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Más allá de las barreras: Competency and practice considerations in language, cultural, and social issues when delivering group CPT to Hispanic immigrants

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Abstract

High rates of under-assessed trauma and psychiatric disorders, particularly posttraumatic stress disorder (PTSD) have been reported among Hispanic immigrants, especially as related to immigration trauma. Multiple studies have shown group cognitive processing therapy (CPT) to be an effective evidence-based practice (EBP) for treatment of PTSD across a number of clinical populations. To date, however, no studies have examined important competency and practice issues in linguistic, cultural, and ethical areas that group CPT providers should consider when delivering group CPT to Hispanic immigrants. This paper aims to outline these and provide future directions for research.

Keywords

group therapy; Hispanic; immigration trauma; cognitive processing therapy; Latino

Immigration Crisis

Since the existence of United States (U.S.) census records, an historic high of 44.5 million immigrants were living in the U.S. in 2017 and they comprised 13.7% of the national population (Zong, Batalova, & Burrows, 2019). Latinos made up the largest immigrant group in 2017, with data showing that they accounted for 44% (19.7 million) of the total U.S. immigrant population (Zong et al., 2019). Between 2010 and 2017, 9.5 million immigrants came to the U.S, with the number of Hispanic immigrants coming from Latin American countries increasing more than from any other part of the world (Camarota & Zeigler, 2018). While the number of immigrants coming from Mexico since 2010 has declined, Mexico continues to be the highest immigration sending country worldwide and accounts for 13.2% all immigrations entering the U.S. between 2010 and 2017 (Camarota & Zeigler, 2018) and there has been enormous immigration growth coming through Mexico from other Latin American countries (Camarota & Zeigler, 2018), too.

With regard to illegal immigration, of the 44.5 million immigrants living in the U.S., it is estimated that there were 11.3 million undocumented immigrants in the U.S. in 2017, with approximately 50% residing in either California, Texas, or New York (Zong et al., 2019). Further, during the 2018 fiscal year, there were a total of 404,142 apprehensions of immigrants attempting illegal entry into the U.S. made by U.S. Border Patrol agents (U.S Customs and Border Protection, 2019a) with 396,579 of these arrests occurring at the Southwest border of the U.S (U.S Customs and Border Protection, 2019b). The majority of these immigrants attempting illegal entry into the U.S. came from Latin American countries with immigrants from Mexico, Guatemala, Honduras, and El Salvador having the highest numbers worldwide. These figures represent a 30% surge in illegal immigrant entry for 2017 during which there were 310,531 apprehensions. This upward trend in illegal immigration, particularly from Latin America, has continued to increase with 2019 already seeing more apprehensions to date (nearing 1 million) than prior yearly totals (U.S. Customs and Border Protection, 2019b).

Why do Hispanic immigrants come?

Generally speaking, Hispanic immigrants come to the U.S. from Latin America seeking reprieve from poverty, political oppression, and violence from various sources (de Arellano, Andrews, Reid-Quinones, Vásquez, Doherty, Danielson & Rheingold, 2018). Along the way from their country of origin to the Southwestern U.S. – Mexico land border, Hispanic immigrants face a host of potential traumatic stressors ranging from assaults, serious illness, and violence to dangerous weather exposure (de Arellano et al 2018). Stressors may be viewed as particularly traumatic for those attempting to enter the U.S. illegally or with an undocumented status (de Arellano et al 2018) and for many, “immigration itself qualifies as a traumatic event, even in the absence of any other identifiable traumatic event” (p. 171, de Arellano et al 2018). Further, Hispanic immigrants may be more likely than non-Hispanics to develop PTSD following exposure to a traumatic event (Valentine et al., 2017; Vásquez, de Arellano, Reid-Quinones, Bridges, Rheingold, Stocker, & Danielson, 2012) and yet may experience more barriers in receiving care for PTSD, in part due to immigrant and undocumented legal status (Bridges, Andrews, & Deen, 2012; Valentine et al., 2017).

Thus, for mental health therapists (e.g., social workers, counselors, psychologists, psychiatrists) and other helping professionals (e.g., clergy and pastoral counselors) seeking to treat mental health problems associated with experiences of trauma among the Hispanic immigrant population (e.g., posttraumatic stress disorder; PTSD) it is important to be knowledgeable about immigration-related trauma (i.e., immigration trauma) and related treatment issues. The present paper reviews immigration related trauma; common barriers to mental health care utilization by immigrants; available evidence-based practices for treatment of trauma and stressor-related disorders, with a focus on group Cognitive Processing Therapy (CPT); and, some of the most important practice considerations for therapists engaged in the mental health care of Hispanic immigrants.

Trauma Experienced by Immigrants

When examining immigration-related trauma exposure, the timing of exposure can be divided into three phases: *pre-migration*, *in-transit*, and *post-migration* (Cleary, Snead, Dietz-Chavez, Rivera, & Edberg, 2018; de Arellano et al., 2018; Kirmayer et al., 2011). Pre-migration and post-migration have likely received the most attention in the research literature. Nevertheless, each phase appears to carry distinct types of trauma-related exposure risks (Cleary et al., 2018; Kirmayer et al., 2011). During pre-migration, immigrating adults face myriad potentially traumatic events often forming parts of the “push” factors that drive their migration decisions (e.g., widespread community violence, political violence, domestic violence, and extreme poverty; Alegría et al., 2007; Fortuna, Porche, & Alegría, 2008; Li, 2016; Perreira & Ornelas, 2013). These traumatic events, when defined clinically, are most often those events that include “exposure to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013, p. 271), and these may be compounded by economic, educational, and occupational challenges (Kirmayer et al., 2011). Li (2016) found that approximately half of adult Latino immigrants experienced identifiable traumatic events pre-migration. Among specific event types, Fortuna and colleagues (2008) found that pre-migration political violence exposure varied across different countries of origin, but that more than 10% of many Latin American immigrant groups reported exposure to some political violence pre-migration. Those exposed to political violence also reported poorer health and mental health outcomes, but higher income, healthcare access, and rates of US citizenship. Overall, Cleary et al (2018) reported that among Hispanic immigrant youth, 59% of those who reported trauma experiences associated with migration, experienced it during the pre-migration phase. And experiences of pre-migration trauma predict several forms of acculturative stress for Hispanic immigrants (Li, 2016).

The in-transit phase carries with it arrayed risks, too. The umbrella term (in-transit trauma) refers to the various traumatic experiences immigrants may encounter during the physical relocation process (de Arellano et al., 2018). Physical violence, sexual assault and rape, familial and community separation, kidnappings, abuse and exploitation from human traffickers, malnutrition, witnessing violence and death, and uncertainty about the migration outcome are all risks that immigrants may be exposed to during their migration journeys (de Arellano et al., 2018; Noroña, Velasco-Hodgson, Flores, & Eudison, 2018; Perreira & Ornelas, 2013). Exposure to any of these events places individuals at an increased risk for

trauma-related psychological symptoms and other mental health problems. One study with Hispanic immigrant youth indicated that almost 52% experienced violence during the migration phase (Gudiño, Nadeem, Kataoka, & Lau, 2011). Other studies with Hispanic immigrant youth have found lower, but still high and alarming rates of *in-transit* trauma exposure (Cleary et al., 2018; de Arellano et al., 2018) with adult female immigrants at significantly higher risk for both exposure to any in-transit trauma (Perreira & Ornelas, 2013), including sexual assault, as well as a significantly higher risk for reporting PTSD symptoms (Perreira & Ornelas, 2013).

Most research on post-migration risk factors examines the degree to which immigration-related experiences increase mental health risk in isolation, or how these experiences may accumulate together with other stressful and traumatic experiences compounding the effects of prior and concurrent traumatic event exposure (i.e., stress proliferation; Li, 2016). For adults, post-migration risk factors overlap and extend beyond the pre-migration and in-transit phase challenges (Kirmayer et al., 2011). They include uncertainty about immigration or refugee status after arrival in the host country; continual fear of family separation by government agencies via deportation orders; lack of family or community support; language barriers; concerns regarding family members left in the country of origin; discrimination; poverty; exploitation; violence; and, perhaps most frequently examined, difficulties related to acculturation and adaptation (see acculturative stress, Li, 2016; Bustamante, Cerqueira, Leclerc, & Brietzke, 2018; Cleary et al., 2018; Kirmayer et al., 2011).

Among Hispanic immigrants, legal status represents a critical post-migration risk factor that is related to high levels of emotional distress, poor health, and lower levels of access and utilization of healthcare (Li, 2016; Takeuchi, 2016; Torres & Wallace, 2013). Moreover, having an undocumented immigrant status (and continuous threat of deportation) is an additional barrier to well-being due to increased stress that magnifies the impact of negative events (Kirmayer et al., 2011; Noroña et al., 2018). Immigrant children who have experienced parental deportation are also susceptible to greater mental health and behavioral problems, including depression, anxiety, sleep difficulties, emotional and behavioral dysregulation, and poorer academic performance (Allen, Cisneros, & Tellez, 2015). Given the high degree of uncertainty that occurs during parental deportation, such an event may also be classified as a potentially traumatic event.

In summary, many Hispanic immigrants experience multiple immigration-related traumatic events, as well as compounding stressors such as undocumented legal status, that increase risk for multiple negative mental health outcomes. While epidemiological data have provided mixed results regarding the relative rates of mental health disorders across immigrants and non-immigrants (Alegría et al., 2007; Breslau et al., 2009), it is important for clinicians to thoroughly assess migration related stressors (de Arellano et al., 2018), whether prior or ongoing, and for researchers to consider mental health care access and barriers to service utilization.

Mental Healthcare Services Utilization by Hispanic Immigrants

As noted previously, factors related to the immigration process may not only increase mental health risks for immigrants, but also raise barriers to immigrants' receipt of mental health care (Bustamante et al., 2018; Cleary et al., 2018; Kirmayer et al., 2011; Noroña et al., 2018). Indeed, research has continued to demonstrate that immigrants have lower utilization rates of mental health care services compared to non-immigrants for numerous reasons. Bauldry and Szaflarski (2017) looked at immigrant disparities in mental health care utilization amongst different racial/ethnic backgrounds as well as country of origin. Some of the factors that impacted utilization in health care services were education, income, and health insurance (Bauldry & Szaflarski, 2017). Furthermore, first-generation immigrants utilized mental health care for mood and anxiety disorders less than second-generation and non-immigrants. Disparities related to country of nativity and use of treatment were also observed. The lowest rates of health care utilization were found among individuals of Hispanic (especially Mexican) and African origin.

Some factors that may account for lower usage among 1st generation immigrants may be related to acculturation (Bauldry & Szaflarski, 2017) as well as perceived discrimination and lack of trust of the medical providers (i.e., medical mistrust; López-Cevallos & Harvey, 2016; Oakley, López-Cevallos & Harvey, 2019). For example, Bauldry and Szaflarski (2017) found that higher acculturation was associated with higher probability of mental health care utilization for mood and anxiety disorders. More specifically, results demonstrated that the amount of years living in the United States and higher scores on the identity dimension of acculturation were shown to have a direct relationship with likelihood of services utilization, possibly due to lower medical mistrust, although a relationship between medical mistrust and acculturation has not been shown consistently (Oakley et al. 2019).

Regarding discrimination, foreign born Hispanics report experiences of health care discrimination more frequently than native-born Hispanics (López-Cevallos & Harvey, 2016). It is especially felt among undocumented immigrants and their family members, partly due to the continuous fear of deportation (Noroña et al., 2018; Oakley et al. 2019; López-Cevallos & Harvey, 2016). Immigrants who live in areas where deportations occur frequently are more likely to avoid participating in health care services as there is a greater fear of deportation (Oakley et al. 2019). Additionally, a recent study showed a direct relationship between perceived daily discrimination, the cultural variable of *machismo* and medical mistrust (Oakley et al. 2019). The same study showed a negative relationship between the cultural value of *familismo* and medical mistrust (Oakley et al. 2019). These results suggest that gender and other cultural values may also play a role in predicting health care services utilization.

Other factors to consider regarding service utilization include immigrants' prior negative experiences with health care providers in their native countries (Dow, 2011); low mental health literacy (Jorm, 2012); stigma regarding receipt of mental health care services (Dow, 2011; Hoskins, Duncan, Moskowitz, & Ordoñez, 2018); and, limited English language proficiency (Dow, 2011); as well as knowledge deficits about the U.S. health care system (Bauldry & Szaflarski, 2017); the presentation of options for care inconsistent with

immigrants' cultural perspectives on mental health (Bauldry & Szaflarski, 2017); and, lack of cultural sensitivity among mental health care providers (Bauldry & Szaflarski, 2017). Thus, any specific care or treatment modalities aimed at serving Hispanic immigrants must consider and address access or utilization issues in addition to cultural, linguistic, and other factors noted here.

Why Group Therapy?

Group therapy modalities are appealing because they can increase access and lower utilization barriers to mental health care for immigrants by extending services to a larger number of clients, more cheaply, while achieving beneficial results (Deblinger, Pollio, & Dorsey, 2016). Group therapy requires a fewer number of therapists to reach a greater number of clients, which ultimately reduces waitlists, in underserved areas where access to mental health care is scarce (Deblinger et al., 2016). Group therapy may also be ideal for individuals receiving services through the public sector (Aguilera, Bruehlman-Senecal, Liu, & Bravin, 2018). This is particularly pertinent to services offered to immigrants as providers are usually constrained by funding resources (Afkhami & Gorentz, 2018), therefore making group interventions a plausible solution to lack of funds for client populations with lower socioeconomic status and who typically underutilize mental health services (Stacciarini, O'Keefe, & Mathews, 2007) such as a significant proportion of Hispanic immigrants. Further, because reimbursement rates for group psychotherapy sessions are lower than for individual sessions, there is a higher likelihood of immigrant clients being able to pay the lower fees "out of pocket," even without private- or public-sector 3rd party payor assistance. Therefore, the choice to utilize individual or group therapy may be more relevantly determined by contextual factors such as waiting lists, costs, and client inclinations to a certain approach (Deblinger et al., 2016).

Group Factors that Make It Ideal for Immigrants and Trauma

Group therapy that is focused on trauma can be helpful in diminishing feelings of shame, isolation, and stigma that frequently accompanies traumatic experiences (Deblinger et al., 2016). It can also serve as an important tool for destigmatizing traumatic events and foster a sense of a shared experience among group members that helps to ameliorate shame, guilt, and isolation (Deblinger et al., 2016). The group can be an ideal setting for clients to gain understanding of how interpersonal interactions are negatively impacted by shame, while being (paradoxically) maintained by the unhealthy coping mechanisms to avoid these feelings (Counselman, 2008). This is especially important as previous research has indicated that feelings of shame are strongly correlated with long-term instability and development of PTSD following several types of trauma (Deblinger et al., 2016; Vásquez et al., 2012). Moreover, a group therapeutic modality is an ideal setting for the process of "bearing witness," which refers to an individual's moral duty to "testify" to their experience of a traumatic and seminal event and believing it a moral duty to testify to this issue (Figley, 2012). Bearing witness conveys a truth and requires courage (Figley, 2012). Within the group, therapist and clients (i.e., group members) witness traumatic narratives, which helps survivors in the process of meaning-making of their traumatic experience (Gabriel, 1994; Blackwell, 2005). Thus, bearing witness is a powerful source of healing in group therapy.

The group therapeutic modality is characterized by the therapeutic factors of group cohesion and interpersonal learning (Yalom & Leszcz, 2005). Group cohesion is synonymous with the therapeutic relationship, except that instead of only the client-therapist relationship, group cohesion is comprised of client-client, client-group, and client-therapist relationships (Burlingame, McClendon, & Alonso, 2011). Group cohesion is important in the treatment of trauma because it allows the clients to feel protected and held when experiencing intense emotions (Soo & Schamess, 2005). Moreover, interpersonal learning is another factor that is significant in group therapy for trauma (Yalom & Leszcz, 2005). Many traumatic experiences are, by their nature, interpersonally violent or evoke reactions of fear and helplessness (Foy, Erikson, & Trice, 2001). Thus, victims and survivors of trauma may find themselves questioning whether they may trust others to help them in times of need. Yet, during group therapy they may join others when dealing with consequences of the trauma, including isolation, alienation, and emotional numbing (Foy et al., 2001). Interpersonal learning through sharing intimate experiences, imitating others, providing feedback and receiving feedback help victims and survivors of trauma to restore their sense of trust in others, as well as learning better ways to cope with their symptoms (Foy et al., 2001; Shechtman & Mor, 2010).

Other therapeutic factors that characterize group therapy include instillation of hope and universality (Yalom & Leszcz, 2005). These two factors are particularly important when working with immigrants because they allow group members to connect empathically, gain a shared emotional understanding of their challenges and experiences, while also increasing perceived social support (Aguilera et al., 2018; Chen, Budianto, & Wong, 2010; Chen, Kakkad, & Balzano, 2008). Therapists should also work to instill hope in immigrant group members without dismissing their past, ongoing, and acute difficulties or the reality of their current, often precarious, situations (e.g., deportment; Chen et al., 2010). Thus, because of the therapeutic factors underlying group therapy, it can serve as an effective means to promote resilience among immigrant populations (Chen et al., 2010).

Group Therapy and Hispanic Immigrants' Cultural Values

Generally, group therapy may be especially suitable for individuals belonging to ethnic minorities (such as Hispanic immigrants) as group members may share language, cultural values, religious beliefs, and traditions (Hoskins et al., 2018). Group therapy is aligned with common cultural values of Hispanic immigrants (Taylor, 2006). These include *colectivismo*, *familismo*, *simpatía* and *personalismo* (Aguilera, Garza, & Muñoz, 2010; López, Shealy, & Rheingold, 2014; Taylor, 2006), all of which express the overarching importance Hispanic cultures place on individuals putting the needs of their groups first, and building and preserving strong and warm interpersonal relationships with friends, family, and community members (López et al. 2014; Taylor, 2006). These same values are evident in group therapy as it allows individuals to work together, share their experiences, and establish a collective group experience that promotes a sense of empowerment (Taylor, 2006).

Researchers utilizing a manualized group cognitive behavioral therapy (CBT) protocol for Hispanic immigrants delivered in Spanish and found that the Hispanic cultural values of *familismo* and *simpatía* repeatedly emerged as important aspects of treatment (Aguilera,

Garza, & Muñoz, 2010). *Familismo* is described as the central role that family, and harmonious relationships within a family, plays in Latino culture with both immediate and extended family members (Aguilera et al., 2010; de Arellano, Danielson, & Felton, 2012; López et al. 2014) and even with friends considered “like family,” such as *padrinos* and *madrinas* (“godfathers” and “godmothers,” respectively) or simply *compadres* (“co-parents” or more loosely meant “close friends of the family”). *Simpatia* refers to a demonstration of respect towards others that is characterized by prioritizing friendliness and warmth in social interactions while avoiding internal emotions in order to maintain harmony in relationships (Aguilera et al., 2010; de Arellano et al. 2012; López et al. 2014).

As a strong connection with one’s family is an important part of Hispanic culture, separation from family members can result in a loss of social support and increase psychological maladjustment (Aguilera et al., 2010). Because feelings of empowerment and safety for Hispanic immigrants may come from membership in (and harmonious relationships with) a family, discussing family separation and loss with others in a group setting may bring up increased feelings of vulnerability to external stressors (e.g., such as financial problems or discrimination). In other words, a group member stating, “Half of my family was deported last week,” or “*lo mataron*,” (they [narcotics traffickers] killed him), or “*lo secuestraron*,” (they [narcotics traffickers] kidnapped him), is in essence stating, “I’m vulnerable. We are vulnerable to be taken advantage of right now” and must trust that others will not hurt them. Lower *familismo* may translate into higher feelings of vulnerability or “I cannot trust others. I can’t let anyone know what is happening. I have to go at it alone to protect my family” (similar to the stoicism of *machismo*; de Arellano et al. 2012; López et al. 2014).

In the Aguilera et al. 2010 study, therapy group members witnessed and participated in themes related to *familismo* when group members shared how immigration had distanced them from family and when they discussed killed or otherwise deceased family members. Further, as noted previously, the cultural value of *familismo* was noted to be negatively correlated with medical mistrust (Oakley et al. 2019), potentially allowing Hispanic immigrants high in *familismo* to decrease their feelings of medical mistrust, increase mental health care services utilization and benefit from mental health care. *Simpatia* was practiced in the therapy group when members provided support or and sought it from one another (Aguilera et al., 2010). Additionally, *simpatia* was also observed as new group members introduced themselves to the group and disclosed personal information (Aguilera et al., 2010).

Considering the roles that Hispanic cultural values such as *familismo* (Aguilera et al, 2010; Oakley et al., 2019), *simpatia* (Aguilera et al., 2010) and *machismo* (Oakley et al., 2019) may play in medical mistrust and in group therapy, integrating culturally sensitive aspects into manualized treatments for Hispanic clients (Aguilera, Garza, & Muñoz, 2010) may be an important practice consideration for treating Hispanic immigrants. Cultural adaptations may also decrease attrition, thereby increasing dosage effects, and may decrease the noted gap in treatment effect sizes for non-Hispanic White versus non-White or Hispanic clients seen in some studies (Frisman, Ford, Lin, Mallon, & Chang, 2008; Lamp, Avallone, Maieritsch, & Buchholz, 2019). In fact, in what may be a positive augur, a culturally modified group intervention targeted at Latino youth with trauma demonstrated positive

results with a 93% attendance rate over 10 sessions, 0% dropout rate, and large reductions in PTSD symptomology following treatment (Hoskins et al., 2018).

Specific and Effective Group Therapy Modalities for Hispanic Immigrants

Ideal treatment for Hispanic immigrants (especially those immigrants holding more traditional Hispanic values) include those that are short-term, directive, symptom-relief focused, and provide a problem-oriented structure (Organista & Muñoz, 1996). Taken as a family of trauma focused treatment modalities, both group trauma focused cognitive behavioral therapy (TF-CBT) and group Cognitive Processing Therapy (CPT) show significant promise for use with individuals suffering from immigration related posttraumatic stress disorder (PTSD) and other trauma- and stressor-related disorders. For youth, group TF-CBT has been shown to have beneficial results among boys and girls who have experienced varying types of trauma (Cohen & Mannarino, 2019; Deblinger et al., 2016). A culturally sensitive manualized group therapy approach with a sample of highly traumatized Latino youth found significant reductions in PTSD, depression, and anxiety symptomology (Hoskins et al., 2018). A seven-year follow up study with asylum seekers and refugees that were treated with trauma focused groups found that short term benefits including decreased symptoms of PTSD, depression, and anxiety were maintained at the five-year mark (Drozdek, Kamperman, Tol, Knipscheer, & Kleber, 2013). After five-years, symptoms began to increase, yet they all still remained lower at the seven-year follow-up than at baseline (Drozdek et al., 2013).

Other group interventions such as Trauma Adaptive Recovery Group Education and Therapy (TARGET) have also achieved beneficial results in terms of reductions in PTSD symptoms among substance users (Frisman, Ford, Lin, Mallon, & Chang, 2008). With this being said, non-White participants in this study achieved less beneficial results than White participants, thus highlighting the need to make culturally sensitive adaptations to trauma group interventions (Frisman et al., 2008). Another study comparing group CPT to individual CPT among veterans found that African American clients benefitted significantly less than White clients in terms of PTSD symptom reduction (Lamp, Avallone, Maieritsch, & Buchholz, 2019).

Group CPT as a treatment for immigration trauma

Cognitive Processing Therapy (CPT) is a type of cognitive behavioral therapy that aims to reduce symptoms associated with posttraumatic stress disorder (PTSD) in clients seeking treatment (Gallagher & Resick, 2012). It focuses on challenging the trauma-related maladaptive cognitions that clients hold about themselves, others, and the world around them, which cause them social and occupational impairment (Gallagher & Resick, 2012; Holliday, Holder, & Suris, 2018). The CPT treatment protocol prescribes a process of cognitive-restructuring in which individuals work to achieve a healthier and more balanced view of the traumatic event, themselves, others, and the world (Gallagher & Resick, 2012). CPT begins with developing an understanding of the relationship between thoughts and emotions, identification of automatic thoughts (stuck points) maintaining the PTSD symptomology, then can move to processing the trauma by writing a detailed account of the

experience that is then read in session (Resick, Monson, & Chard, 2016) although this is no longer required. Next the therapist engages the client in Socratic questioning to identify and modify maladaptive cognitions. The client then proceeds to practice this on her own using a series of worksheets (Resick et al., 2016).

The American Psychological Association (APA) as well as the U.S. Department of Veterans Affairs (VA) has listed CPT as an empirically supported treatment (EST) for PTSD (Gallagher & Resick, 2012) and meta-analytic studies have shown it to have the largest treatment effect sizes as compared to other PTSD treatments (Resick, Schuster Wachen, Dondanville, Pruiksma, Yarvis, Peterson, Mintz, & STRONG STAR Consortium, 2017). CPT reduces symptoms of depression and suicidal ideation in veteran and civilian populations (Holliday et al., 2018; Resick et al., 2017). Further, longitudinal and other follow-up studies demonstrate long-lasting (5 to 10 years) symptom reduction (Resick et al., 2015). In examining the effectiveness of CPT in an area closely related to immigration trauma, Schulz, Resick, Huber and Griffin (2006) found that CPT, even when using interpreters, was highly effective in reducing PTSD symptoms for Bosnian refugees.

Originally formulated as a group therapy modality (Resick & Schnicke, 1993; Resick, 2017), group CPT has been used to treat PTSD in various populations, including military and civilian sexual trauma victims, childhood sexual abuse survivors, and combat veterans (Chard et al., 2014). The biggest difference between individual and group CPT is that in individual CPT clients are afforded an opportunity to reexperience their trauma emotions in a one-on-one setting with the therapist, while in group CPT clients do not read their accounts out loud to prevent other group members from experiencing secondary traumatization (Chard et al., 2014). Instead, clients are asked to discuss and explore reactions they had during the process of writing about the event, as well as how much detail they included and stuck points identified (Chard et al., 2014).

Repeated studies have demonstrated significant treatment effectiveness of CPT over no treatment, “treatment as usual,” (TAU), and other trauma-focused process-oriented group therapy conditions whether CPT is delivered to an individual or group format (Alvarez, McLean, Harris, Rosen, Ruzek & Kimerling, 2011; Chard, Schumm, McIlvain, Bailey & Parkinson, 2011; Lamp et al., 2019; Resick et al. 2015) in veterans and active duty military personnel. Group CPT can be effectively delivered via video conferencing (VTC) with results comparable to face to face (F2F) delivery (Morland, Hynes, MacKintosh, Resick, & Chard, 2011; Morland, Mackintosh, Greene, Rosen, Chard, & Resick, 2014), a potential boon to Hispanic immigrants living in rural or otherwise underserved areas (see Ralston, Andrews, & Hope, 2019 for a review).

Researchers have noted that group therapy clients have the opportunities for increased social support; for receiving validation from their peers; to learn from other group members’ experiences; opportunities to discuss homework; and, to share symptoms and current psychosocial issues as well as emotional experiences (Chard, 2005; Lamp et al., 2019). Group therapy clients can also process their emotions with someone other than the therapist, allowing them to rely less on the therapist as time goes on and more on the group members (Chard, 2005). This process may allow clients’ experiences to be normalized and

universalized and may help clients to develop and implement new adaptive behaviors (Chard, 2005). Lastly, group CPT may increase the likelihood that a client completes a course of CPT when comparing individual to group CPT (Lamp et al., 2019; Sripada, Bohnert, Ganoczy, Blow, Valenstein, & Pfeiffer, 2016).

Research suggests CPT's mechanism of change is that it decreases the cognitive schema of hopelessness as a result of working through maladaptive cognitions related to the trauma (Gallagher & Resick, 2012). While CPT does not directly address hopelessness, researchers noted that challenging maladaptive cognitions about the trauma decreased hopelessness and improved cognitive functioning generally (Gallagher & Resick, 2012). In a randomized clinical trial, group CPT was compared to present-centered group therapy (PCGT) and results showed that significant improvements in PTSD symptom severity were noted in both conditions; however, CPT participants had greater improvement than those in the PCGT condition (Resick et al., 2015). This is similar to results from prior studies (Frost, Laska, & Wampold, 2014) showing similar decreases in overall PTSD symptom severity for clients completing individual present-centered therapy (PCT), except for some measures. While it is likely group common therapeutic factors (i.e., universality, cohesion, interpersonal learning; Yalom & Lezcz, 2005) are the most important and largely account for the efficacy of other group therapy modalities for trauma treatment in decreasing PTSD symptomology (such as PCGT), the available literature suggests group CPT may offer greater relief of PTSD symptoms for Hispanic clients via its structure and emphasis on challenging maladaptive cognitions related to the causes and effects of the trauma (Gallagher & Resick, 2012; Resick et al., 2015) as well its time-limited nature and symptom focus (Organista & Muñoz, 1996), as aforementioned. However, further dismantling studies examining therapeutic mechanisms and cultural congruency of CPT are needed to confirm these claims especially as there is a growing literature base suggesting that race and culture may matter more than previously considered as related to therapeutic effect size and attrition (Lamp et al., 2019; Maguen, Li, Madden, Seal, Neylan, Patterson, DuVall, Lujan & Shiner, 2019). Further, therapeutic mechanisms included in PCT and PCGT such as focus on maladaptive relational patterns, psychoeducation, and practical problem solving strategies (Frost et al 2014) may also be of significant value to Hispanic clients.

Therapeutic effect size differences have been noted related to CPT format delivery and client ethnicity. Both group and individual CPT modalities led to significant reductions in PTSD symptoms, but emerging research has shown larger treatment effect sizes (Lamp et al., 2019) as well as quicker treatment responses (Resick et al., 2017) for clients who complete individual CPT versus group CPT completers. Non-Hispanic Whites tend to have significantly larger therapeutic effect sizes than others suggesting that "additional attention needs to be paid to understanding the influence of race and culture on the development of... beliefs about oneself, others, and the world. Certain stuck points may involve race or culture, and working with these stuck points may be particularly important" (Lamp et al., 2019, p. 204). Indeed, recent research has shown significant racial disparities in likelihood of completion of CPT with Hispanic ethnicity linked to a lower likelihood of CPT completion at VA medical centers (Maguen et al., 2019).

Practice Considerations when Delivering Group CPT to Hispanic Immigrants

Language

One of the most important clinical practice considerations (and challenges) when working with Hispanic immigrants is language. From the sore lack of Spanish-speaking providers in the health care service centers where Hispanic immigrants seek care (Valentine, Borba, Dixon, Vaewsorn, Gallegos Guajardo, Resick, Wiltsey Stirman, & Marques, 2017) to issues related to the use of interpreters (Shulz, Resick, Huber, & Griffin, 2006), problems related to language can decrease the likelihood of individuals accessing care (Kirmayer et al. 2011; Valentine et al. 2017) as well as affect therapeutic outcomes by impeding the emotional immediacy between the therapist and client. And even when there are bilingual therapists available there is a dearth of available and sufficient Spanish-adapted protocols (Valentine et al. 2017), which can be frustrating to therapist and client alike.

Still, as Kirmayer et al. (2011) acknowledges, clients who have difficulty in speaking the language of their healthcare professionals, should use interpreters. They could be *ad hoc* (e.g., family members, conveniently available medical care staff members) or professional interpreters trained in symptom and health care related communication (Flores, 2005; Karliner et al., 2007). *Ad hoc* interpreters are not recommended because as Shulz and Resick (2006) have noted, they could be more likely to limit what information a client is willing to disclose to their mental health care providers, insert their opinions, or seek to confirm what they believe the medical provider wants to hear.

It is not surprising that undocumented immigrants report being apprehensive about disclosing certain personal and mental health information to their counselors, due to fear that this will be released to immigration authorities, potentially making it less likely they seek counseling or postpone it until a state of crisis has been reached (Furman et al., 2012; Yakushoko & Chronister, 2005). These fears may be compounded if an interpreter is being utilized in a group setting. This is especially of concern when translators are present as immigrants feel that their confidentiality is tied to the relationship that they and their family have with the interpreter (Yakushoko & Chronister, 2005).

Kirmayer and colleagues (2011) have discussed multiple approaches that CPT providers should consider when working with interpreters or other culture brokers. These include: 1. Explaining to the interpreter how the interview session is conducted; 2. Eliciting from the interpreter any personal biases they might have based on the country of origin of the clients or other client demographic variables; 3. Requesting that the interpreter maintain as close a translation as possible when assessing mental status; 4. Explaining to the interpreter the possibility that translation failure could result in misdiagnosis or iatrogenic treatment; and, 5. Creating an accepting environment for the interpreter such that they are encouraged to notify the care provider or the client when a question or response is too difficult to translate. Additionally, it is important that the limits of confidentiality are fully explained and agreed upon by all group members, including the interpreter, that all group members consent to the

use of the interpreter, that the therapist focus on eye contact and communication with the clients rather than interpreter (Kirmayer et al., 2011).

Interpreters and therapists alike need to prepare before sessions; specifically, for interpreters, they need to be aware of the role they will fulfill in the session, the therapist's preferred interpretation method, and also be familiar with the treatment approach that the care provider will be utilizing (Schulz & Resick, 2006). Interpreters should also be knowledgeable in the ethics of medical and mental health interpreting, and be provided with regular and ongoing training regarding how to handle sensitive topics that result in personal discomfort or distress and misunderstanding (Schulz & Resick, 2006). Additionally, as Aranda (2016) suggests, the commitment of achieving cultural competence when working with immigrants extends to interpreters, as language barriers are frequently present when working with immigrant populations, and thus, translation services are routinely utilized. Lastly, issues related to language (e.g., monolingualism, bilingualism, multilingualism) may have more significant impact than previously understood in counseling research in various areas including emotional expression, power dynamics, psychological flexibility, identity formation and memory encoding (see Costa & Dewaele, 2018 for a review), for both the client as well as the therapist (Gulina & Dobrolioubova, 2018), especially when trauma treatment is performed (Costa & Dewaele, 2018).

Multicultural competency

It is important to engage in culturally sensitive (Yakushoko & Chronister, 2005) and multiculturally oriented (Kivlighan, Adams, Drinane, Tao & Owen, 2019) group therapy treatment. Yet, research into cultural diversity (and by implication multicultural counseling competency) within groups may be the most under-researched area of group therapy scholarship particularly as compared to the work done in individual psychotherapy (Arczynski, 2017; Chen et al., 2008). Group psychotherapy has not taken a multicultural stance or application, and instead has predominantly operated under a Western Euro-American worldview (Bernak & Chung, 2004) and monolingual mode of psychotherapy (Costa & Dewaele, 2018). Important to note, is the fact that an ethnically homogeneous group with a group therapist of a different ethnicity does not guarantee a culturally sensitive environment. While no studies have explored situations where the group is ethnically homogeneous and the group therapist is of a different ethnicity, studies with cross-racial therapy dyads suggest minority clients often have a different set of expectations and standards to evaluate aspects of therapy, including expertise, credibility, and competence (Chang & Berk, 2009). In general, the lack of multicultural applications of group psychotherapy is puzzling and problematic as it does not allow for the training in, and dissemination of, the culturally sensitive evidence-based group therapy practices (Chen et al., 2008) that could improve retention rates (Hoskins et al., 2018; Sripada et al. 2016) and narrow the treatment effect size gaps between Whites and non-White clients (Frisman et al., 2008; Lamp et al., 2019; Kivlighan et al., 2019). One explanation for the lack of scholarship in this area is the lack of graduate school training in multicultural group counseling (Chung, Bemak, Talleyrand, & Williams, 2018) as well as lack of student exposure to this area of scholarship. Chung and colleagues (2018) suggest that this is because of the emotion-charged and difficult conversations that would need to take place between professors and

graduate students for the training and scholarship in multicultural group counseling to occur. Nonetheless, we offer the following recommendations to CPT providers engaged in this important work.

Practical recommendations for CPT therapists

First, CPT therapists should demonstrate a genuine curiosity for understanding immigrant clients' unique experiences, cultural framework, beliefs, expectations, and counseling goals (Yakushoko & Chronister, 2005) as well as have self-awareness of their own cultural values, beliefs, and prejudices (Bemak & Chung, 2004) not only concerning individuals of Hispanic descent but immigrant clients specifically, both documented and undocumented, and about immigration issues, generally.

Second, CPT therapists should be aware of, and seek training regarding, how Hispanic cultural values, including religion and spirituality, may influence group interpersonal processes between group leaders and clients as well as with their peers, communication flow, and content of the sessions (Bemak & Chung, 2004; Kivlighan et al. 2019; Valentine et al. 2017; Yakushoko & Chronister, 2005). For example, in a mixed-gender group, men adhering to the Hispanic cultural value of *caballerismo* (conceptualized as a more beneficent form of *machismo*, which is defined as the traditional masculine gender role prescription within Hispanic culture that requires men to be tough, aggressive, domineering, controlling, and womanizing; Terrazas-Carrillo & Sabina, 2019), may not feel comfortable discussing certain traumatic events in an effort to protect women or even to protect female counselors. Clients high in *machismo* may have higher medical mistrust for their providers (Oakley et al., 2019) or men may not wish to discuss events that make them feel vulnerable or discuss sexual content in front of female counselors or peers (Valentine, 2017). Similarly, women high in *marianismo* (defined as the gender role prescribing women to reflect the attributes of the Virgin Mary, such as virtue, humility, spirituality, self-sacrifice, and seeing sexuality as a way to procreate; Terrazas-Carrillo & Sabina, 2019) may regularly defer to men during group sessions. And any client that is high in *familismo* may regularly defer to the group, seeing themselves as sacrificing their own needs for those of their new group "family."

Third, CPT therapists should provide written and verbal explanation of the counseling process and limits of confidentiality at the onset of therapy, and routinely discuss these issues with immigrant clients (Yakushoko & Chronister, 2005) while also considering clients' literacy levels (even for Spanish translated materials) or understanding of Western psychological concepts or practices (Valentine et al 2017), including confidentiality. Providers should note that many Hispanic immigrants may not be literate in Spanish, or speak it well, as a significant proportion of them may be unschooled or speak an indigenous language found in rural areas of Latin America. This could be a particular problem for a therapy modality that extensively uses written homework as part of the standard protocol. Discussions regarding private health information (PHI) and confidentiality may be especially important with clients who are fearful of disclosing certain personal (e.g., home address) or demographic information (e.g., Social Security number) as a result of their origin countries' health care privacy practices (Dow, 2011) or their undocumented status (Yakushoko & Chronister, 2005).

Fourth, CPT therapists need to be knowledgeable about and consider legal issues, psychological hardship evaluations, and deportation in order to better understand their clients circumstances and to consider their own ethical and legal responsibilities. And although a review of these issues is outside of the scope of the present paper we do point CPT providers to the following researchers as a starting point for therapists: Allen, Cisneros, and Tellez (2015); Aranda (2016); Cervantes, Mejia, Guerrero Mena (2010); Dettlaff & Finno-Velasquez (2013); Filone (2016); Lewis, Paik, and Tseng (2017); and, Stutman and Brady-Amoon (2011).

Fifth, it is important for CPT providers to recognize that the larger sociopolitical climate, which includes negative sentiments towards immigrants has implications for group psychotherapy and therapists will need to be skilled in promoting dialects about race, discrimination, oppression, culture, and racism, especially as they are tied to the mental health challenges of immigrant and refugee clients (Bemak & Chung, 2019). Group therapists have an obligation to be knowledgeable about changing demographic and sociopolitical environment in order to develop and deliver culturally sensitive interventions adept at dealing with racial, political and legal issues as part of psychological healing (Bemak & Chung, 2004). We review some of these issues presently.

Attitudes towards immigrants

Accelerating global connectivity has also ratcheted up the probability that individuals from different countries and cultural, ethnic, racial and linguistic backgrounds will come into contact and clash over issues important to them (Bemak & Chung, 2019). Seen through the window of national security (or the opioid crisis), the surging migration rates to Western countries (the U.S. and Europe) represent threats to many U.S. and European citizens and have raised the specters of xenophobia, ethnocentrism, and nativism (Furman, Ackerman, Loya, Jones, & Egi, 2012) in Western countries. Since 9/11 even people groups not generally associated with terrorism (Furman et al., 2012) are seen as threats to public safety, broadly, or as national security threats, more specifically. They are called criminals or terrorists (Bemak & Chung, 2019) as soon as one foot reaches U.S. soil because for Hispanic undocumented immigrants that first step is actually illegal.

Although many perceptions of Hispanic immigrants are inaccurate (Furman et al. 2012; Parmet, Sainsbury-Wong, & Prabhu, 2017; Yakushoko & Chronister, 2005) these views have continued to spread (Furman et al., 2012) because many majority group members believe that their economic, cultural, and belief systems are under threat (Murray & Marx, 2013). Murray and Marx (2013) suggest that these threats can be perceived as either *realistic* (i.e., economic competition or economic burden) or *symbolic* (i.e., cultural, political or religious), with realistic threats typically leading to higher levels of prejudice (Murray & Marx, 2013) and potentially being more menacing to majority group members. Individuals who are politically conservative, are generationally further removed from immigration (e.g., a 4th generation immigrant versus a 2nd generation immigrant), have less contact with immigrants, are older, and who are of lower educational attainment and socioeconomic status demonstrate higher prejudicial attitudes towards immigrants (Keihne & Ayon, 2016; Murray & Marx, 2013). However, even U.S. border residents (many of whom are 1st, 2nd or

3rd generation immigrants) demonstrate higher prejudice against undocumented immigrants due to perceiving them as realistic threats (Murray & Marx, 2013).

Research examining interventions that may decrease prejudiced attitudes toward immigrants is in its nascency but has thus far shown that exposing study participants to the vicarious experiences of undocumented immigrants as well as a documentary film, decreased reported prejudicial attitudes toward immigrants with researchers noting that attitudes toward undocumented immigrants were less mutable (Cadenas, Cisneros, Todd, & Spanierman, 2018).

Future Directions

The aim of the current paper was to provide a broad outline of practice considerations for mental health providers treating Hispanic immigrants for PTSD and other trauma- and stressor -related disorders, especially as related to immigration trauma. Although, people have migrated since time immemorial, research into the psychological effects of that process is in its nascency. And although numerous research studies have examined the effectiveness of therapy modalities such as group CPT in several populations, very few have examined its effectiveness with Hispanic clients, and none have examined the efficacy or effectiveness of a culturally sensitive or culturally modified version with Hispanic immigrants whose index trauma is immigration related. Thus, although this paper gave recommendations to culturally sensitive adaptations to improve group CPT, none of these recommendations have been directly tested to determine their effectiveness or whether they improve anything about group CPT. We know that group CPT works individually and in a group format, but does it work to treat (mostly Spanish speaking) Hispanic immigrants suffering from PTSD related to index traumas related to their immigration experience? If so, how, and why, and how can we improve it and improve access to it and utilization of it. We think it will. Future research should start here and continue to progress *más allá de las barreras*.

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