to appointments. In the presence

of IS, parents' views on IS effectiveness might be a significant indicator of whether appointments are kept. Work with children in the presence of IS also required additional parental involvement during treatment delivery. One of those involvements was relying on parents to participate in intake and treatment planning stages as parents were more able to share detailed accounts of symptoms of concern. There were other key considerations of how IS could influence treatment needs in pediatric and adolescent population, ages 4-17 years, that included developmental process that have not been comprehensively evaluated in currently available literature (Clark, 2018). The completion of this study was vital to answering and understanding how pediatric treatment outcomes were influenced by IS presence.

Problem Statement

Today, more than 5.5 million pediatric and adolescent clients are at risk for mental health conditions that require treatments due to conditions that deal with resettlement uncertainties (Think Global Health, n.d.). While available quantitative studies have provided thoughts on how treatment work is facilitated by IS when counseling adult clients (Bischoff et al., 2003; Brune et al., 2011; d'Ardenne et al., 2007; Lambert & Alhassoon, 2015; Sander et al., 2019; Schulz et al., 2006), studies that address children with LEP with mental health treatments needs were fewer.

The use of IS to deliver quality mental health care has been an important discussion, especially when providing services to communities who report identifying with cultures and languages other than the national mainstream culture (Shrestha-Ranjit et al., 2020). Prior to IS availability, persons with LEP, like many in the Hispanic

community, did not seek mental health services even though mental health issues have been reported to be prevalent in that population (Anderson et al., 2017). Ever since the inclusion of IS in mental health delivery processes, underserved communities, such as the Hispanic community, have benefited from expanded access to quality care (Garcia-Jimenez et al., 2019). As a result of the use of IS in counseling, members of this community now have a broader access to mental health care both in person and via telehealth options from highly diverse clinical providers (Ohtani et al., 2015). Because of those dramatic shifts in clinical services, it was important to examine whether IS resolved the communication issues that influence treatment outcomes when language barriers are present. This study focused on this primary concern dealing with mental health care in pediatric and adolescent clients of ages 4-17 years with LEP.

Purpose

The purpose of this study was to determine if pediatric and adolescent (ages 4-17 years) counseling, delivered with the use of IS can reflect the same: (a) client progress in treatment and (b) treatment outcomes as counseling delivered with no IS needed. This study followed a quantitative ex post facto design (Edmonds & Kennedy, 2017) that focused on clients with specific diagnoses of anxiety, attention deficit hyperactivity disorder (ADHD), depression, and disruptive mood dysregulation disorder who needed IS services in counseling and those who did not. Secondary data records obtained from an outpatient mental health facility was used for this study. The examination of those records answered the question of whether dependent variable of treatment outcome was different based on independent variables of IS status and time.

Research Questions and Hypotheses

RQ1: Are there differences in overall treatment outcomes when clients ages 4-17 receive clinical services with the presence of IS compared with clients ages 4-17 who receive clinical services without the need for IS through Youth Outcome Questionnaire measurements?

$H_0$1: There is no statistically significant differences in overall treatment outcomes when clients ages 4-17 receive clinical services with the presence of IS compared with clients ages 4-17 who receive clinical services without the need for IS through Youth Outcome Questionnaire measurements.

H_a1: There will be differences in overall treatment outcomes when clients ages 4-17 receive clinical services with the presence of IS compared with clients ages 4-17 who receive clinical services without the need for IS through Youth Outcome Questionnaire measurements.

Framework

This study used Ridley et al.'s (2021) process model of multicultural counseling competence as its conceptual framework. Ridley et al.'s model focused counselors' multicultural counseling skills and cultural integration to counseling work. The model proposed that counseling unfolds in three phases: (a) preparation, (b) intake and in-sessions, and (c) termination. This research focused on the latter two stages. The model addressed the counseling operations of: (a) preparation, (b) developing a therapeutic alliance, (c) adapting interventions, and (d) evaluating process and outcome. This research focused on the latter operation of evaluating process and outcome. Key to this

research was the underlying idea that all progress in counseling was supported by understanding of culture. This coupled with the model of IS in counseling which has evolved from being an interpreter to being a cultural broker (Ridley et al., 2021).

Earlier opinions on the use of IS emphasized complete transfer of information through methods called “blackbox” (Becher & Wieling, 2015). Interpreters were viewed as a nonentity whose sole purpose was to provide translation from one language to another (Becher & Wieling, 2015). Clinicians expected interpreters to translate entirely and exactly what was being shared during therapy conversations (Becher & Wieling, 2015). The “blackbox” approach did not consider how information flow is altered between languages nor how language and culture are inextricably linked (Becher & Wieling, 2015). Another important point of consideration was how LEP clients understand their symptoms of mental illness and how they convey them was rooted in their cultural backgrounds (Becher & Wieling, 2015). The “blackbox” approach was associated with alterations of counseling communication patterns as clients shared their symptoms with providers (Becher & Wieling, 2015).

These pitfalls fueled the arrival of a newer approach to IS called the “cultural broker” model (Ridley et al., 2020). Learning from previous deficits seen with the “blackbox” approach, the cultural broker model considers interpreters as not only being individuals who have capacities to speak clients’ languages, but as individuals who are familiar with cultural values and teachings of the clients so that the translation of information between languages is conveyed to encompass cultural considerations (Oquendo, 1996; Tribe & Tunariu, 2009; Santiago-Rivera, 1995; Westermeyer, 1990).

That theme was confirmed by Chang et al. (2021) in a study that evaluated clients' abilities to develop therapeutic alliances through presence of interpreters. Participants of that study shared that, in addition to being able to verbally communicate with their providers, the presence of interpreters as cultural brokers provided opportunities to where providers' tone of speech matched clients' necessities in clinical presentations (Chang et al., 2021).

The implementation of this cultural broker model can be achieved through process model of multicultural counseling Competence (Ridley et al., 2021). By serving as a cultural broker, IS services extend beyond the translation of languages and aids counselors in understanding the cultural background of their clients and the meaning they ascribe to their mental health issues. As Ridley noted the ". . . model aims to provide guidance on the translating of cultural knowledge about clients into action and tailoring of treatment to them as individuals" (Ridley et al., 2020, p. 542).

When clients can make deeper connections between issues presented in therapy and other contributing factors that may be present in their lives outside of therapy, they are then much more likely to work through issues of concern (Schweitzer et al., 2013). To be able to make those connections, clients and counselors will need to bring a lot of energy to work together to reflect on issues presented and process them so that challenges maybe resolved in a manner that is culturally inclusive. A more detailed discussion about this model was provided in Chapter 2.

Nature of the Study

My study followed ex post facto design in that I gathered data from existing de-identified client records from a clinic. The records covered the years 2020 to 2021. The purpose of the study was to gain a deeper understanding of how treatment processes and treatment outcomes may be influenced when IS options are used to communicate with pediatric and adolescent clients, ages 4-17 years, who are not proficient in English and who identified as Hispanic. To be included in this study, they experienced symptoms of either: (a) depression, (b) anxiety, (c) attention deficit hyperactivity disorder (ADHD), and (d) disruptive mood dysregulation disorder and were typically in treatment from 6 months to a year. Two groups, where one has used IS and the other did not, were compared in this examination. Given the availability of de-identified client records of those who did and did not use IS to support counseling, it made good sense to choose a quantitative approach as that allowed comparisons to be made (Kunie et al., 2017). To answer the research question, a repeated measures analysis of variance (ANOVA) was conducted on the results of the Youth Outcomes Questionnaire (Y-OQ 30.2) taken at entry into treatment and then at three, six, and nine months. These measurements provided how presence or absence of IS contributed to treatment processes in participants according to diagnoses.

Definitions

Diagnosis

Specific mental health disorders identified among youth, to include: (a) depression, (b) anxiety, (c) attention deficit hyperactivity disorder (ADHD), and (d)

disruptive mood dysregulation disorder. The diagnostic criteria aligned with that of the DSM-5 (American Psychiatric Association [APA], 2013).

Interpretive services (IS)

IS is used in one-on-one counseling situations when the client is not sufficiently proficient in English to be understood by the counselor and/or to understand the counselor. IS services are provided by professional interpreters. It should be noted that any given interpreter may or may not be engaged throughout clients' treatment, that is, clients and counselors may have to work with various interpreters throughout any client's treatment. Interpreters have been valuable members of treatment team that support clients and families communicate their presenting mental health concerns (Chang et al., 2021).

Treatment Outcomes (TO)

TO speaks to objective changes in symptoms due to the treatment process. TO is measured through requesting clients to complete Youth Outcome Questionnaire (Y-OQ 30.2) for pediatric and adolescent clients (ages 4-17 years) containing 30 items.

Mental health provider

The terms, "clinicians, providers, counselors, or therapists" have been used in this dissertation to describe professionals working in the mental health field who are offering clinical counseling services.

Assumptions

The data from this study was collected from de-identified client records. For this study, it was assumed that the clinicians who provided input to these records were accurate in their entries. Also, it is assumed that the level of impairment of clients who

have been given a specific diagnosis was about the same, and the symptomology aligned with that described in the DSM-5 (American Psychiatric Association [APA], 2013). For example, clients who have been diagnosed with depression, who are not proficient in English, were considered to have the same level of symptoms as clients who have been diagnosed with depression who were proficient in English. Additionally, it was assumed the IS provided were of equivalent accuracy and quality. It was assumed IS extended beyond a strict word for word interpretation of client concerns and extended to the cultural broker model. It was assumed that the associated mental health providers were adequately trained and prepared to use IS in providing counseling. These above-mentioned assumptions were necessary as this study was not involved in the data collection or treatment processes. This study used existing data that has been made available.

Scope and Delimitations

It was acknowledged that from ages 4 to 17 years, pediatric and adolescent clients are developing cognitive and language skills which influence their communication abilities (Clark, 2018). Developments of these skills were not the focus of this study. The terminologies used to describe the topic of the study including "IS, language barriers, or communication barriers," may be wide-ranging and overlap with other forms of communication processes. With those considerations in mind, communication barriers dealing with hearing limitations, cognitive impairments, or in medical settings addressing problems of physical health were excluded from this study. This study examined the use of IS services in pediatric and adolescent counseling settings to provide counselors a

means of communicating with clients who have LEP. This study only considered clients who identify as Hispanic. Therefore, readers of this study should consider these limitations when evaluating generalizability due to restrictions based on diagnoses and region.

The study did not consider other issues relevant to the use of IS services in counseling such as (a) the training and preparedness of the mental health services providers in using IS and (b) the qualifications of those delivering the IS.

Limitations

This study considered the data from de-identified client records from a single clinic in a central city area in the United States where the mainstream cultural language is English. The clients who required IS services were Spanish speakers from a variety of cultural backgrounds. Therefore, conclusions made at the end of this study were limited to how IS services influence treatment processes among Spanish-speaking clients. Additionally, because this was an ex post facto study, there were concerns for internal validity such as selection. The inclusion criteria for this study required that participants must have had remained in counseling for one year to be selected for the study. Clients who may have left counseling less than a year were not in the study.

Significance

Increasing number of migrations to the U.S. (Migration Policy Institute [MPI], n.d.) has led to more people needing IS to communicate during their counseling sessions. In the absence of IS those individuals may have limited or no access to mental health care. However, there is a gap in the literature regarding the impact and effectiveness of

IS services, specifically in the provision of mental health counseling services to pediatric and adolescent clients, ages 4-17 years, who have LEP and need to use IS services.

This study examined if using IS services in counseling can help clients achieve the same treatment outcomes as pediatric and adolescent clients who did not need IS services. IS allowed those persons greater access to those counseling services, and this study helped determine if it allowed them the full the benefits to be had from those services. This was the first research study to examine the effectiveness of counseling services provided using IS to pediatric and adolescent clients, ages 4-17 years, with LEP in the United States. Counselors and policymakers can reflect on the outcomes of this study and use it as a guidance tool in their efforts to establish effective pediatric mental health treatment programs.

Chapter Summary

This chapter outlined how increasing migrations have created a concern about the rise of LEP and its implications in the delivery of counseling services. In the United States, clients who have LEP, are limited in their abilities to benefit from mental health services. This is specifically a concern as mental health issues are more prevalent in clients with migration histories (Anderson et al., 2017; Solberg et al., 2020). In addition to mental health challenges faced by adults with LEP and with migration histories, pediatric and adolescent clients of those families are impacted by those migration challenges. Therefore, appropriately allocating mental health treatment needs using IS for children is equally vital. To date, this treatment need has not been addressed in the literature.

Moreover, a conceptual framework that informed mechanisms of information flow with the use IS was described. In that framework, the mechanics of information flow under two assumptions were presented. These were the “blackbox” and cultural broker model (Becher & Wieling, 2015, Ridley et al., 2020). The chapter then provided a brief insight into how the blackbox approach lacked cultural integration into the information flow process. It also pointed out how this cultural integration was present in the cultural broker model.

Additionally, the chapter described how the extent of IS use was helpful to support mental health services. Using a two-group comparison approach, research questions that examine selected diagnoses were shared. These questions particularly inquired about how treatment outcome changed with the presence of IS through use of secondary data analysis. In Chapter 2, a more thorough examination of the available literature was conducted to establish IS influence in mental health counseling treatment.

Chapter 2: Literature Review

Introduction

Recent international crises have led to a global flow of refugees in need of mental health services to support their transitions from often traumatic pasts to integration into new cultures (MPI, n.d.). Language interpretation issues are identified as a core problem both in Dubus and LeBouef's (2019) study of refugees' use of community health services in the United States. and in White et al.'s (2019) study of the same in Australia. Due to increasing trends of migration to the United States within the last three decades (MPI, n.d.), there is a growing number of people who report LEP. This shift in the population creates a growing demand to provide counseling services to individuals who are not proficient in English, which, in turn, causes an increase in the reliance of IS in delivering counseling. It is therefore important to understand how the addition of IS influences treatment processes and outcomes.

IS are defined as professionals who specialize in assisting with communications between clients and mental health professionals (Boyles & Talbot, 2017). The body of knowledge of the use of IS in delivering counseling services has largely been developed globally within the last 20 years. It began with identifying opportunities and barriers usually via case studies, qualitative studies, and literature reviews (Amouyal et al. 2020; Asfawetal al al. 2020; Floyd et al. 2016; Jidong et al, 2020; Paone & Mallot, 2008; Woodward et al. 2020). Quantitative studies examining outcomes have provided support for the benefits of IS (d'Ardenne et al., 2007; Van der Rijken et al. 2016). As the research has developed, recommendations for best practices have evolved. In addition to those

studies focusing on outcomes not being completed in the United States, they also did not evaluate how IS influenced treatment outcomes in pediatric and adolescent clients and in specific diagnoses like the ones that are of focus for this study.

The following literature review was completed to support a comparison of the outcomes of pediatric and adolescent clients from one outpatient mental health facility who have been diagnosed with depression, anxiety, ADHD, and disruptive mood dysregulation disorder. Within this group of clients, some of them reported using IS while others received treatments without IS. The focus of this study was on understanding how IS contributed to treatment outcomes. This study was different from previous work because it is conducted in the United States. and focused on understanding how IS directly correlated with treatment outcomes in a comparison analysis under a few selected diagnoses.

Within this chapter, major sections discussed were: (a) strategies that have been used to search for related literature, (b) the conceptual framework for the study, and (c) literature findings that speak to the use of IS in counseling. The report of the current body of knowledge included: (a) barriers and challenges to working with IS, (b) benefits of working with IS, and (c) recommendations for best practices when working with IS.

Literature Search Strategies

Since this study was specific to pediatric and adolescent counseling treatment in the presence of IS in mental health counseling, search of the professional literature was narrowed to studies discussing counseling when language proficiency issues were determined. During this search process, I found studies that discussed the use of IS when

working with clients who are dealing with hearing disabilities (Collins, 2021; Welch, 1998). I also found studies that focused on comparisons between use of professional and ad hoc or family interpreters (Elkington & Talbot, 2016; Hagan et al., 2013; Hagan et al., 2020). Since these areas were not the focus of my study, those publications were excluded from the literature used to support my study. I included in this literature review studies done both internationally and in the U.S. that addressed using professional IS to support either medical care or counseling.

I have used the databases "APA PsycInfo", "MEDLINE with Full Text", and "socInDEX with full Text". Key search terms that were used included *language barriers to mental health, interpreter services, insufficient interpreter services in counseling, counseling or counsel*, treatment outcomes and interpretation in counseling, interpreter process, communication process, and interpreter use in mental healthcare settings.* The literature report generated was limited to peer-reviewed studies published between1995 to 2021. In addition to reviewing those studies, I have also reviewed books that addressed the understanding of counseling communication processes. Moreover, my dissertation chair, who is well-versed about my topic, provided me additional studies that spoke to core issues that were of importance to my study.

Conceptual Framework

This study used Ridley et al.'s (2021) process model of multicultural counseling competence as its framework. While determining this framework, I have reviewed two competing models, which are "black box" and "cultural broker." Both explained how IS influences counseling work.

Becher and Wieling (2015) explained two distinct approaches of how IS could be used to deliver services to clients with different cultures and languages. In one of those approaches, which has now evolved, a verbatim interpretation of session content known as “black box” was described (Becher & Wieling, 2015). Although still helpful, the concern with the “black box” approach includes possible confusion resulting from direct transliteration of clinical information to client languages or from client languages (Oquendo, 1996; Tribe & Tunariu, 2009; Santiago-Rivera, 1995; Westermeyer, 1990). An additional concern is that clients may not receive culturally competent care as interpreters are not able to broker communication of cultural contents through this exact translation (Becher & Wieling, 2015). Those limitations associated with “black box” fueled a new approach to interpretation referred to as “cultural broker” being formed (Oquendo, 1996; Tribe & Tunariu, 2009; Santiago-Rivera, 1995; Westermeyer, 1990).

The distinction found with the “cultural broker” approach was that interpreters assist with more than direct transliteration of session information, which was a step further than what was offered with the “black box” option (Weidman, 1975). This argument about interpreters being able to assist with more than translation of language was evident in the work printed by Chang et al. (2021). In their study, use of the cultural broker model promoted clients and providers to work together at higher comprehensive levels. Client participants from that study who experienced LEP shared that, despite the presence of language differences, they were still able to communicate culturally relevant information about their treatment needs to their providers (Chang et al., 2021). That level of communication allowed providers to recognize various meanings of information

shared by clients, which then supported clients resulting in them feeling validated (Chang et al., 2021).

While the described approach of how IS can assume the role of a cultural broker is promising, a question to consider is how counselors can maximize the approach in clinical settings. Ritley et al. (2021) provided a roadmap referenced as "process model" that explained how counselors can maximize cultural incorporations in counseling settings. The model was built on two foundations. In one of those foundations, Ritley et al. (2021) talked about three clinical phases. These phases were preparation, therapeutic work, and closing (Ritley et al., 2021). Ritley et al. also explained external ways of how providers can effectively incorporate deep culture integration to practice. Those ways included counselors' efforts to monitor for both observable and unobservable components of client cultures and how they contribute to conditions of treatment processes (Ritley et al., 2021). Guided by those observations, counselors can conduct counseling work informed by deep culture integration in the described phases of counseling.

Barriers and Challenges to Working with IS

The professional literature has well established that there are challenges and barriers in work with clients who have limited proficiency in English (Amouyal et al., 2020, Asfaw et al., 2020, Baker et al., 2015, Bischoff et al., 2003, Fennig & Denov, 2021, Floyd et al., 2016, Gartley & Due, 2017, Hsieh, 2015, Jidong et al., 2020, Paone & Malott, 2008, Raval & Smith, 2003, Sander et al., 2019, Searight & Armock, 2013, Woodward et al., 2020). I have organized the literature into case studies, qualitative studies, and major literature reviews. I focus initially on case studies to emphasize how IS

and barriers hinder treatment conceptualizations and processes. Using that as a foundation, I review qualitative studies to further identify how those barriers and challenges impact counselors' abilities to work with clients with language limitations. Lastly, I present literature reviews that speak to the current state of the body of knowledge on barriers and challenges of using IS in providing counseling services.

Woodward et al. (2020) completed a case study using "prolonged exposure" treatment while using IS to augment the communication process with the identified client in the case. Although the selected case focused on understanding the traumatic experience of a Spanish-speaking female who had reported going through a violent burglary while she was at her home with her husband, focus was also placed on how use of IS facilitated client's ability to communicate those symptoms. Even with the use of IS to assist with the treatment process for this client, Woodward et al. reported challenges and limitations in using IS including (a) access, (b) limitation of quantity of information delivered with IS, and (c) inability to transfer specific clinical information to client's primary language.

Woodward et al. (2020) explained that although qualified medical interpreters were needed to assist with the delivery of clinical services, there were agency operational restrictions that prevented the scheduling of IS to assist with translations unless clients were physically present for appointments. Those scheduling restrictions inadvertently caused two more challenges. First, although in person interpreters were ideal for assisting with communication, finding those methods of interpretations were not always possible.

Also, the client identified in this case study could not be matched with a single reoccurring interpreter, which consecutively resulted in rapport challenges.

Woodward et al. (2020) noted that the utilization of IS to assist with communication limited sharing of information. With the presence of an interpreter, the provider working with this case could not speak extensively to the client. To allow time for information transfer and processing, the provider spoke in shorter sentences. This limitation in communication impeded progress through treatment strategies as clinically appropriate.

The concern about how much IS can simplify information transfer when matched appropriately was also repeated in another study (Baker et al., 2015). In 2015, Baker et al. completed a study on three cases while using IS at a resident-operated clinic in the U.S. Each of the described cases has been given a diagnosis of anxiety or depression. Although each of those cases described how IS may be included into treatment processes, a general theme about how unsuitable use of IS leads to barriers in treatments were described. Those barriers were grouped as: (a) consent to IS presence, (b) IS matching issues, and (c) role and boundary confusion.

In the first case, Baker et al. (2015) explained that the provider failing to obtain consent to include IS to treatment process caused the client to lose trust in the treatment process. At the beginning phase of the treatment, the provider assumed that because the client was experiencing communication challenges, that inclusion of IS was necessary. The provider failed to recognize how the client would perceive bringing a person unknown to him to treatment. Because the provider unilaterally made this decision, the

client “reported feeling alienated by this decision, which impacted rapport development” (p.119).

Determining how to match IS to client needs and preferences was another challenge reported (Baker et al., 2015). In another case involving a Middle Eastern client, the provider assumed that matching the client with an interpreter who shares commonality in gender would assist more with meeting client’s needs. Instead, it was found that the opposite was true. When the provider matched IS according to gender similarities, the client was less likely to participate in treatments due to concerns that the interpreter would be judgmental towards the client (Baker et al., 2015).

IS used with clients needing communication support have been associated with role confusion and boundary issues (Baker et al., 2015). Although Baker et al. (2015), explained that using IS supports clinicians to understand client presentations through cultural lenses, having too much interpreter involvement also leads to violation of boundary issues. Clinicians working with clients who need language support have reported that they have observed interpreters struggling with remaining only within roles of interpreters in the counseling setting. Interpreters have been reported to interact with clients outside of the professional clinical setting. This additional involvement by interpreters caused clinicians to feel marginalized, thereby creating barriers between providers and their clients.

Communication challenges resulting from IS addition was also described in other studies (Raval & Smith, 2003). In 2003, Raval and Smith completed a qualitative study focused on understanding working conditions between providers and clients when IS

supplements treatment processes. The study was based in the United Kingdom, and a total of nine providers were included in the process. Raval and Smith reported that the addition of IS to treatment processes resulted in a few challenges that included (a) increase communication difficulty, (b) negative influence to treatment procedures, and (c) loss of information in translation.

Raval and Smith (2003) explained that adding interpreters to counseling work minimizes providers' efforts to engage in lengthy treatment discussions with clients. When interpreters are present, providers have reported to use brief sentences in their questions to clients to find out about more their presenting issues. Providers said that they were constantly mindful about the detail of questions they asked clients through interpreters.

In addition to the limitation in communication, Raval and Smith (2003) explained how that experience caused even more confusions that resulted from lack of clarity in roles in the therapy process. When using IS, providers reported challenges with forming treatment coalitions with interpreters. This lack of teamwork caused clients to not know specific roles of each member of their treatment teams. This missing clarity then caused clients and providers to experience additional barriers in their communications.

Verification of complete information transfer between clients and providers was another challenge reported with IS use (Raval & Smith, 2003). When using IS to deliver care, providers have reported concerns relating to how much of what they have shared was being communicated to clients (Raval & Smith, 2003). Providers have reported that, although some information loss was inevitable, there was no way for them to tell how

much of what they were sharing with clients were being lost in translation (Raval & Smith, 2003).

Challenges relating to flow of information giving raised by Raval and Smith (2003) were also echoed in Floyd et al.'s (2016) qualitative study. Floyd et al. (2016) focused on how barriers in communication influenced clients needing IS in selecting a pregnancy screening test. The study used interviews to collect information speaking to communication challenges from 24 pregnant women, 10 of which were non-English speakers. In comparing the group who spoke English to the non-English speakers concerns for the group requiring IS, included challenges with delivery of (a) complete informed consent and (b) cultivating a trusting relationship.

When clients did not speak the same languages as their providers, Floyd et al. (2016) found that criteria to satisfy best practices for informed consent, such as full information disclosure, were not included. When asked why clients with language barriers committed to screening methods that they did not understand, clients have reported that they blindly followed the judgments of their providers as justifications for why they chose screening tests. That lack of informed consent directly hinders providers' abilities to form trusting relationships with clients. Even when clients are following recommendations of providers for recommended screening tests, the absence of trust can cause clients to withhold treatment-pertinent information in future appointments, thereby adding more challenges to the process.

Factors disturbing trust were also described in another qualitative study (Gartley & Due, 2017). In 2017, Gartley and Due completed a qualitative study that explored the

opinions of mental health providers on their perceptions of challenges associated with working with IS. Their study was completed in South Australia, and they interviewed 7 providers from various mental health specialties. Although Gartley and Due (2017) talked about how IS improves care delivery of refugee clients, they also found challenges relating to use of IS that was described as (a) lack of consistency in professionalism and (b) training standards.

Gartley and Due (2017) explained that there were variations in how professional interpreters interacted with clients with whom they differed in opinions. For example, when interpreters had different worldviews than clients, they had trouble remaining professional and impartial. This was evidenced by one of the participants reporting how interpreters were dismissive of domestic violence presentation in one client case. Providers have reported how those behaviors that included this mentioned example communicated to clients that they felt being wrongfully judged by interpreters.

Gartley and Due (2017) also communicated those providers were not afforded appropriate training to be able to successfully work with interpreters. Similarly, the authors shared those interpreters lacked extensive experience in working in the clinical mental health settings. The presence of those two limitations in training and experience resulted in insufficient collaboration between them to support the common interest of clients. That inadequacy caused clients to not have their treatment needs met.

Reported challenges in communication due to language limitations also appear when working with clients who have reported experiencing economic and political trials (Amouyal et al.). Because of the important diversity growth in Canada which resulted in

a growing need for IS, Amouyal et al. (2020) completed a qualitative study focused on specific problems associated with interpreter use during the delivery of quality care. They interviewed seven professional interpreters and used the Enhanced Critical Incident Technique Study to analyze what impaired and what promoted their provision of IS. Although Amouyal et al. shared some helpful ideas about how interpreter use can contribute to quality care communication, they have also discussed barriers that would prevent effective communication. Amouyal et al. (2020) characterized those barriers as (a) ineffective triadic communication arrangements, (b) distribution of roles in therapy relationships, and (c) secondary vicarious trauma experienced by interpreters.

In the first barrier, Amouyal et al. (2020) explained that lack of clear expectations in communication plans create problems where interpreters are adding additional information to clients' shared messages because they feel that communications will be better received by providers when added with additional explanations. Interpreters have also been reported to reshape wordings of original client or counselor messages in their attempts to assist with transfer of information. Each of those barriers in the communication triad reduces probabilities of clients and counselors understanding each other.

In discussing roles within therapy relationships, Amouyal et al. (2020) indicated counselors have been reported to not work jointly with interpreters to support need for client communications. That lack of partnership in the communication effort introduces two more challenges. In one of those challenges, interpreters have been reported to mistakenly provide incorrect informed consent information to clients because counselors

were not clear on expectations. Lack of teamwork with interpreters have also resulted in interpreters not being able to do their jobs of assisting with exploring all symptom origins.

Amouyal et al. (2020) found interpreters, like counselors, are at risk for secondary vicarious trauma. Although the work of interpreters is to assist with interpretations, interpreters' fluencies in languages and cultures of clients may cause them to experience vicarious trauma when session information contains sensitive issues. Repeated exposure of such information to interpreters have resulted in them forming empathetic bonding with therapy cases, which may then influence their interpretations of information to providers.

Barriers in communication caused by the addition of interpreters were also discussed by Hsieh in a 2015 study. Hsieh's (2015) qualitative study conducted in the U.S. focused on interviewing multidisciplinary teams to further understand conditions and barriers that determine whether providers recruit IS to support clients who need communication support. Hsieh reported two themes that provided insights into types of barriers experienced by providers leading to IS recruitment. Those barriers included (a) lack of IS availability during critical times and (b) clients having preferences for family interpreters instead of professional interpreters.

Hsieh (2015) explained that availabilities of IS to support client needs was so limited that it resulted in restricting providers' efforts to support clients' care needs. One of the participants described that in emergency care settings where the number of patients waiting for care were many, interpreters were not routinely available to facilitate

communication needs. That restriction in access caused providers to proceed with attempts to communicate with clients despite existing language barriers. When that occurred, patients received treatment care without complete understandings of their own care processes.

Hsieh (2015) also explained that patients having more trust in their own family interpreters, compared to professional IS options being offered, further challenged providers efforts to communicate informed consent about treatment specifics. In some cases, patients have been reported to bring with them family in place of professional interpreters because they have more alliances with them. However, providers have reported challenges monitoring for situations where such arrangements of interpretations were harmful to client treatment processes due to those family interpreters influencing clients' autonomy.

Barriers related to addressing needs of migrant populations were referenced in another study (Asfaw et al., 2020). Asfaw et al. completed a qualitative study focused on understanding challenges and barriers experienced by 10 mental health providers who worked with refugee and asylum seekers in Germany. The argument for this study was that because the country of Germany accepted more than a million refugee and asylum seekers in just a nine-year period, it was imperative for providers to understand challenges and barriers that limit delivery of services. The providers interviewed identified three challenges and barriers to treatment that included (a) client's lack of clarity as to the purpose and process of counseling (b) differences in cultural beliefs as to causes of symptoms, and (c) when IS were used to address the communication problems,

some therapists had concerns regarding accuracy of the interpreters to convey the clients' feelings.

Asfaw et al. (2020) explained that clients who have LEP experienced challenges with understanding the scope of their treatments when providers are not clear on purposes and goals of treatments. Even though interpreters were being utilized for therapy sessions, enough time was not spent on understanding clients' expectations on what they hoped to gain through attending counseling appointments. That lack of transparency caused clients to report dissatisfactions about their treatment processes and outcomes.

In one study, Asfaw et al. (2020) underscored the significance of failing to recognize how clients' cultural views contributed to symptom presentations, and how that adds more communication challenges or barriers to therapy processes. As clients present with their symptoms according to their worldviews, IS being utilized should perform the job of bridging the communication needed for counselors to be able to understand what clients feel are the basis for their symptom origins.

Clarity in communication issues were also referenced by Sander et al. (2019) in another study. Sander et al. (2019) focused on ways in which IS limits therapeutic delivery in work with refugee clients who experienced trauma. The study was based in Denmark and recruited 825 participants. Sander et al. (2019) divided participants into two groups, where one group received IS while no IS was required for the other group. For this study, Sander et al. (2019) was focused on changes in treatment outcomes in two areas that included PTSD and anxiety and depression. Both groups were offered eight therapy appointments before the analysis of IS influence was made. The authors found

that one of the ways IS limits treatment was slowing the communication process between providers and their clients.

Sander et al. (2019) shared that the use of IS in treatment delivery resulted in the slowing of information flow between clients and providers. When interpreters were included in the communication process, providers were faced with conditions where how much information that was communicated at a time was restricted to the speed in which interpreters were able to translate clinical information to clients. Also, interpreters' limitations in language fluencies further added to that delay in information flow. Because of this delay, it was not possible for providers and clients to work on issues of interest in a reasonable timeframe.

The value of good communication in work with refugee clients was also discussed in a different quantitative study (Bischoff et al., 2003). Although completed by nurses instead of licensed counselors, Bischoff et al.'s 2003 study provided a reflection on consistent challenges faced by providers when language barriers are present in delivery of care services. In Geneva, Switzerland, Bischoff et al. (2003) examined surveys nurses collected from asylum seekers during a six-month period. While evaluating a mixture of participants of various age groups, and while closely focusing on traumatic experiences resulting from migration issues, Bischoff et al. (2003) identified consistent challenges presented by language barriers regardless of the class of providers.

Bischoff et al. (2003) explained that when language needs were appropriately matched for participants, they shared more detailed information about their trauma and their migration experiences. On the other hand, findings from the study explained that

poor communication between participants and nurses showed a two to threefold decrease in the amount of symptom description shared by clients. Bischoff et al. (2003) further pointed out that communication fluencies between clients and providers were most ideal when either professionally trained interpreters or when staff with a high degree of language fluency were used in treatment processes. During other times when other forms of language support were implemented into treatment processes, correlations of decreased levels of symptom sharing were reported.

The challenges of (a) accurate interpretation when dealing with sensitive issues, (b) multitasking in having to convey literal words, feelings, and cultural meanings (c) risk of vicarious trauma and (d) insufficient organizational support were identified as themes (p 48) in Jidong et al.'s (2020) qualitative study using interpretative phenomenological analysis (IPA). Jidong et al. (2020) interviewed three professional interpreters providing IS in East London community mental health settings. The alignment in perspectives of mental health professionals and IS professional interpreters provides substantial evidence of the actuality of these challenges in providing IS services in mental health settings.

Accuracy in language interpretations in mental health care that were raised by previously discussed studies appear to be reoccurring concerns in literature reviews. In 2008, Paone and Malott published a literature review of articles taken from PsycInfo and ERIC databases of using IS in mental health counseling. Their review spanned between 1975 and 2007. No articles of IS use were found that predated 1975. Paone and Malott (2008) found eight studies. Of those studies, five were based in clinical settings and three were in school settings. While focus was on collaborative practices between interpreters

and mental health providers, Paone and Malott (2008) identified challenges and barriers to mental health professional when using IS. Those challenges and barriers could be grouped as concerns about (a) interpreters' skills and (b) interpreter roles in counseling sessions.

One of the concerns Paone and Malott (2008) noted arose from utilizing non-professional interpreters, where the use of any available bi-lingual persons took place. Those approaches created doubts about services delivered under those methods of IS. Even when using professional interpreters, other challenges therapists identified arose from complexities of worldviews and languages, such as idioms, adages, and humor, that could result in inaccuracies in interpretation and misunderstandings between therapists and their clients. While speaking clients' languages, interpreters may not be grounded in cultural contexts of clients, and they may misunderstand clients' norms and behaviors. Therapists have also identified barriers as inaccuracies arising from interpreters' lack of fluencies in languages being employed, their desire to avoid embarrassment, or their disregard for nuances.

Paone and Malott (2008) indicated that the presence of a third party led to therapists having concerns about their competencies being judged. In the presence of additional personnel, therapists have shared concerns that interpreters might either undermine counseling processes by failing to convey emotional content or by assuming counselor roles. Therapists were also concerned that interpreters might not understand the professional and organizational context of mental health counseling services.

While over a decade has passed since Paone and Malott's (2008) literature review, and while their sample was limited to eight articles, they identified many challenges and barriers to mental health professionals using IS which have been echoed in other reviews more recently. For example, Searight and Armock (2013) conducted a literature review on the use of IS in mental health when clients have LEP. They reviewed several databases including PsycInfo and Medline but did not specify the timeframe of their search or the number of studies they reviewed to support their study. They identified themes which included (a) legal requirements for using IS, (b) LEP and mental health, (c) general clinical guidelines, (d) interpreter accuracy, (e) diagnostic issues, (f) the interpreter's role, (g) ethical issues, and (h) interpreter-facilitated psychotherapy.

The themes of interpreter accuracy and interpreter roles identified align closely with messages Paone and Malott's (2008) identified as concerns for therapists using IS. Searight and Armock (2013) cited studies of interpreters either substituting or omitting in conveying instructions of health professionals to clients. Searight and Armock also noted studies documenting mistranslations in providing mental health care. These occurred for a variety of reasons, ranging from unfamiliarity with mental health care to a desire to save clients from experiencing distress or embarrassment. The interpreter's role was problematic in studies that noted the existence of cross talk between interpreters and clients where clinicians were excluded from the triadic conversations. Interpreters were also reported as assuming the advocate role for clients. The challenge with advocating interpreters is that they might report symptoms they have noticed, even when clients have not stressed those symptoms, or that they might make recommendations to clients based

on their own experiences. Additionally, they might undermine the recommendations to clients, such as suggesting a prescribed medication might be harmful. Searight and Armock (2013) reported studies where interpreters intervened with clinicians' treatment, for example impeding communications that evoked strong emotions such as recounting traumatic events.

Searight and Armock (2013) also reported barriers and challenges arising in other areas such as ethical considerations. They indicated that although clinicians have responsibilities to provide high quality IS, mental health professionals often are not qualified themselves to determine competencies of those offering IS. They indicated shortages of IS professionals who are trained to work in mental health contexts. Searight and Armock (2013) pointed out that confidentiality can be a challenge when employing IS. Interpreters may not understand boundaries of confidentiality in mental health treatment. For example, interpreters should know that therapists should not seek information from interpreters about clients if the clients have not disclosed that information to the therapists (Searight & Armock, 2013).

Fennig and Denov (2021) focused on IS in mental health settings when working with refugees by conducting a scoping review of the professional literature. Fennig and Denov searched databases of the professional literature to include "Ovid Medline PsycINFO, Ovid, Web of Science Core Collection, Social Services Abstracts, CAIRN, and Erudit for empirical research, clinical case studies, best practice guidelines, editorials, and articles that addressed reflections on practice published between 1990 and 2019" (p 52). They identified 84 relevant research studies to their research question of

"What are the challenges and opportunities when considering interpreters in mental health settings with refugees?" (p 52).

As noted earlier in this literature review, Fennig and Denov (2021) identified barriers to using IS in mental health settings, but they also identified benefits of IS according to how they improve trust and safety in therapy processes. Fennig and Denov (2021) shared the presence of interpreters reinforced clients' levels of comfort. When interpreters were present, clients have reported feeling that someone else in the room other than themselves understood their problems. Because those clients felt understood, they had more reasons to trust the healing relationship. That trust then promoted clients to share more of presenting needs, which was linked with positive treatment effectiveness.

The review of applicable literature on barriers and challenges confirmed a few concerns related to impressions IS have on therapy work shared in the framework section of the chapter. Those concerns reported that incorporating insufficient IS absolutely affects many aspects of treatment procedures in mental health. Potential areas of impact include intake work, beginning of therapeutic alliances, and sorting through therapeutic issues. Even in situations where IS may appear to be helpful, implications IS have on long-term recovery processes in clients with language barriers are unclear. The review of studies relating to challenges and barriers confirmed many of those concerns on how obtaining access to acceptable IS continues to be a challenge. Also, this review uncovered how barriers to access issues lead to reliance on ineffective methods of interpretations, which have been reported to cause ethical and insufficient informed consent issues. Failing to use appropriate methods of interpretations have been shown,

within this review, to be linked with inaccurate flow of information from each person involved in triadic communications of therapy relationships. Those inaccuracies, when present, further confuse work that can be done with clients in need for care. It is therefore worth noting that when these barriers to care are present, providers are left without proper tools to be able to do their jobs. Even though these barriers and challenges are real and should be addressed to encourage improvement of care, there can be benefits of working with IS when used appropriately.

Benefits of Working with IS

Studies that speak to benefits of IS when used appropriately are next examined for this review. To bring those associated IS benefits to focus, a case study, quantitative research studies, and literature reviews were identified. In those reviews, emphasis was placed on how patterns of IS improve communication in counseling. In addition to outlining those patterns observed in IS, implications they had on treatment effectiveness were explored.

Schweitzer et al.'s 2013 study provided a fresh perspective on the usefulness of IS when applied to psychodynamic treatment approaches. The case study was focused on one client living in Australia who migrated from Hong Kong. The case used a consistent interpreter who shared cultural and language similarities with the client. Schweitzer et al. (2013) reported that use of IS in that psychodynamic setting had benefits that included assisting with transference and countertransference conditions in treatments.

Schweitzer et al. (2013) explained that the identified client in this case was experiencing symptoms of depression that were linked to grief from the loss of his wife

and from being away from what was familiar to him. The client's reported symptoms of depression were alleviated by having an interpreter who shared culture and language in the therapy office. This IS arrangement afforded the client to feel understood, and it provided him an opportunity to share his struggles and symptoms in his own language. The process of treatment had more meaning for the client because of the interpreter's knowledge of the client's language and culture, which allowed the client to be able to transfer concerns and challenges that he was experiencing.

Cultural understanding was also commented on by Mirdal et al. (2012) in their qualitative study about working with refugee clients in Copenhagen. Mirdal et al. explored factors that supported refugee clients with language barriers. Providers, clients, and interpreters were all included in the study. The purpose was to understand how IS supported client needs by comparing between successful and unsuccessful cases. Mirdal et al. (2012) reported that refugee clients best benefited from IS-mediated services as that allowed them to freely express themselves as well as understand their symptoms and treatment processes.

Mirdal et al. (2012) reported that clients being provided the ability to talk through interpreters had beneficial "curative" effects on their symptoms. Because these clients have been through traumatic experiences, being able to talk about their experiences in their own languages was beneficial to them. Clients have reported, through use of IS, being able to just describe their own lived experiences. Use of interpreters was also helpful to providers as that provided them to share with clients about clinical meanings of traumatic symptoms described by clients.

IS inclusion in work with refugee clients were also discussed in quantitative studies. In 2007, d'Ardenne et al. completed a quantitative study focused on understanding benefits of IS when applied to mental health care settings. d'Ardenne et al. (2007) reviewing the records of "…patients referred to an East London mental health service specializing in the psychological treatment of posttraumatic stress disorder (PTSD) between 2000 and 2004" (p 294). All patients received cognitive behavior therapy (CBT). d'Ardenne et al.'s (2007) data reviewed pre and post measures taken using the (a) Impact of Events Scale (IES), (b) Beck Depression Inventory (BDI), and (c) Manchester Short Assessment of Quality of Life (MANSA). They compared three treatment groups (a) refugees who did not receive IS services, (b) refugees receiving IS, and (c) non-refugees. All treatment groups had significant differences pre to post on the IES and BDI. While all groups showed gains on the MANSA, refugees who received IS services did not achieve significance. While there was no significant difference in outcomes found among the three groups of patients, a greater proportion of refugees who received IS demonstrated gain than those refugees who did not receive IS. Overall, d'Ardenne et al.'s (2007) study speaks the effectiveness of CBT in treating symptoms of PTSD among refugee populations and the usefulness of IS in prompting better outcomes. While the evidence was not strong, d'Ardenne et al. (2007) noted, "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" (p 298).

The value of good IS implementation was also discussed in another quantitative study. In 2011, Brune et al. completed a quantitative study based on 190 participants that received treatments in Sweden and in Germany between 1990 and 2004. The study compared whether those clients, all of whom have been diagnosed with PTSD, had a change in their treatment outcomes based on the presence of IS. The study described two therapists and eight interpreters being involved in the delivery of treatments. Using these arrangements, Brune et al. (2011) concluded from this study that integration of IS into treatment delivery is as effective as services delivered without IS presence.

Although both groups being compared had presented a history of trauma resulting from political and economic uncertainty, Brune et al. (2011) explained that the group that received treatments without IS showed more fluency in the language and higher rates of integration to the new country of settlement. However, Brune et al. (2011) shared that the integration of interpreters who shared commonalities with participants needing language support permitted those participants to be able to compensate for those existing barriers that might have negatively impacted delivery of treatments. This message reiterated the value of good IS integration, which in this study facilitated equal outcomes in treatments between the two groups.

Benefits of using IS services were supported by Van der Rijken et al. (2016) who conducted a qualitive study of the effectiveness of MST with delinquent youth in the Netherlands. Van der Rijken et al. (2016) noted the crime rate among youth identifying with “ethnic minority groups” is higher than that of the “average Dutch population” (p. 94), necessitating the use of IS for therapists delivering MST. Van fer Rijken et al. (2016)

collected data from 50 MST therapists using the Interpreter Questionnaire and from "information stored in the MST Institute (MSTI) web database" where "therapists keep a record of, among other things, each case's progress, treatment duration in days, and treatment outcomes" (p. 94). For their data analysis, Van der Rijken et al. (2016) compared (a) those who used either a professional or family interpreter with (b) those who needed no interpretive services (i.e.: spoke Dutch). Van der Rijken et al. (2016) ". . . the (long term) official judicial data did not reveal any differences between the interpreter group and the matched control group" (p. 96). From that analysis, Van Der Rijken et al. (2016) reported value of IS improved care experience to same levels as provided native Dutch speakers.

Like Van der Rijken et al.'s (2016) comparison study about the use of IS, Schulz et al. (2006) completed a quantitative study aimed at understanding efficacies of treatments when comparisons were made between clients who were able to engage with their providers directly to those who needed IS in their communications. This study was completed in the U.S., and it included a total of 53 participants, all of which had migrated to the U.S. around the same time interval between 1993 and 2004. From 53 clients, 25 used IS while the remaining clients did not require IS to communicate with their providers. Schulz et al. (2006) found that, when used appropriately, IS achieved similar levels of treatment support for clients dealing with PTSD symptoms when symptom measurements were made at closing of treatments.

The use of IS provided similar efficacies in treatments compared to clients who do not need communication assistance (Schulz et al., 2006). When cognitive processing

therapy (CPT) was delivered through interpreters to clients who experienced PTSD symptoms, similar levels of symptom reduction as with the other group communicating directly without interpreters were reported (Schulz et al., 2006). This meant that even in the presence of interpreters, clients and providers were able to engage in prescriptive treatment discussions guided by cognitive processing therapy that allowed treatment area identification and processing (Schulz et al., 2006).

An even broader outcome comparison was completed by Lambert and Alhassoon (2015) who provided a focused literature review to understand how trauma-focused treatment strategies differed between clients needing IS support and those who did not require IS support. The review considered more two thousand studies drawn from various databases before eventually narrowing the selection criteria to only 12 studies. Those selected studies were chosen based on whether they treated refugee clients, who were of certain ages, and whether they made comparisons of trauma-focused treatment approaches to standard methods of care. Lambert and Alhassoon (2015) found that IS inclusion continued to result in similar effect sizes when trauma-focused treatment methods were utilized.

The claim by Lambert and Alhassoon (2015) of similar effect sizes is statistical evidence that good IS practices provide similar levels of treatment support for clients that need communication support. In this review where multiple comparisons of studies using trauma-focused treatment strategies were made, post-treatment PTSD symptoms did not vary between those who communicated through IS and those that were able to directly speak to their providers. The interpretation that can be made here is that clients and

providers, regardless of whether language differences were present, were able to still achieve similar levels of treatment goals through IS implementations (Lambert & Alhassoon, 2015).

After reviewing studies that discuss how IS increase treatment effectiveness, reoccurring themes were clear. First, review of those studies communicated that consistency in application of IS made it easier for providers to be able to work with clients with limited English proficiencies (Lambert & Alhassoon, 2015). Those consistencies described included appropriately matching clients with interpreters that are most likely to support client needs (Lambert & Alhassoon, 2015). These reviews also found that matching of interpreters promoted more trust and therapeutic alliances. This finding echoes the message about using interpreters as "cultural brokers" referenced in framework (Lambert & Alhassoon, 2015). Clients have reported finding comfort, while in the therapy office, from knowing that interpreters were there who knew and understood their cultures and languages (Lambert & Alhassoon, 2015). In some of the examples demonstrated through this review, clients have shown more willingness to commit to therapy after finding out that their matched IS were sufficient to address their clinical needs (Lambert & Alhassoon, 2015). Other clients from studies reviewed communicated that IS provided them opportunities to share their accounts of traumatic experiences during discussions with their clinical providers (Lambert & Alhassoon, 2015). Finally, reviews completed communicated that proper use of IS lead to similar levels of treatment efficacies between clients with communication needs and those who are proficient in English (Lambert & Alhassoon, 2015). Those accounts of IS benefits,

when used appropriately, inform the work ahead about forming best practices for using IS in mental health settings (Lambert & Alhassoon, 2015).

Recommendations for Best Practices

This next piece of the literature review is focused on exploring available work to synthesize new ideas that support best practices for using IS in the delivery of mental health care. First, the focus was placed on qualitative and quantitative studies that inform best practices. This was followed by analyzing more comprehensive reviews that consider different characteristics of IS and how they support best practices. Later in this section, reoccurring themes were outlined to inform readers about issues important to IS' best practices.

Tribe and Lane (2009) completed a focused review of the literature to form ideas that support best practices for working with IS in mental health. Tribe and Lane searched for works published between 1996 to 2006 in the databases PubMed, PsycInfo, CINAHL, Ethnomed, OMINI and Education Resources Information Centre (p 235). Recommendations they gathered that inform best practices when using IS were grouped into: (a) training issues and (b) procedural processes in therapy work.

Tribe and Lane (2009) explained that clients are best supported when only professionally trained interpreters are used in treatment processes. In addition to using technical information during the delivery of care, there are also assumed expectations about the professional therapy relationship. Those assumed expectations include the need for confidentiality and boundary. Trained interpreters are more knowledgeable about these expectations than non-trained interpreters.

Tribe and Lane (2009) also explained that monitoring the wellness of interpreters directly influences work that can be done with clients. Because therapy appointments may sometimes contain sensitive information, monitoring emotional wellness of interpreters should be done. This can be done through providing supervision to interpreters either before or after therapy appointments. Taking that important step not only safeguards the wellness purpose, but also reinforces important values interpreters bring to therapy processes.

Like with Tribe and Lane (2009), Elkington and Talbot (2016) also talked about value of training in interpreters in their study. Elkington and Talbot completed an opinion piece based on the use of IS in mental health settings in South Africa. They focused on understanding how IS can best support mental health service delivery. Elkington and Talbot (216) explained that when used with appropriate arrangements, IS can improve client experiences, treatment processes, and outcomes. Elkington and Talbot (2016) explained best practices for IS as (a) defining meaning of interpretation and (b) how understanding trainings of IS service providers facilitate communication processes.

Elkington and Talbot (2016) explained that proper use of IS dependent on making a distinction between interpretation from other forms of communication support. Interpreters are defined as individuals supporting the transfer of spoken information between clients and counselors. In that transfer of information, interpreters are supposed to translate messages from one language to another without subtractions of meanings. Those meanings interpreters can help communicate include working with providers to

understand how client symptoms can be understood through sociocultural lenses (Elkington & Talbot, 2016).

Training further supports the understanding between client and provider communications (Elkington & Talbot, 2016). During therapy work, it is not only that a lot of information transfer is occurring, but that a lot of that information also contains clinical terms that may be challenging for clients to understand (Elkington & Talbot, 2016). Training of interpreters allow that information to be simplified in ways that are easier to understand by clients. When information is clear to clients, opportunities for miscommunications and errors are fewer (Elkington & Talbot, 2016).

In 2015, Kuay et al. conducted a qualitative study in Australia to (a) determine if guidelines for using IS in counseling (Tribe & Lane, 2009; Tribe & Thompson, 2011) were being followed in practice, (b) how therapists resolved issues arising with IS in the counseling process, and (c) better understand how socio-cultural factors influenced therapy. To provide this understanding, the authors collected information from 10 therapists who were able to provide insights on best practices. Kuay et al. (2015) found the therapists perceived those clients preferred to use IS when interpreters were present in person. While offering IS via telephone eased issues of confidentiality, therapists reported client resistance since they were not able to directly interact with individuals who were part of their care team.

Kuay et al. (2015) found matching of interpreters according to clients' preferences was also important. Some of the matching criteria that were reported to assist with clients' comfort levels included matching of gender, religion, and cultural identity. Kuay

et al. (2015) discussed how therapists indicated they would deal with troubleshooting IS problems in therapy such as (a) accuracy checks, (b) clarify roles and setting boundaries, and (c) supporting the counseling process such as teaching how to project empathy. They noted special concerns in using IS services including the interpreter as both a cultural consultant and advocate for clients. Overall, while finding the existing guidelines provided a useful framework, Kuay et al. (2015) stressed the "need to be flexible in one's approach to psychotherapy depending on clinician, interpreter and patient factors" (p. 296).

Much of those same guidelines about what works in therapy (Tribe & Lane, 2009; Tribe & Thompson, 2011) were also referenced in a book written by Boyles and Talbot (2017). In this book, recommendations that promote similar outcomes in treatments between when IS are used compared to other times were made. In those suggestions, Boyles and Talbot (2017) state that when counselors consider the following criteria about the use of IS, outcomes in treatments are more likely to be similar. Counselors should be mindful about using technical terms that may be more difficult to explain in client languages in the presence of interpreters (Boyles & Talbot, 2017). Counselors should not rearrange treatment strategies in their work with clients needing communication support in ways that are different from English-speaking clients (Boyles & Talbot, 2017).

The original value of collaborative work raised earlier in this review was recently described in another study (Martin et al., 2020). Martin et al. published a paper focused on recommendations providers should consider when working with IS. Martin et al. (2020) explained that although other medical settings have clear guidelines that provide

directions on how to best apply IS use, this issue is still a developing area in mental health settings. To improve guidelines when working with IS in mental health settings, Martin et al. (2020) provided a few solutions that improve care quality. Those solutions were grouped as (a) initial education on relationship expectations and (b) promoting inclusion in the therapeutic relationship.

Martin et al. (2020) explained that although interpreters may be knowledgeable in their abilities to interpret therapy appointment contents, they may not be as knowledgeable about expectations and standards of the professional therapy relationship. Providing education to interpreters about maintenance of boundaries from early in the process is important. It was also shared that since different interpreters have varying degrees of fluencies in therapy work due to years on the job, providing that initial consultation should be made a standard practice.

Chapter Summary

In the framework section of this chapter, a more recent cultural broker model was described to explain a unique opportunity where interpreters can support the incorporation of cultural competency in counseling. Associated benefits to interpreters operating from a cultural broker model appear to be clear based on challenges and barriers reported in this chapter during times when effective IS could not be arranged for clients. Some of those reported challenges and barriers that good IS assist with included transfer of accurate clinical information with cultural relevance to clients. In the absence of cultural brokers, not only was there a problem with flow of information to clients, but

additional issues that also deal with informed consent and role confusion were evident in the care process.

This chapter also provided a view into what occurs in therapy relationships when IS arrangements work. Studies reviewed to support that view communicated that proper use of IS allowed clients to communicate symptoms and participate in psychoeducation. In some cases, according to described cases earlier in this chapter, proper use of IS was powerful enough to result in similar outcomes in treatments.

Additionally, reviews of applicable literature disclosed a few important suggestions about trainings and preparedness of interpreters. First, training for interpreters and the use of professionally trained interpreters were incredibly important to treatment outcomes. The use of professionally trained interpreters was correlated with adherence to professional ethics, awareness of boundary issues, and confidentiality. Also, using collaborative approach in the triadic communication was found to support both clients and the healing relationship. While considering the literature review findings outlined in chapter two, the next chapter focused on creating a methodology to examine how IS may influence treatments in pediatric and adolescent population in age groups 4-17.

Chapter 3: Research Method

Introduction

The purpose of this quantitative, ex-post facto study was to determine if pediatric and adolescent counseling in age groups 4-17 years that is delivered with the use of IS can reflect the same treatment outcomes as counseling delivered with no IS support. Four different mental health diagnoses including, anxiety, ADHD, depression, and disruptive mood dysregulation disorder, were considered to understand the effect IS presence had on treatment processes. Over the next sections of this chapter, the presence or absence of IS variable, diagnoses inclusion and exclusion criteria, and sample selection are shared. Variable explanations and how they match with the identified design approach are also explored. Additionally, population description and statistical testing chosen is described. Plans to operationalize data processing and interpretation are also included. The position of internal and external validity, as they impact this study, are described.

Research Design and Rationale

This study has employed an ex post facto quantitative design, drawing data from treatment records. The independent variable in this study was the use of IS services in counseling with the attributes that they were or were not used. The dependent variable was treatment outcomes.

Measures of treatment outcomes was made using the Youth Outcome Questionnaire (Y-OQ 30.2), which is included in appendix A and B (Loew & Swerdlik, 2007). This questionnaire provided rating scales from which clients could choose severity of symptoms in areas of concern. If clients were younger than the age of 12, parents were

asked to complete assessment questionnaire to accurately reflect symptoms. Results were achieved through offering objective, scaling questions to clients aimed at assessing quantitative changes in clients' functioning. If treatment outcomes have changed for clients, numerical changes in functioning levels were reported. Because this study compared two groups according to IS presence or absence, and examined their treatment outcomes across time, a repeated measures analysis of variance (ANOVA) was used in the data analysis. This design allowed for numerical values about treatment progress to be generated at multiple intervals over the course of treatment time.

Using existing data from a clinic required both time and effort to deidentify the data and identify clients who met the criteria for the sample. As shared in earlier explanations that prompted the completion of this study, the hope was to add more meaning and significance to the body of literature that spoke to the effectiveness of IS application to mental health treatments. This study provides a unique perspective when compared to previous studies that explored how IS influences counseling treatments. For example, this study did not specifically focus on refugee clients. Instead, this study focused on pediatric and adolescent clients who have relocated to the United States and who need additional language support. The professional literature reflected no other study of this type focusing on pediatric and adolescent population and on diagnoses described in chapter one has been completed in the United States.

Methodology

Population

The population for this study was pediatric and adolescent counseling clients, ages 4-17 years, who had LEP and who used IS services**.** The population was selected only from one mental health facility in the Midwest region of the United States. The estimated sample size for this study was determined to be 36 participants after a power analysis, which is explained later in this chapter, was completed.

Sampling Procedure

The sample from this research was drawn from the records of one outpatient mental health facility in the Midwest of the United States. This facility predominately serves clients who identify as belonging to low to mid-socioeconomic statuses. These clients primarily presented with symptoms leading to a DSM-5 diagnoses of: (a) anxiety, (b) depression, (c) attention deficit/hyperactivity disorder and (d) mood disorders (APA, 2013). Most clients this facility served can be grouped into one of two categories: (a) clients who communicated with their providers in English and (b) clients who needed additional communication support, which was achieved through use of IS. Those client records were divided into two virtually equal groups based on presence and absence of IS use and diagnoses.

Quota sampling method was chosen to facilitate data collection guidelines for this study. The decision to choose quota sampling was due to the main purpose of the study – to understand how IS may have affected treatments in pediatric and adolescent counseling. Two groups of participants were compared to one another based on the

presence or absence of IS and based on diagnoses determined. I was interested in following a particular group who fit unique socioeconomic and language classifications; hence quota sampling can be used to help direct the inclusion process based on conditions explained in the purpose of the study. That inclusion process is once again presented here. First, only treatment records identified as belonging to clients between ages 4-17 were selected. Next, only clients who met the criteria of (a) mental health diagnosis and(b), identify as Hispanic or Latino were included. Only diagnoses of (a) anxiety, (b) depression, (c) attention deficit/hyperactivity disorder and (d) mood disorders were considered for this study.

The study used data from existing records of clients. Clients' records were de-identified. Records of interest for this study were obtained over the course of a year between August of 2020 to October of 2021. Not all the clients seen at this facility were included in this study. First, all records were de-identified. Next, only clients who meet the diagnostic criteria of interest were selected for additional consideration. Then, clients who did not meet the age criteria of 4-17 were excluded. Clients who did not remain in treatment for a year were also excluded. Finally, clients who did not belong to similar socioeconomic levels were excluded from the study. Those records were coded based on the presence or absence of IS use.

Anticipating the use of repeated measures of ANOVA for data analysis, G*Power software was used to determine the needed sample size. Treatment outcome measures were taken at entry to treatment at 0 months. Then at three, six, and nine months. The alpha level was set at the traditional 0.05, the effect size was set to a moderate level of

0.25, with a power of 0.95 (Cumming, 2012). A total sample size of 36 participants records was determined to be needed.

Data Record Access

This study did not collect real-time data from participants. Therefore, no participant recruiting efforts occurred. Instead, only one facility that offered mental health services provided existing client records. The researcher had reached out to the decision-makers of this organization with a formal request for data of interest. Permission for the use of de-identified data for research purposes was obtained from the outpatient mental health facility.

Instrumentation and Operationalization

The independent variable in this study was the use IS services during client treatment or if treatment was delivered in English, without using IS services.

The dependent variable was the Treatment Outcome (TO). The TO measured whether changes in symptoms occurred for each client based on data records examined. The TO was measured using the Youth Outcome Questionnaire (Y-OQ 30.2) given to clients (or clients' parents if clients were younger than 12 years of age) at entry to treatment, each time where treatment reviews were completed at three, six, and, nine months intervals (Loew & Swerdlik, 2007). These questionnaires were given to all participants at the time of clinical treatment plan reviews. Questionnaires contained 30 items with frequency rating scale options of *never, rarely, sometimes, frequently, or almost always* (Loew & Swerdlik, 2007). Items in the Y-OQ 30.2 focus on seven domains: (a) Aggression, (b) somatic, (c) Conduct, (d) Social isolation, (e) Hyperactivity/distractibility, (f)

Depression/anxiety, and (g) Critical items (Loew & Swerdlik, 2007). These were subcategories in the assessment scale and each subcategory produced a numerical value (Loew & Swerdlik, 2007). A numerical value for each subcategory was calculated each time Y-OQ 30.2 was completed with clients and parents (Loew & Swerdlik, 2007). Critical items speak to changes in symptoms that are unique to diagnosis of concern since last assessment evaluation (Loew & Swerdlik, 2007). For example, critical items speak to whether ability to manage emotions improved or deteriorated since last assessment evaluation (Loew & Swerdlik, 2007). Critical items also provided a unique numerical value different than the overall outcome score (Loew & Swerdlik, 2007). The questionnaire was completed on the computer, and the questionnaire software completed all scoring and numerical value generation for overall score and individual scores for each subcategory (Loew & Swerdlik, 2007). An example of items listed in the self-report Y-OQ 30.2 is *"'I have headaches or feel dizzy'* with answer choices from which to choose include *Never or Almost Never, Rarely, Sometimes, Frequently, Almost Always or Always"* (Loew & Swerdlik, 2007). An example of items listed in the parent report Y-OQ 30.2 is *"'My child complains of dizziness or* headaches' with answer choices include *Never or Almost Never, Rarely, Sometimes, Frequently, Almost Always or Always"* (Loew & Swerdlik, 2007).

The Y-OQ 30.2 is valid when at least 28 of the 30 questions are completed by participants (Loew & Swerdlik, 2007). The internal consistency for Y-OQ 30.1 is reported to be 0.96 for the parent report version while the self-report was reported as 0.93 (Loew & Swerdlik, 2007). The reliability for test-retest for the parent report version is

0.80 and 0.91 for the self-report (Loew & Swerdlik, 2007). When the YOQ criterion-related validity was compared to another assessment instrument, Child Behavior Checklist, a coefficient of 0.76 value was found (Loew & Swerdlik, 2007). The Y-OQ 30.2 generated reports that determined whether improvements in areas of treatment were present by assigning a numerical value at each time Y-OQ was used which were at entry to treatment, three, six, and nine months (four measures of outcomes across treatment) (Loew & Swerdlik, 2007).

Data Analysis

A repeated measures analysis of variance (ANOVA) was used to complete treatment outcome comparisons while using time and IS status as independent variables. Four different treatment outcome values, entry to treatment, three, six, and nine months, were compared between groups. SPSS version 25 was used to support the data analysis (IBM Corp, 2017). Before data entry into the SPSS software was completed, manual sorting of the data was completed by the researcher. For example, records where outcome assessments had not been completed were eliminated as they did not allow justifiable comparisons. The intention was to match the two groups based on available demographic variables that include age similarities, diagnoses, and socio-economic statuses. Data records from each group shared similarities in socio-economic statuses. To confirm that the groups were alike based on these demographic variables, t-tests and chi-squares were used. To confirm that the two groups were similar in age ranges, t-tests, mean, standard deviation, and variance were calculated to determine a t-value. Individual ages of client records in each group were also plotted on a normal distribution curve. From there, a chi-

square graph was formulated. Through this record examination, the goal was to answer the following research questions and hypotheses:

RQ1: Are there differences in overall treatment outcomes in clients between when clinical services are provided with the presence of IS compared with when services are offered without the need for IS in pediatric and adolescent clients of ages 4-17?

$H_0$1: There is no statistically significant difference in overall treatment outcomes in clients between when clinical services are provided with the presence of IS compared with when services are offered without the need for IS in pediatric and adolescent clients of ages 4-17.

H_a1: There will be differences in overall treatment outcomes in clients between when clinical services are provided with the presence of IS compared with when services are offered without the need for IS in pediatric and adolescent clients of ages 4-17.

Threats to Validity

External validity threats were determined to be minimal for this study. Since examination of secondary data records from an actual clinic was completed, no testing of participants was done. This meant that no experiment was done, hence making external validity threat minimal. Additionally, since data evaluated was real world, i.e.: this study was not an experiment, there was no real claim that treatments provided caused the outcomes that were measured.

Like the external validity, internal validity concerns were also minimal. Since real-time data collection did not occur in this study, no testing was present. Data information that was used to answer research questions and null hypothesis were already

present in the data record. No manipulation of data took place. However, it is recognized that the sample selection conditions of this study may create a potential validity threat. For example, records from participants who found either the IS services or treatments unhelpful may have dropped out before completing treatment courses. Also, changes in English proficiency in children and families over time may cause them to depend on IS less than they might have been in earlier parts of treatment processes. Although no administration of testing occurred in this study, it should be noted that testing may also create a potential validity threat. For example, participants' proficiency levels in completing the testing instrument may change over the course of treatment. Generalizability is another validity concern for this study. Data records examined were limited to one mental health facility, thereby limiting the generalizability of outcome.

Ethical Procedures

Data record examination for this study did not begin until IRB approval was received. No primary data collection steps occurred during the completion of this study. However, existing data records from human participants were accessed and examined, which required the appropriate IRB approval before data access and examination could be done. No participants were recruited or contacted during this study. Therefore, no real-time data collection occurred. Since existing data was only needed for this study, the de-identification process was completed to remove identifying or any confidential information. Participant names, date of births, identifying information, and any other identifying record numbers were removed. Once de-identification process was completed, each participant was assigned a numbering system to illustrate changes in

treatment outcomes between groups being compared. Only de-identified values containing numerical values with variables of interest were extracted from available data record. As a secondary safety measure, a representative from the facility that collected the data verified that all identifying and confidential information had been removed before any of that data was used to address identified research questions. Until the outpatient facility confirmed the de-identification process, only the researcher completing this dissertation, who has been granted permission by the facility, was able to view the data. Although the researcher of this study is employed by this facility, there are no additional ethical considerations as the researcher is not conducting a real-time experiment. Data used for this study was stored in a secure drive in a locked cabinet inside a locked room and will be kept for five years. After that period is completed, stored data will be permanently destroyed.

Chapter Summary

The purpose of this study was to use ex post facto design to understand whether presence or absence of IS caused changes in treatment outcomes in pediatric and adolescent clients of ages 4-17. Variables of interest were clearly defined, including how they addressed external and internal validity concerns for this study. Whether described variables matched the population from which data was obtained was another area of discussion during this chapter. Using data records that were made available, how sample selection process was conducted was also explained in the details of this chapter. Statistical testing, conditions, and effect sizes were also clarified. How determined statistical testing either supported or contradicted the determined hypotheses were also

described. Ethical implications relating to this study were also explained. In chapter four, methodology settings explained in this chapter was used to examine whether IS influenced treatment outcomes.

Chapter 4: Results

Introduction

This study was conducted to explore whether differences existed in treatment outcomes in pediatric and adolescent clients between ages 4-17 years who received or did not receive counseling treatments using IS services. This was a quantitative study that followed ex post facto design using secondary data analysis. Through this examination of secondary data records for clients, the purpose was to answer the primary research question, null hypothesis, and alternate hypothesis, respectively as presented below: Are there differences in overall treatment outcomes when clients ages 4-17 years receive clinical services with the presence of IS compared with clients ages 4-17 years who receive clinical services without the need for IS through Youth Outcome Questionnaire measurements? There is no statistically significant differences in overall treatment outcomes when clients ages 4-17 years receive clinical services with the presence of IS compared with clients ages 4-17 years who receive clinical services without the need for IS through Youth Outcome Questionnaire measurements. There will be differences in overall treatment outcomes when clients ages 4-17 years receive clinical services with the presence of IS compared with clients ages 4-17 years who receive clinical services without the need for IS through Youth Outcome Questionnaire measurements. The next section of this chapter follows the sequence of data collection, demographics, and result analysis.

Data Collection

Prior to the start of this study, the researcher conducted a power analysis using G*Power to determine the needed sample size for a repeated measures analysis of variance (ANOVA) with between and within interactions (Erdfelder et al., 1996). The level of significance was set at alpha .05, power at .95 and the effect size was estimated to be .25. The analysis was a two-group comparison with four total measurements (entry to treatment, three, six, and nine months). This power analysis reflected that a sample of 36 was needed for this study.

Data released to the researcher were from treatment records collected between August 2020 and October 2021 on pediatric and adolescent clients who sought treatment for symptoms of either: (a) anxiety, (b) ADHD, (c) depression, or (d) disruptive mood dysregulation disorder. Tracking clients' outcomes using the Youth Outcome Questionnaire (Y-OQ 30.2) began at this clinic in August 2020, therefore there were a limited number of cases meeting the eligibility criteria for age and diagnosis (Loew & Swerdlik, 2007). A total of 36 completely de-identified treatment records were released from the mental health facility.

The clinic where data treatment records were obtained from is located at the heart of a culturally diverse community in inner city of central Ohio. Both English and Spanish are commonly spoken languages in the area. The clinic serves lower income status families. Clients referred to the clinic are either self-referred, referred through their school systems, or through their primary care providers. The demographics of the sample seem to reflect those of the individuals in the larger community.

Results

Demographics

Table 1

The Demographic Data of Gender, Age, Racial Identity, Diagnosis, and Annual - Household Income Broken Down by IS Services Use

Baseline Characteristics	Without IS Services (n = 26)		With IS Services (n = 10)	
	n	*%*	*n*	*%*
Gender				
Male	14	54	4	40
Female	12	46	6	60
Ethnic Identity				
Hispanic	2		10	
Non-Hispanic	24		0	
Age (Mean)	11.35		13.60	
Annual Household Reported Income	$16,127.77		$21,778.30	
Diagnosis				
Depression	4	15	6	60
ADHD	15	58	2	20
Anxiety	4	15	2	20
Mood Dysregulation Disorder	3	12	0	0

Chi-square tests were run to examine if there were significant differences between the groups of using and not using IS services. A Chi-square test revealed no significant differences in gender identity between those who did and did not use IS services, X^2 (1, 36) = 0.111, p = 0.739. A Chi-square test revealed there were significant differences in diagnosis between those who did and did not use IS services, X^2 (3, 36) = 8.594, p = 0.035, Φ = .489. The majority of those who did not use IS services were diagnosed with

attention deficit hyperactivity disorder (ADHD), while the majority of those who used IS services were diagnosed with depression.

Table 2

The Demographic Data of Diagnosis Frequency

Diagnosis	Present	Absent	Total
Depression	6	4	10
ADHD	2	15	17
Anxiety	2	4	6
Mood Dysregulation Disorder	0	3	3
	10	26	36

Chi-square also showed that there were differences by ethnic identity of those who did and did not use IS services, X^2 (1, 35) = 27.692, p = 0.001, Φ = .877. All of those who used IS services identified as Hispanic (n = 10); of those who did not use IS services, two identified as Hispanic and the rest as non-Hispanic (n = 24).

Age

An independent samples t-test revealed significant differences in mean ages (34) = 2.508, p = .017, d = 0.933, 95% *CI* [0.428, 4.08]. The effect size is greater than the .8, which Cohen suggested indicated a large effect. The group where IS services were not used had a lower average age (M=11.35, SD=2.33) while the group with IS services used had a higher average age (M=13.60, SD=2.63). The overall quota sampling process was not impacted as individual ages for participants in each group were closer together and they still satisfied additional inclusion criteria that included income, diagnosis, and IS status.

Annual Reported Household Income

An independent sample t-test revealed no significant differences in reported annual income, t (34) = 0.664, p = .511, d = 0.247, 95% *CI* [-11631.80, 22932.86]. The results showed that the group where IS services was used had a higher annual income (*M*=$21,778.30, *SD*=$22,718.42) than the group where IS services was not present (*M*=$16,127, *SD*=$22,902.58) but these differences were not great enough to be statistically significant.

Treatment Outcome

Treatment outcomes were recorded using the Youth Outcome Questionnaire (Y-OQ 30.2). Four treatment outcome readings were recorded for each participant starting with entry to treatment, then three, six, and nine months. As time progressed it was expected that clients would report lower levels of symptoms. Lower levels of symptoms as measured on the Youth Outcome Questionnaire (Y-OQ 30.2) is reflected in lower scores (Loew & Swerdlik, 2007). Descriptive statistics were run to reflect the means of the YOQ 30.2 across time for each of the IS statuses. As shown in table 3, both groups appear to have reductions in symptoms (i.e.: improved treatment outcomes).

Table 3

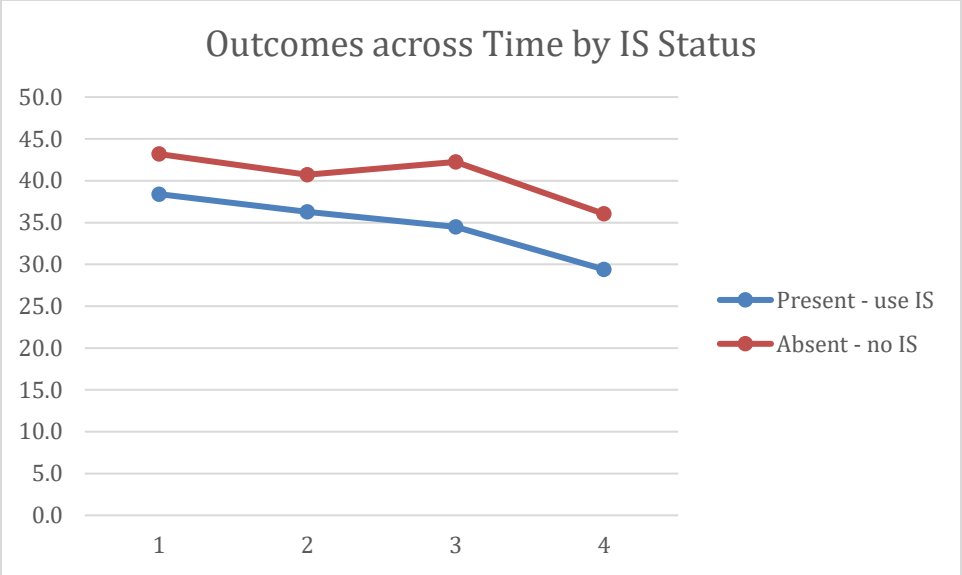
Treatment Outcome Averages

Presence/AbsenceIS	Treatment	Outcome	Measures	
	n	*M*	*SD*	*Range*
With IS Services	10			
0 months		38.4	11.15	33
3 months		36.3	16.69	47
6 months		34.5	12.64	36
9 months		29.4	13.36	43
Without IS Services	26			
0 months		43.19	18.44	76
3 months		40.73	17.15	62
6 months		42.27	18.86	73
9 months		36.04	17.36	64

A line graph, represented below in figure 1, illustrates that when IS services were used, treatment outcome values were consistently lower across time than for the group that did not use IS. As time progressed, the group that did not use IS appeared to have more variance, with an increase in treatment outcomes reported at time 3. For the group using IS, the treatment outcomes were consistently lower across time. The visual display suggested there would be differences in means across time both within each group and across the groups, but there was no interaction between the groups. Also, range values were examined to assess for outliers in treatment outcome averages. The group using IS services showed robust and closer range values compared to the group not using IS services. However, it needed to be determined whether statistically significant differences existed between the two groups in these treatment outcomes over time.

Figure 1

Outcomes in Treatments Over Time According to IS Status.



A two-way repeated measures analysis of variance (ANOVA) was used to address the research question to see if there were differences in treatment outcomes between the clients who used IS and those who did not over time. The dependent variable was treatment outcomes and independent variables were the presence or absence of IS and time, i.e., the outcomes data collected at baseline, three, six, and nine months. The two-way repeated measures ANOVA allows looking at the main effect for IS status, the time effect on treatment outcomes, and the interaction between the IS status and the time effect on treatment outcomes. Basically, it looks at (a) whether clients, on average, report statistically significant differences in outcomes based on IS status, (b) whether, on average, report statistically significant differences in treatment outcomes at baseline, three, six, and nine months, (c) whether differences in the treatment means between those

in each IS status vary depending on if the treatment outcome was measured at baseline, three, six, and nine months.

The two-way repeated measures ANOVA has assumptions that must be met to insure accurate results. The dependent variable must be continuous (Troncoso Skidmore & Thompson, 2013). The Youth Outcome Questionnaire (Y-OQ 30.2), which was used to measure the outcome, yields a continuous global score captured at the interval level. There must be independence of observations, that is the persons contributing the data can belong to only one IS status group and the treatment outcome measures for one individual are independent of the treatment outcomes measures for any other individual (Troncoso Skidmore & Thompson, 2013). The dependent variables must be normally distributed; each measure of the treatment outcomes reflected a skew statistic of less than one, indicating an approximately normal distribution (Troncoso Skidmore & Thompson, 2013). No outliers were found. One of the independent variables must be categorical, which was reflected in the use of IS services or not (Troncoso Skidmore & Thompson, 2013). The last assumption that must be considered is sphericity, that is the variances of the differences between all combinations of related groups must be equal (Troncoso Skidmore & Thompson, 2013). This is a notion like the assumption of homogeneity for an ANOVA.

Sphericity Testing Between Groups

For this data, sphericity conditions were not met [$X^2(5) = 15.28$, $p = 0.009$]. Mauchly's W is not to be trusted with a small sample size as was the case with this study. Therefore, Greenhouse-Geisser was used to determine if the assumption of sphericity was

met. As Greenhouse-Geisser was .804, i.e., greater than .75, then the Huynh-Feldt less conservative correction was used to determine sphericity conditions of within-subject effects. Under the Huynh-Feldt assumption, results showed that there were statistical differences in treatment outcomes and reductions in symptoms within each participant in the same group over the course of treatment [F (3, 34) = 3.0, p = 0.040; partial $\eta 2$ = 0.081]. In other words, between the two groups of participants who were using or not using IS, the individuals had significant differences in their treatment outcomes with a moderate effect size. However, when treatment outcomes were compared based on interactions between time and presence or absence of IS service under the Huynh-Feldt assumption, results showed that no statistical differences existed [F (3, 34) = 0.157, p = 0.908; partial $\eta 2$ = 0.005]. In other words, treatment outcomes did not vary over time based on using or not using IS services.

Within Subjects Effect of Treatment Outcome Trending Over Time

Patterns of treatment outcome trending were assessed at two levels. First, treatment outcome trending, regardless of which group treatment records evaluated belonged to, was completed. As time progressed, symptom levels in clients decreased, thereby improving treatment outcomes [F (1, 34) = 7.169, p = 0.011; partial $\eta 2$ = 0.174]. Second, when patterns of treatment outcome trending were evaluated based on interactions between time factor and presence or absence of IS, rates of symptom reduction and treatment outcome were not significantly different between members of groups shown in Appendix C [F (1, 34) = 0.238, p = 0.629; partial $\eta 2$ = 0.007].

Between Subjects Effect of Treatment Outcome Trending Over Time

Treatment outcome averages were next calculated with respect to time for both groups. Averages of treatment outcomes were determined at entry to treatment, then three, six, and nine months. Using those mean values from each group, comparisons were made to determine differences in rates of treatment outcome and symptom reduction. Results showed that rates of treatment outcome changes were not significantly different between the two groups based on the presence or absence of IS shown in Appendix D [F (1, 34) = 1.254, p = 0.271; partial $\eta 2$ = 0.036].

Treatment Outcome Comparison at Each Time Point

Next, pairwise comparisons at each time point (i.e.: from three to nine months treatment outcome readings) in treatment process were made between the two groups explained in table 4. When compared at the three-month treatment outcome readings, there were no differences in rates of treatment progression between the groups with a significance of p = 0.489. When compared at the 6-month treatment outcome readings, there were no differences in rates of treatment progression between the groups with a significance of p = 0.239. When compared at the 9-month treatment outcome readings, there were no differences in rates of treatment progression between the groups with a significance of p = 0.284.

Table 4

Treatment Outcome Comparison at Each Time Point

	With IS Services	Without IS services
Time		
3 Months		
Mean Difference	-4.431	4.431
Sig	0.489	0.489
95% Confidence Interval for Difference		
Lower Bound	-17.312	-8.450
Upper Bound	-8.450	17.312
6 Months		
Mean Difference	-7.769	7.769
Sig	0.239	0.239
95% Confidence Interval for Difference		
Lower Bound	-20.949	5.410
Upper Bound	-5.410	20.949
9 Months		
Mean Difference	-6.638	6.638
Sig	0.284	0.284
95% Confidence Interval for Difference		
Lower Bound	-19.039	5.762
Upper Bound	-5.762	19.039

Chapter Summary

The focus of this chapter is to provide clear descriptions of how data collected answered the primary research question. The aim was to first establish that the two groups being compared closely aligned with one another. To complete this process, average age and gender distributions were determined using both descriptive statistics and independent t-tests. Socioeconomic considerations that included evaluations of annual household income between the groups were analyzed, again using both descriptive statistics and t-tests. To determine whether the sample accurately reflected diagnoses of

focus was another step completed. While keeping diagnostic variable between the two groups similar, results showed that presence or absence of IS did not have an impact in treatment outcomes of treatment records examined. The outcome of this study is crucial to understanding how mental health providers working with clients who need language support should plan and implement treatment strategies. Soon in chapter five, recommendations and social change implications from this study are discussed.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to determine if pediatric and adolescent (ages 4-17 years) counseling, delivered with the use of IS could reflect the same: (a) client progress in treatment and (b) treatment outcomes as counseling delivered with no IS needed. This was an ex post facto quantitative design that examined treatment records of pediatric and adolescent clients from one outpatient mental health facility. Treatment record data examined were collected for over a period of a year where the application of IS was present for one group. The introduction of IS started at the beginning of treatment and it was maintained for the duration of treatment. Treatment outcomes were measured at intake, 3 months, 6 months, and 9 months. No differences in: (a) client progress in treatment or (b) treatment outcomes were found between clients who used IS services and those who did not.

Since the group of clients receiving treatment needs through the presence of IS were provided similar levels of care in an outpatient capacity, interpretations that can be made from outcomes observed would be that clients with limited English proficiency were still able to adequately communicate with their providers. Also, the assumption is that clients with language barriers may have still been able to develop enough levels of therapeutic alliance to work with their counselors about their treatment needs for outcome results to show no statistically significant differences between the two groups evaluated.

Interpretations of Findings

Findings from this study indicated that for pediatric and adolescent clients having diagnoses of: (a) anxiety, (b) ADHD, (c) depression, and (d) mood dysregulation disorder, who used and did not use IS, no difference in treatment outcomes over time were found. This suggests that the use of IS was not a barrier to the effectiveness of therapeutic delivery. Quantitative research on how the use of IS influenced treatment outcomes has all focused-on adult populations, many of whom were identified as refugees (d'Ardenne et al. 2007; Brune et al. 2011; Lambert & Alhassoon 2015; Schulz et al. 2006; Van der Rijken et al. 2016) has supported that using IS services is not barrier to achieving treatment outcomes equal those were IS was not used.

Schulz et al. (2006) focused on adult refugee clients who have migrated to the United States and who presented with symptoms of PTSD. Half of those clients reported using IS to receive treatments while the other did not require IS. Schulz et al. concluded that IS use was not a barrier to treatment delivery. Similarly, d'Ardenne et al. (2007) examined adult clients with PTSD symptoms in England who were receiving CBT-focused treatment delivery. Like with Schulz et al. (2006), use of IS supported clients to achieve positive treatment outcomes. Brune et al. (2011) also focused on refugee clients in two European countries who have reported symptoms of PTSD. Again, this study focused on adult clients. Brune et al. also communicated that IS use was not a barrier to treatment and that outcomes between groups using and not using IS were similar. Adding to this position was Lambert and Alhassoon's (2015) study concentrating on trauma-focused treatments in the presence of IS in adults. Once again, IS use resulted in similar

outcomes as no IS use. Van der Rijken et al. (2016) was the only study focusing on youth crime rates that was completed in the Netherlands. While using treatment conditions of multisystemic therapy (MST), outcomes again showed that post-treatment crime rates were not different between group using and not using IS. This dissertation study was the first of its kind that has been done in the U.S. that focused on use of IS in children receiving mental health treatments. This study found that the presence of IS was not a barrier to treatment in pediatric and adolescent clients.

This study was grounded in Ridley et al.'s (2021) Process Model of Multicultural Counseling Competence that discussed processes dealing with therapeutic alliance formation and implementation of treatments needs. Ridley et al. also explained external ways of how providers can affectively incorporate deep culture integration to practice. With the use of IS services in this study, the interpreters did more than just literature translation. They served in the role of culture broker, providing counselors awareness of clients' cultural backgrounds and customs.

Limitations of the Study

Several limitations are noticeable from this study. For example, sample selection for this study was limited to a few clients obtained from one outpatient mental health facility. The sampling process did not include other non-English speakers. Only treatment outcomes of Spanish-speaking clients were compared against English-speaking clients. Other limitations of this study include other clients who were Spanish speaking being excluded from the study if they did not meet specified diagnostic criteria. Also, the two groups compared were not equivalent in that they varied in age and diagnosis

distributions. In a secondary data analysis, there are no defenses for threats to internal validity which include selection threats and threats from repeatedly using the same measuring instrument. First, selecting only those clients who completed the full course of treatment that lasted nine months. Those who may have found treatment unsatisfactory and dropped out are not included in the study. We also do not know if one reason for why they may have left treatment was due to IS not working for them. Those who stayed in treatment may have realized that completing the measuring instrument to indicate diminishment of symptoms was desired by influential figures such as counselors, parents, and even interpreters. Therefore, readers are advised to consider the generalizability of this study's findings under limitations identified.

Recommendations

This study was possible because of the use of standardized assessment measures of treatment outcomes of those who did and did not use IS services while receiving counseling treatments at an outpatient mental health facility. As noted by Lyon et al. (2015), use of standardized assessment measurements is integral to developing evidence-based practice protocols for mental health needs. Therefore, a recommendation for both best practice and future research is the routine inclusion of standard treatment outcome assessments collected during beginning and ending stages of treatment processes. This approach to treatment can promote closer monitoring of symptomatic changes in clients over the course of treatments (Lyon et al., 2015).

This study used the theoretical underpinnings of Ridley et al.'s (2021) process model of multicultural counseling competence, which puts culture at the center of the counseling process. This model supports the position that interpreters provide more than literal word-for-word interpretations, and the need for counselors to accept them as cultural brokers working to increase counselors' understandings of their clients' contextual frameworks (Ridley et al., 2021). When IS services were used in this study, it was assumed they were equivalent and that they followed the cultural broker model. Greater insight into the operationalization of the cultural broker model and its value in support of counseling merits further research.

This study found that equal treatment outcomes resulted when appropriate use of IS services were implemented. When followed over the course of 4 three-month interval treatment periods, outcome differences in treatments were not present even when treatments were delivered through triadic communications through IS services. These findings were made under restricted conditions that included diagnoses, treatment length, and treatment providing facility. However, this study did not answer the question of whether differences in treatment outcomes existed in the presence of IS when treatment lengths are longer than a year or under other diagnostic and language barrier conditions not evaluated in this study. Future researchers are encouraged to consider the evaluation of whether IS presence makes a difference in treatment outcomes in languages other than Spanish and when diagnostic criteria are broader.

Implications

This study is aligned with the body of knowledge supporting that use of IS while counseling various adult client populations in various situations has yielded outcomes equivalent to those receiving counseling without needing IS. This study extended these finding to a new population of child clients. Over the past three decades, there has been increasing numbers of immigrants entering the U.S. seeking refuge from political and economic crisis (MPI, n.d.). Sadly, current world events suggest that this flow of immigrants will increase with war in Europe as well as other parts of the world. As families flee from these dire circumstances, they often develop mental health issues associated with trauma, anxiety, and depression (Solberg et al., 2020). Their mental health may be further jeopardized by displacement, having to re-build their lives in a new culture, and separation from extended families and other support systems (Solberg et al., 2020). Many of these families may have LEP and may therefore benefit from counseling when proper IS services arrangements are made (Chang et al., 2021). For counselors to have confidence that IS can be used to support positive treatment outcomes with these clients reflects positive social change.

The hope is that the results of this study will provide reassurance and guidance to both communities and mental health providers that quality clinical services can still be delivered to non-English speaking clients when effective IS services that are consistent with Ridley et al.'s (2021) process model of multicultural counseling competence are implemented. This model supports the position that interpreters provide more than literal word-for-word interpretations, and the need for counselors to accept them as cultural

brokers working to increase counselors' understandings of their clients' contextual frameworks. Findings from this study also reiterate the message that effective communication is a precursor to high treatment efficacy. At an institutional policy-making level, the hope is that this study was also able to highlight the demand for expansion of culturally competent mental healthcare access due to continued growth in population and in diversity. At the clinical, mental health providers can be informed about best treatment practices under the Process Model of Multicultural Counseling Competence.

Conclusion

This secondary analysis of treatment outcomes data from an inner-city clinic indicated no differences between children who did not need to use interpreters in counseling and those who, because of limited English proficiency, did need IS services. This study is the first known to examine the use of IS services in counseling with child clients. It affirms that IS services may help counselors in achieving beneficial outcomes even when working with children who cannot directly communicate with the counselor in their languages. This provides support for using counseling with non-English speaking populations who have frequently been underserved and who, because of the challenges of moving to a new country, often need counseling services to help them adapt.

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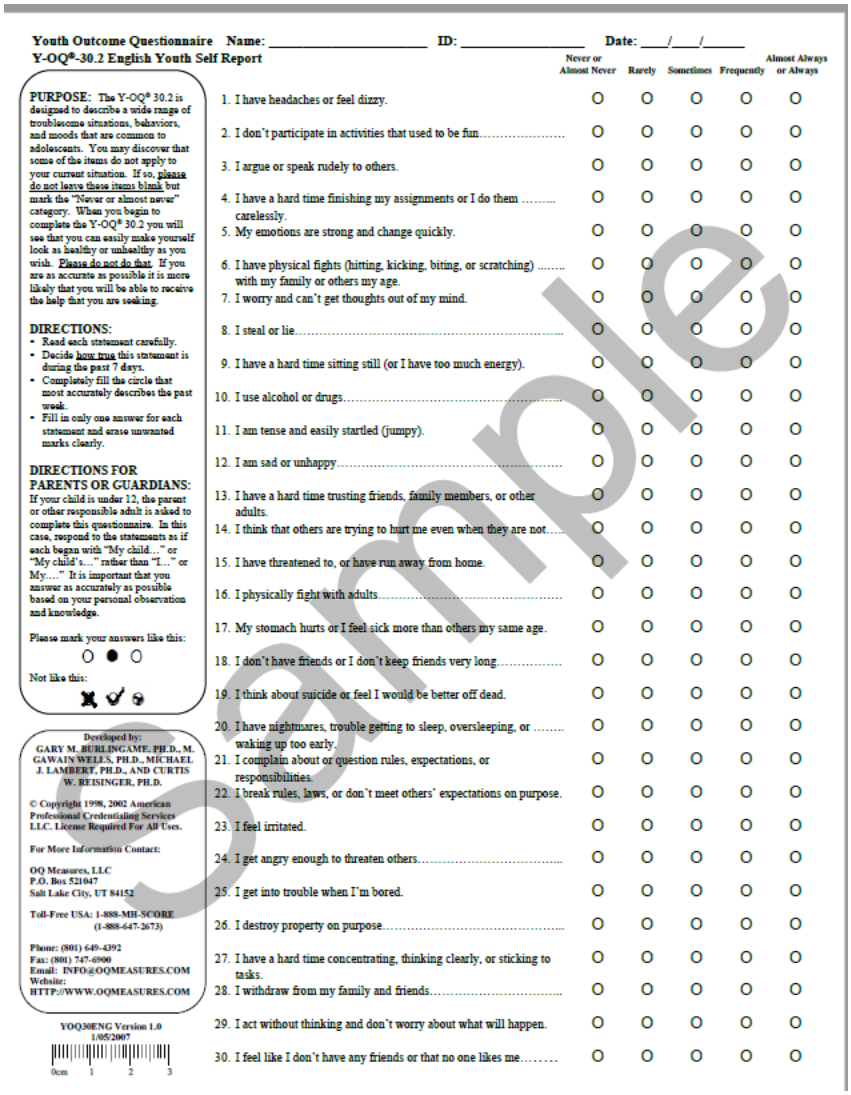
Appendix A: Youth Outcome Questionnaire Self Report (Y-OQ) 30.2



Youth Outcome Questionnaire Name: _____ ID: _____ Date: ____/____/_____

Y-OQ®-30.2 English Youth Self Report

PURPOSE: The Y-OQ® 30.2 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but mark the "Never or almost never" category. When you begin to complete the Y-OQ® 30.2 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS:
- Read each statement carefully.
- Decide how true this statement is during the past 7 days.
- Completely fill the circle that most accurately describes the past week.
- Fill in only one answer for each statement and erase unwanted marks clearly.

DIRECTIONS FOR PARENTS OR GUARDIANS: If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child…" or "My child's…" rather than "I…" or My…." It is important that you answer as accurately as possible based on your personal observation and knowledge.

Please mark your answers like this: O ● O

Not like this: ✖ ✔ ⊘

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy.	O	O	O	O	O
2. I don't participate in activities that used to be fun.	O	O	O	O	O
3. I argue or speak rudely to others.	O	O	O	O	O
4. I have a hard time finishing my assignments or I do them carelessly.	O	O	O	O	O
5. My emotions are strong and change quickly.	O	O	O	O	O
6. I have physical fights (hitting, kicking, biting, or scratching) with my family or others my age.	O	O	O	O	O
7. I worry and can't get thoughts out of my mind.	O	O	O	O	O
8. I steal or lie.	O	O	O	O	O
9. I have a hard time sitting still (or I have too much energy).	O	O	O	O	O
10. I use alcohol or drugs.	O	O	O	O	O
11. I am tense and easily startled (jumpy).	O	O	O	O	O
12. I am sad or unhappy.	O	O	O	O	O
13. I have a hard time trusting friends, family members, or other adults.	O	O	O	O	O
14. I think that others are trying to hurt me even when they are not.	O	O	O	O	O
15. I have threatened to, or have run away from home.	O	O	O	O	O
16. I physically fight with adults.	O	O	O	O	O
17. My stomach hurts or I feel sick more than others my same age.	O	O	O	O	O
18. I don't have friends or I don't keep friends very long.	O	O	O	O	O
19. I think about suicide or feel I would be better off dead.	O	O	O	O	O
20. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early.	O	O	O	O	O
21. I complain about or question rules, expectations, or responsibilities.	O	O	O	O	O
22. I break rules, laws, or don't meet others' expectations on purpose.	O	O	O	O	O
23. I feel irritated.	O	O	O	O	O
24. I get angry enough to threaten others.	O	O	O	O	O
25. I get into trouble when I'm bored.	O	O	O	O	O
26. I destroy property on purpose.	O	O	O	O	O
27. I have a hard time concentrating, thinking clearly, or sticking to tasks.	O	O	O	O	O
28. I withdraw from my family and friends.	O	O	O	O	O
29. I act without thinking and don't worry about what will happen.	O	O	O	O	O
30. I feel like I don't have any friends or that no one likes me.	O	O	O	O	O

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YOQ30ENG Version 1.0
1/05/2007

Appendix B: Youth Outcome Questionnaire Parent Report (Y-OQ) 30.2

Youth Outcome Questionnaire **Name:** _____ **ID:** _____ **Date:** ___/___/_____

Y-OQ®-30.2 English Youth Omni-Form

PURPOSE: The Y-OQ® 30.2 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but mark the "Never or almost never" category. When you begin to complete the Y-OQ® 30.2 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS:

- Read each statement carefully.
- Decide how true this statement is during the past 7 days.
- Completely fill the circle that most accurately describes the past week.
- Fill in only one answer for each statement and erase unwanted marks clearly.

DIRECTIONS FOR PARENTS OR GUARDIANS: If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child…" or "My child's…" rather than "I…" or My…." It is important that you answer as accurately as possible based on your personal observation and knowledge.

Please mark your answers like this: O ● O

Not like this: ✖ ✔ ◒

Developed by:
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YOQ30ENG Version 1.0
1/05/2007

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. My child complains of dizziness or headaches.	O	O	O	O	O
2. My child doesn't participate in activities that were previously enjoyable.	O	O	O	O	O
3. My child argues or is verbally disrespectful.	O	O	O	O	O
4. My child has difficulty completing assignments, or completes them carelessly.	O	O	O	O	O
5. My child experiences rapidly changing and strong emotions.	O	O	O	O	O
6. My child gets into physical fights with peers or family members.	O	O	O	O	O
7. My child worries and can't get certain ideas out of his/her mind.	O	O	O	O	O
8. My child steals or lies.	O	O	O	O	O
9. My child is fidgety, restless or hyperactive.	O	O	O	O	O
10. My child uses alcohol or drugs.	O	O	O	O	O
11. My child seems tense, easily startled.	O	O	O	O	O
12. My child appears sad or unhappy.	O	O	O	O	O
13. My child has a negative, distrustful attitude towards friends, family members, or other adults.	O	O	O	O	O
14. My child believes that others are trying to hurt him/her even when they are not.	O	O	O	O	O
15. My child threatens to, or has run away from home.	O	O	O	O	O
16. My child is aggressive toward adults.	O	O	O	O	O
17. My child complains of stomach pain or I feeling sick more than other kids of the same age.	O	O	O	O	O
18. My child doesn't have close friends.	O	O	O	O	O
19. My child thinks about suicide, says s/he would be better off if s/he were dead.	O	O	O	O	O
20. My child complains of nightmares, difficulty getting to sleep, oversleeping, or waking up from sleep too early.	O	O	O	O	O
21. My child complains about or challenges rules, expectations, or responsibilities.	O	O	O	O	O
22. My child deliberately breaks rules, laws, or expectations.	O	O	O	O	O
23. My child is irritable.	O	O	O	O	O
24. My child becomes angry enough to be threatening to others.	O	O	O	O	O
25. My child seems to stir up trouble when bored.	O	O	O	O	O
26. My child has deliberately destroyed property.	O	O	O	O	O
27. My child has a hard time concentrating, thinking clearly, or attending to tasks.	O	O	O	O	O
28. My child pulls away from family or friends.	O	O	O	O	O
29. My child acts impulsively, without thinking of the consequences.	O	O	O	O	O
30. My child feels that he/she doesn't have any friends or that no one likes him/her.	O	O	O	O	O

Appendix C: Within Subjects Effect

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power[a]
Time	Linear	857.255	1	857.255	7.169	0.011	0.174	7.169	0.739
	Quadratic	82.735	1	82.735	1.205	0.280	0.034	1.205	0.187
	Cubic	85.299	1	85.299	0.556	0.461	0.016	0.556	0.112
Time * UseofIS	Linear	28.455	1	28.455	0.238	0.629	0.007	0.238	0.076
	Quadratic	1.068	1	1.068	0.016	0.901	0.000	0.016	0.052
	Cubic	24.099	1	24.099	0.157	0.694	0.005	0.157	0.067
Error(Time)	Linear	4065.672	34	119.579					
	Quadratic	2335.154	34	68.681					
	Cubic	5220.051	34	153.531					

Appendix D: Between Subjects Effect

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power[a]
Intercept	163401.246	1	163401.246	203.252	0.000	0.857	203.252	1.000
UseofIS	1008.246	1	1008.246	1.254	0.271	0.036	1.254	0.193
Error	27333.754	34	803.934					