Lorraine T. Benuto   *Editor*

Toolkit for Counseling Spanish-Speaking Clients

Enhancing Behavioral Health Services

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Springer

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Para todos los latinos que se encuentran en los Estados Unidos buscando recursos en español, que puedan encontrar curación y tratamiento cuando lo necesiten.

Y especialmente para mis queridos primos: Mario, Estela, Marisela, Herman, Lulis, Felipe, Chuy, Neli, Saul, Yani, Techis, Alex, Mari, Ismael, Joel, Chayito, Hugo, Xochil, Veronica, Gustavo, Sandra, Toño, Beto, Linda, Mariana, y Niño Beto.

Preface

Approximately 17% of the US population is Latino making this group the largest minority group in the USA (US Census Bureau, 2015). An astounding 35.8 million Latinos speak Spanish at home, and only 34% of Latino immigrants who reside in the USA speak English proficiently. One of the inherent challenges in the delivery of behavioral health services to Spanish-speaking clients (in addition to the limited number of providers who speak Spanish) is the paucity of tools and/or resources available to Spanish-speaking clinicians. In graduate school, I worked with Spanish-speaking clients, and throughout my entire training, I didn't encounter a single resource designed for Spanish-speaking clients. When I completed my predoctoral internship at the Veterans Administration in Puerto Rico, I worked with an almost exclusively Spanish-speaking population. While there were some resources available in Spanish, the majority of them had been translated by local practitioners.

The idea for this book came to me when a friend (who is also a clinician) emailed me one day and asked if I knew of any resources that detailed psychological terminology in Spanish. At this point, I had spent several years working with Spanish-speaking clients, and much of that time was spent either struggling to find already-translated treatment materials or arduously translating the materials myself. I wondered if there was a handbook that housed evidence-based treatment protocols in Spanish and set out to look for one. My search left me empty-handed. Thus, my vision for this book came out of my own work with clients and lamentations from other Spanish-speaking clinicians who also noted that there were very limited resources available for them to work with clients. The absence of a resource that housed evidence-based treatment protocols in Spanish presented a serious limitation as most evidence-based interventions often include handouts and homework sheets as part of the treatment protocol. I thought to myself, "Wouldn't it be nice if there was a book that I could go to to find a chapter specific to my client's presenting problem and/or diagnoses, that contained the materials I needed to administer treatment?" And so I emailed my beloved editor Janice Stern, who readily agreed to let me tackle this project.

As I embarked on finding authors for the various chapters that make up *Toolkit for Counseling Spanish-Speaking Clients: Enhancing Behavioral Health Services*, I encountered some challenges largely related to the paucity of Spanish-speaking therapists and psychologists across the USA. This was challenging as most therapists in private practices declined my invitation largely due to their work being focused on service delivery. In the academic

arena, many of my invitations were declined as while those in the academy were often researching interventions, they were not working in actual service delivery. I am beyond grateful for the authors that agreed to be part of this book not only for their hard work but also for the many referrals that they provided which led me to other authors.

Each chapter in this book provides an overview of the disorder and associated cultural factors (including prevalence of the disorder among Hispanics/Latinos); a discussion of a culturally variant presentation (if applicable) including a description of how the disorder might present with a Hispanic/Latino client, relevant cultural idioms of stress that are specific to the disorder, etc.; an overview of the "gold standard" treatment for the disorder (rooted in evidence-based principles) and a summary of the literature on this treatment with Hispanics/Latinos (if any); a treatment plan; and a series of handouts, tools, worksheets, informational sheets, etc. that can be used in sessions as part of the treatment plan. My hope is that this book provides clinicians with much-needed resources to facilitate their delivery of evidence-based interventions to Spanish-speaking clients and more importantly that it increases the number of Spanish-speaking clients who are able to access behavioral health services.

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Evidence-Based Practices for Conducting Therapy with Spanish-Speaking Clients

Lorraine T. Benuto and Brian D. Leany

Latinos in the USA

Approximately 17% of the US population is Latino making this group the largest minority group in the USA (US Census Bureau, 2015). According to the US Census Bureau (2017), Latinos and Hispanics are individuals of "Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race." The Pew Research Center (2012) reported that persons of Mexican origin make up nearly two-thirds (65%) of the US Latino population, with the remaining third distributed primarily among persons of Puerto Rican, Cuban, and Central American origin. Of the Latinos residing in the USA, 35% are immigrants with the remaining 27 million being US born (Zong & Batalova, 2017).

The extant literature cites Latino cultural characteristics such as the emphasis on respect and the family as being grist for the cultural con-

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sideration mill. However, Latinos face several contemporary issues including issues with regard to immigration status, acculturation, self-identification, language, poverty, and discrimination. Benuto (in press) also discussed how there is substantial heterogeneity among Latinos with regard to immigrant status, acculturation level, and English-language fluency among others. While Latinos face many challenges, this chapter (and book) emphasizes the substantial rates of mental illness and the associated barriers that Latinos encounter when attempting to access behavioral health services. Indeed, a considerable number of Latinos residing in the USA are affected by mental illness and have behavioral health concerns. The prevalence of mood and anxiety disorders is high among Latinos (Kim et al., 2011) with 28–30% of Latinos experiencing some form of mental illnesses in their lifetime (Alegria et al., 2008; Kim et al., 2011). Despite these high prevalence rates, the extant literature indicates that Latinos have low utilization rates for behavioral health services due to a combination of internal and external barriers.

Barriers to Services

Despite the substantial prevalence rate of mental health disorders among Latinos, Latinos have been noted to have low-treatment-seeking rates. This has been attributed to both external and

internal barriers, and as compared to 40% of non-Hispanic whites (Agency for Healthcare Research and Quality [AHRQ], 2015), only 27% of Latinos who have a probable need for behavioral health services seek out behavioral healthcare (Bridges & Anastasia, 2016). With regard to internal barriers, stigma and low mental health literacy (Griffiths, Batterham, Barney, & Parson, 2011; Guarnaccia et al., 2009; Gulliver et al., 2012; Hirari, Vernon, Popan, & Clum, 2015; Interian et al., 2010; Jimenez, Bartels, Cardenas, & Alegria, 2012) should be taken into account as these can impact a person's decision to seek behavioral health services (Borrayo, Rosales, & Gonzalez, 2016; Jibaja-Weiss et al., 2011). External or environmental barriers are generally related to economic status and have been amply cited in the literature as an explanation for why Latinos do not seek out needed behavioral healthcare. These include lack of transportation and/or childcare, an inability to pay for services, and an inability to take time off from work (Bridges, Andrews, & Deen, 2012; Bridges et al., 2014; Gonzalez & Follette, 2015). An additional external barrier to services for Latinos is the availability of Spanish-speaking clinicians.

Language as a Barrier to Services: Enter the Spanish-Speaking Clinician

Given the large number of Latinos who are immigrants, it is not surprising that a large proportion of Latinos who reside in the USA are Spanish speaking. Indeed an astounding 35.8 million Latinos speak Spanish at home, and only 34% of Latino immigrants who reside in the USA speak English proficiently (Krogstad, Stepler, & Lopez, 2015). Thus, language has the potential to act as both internal and external barrier. The latter can be considered daunting because there are simply not enough Spanish-speaking clinicians available to meet the needs of Spanish-speaking clients. In fact, the challenge of meeting the behavioral health needs of Spanish-speaking clients has been noted by professional bodies such as the American Psychological Association. In a featured article,

entitled *Wanted: Spanish-Speaking Psychologists*, Stringer (2015) discussed the substantial need for Spanish-speaking providers and the negative impact of having too few bilingual mental health professionals. Stringer noted that when clients are assessed in their second language(s), they are more likely to be incorrectly diagnosed. Likely as a result of those issues, Stinger also highlighted several training programs where therapists can learn to provide services in Spanish, many of which provide cultural immersion experiences in Latin American countries.

While cultural immersion can be an excellent second-language training experience and experts have noted that it may be easiest to train therapists to be conversant in Spanish (Dingfelder, 2005), native Spanish-speaking clinicians can also help to meet the behavioral health needs of Spanish-speaking clients. Heritage speakers are those individuals who have a proficiency in or a cultural connection to a language. An additional relevant term is a heritage language learner—this is an individual who has a proficiency in Spanish or a connection to the Spanish language and who is studying Spanish (Kelleher, 2010). These represent an additional mechanism of addressing the behavioral health needs of Spanish-speaking clients.

Regardless of the mechanism of language acquisition (and the literature appears to be equivocal on which, if any is superior), it has been noted that it is optimal to work with a client in his/her native language (Benuto & Bennett, 2015; Costa, 2010) and that the use of English as the standard in therapy puts those who cannot communicate in English at a clear disadvantage (Sue & Sue, 1999). Bilingualism has been noted to act as part of the therapeutic alliance between the client and therapist (Nguyen, 2014). Santiago-Rivera (2009) and colleagues examined how and when therapists switched from one language during therapy as well as how their clients switched language. They found that therapists use language switching as a way to establish trust, to bond with their clients, and to promote disclosure through the use of specific phrases or words. Clients were noted to switch from English to Spanish when recounting experiences that involved certain emotions and to improve communication and connect with the therapist. These find-

ings highlight how Spanish-speaking clinicians can reduce internal barriers to service by establishing a strong therapeutic alliance with their clients.

Researchers have found that satisfaction with a therapist hinges on how the Latino clients feel the therapist understood Latino culture and not on the therapist's ethnicity (Fraga, Atkinson, & Wampold, 2004). The above highlights the importance of service delivery in Spanish. One of the inherent challenges in the delivery of services to Spanish-speaking clients (in addition to the limited number of providers who speak Spanish) is the paucity of tools and/or resources available to Spanish-speaking clinicians. This presents a serious limitation as most evidence-based interventions often include handouts and homework sheets as part of the treatment protocol. In spite of evidence that suggests that Latinos benefit from evidence-based therapies regardless of whether or not the therapy has been adapted (Benuto & O'Donohue, 2015; Huey, Tilley, Jones, & Smith, 2014), there exists a fundamental challenge for clinicians working with Spanish-speaking clients who may be forced to translate handouts and homework sheets (an arduous process) and/or abandon evidence-based treatment protocols that include these components all together, which could be detrimental to Spanish-speaking clients. Further, should the clinician decide to adapt or translate a resource, it inevitably means that this scarce resource (a Spanish-speaking clinician) is pulled away from direct clinical care in order to adapt the resource.

To Adapt or Not Adapt: That Is the Question

While there are many processes that can be used to modify a treatment on account of culture (i.e., adapting, tailoring), ultimately the goal of these procedures is to modify the intervention based on cultural values and practices so that the treatment is more compatible with the client's culture (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Additionally, cultural modifications can be aimed at improving reach and engagement (Falicov, 2005) and increasing the appeal and

effectiveness of the intervention with the group of interest (Barrera, Castro, Strycker, & Toobert, 2013). Despite the above criticisms, the literature suggests that cultural modifications to ESTs do not result in improved outcomes for minority clients (Benuto & O'Donohue, 2015; Huey et al., 2014).

Benuto, O'Donohue, and Bennett (Unpublished Manuscript) summarized how psychological treatments have been classified as efficacious or possibly efficacious based on their evaluation by randomized controlled trials (RCTs) and/or single-subject experimental designs (Chambless & Hollon, 1998). The Society of Clinical Psychology (2016) has classified the empirically supported treatment (EST) status of cognitive behavioral therapy (CBT) for depression and anxiety as having strong research support. Benuto and colleagues (Unpublished Manuscript) summarized the literature on CBT and noted that meta-analyses have established that CBT is an efficacious treatment for generalized anxiety disorder, social anxiety disorder, panic disorder (Cuijpers, Cristea, Weitz, Gentili, & Berking, 2016), hypochondriasis/health anxiety (Olatunji et al., 2014), post-traumatic stress disorder (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010), and depression (Cuijpers et al., 2016; Okumura & Ichikura, 2014) not only among adults but also among children (Reinecke, Ryan, & DuBois, 1998) and adolescents (Lenz & Hollenbaugh, 2015; Reinecke et al., 1998).

In response to criticisms regarding the extent to which findings from randomized controlled trials (RCTs) on empirically supported treatments (ESTs) generalize to ethnic minorities (because the cultural values and assumptions in these therapies may not be representative of the values and assumptions held by ethnic minorities and because ethnic minorities have been underrepresented in clinical trials), Benuto et al., (Unpublished Manuscript) investigated the degree to which Latina/Latino victims of crime experience treatment success when they are treated with culturally untailored/unadapted ESTs in a real world compared to non-Hispanic whites via an uncontrolled effectiveness study. Results from a logistic regression revealed that ethnicity was not a predictor of treatment success

in this sample. Indeed treatment outcomes for untailored ESTs were comparable for Latinos and non-Hispanic whites (with 77% of Latinos successfully completing treatment compared to 69% of non-Hispanic whites). These results suggest that formal adaptions to ESTs may not be necessary and that results from RCTs on ESTs can be generalized to Latinos. These findings support findings from RCTs that conventional, unmodified CBT works effectively with Latinos for anxiety disorders (Barrios, 2010) and from two reviews of the literature on cultural adaptations (Benuto & O'Donohue, 2015; Huey et al., 2014). Thus, if the tools and resources that are used in standard, non-adapted evidence-based interventions are available for clinicians to use in Spanish, the research supports that Latino clients will benefit from evidence-based interventions.

Summary and Conclusion

As illustrated throughout this chapter, Latinos are a large segment of the greater US population, and there are a substantial number of Latinos who need behavioral services in Spanish. Because the shortage of Spanish-speaking mental health providers is beyond the scope of this book chapter, the editor and selected authors have set out to address the dearth of resources available in Spanish for those providers who do exist as well as (and primarily) for their Spanish-speaking clients. Thus, each chapter in this book provides an overview of the disorder and associated cultural factors (including prevalence of the disorder among Hispanics/Latinos); a discussion of a culturally variant presentation (if applicable) including a description of how the disorder might present with a Hispanic/Latino client, relevant cultural idioms of stress that are specific to the disorder, etc.; an overview of the "gold standard" treatment for the disorder (rooted in evidence-based principles) and a summary of the literature on this treatment with Hispanics/Latinos (if any); a treatment plan; and a series of handouts, tools, worksheets, informational sheets, etc. that can be used in sessions as part of the treatment plan. It is important to note that because there is limited

research on actual treatment protocols with purely Latino participants, the majority of tools in this book are based in evidence-based principles but in and of themselves would not meet empirically supported treatment status.

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Tools for Treating Generalized Anxiety Disorder Among Latinos

Frances R. Gonzalez

Anxiety disorders are prevalent among Latinos in the United States with 6% of Latinos experiencing generalized anxiety disorder (GAD) in their lifetime (Alegría et al., 2007; Asnaani, Richey, Dimaite, Hinton, & Hofman, 2010). While the treatment for GAD has been well researched among the general population, the bulk of this research has not included Spanish speakers (Chavira et al., 2014). Thus not surprisingly, the resources available for working with Spanish speakers are very limited. This book chapter provides an overview of evidence-based principles for treating Spanish speakers who have GAD and worksheets, resources, and other tools that can be used with Spanish-speaking clients. This chapter is organized as follows: (1) cultural considerations in the presentation of GAD among Latinos, (2) evidence-based practices as they apply to Latinos in general and with regard to GAD specifically, (3) a session plan for treating GAD from an evidence-based perspective, and (4) Spanish language worksheets and tools that can be used in session.

Generalized Anxiety Disorder

Generalized anxiety disorder has been characterized as an individual experiencing excessive worrying and anxiety about a number of different events or activities (American Psychiatric Association, 2013). This constant worrying occurs most days of the week and may include feeling restless, fatigued, difficulty concentrating, feeling irritable, muscle tension, and disturbed sleep. These symptoms make it difficult for an individual to carry on in daily activities and may impair overall functioning (American Psychiatric Association, 2013). It is estimated that 3% of the US population or 6.8 million people meet criteria for generalized anxiety disorder, with 32% of these cases being classified as "severe" (Kessler, Chiu, Demler, & Walters, 2005).

The lifetime prevalence rates for generalized anxiety disorder (GAD) among Latinos in the United States range from 1% to 11% (Asnaani et al., 2010; Grant et al., 2005; Hirai, Stanley, & Novy, 2006; Moreno-Peral et al., 2014). While the literature is mixed regarding ethnic differences in prevalence rates of GAD, there is documentation that prevalence rates of GAD vary across Latino subgroups (Asnaani et al., 2010; Bjornsson et al., 2014; Chavira et al., 2015; Hirai et al., 2006; Karno et al., 1989; Moreno-Peral et al., 2014; Street et al., 1997). For example,

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Puerto Ricans have been noted to have a higher prevalence of anxiety than other Latino subgroups (Camacho et al., 2015; Wasswetheirl-Smoller et al., 2014). These limited studies highlight the diversity across the Latino population and suggest that different (sub)cultural factors can impact mental health rates, presentation, treatment, and treatment outcomes.

Clinical Presentation of Generalized Anxiety Disorder Among Latinos

In addition to variations across ethnic groups in terms of prevalence rates, cultural implications in symptom presentation have been documented. Latinos are more likely to report physical or somatic symptoms when describing mental health concerns (Borkovec, 1985; Canino, Rubio-Stipec, Canino, & Escobar, 1992; Carter, Mitchell, & Sbrocco, 2012; Hirai et al., 2006; Kirmayer & Young, 1998; Snipes, 2012; Zvolensky et al., 2015; Blumberg et al, 2015; Hovey & Magaña, 2002). In the case of GAD, Latinos report more somatic symptoms including feeling restless or tired and tend to overreport feeling anxious (Canino et al., 1992; Carter et al., 2012; Hirai et al., 2006). Consistent with many cultures, stigma is associated with mental illness among Latinos. This somatic clinical presentation described above suggests that Latinos present with somatic symptoms in lieu of cognitive symptoms as a means of blocking the stigma associated with mental health illness. This group may fear being labeled as "crazy" and may find it more culturally acceptable to focus on physical symptoms or idioms of distress (Borkovec, 1985; Canino et al., 1992; Kirmayer & Young, 1998).

Indeed several idioms exist among the Latino culture to describe distress. *Nervios* and *ataque de nervios* are two idioms that have been likened to anxiety (Guarnaccia, Lewis-Fernández, & Marano, 2003; Guarnaccia et al., 2009; Hinton, Chong, Pollack, Barlow, & McNally, 2008; Hinton, Lewis-Fernández, & Pollack, 2009). Although these two idioms are more popularly used by Latinos with a Caribbean background (e.g., Puerto Ricans and Cubans), they are also used by other Latino subgroups (Guarnaccia et al., 2009). *Nervios* has been described as being a debilitating condition where a person has too many thoughts that overwhelm the person, causing them to be restless, speak rapidly, act erratically, feel fearful and/or irritated, and react to stressors easily (Guarnaccia et al., 2003, 2009). *Ataque de nervios* has been described as a reaction to a traumatic or stressful life event. This reaction includes a sudden onset of symptoms including crying, shouting, trembling, shaking, having shortness of breath, and aggression (Guarnaccia et al., 2003, 2009). While both *nervios* and *ataques de nervios* have descriptions of symptoms that overlap with GAD, they are not synonymous of GAD (Guarnaccia et al., 2003; Hinton et al., 2008). Both idioms of distress have also been linked to depression, post-traumatic stress disorder, and psychosis and are thus not solely related to anxiety (Guarnaccia et al., 2003, 2009; Hinton et al., 2008). However, it is important to note that GAD could be labeled as, or present as, *nervios* and *ataques de nervios.* Thus clinicians will need to conduct careful assessment to establish whether cultural idioms of distress represent GAD.

When assessing for GAD among Latinos, it is important to note all symptoms reported by the individual and to keep in mind the potential of a culturally variant presentation. Since stigma of mental health still persists among Latinos; Latinos may use the language and descriptors that they have been provided in their upbringing to describe what they are experiencing. The language and descriptors used may focus on somatic or cognitive symptoms, in addition to culturally specific idioms of anxiety (Snipes, 2012). Given the diversity of the symptoms reported by Latinos, it is important to remember that standardized assessment materials may fail to capture a GAD diagnosis; therefore clinical interviews may be used to supplement standardized assessment materials. A thorough assessment is the foundation to therapy, since it allows clinicians to decide on what treatments to use for individuals; therefore diverse cultural presentations of disorders are an important factor to consider.

Other Factors to Consider During Assessment

In addition to cultural considerations that are specific to how GAD may present, it is important to also consider contemporary cultural factors that can lead to anxiety. Acculturation, immigration status, and family cohesion are important factors to consider when working with any diverse population (Benuto, 2016). Acculturative stress and immigration status can be related to the onset of anxiety-related symptoms. Worrying about acculturating into a new environment and about immigration status can impact anxiety levels (Burnam, Escobar, Karno, Hough, & Telles, 1987). Moreover being separated from one's family and loss of income can create immense anxiety in some individuals.

Acculturative stress and immigration status can also have an impact on family cohesion. Some individuals may live in households where family members are at different levels or points in the acculturation process. Other individuals may experience a lack of family cohesiveness due to recent immigration that caused physical distance between loved ones. This is relevant to GAD as family cohesion has been noted to relate to the onset of GAD. According to Priest and Denton (2012), family cohesion and positive interactions with family members are very important for the well-being of an individual. Family cohesion has been linked to reducing anxiety symptomology for those who develop GAD (Priest & Denton, 2012); given the above family cohesion is highly relevant to Latinos.

In addition to acculturative stress and the stress associated with immigration status, barriers to treatment are relevant as if a person is unable to access treatment, their symptoms may persist and worsen. As described above, Latinos may face language barriers, discrimination, poverty, and social isolation. They may also experience challenges in accessing health care, which can lead to anxiety (Benuto, 2017; Burnam et al., 1987; Ai et al., 2014; Ai et al., 2015). This highlights the potential relationship between socioeconomic status (SES) and anxiety. Socioeconomic status (SES) is an amalgam of income, education, and

social status (Benuto & Leany, 2011). Latinos in the United States have been noted to have lower SES than non-Hispanic whites (Feeding America, 2014; National Education Association, n.d.), and lower SES has been linked to lower psychological and physical well-being (American Psychological Association, 2016) and treatment-seeking behavior (Adler & Newman, 2002). Specific to Latinos, acculturation, SES, immigration status, language barriers, and lack of social support are related to low treatment-seeking behavior (Pampel, Krueger, & Denney, 2010; Woodward, Dwinell, & Arons, 1992). While the mechanism for helping clients access treatment is beyond the scope of this chapter, it is important for the treating clinician to consider the above factors in light of treatment engagement and in consideration of factors that may prevent the client from continuing treatment.

Research on the Treatment of Generalized Anxiety Disorder Among Latinos

Cognitive and behavioral therapies have been identified as evidence-based treatments for GAD (Beck, 1995a, 1995b; Brokovec et al., 1987). Since the symptoms of GAD involve excessive uncontrollable worry, maladaptive thinking, difficulties relaxing, and avoidance, both cognitive and behavioral therapy have been identified as therapies that reduce symptoms (American Psychiatric Association, 2013; Roemer et al, 2005; Borkovec et al, 2004; Craske, 2003; Barlow et al, 1996; Borkovec & Roemer, 1995). Cognitive therapy focuses on using cognitive restructuring to modify the negative thoughts, beliefs, and images, while behavioral therapy focuses on relaxation training, planning pleasurable activities, and controlled exposure to situations that are avoided (Beck, 1995a, 1995b; Brokovec, Newman, Pincus, & Lytle, 2002). Since both therapies are effective in reducing the different symptoms of anxiety disorders, researchers and clinicians developed cognitive behavioral therapy (CBT), which focuses on both the cognitive and behavioral symptoms

(Brokovec et al., 1987, 2002; Butler, Fennell, Robson, & Gelder, 1991; Öst & Breitholtz, 2000). When cognitive and behavioral approaches are combined, they create a more effective treatment; hence, CBT has been used effectively to treat a range of anxiety disorders, including GAD (Chapman et al., 2011; Barlow & Craske, 2007; Barlow, 2002a, b; Roemer et al, 2002; de Beurs et al., 1995; Foa & Meadows, 1997; Foa & Kozak, 1986). Various meta-analyses have been completed examining CBT as a treatment for GAD. A majority of the meta-analyses have identified CBT as a prime therapy for reducing symptoms of GAD among different groups and populations (Butler, Chapman, Forman, & Beck, 2006; Gould, Safren, Washington, & Otto, 2004; Gould, Otto, Pollack, & Yap, 1997; Mitte, 2005).

Despite the prolific literature on the use of CBT to treat anxiety disorders, there has been limited research on effective evidence-based treatments in treating generalized anxiety disorder among Latinos. Most of the research on evidence-based treatments among Latinos has been on depression and has been noted to be an effective means of treating depression among Latinos (Aguilera, Garza, & Muñoz, 2010; Organista & Muñoz, 1996; Organista, Muñoz, & González, 1994), and findings from a review of the literature suggest that Latinos can benefit from CBT (Benuto & O'Donohue, 2015). These findings apply to both adolescents (Pina, Silverman, Fuentes, Kurtines, & Weems, 2003) and adults (Barrios, 2010).

Of the research that does exist specific to GAD, CBT has been found to be an effective mechanism of treating Latinos who have GAD (Pina et al., 2012; Aguilera et al., 2010; Organista & Muñoz, 1996; Organista et al., 1994). Most recently, Chavira et al. (2014) examined CBT with Latino adults who had GAD. Specifically Chavira et al. studied treatment engagement and response of three treatments for anxiety disorders among 85 Latinos: (1) a 12-week traditional CBT treatment, (2) a medication-only treatment, and (3) a CBT combined with medication. The CBT with medication condition was favored by Latinos over the other two conditions. The CBT

and CBT with medication conditions were more effective than the medication treatment-only condition in reducing symptoms of anxiety among Latinos including among Spanish-speaking Latinos. In conclusion, the results from available studies do indicate that CBT is an evidence-supported treatment to use with Latinos who have GAD.

In summary, Latinos experience rates of GAD similar to, if not higher than, the general US population. In addition, the literature indicates that cultural factors may contribute to a presentation of GAD that may not be commonly seen in the general population (Canino et al., 1992; Carter et al., 2012; Guarnaccia et al., 2009; Hirai et al., 2006), due to cultural factors that may be unique to this population (Benuto, 2017). Regardless of how different or similar the presentation of GAD is among Latinos, CBT continues to be the most effective evidence-based treatment for GAD. The evidence suggests that both Spanish-speaking and English-speaking Latinos report improvement with GAD symptoms when exposed to CBT (Chavira et al., 2014). A sample session plan and associated worksheets and handouts can be found below, which are based on the CBT model.

Sample Session Plan

Chavira et al. (2014) provided the following format for cognitive behavioral therapy program for generalized anxiety disorder among Latinos: (1) educate the patient about GAD, (2) self-monitor behaviors, (3) exposure hierarchy development, (4) breathing training and other relaxation exercises, (5) cognitive restructuring, (6) exposure to stimuli, and (7) relapse prevention. An 8–12 session treatment plan, with weekly 1-h sessions, has been recommended for CBT treatment. Eighteen Spanish language handouts and worksheets are included with the sample session plan. The session plan has been modeled by that one used by Escovar, Hitchcock, and Chavira (2017).

Session 1
This session includes therapist introduction and assessment:

- The therapist should spend some time explaining what the therapist's role is and what the treatment process is like.
- Explaining what is expected from the client should be explained, for example, they should be on time, leave children with childcare, and call 24 h in advance if they cannot attend session.
- Time should be set aside for therapist to ask questions regarding confidentiality, treatment, barriers to care, and family participation. Sometimes fear of immigration status being revealed to others is a concern. Barriers to care should be addressed and may include transportation, childcare, unable to take time off work, and other family responsibilities. It is possible that the client may ask if family members can join in sessions; the therapist should remember that social support and family cohesion are important for Latinos and are important factors that may benefit the client in treatment.

Worksheets and Handouts: Evaluación de los Síntomas de Ansiedad.

Session 2
This session should focus on educating the client about the origins and symptoms of anxiety:

- Explain the origins of anxiety and its normality.
- Ask the client what symptoms they have experienced when distress, even asking them where in their body they feel anxiety.
- Connect bodily sensations with thoughts and behaviors as all being a part of anxiety.
- Some education on panic attacks may be addressed if client reports symptoms that can be related to *Ataque de Nervios* or *Nervios.*

Worksheets and Handouts: La Ansiedad, Síntomas de Ansiedad, ¿En Que. Partes del Cuerpo Sientes la Ansiedad?, Ataque de Pánico, and Las Causes de Su Estrés o Ansiedad.

Session 3
This session should be focused on identifying fears and worries the client has:

- Create a hierarchy of fears and worries the client has to use later for exposure hierarchy.
- The client can also address any problems that may be escalating their anxiety.
- Educate the client on how worries, fears, and thoughts impact bodily sensations and behaviors, such as avoidance.
- Have the client begin to monitor their thoughts, worries, and fear at home. Provide them a diary card.

Worksheets and Handouts: La Escala de Preocupación; La Relación entre Síntomas Físicas, Pensamientos, y Acciones con La Ansiedad; and Diario De La Ansiedad.

Session 4
This session will be dedicated to teaching the client ways to reduce anxiety and worry:

- Educate the client on how relaxed breathing can improve symptoms of anxiety and then practice relaxed breathing with the client.
- Educate the client on how muscle relaxation exercises can improve symptoms of anxiety and then practice muscle relaxation exercises with the client.
- Educate the client on mindfulness and being in the present moment. Practice using the five senses to help the client be in the present moment and not caught in thoughts, fears, and worries.
- Educate the client how participating in pleasant events and rewards help reduce anxiety.
- Have the client brainstorm activities and rewards they can do after accomplishing something stressful or anxiety provoking.
- Have the client begin to practice exercises for their homework and track their work on the diary card.

Worksheets and Handouts: Respiración Relajada, Relejación Musular, Recompensas, ¡Enfócate en El Presente!, Actividades Para Utilizar los Cinco Sentidos, and Diario: Practicando Los Ejercicios Para Reducir la Ansidad.

Sessions 5–12

These sessions will be focused on problem-solving, working on changing automatic thoughts, and exposure exercises:

- Have the client create a list of problems they are facing and explore solutions.
- Revisit the fear hierarchy from Session 3 and edit it if necessary.
- Introduce exposure exercises and how they help improve anxiety symptoms.
- Answer any questions and fears the client may have about exposure therapy.
- Begin exposure therapy based on fear hierarchy.

- Have the client begin to do exposure exercises at home and keep track using the worksheet *Enfrentando los Pensamientos Negativos y Preocupaciones.*
- Have the client to continue to practice mindfulness and relaxation exercises as part of their homework.

Worksheets and Handouts: Resolviendo Problemas, *¿Que es la Terapia de Exposicón?*, *Enfrentando los Pensamientos Negativos y Preocupaciones*, and *Diario: Practicando Los Ejercicios Para Reducir la Ansidad.*

Evaluación de los síntomas de Ansiedad

En las ultimas dos semanas ¿ha tenido uno (s) do los siguientes síntomas?

Chequee o Marque todo lo que se aplica en su caso

Síntomas Físicas:

❑ Dolores musculares   ❑ Mareo

❑ Temblores   ❑ Sequedad en la boca

❑ Necesidad frecuente de orinar   ❑ Dolores de cabeza

❑ Dolor abdominal   ❑ Respiración rápida

❑ Sudor   ❑ Falta de aire

❑ Diarrea   ❑ Nausea o Vomito

❑ Cambio en apetito   ❑ Hormigueo

❑ Cansado o sentirse cansado ❑ Opresión o presión en el pecho

❑ Palpitaciones del corazón rápido o palpitaciones irregulares

Síntomas Psicológicas:

❑ Dificultad para concentrarse

❑ Problemas con la memoria

❑ Dificultad para dormir o pesadillas

❑ Sentirse irritado

❑ Tener problemas sexuales o no querer tener relaciones sexuales

❑ Sentirse nervioso, ansioso, con los nervios de punta

❑ No ha sido capaz de parar o controlar su preocupación

❑ Se ha preocupado demasiado por motivos diferentes

❑ Ha tenido dificultad para relajarse

❑ Ganas de huir situaciones

❑ Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)

❑ Ha tenido miedo de que algo terrible fuera a pasar

¿Con que frecuencia le han molestado sus síntomas?

❏ Varios días

❏ Mas de la mitad de los días en la semana

❏ Casi diario o todos los días

La Ansiedad

La ansiedad es parte de nuestro cuerpo y actúa como un mecanismo defensivo.

La ansiedad es una respuesta normal que se da en todas las personas y nos ayudar sobrevivir amenazas y situaciones peligrosas. Cunado nos encontramos en situaciones evaluadas como peligrosas, la ansiedad se convierte en nuestro sistema de alertas.

La mente y el cuerpo trabajan juntos para movilizarnos y decidir si queremos huir, atacar, neutralizar, afrontar, o adaptarnos a las situaciones peligrosas que se presentan.

En unos casos hay personas donde la ansiedad normal cambia y es alterada. En estos casos personas empiezan a sufrir problemas de salud que afectan su vida diaria.

Unas situaciones o eventos que influyen cambios en la ansiedad normal son:

* Factores biológicos, algunos que son genéticos.

* Estilo de vida

* Estrés del ambiente en la casa, trabajo, con amigos y de dinero.

* Teniendo miedo de varios situaciones

* Eventos negativos en la vida

* Alcohol, estimulantes, y drogas

* Efectos de medicamentos

* Problemas de salud

* Falta de oxigeno

Normalmente, los problemas de ansiedad resultan por una combinación de estas situaciones y eventos durante un periodo de tiempo.

Síntomas de la Ansiedad

Cada persona reporta diferente síntomas de la ansiedad, aunque unas síntomas son mas comunes que otras. Abajo hay una lista de las síntomas mas reportadas:

Síntomas Físicas

❖ Dolores musculares   ❖ Mareo

❖ Temblores   ❖ Sequedad en la boca

❖ Necesidad frecuente de orinar   ❖ Dolores de cabeza

❖ Dolor abdominal   ❖ Respiración rápida

❖ Sudor   ❖ Falta de aire

❖ Diarrea   ❖ Nausea o Vomito

❖ Cambio en apetito   ❖ Hormigueo

❖ Cansado o sentirse cansado   ❖ Opresión o presión en el pecho

❖ Palpitaciones del corazón rápido o palpitaciones irregulares

Síntomas Psicológicas

❖ Dificultad para concentrarse

❖ Problemas con la memoria

❖ Dificultad para dormir o pesadillas

❖ Sentirse irritado

❖ Tener problemas sexuales o no querer tener relaciones sexuales

❖ Sentirse nervioso, ansioso, con los nervios de punta

❖ No ha sido capaz de parar o controlar su preocupación

❖ Se ha preocupado demasiado por motivos diferentes

❖ Ha tenido dificultad para relajarse

❖ Ganas de huir situaciones

❖ Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)

❖ Ha tenido miedo de que algo terrible fuera a pasar

¿En que Partes del Cuerpo Sientes la Ansiedad?

Lista las partes del cuerpo donde siente mas la ansiedad. Usando una escala de 0 a 10, con 0 representando nada de dolor y 10 representando mucha molestia con esta parte del cuerpo.

0-10 | Parte del Cuerpo Que le Molesta Con la Ansiedad

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Ataque de Pánico

Cuando uno esta sufriendo ansiedad muy intensa, a veces el cuerpo responde de un modo extremo. Un ataque de pánico resulta después que nos pasa un medio, situación, o evento.

Síntomas de un Ataque de Pánico:

◆ Respiración dificultosa

◆ Palpitaciones o dolor en el pecho

◆ Intensa sensación de miedo

◆ Dificultad para respirar

◆ Sensación de ahogo o asfixia

◆ Mareos o sensación de desmayo

◆ Temblores o sacudidas

◆ Transpiración

◆ Náuseas o dolor de estómago

◆ Hormigueo o entumecimiento en las manos y los pies

◆ Escalofríos o sofocos

◆ Un miedo que está perdiendo el control o está a punto de morir

Los síntomas de un ataque de pánico por lo general se sienten mas fuertes en los primeros 10 minutos del ataque.

Las síntomas del ataque se sienten tan graves que a veces personas piensan que están sufriendo un ataque de corazón, cunado en realidad es un ataque de pánico.

Las Causas de Su Estrés o Ansiedad

Instrucciones: Escribe todos las situaciones, eventos, o personas que te causan estrés o ansiedad.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

13. _____

14. _____

15. _____

Usa otra pagina si necesita mas espacio

La Escala de Preocupación

Instrucciones: Esta escala es para medir preocupación que esta conectada con su ansiedad, miedo o estrés. Comience la escala con los eventos o situaciones que le causan la mayoría de preocupación (10), seguidos por los eventos o situaciones que producen menos preocupación.

🙁 Muy Preocupado 10

9

8

7

6

5

4

3

2

1

Muy Relajado 0

🙂

La Relación entre las Síntomas Físicas, Pensamientos, y Acciones con La Ansiedad

Nuestros síntomas físicas, pensamientos, y acciones influyen nuestros niveles de ansiedad. En cambio la ansiedad influye nuestros síntomas físicas, pensamientos, y acciones.

Síntomas Físicas: "Mi corazón esta palpitando muy rápido", típicamente las síntomas físicas de ansiedad se presentan primero que otras señas. Cuando las síntomas físicas se presentan, la ansiedad se intensifica. A veces las síntomas físicas son causadas por las pensamientos o acciones que experimentamos.

Pensamientos: "Voy a tener un ataque de corazón", a veces nuestra mente puede se nuestro peor enemigo porque a veces empieza a pensar cosas negativas que a veces no son ciertas o inexactos. Cuando estos pensamientos empiezan o se escalan, empezamos a sentir síntomas físicas mas fuertes, "Mi corazón se esta acelerando muy pronto, algo debe de estar mal". A veces nuestros pensamientos nos hace evitar las cosas que nos causan ansiedad.

Acciones: "Mejor no voy a la fiesta porque es muy estresante para hablar con otros", Para evitar las síntomas de la ansiedad evitamos lugares, situaciones, o personas. A veces tomamos medidas o adoptamos comportamientos que no son saludables para evitar nuestro pensamientos y sentimientos físicos, pero solo funciona temporalmente.

```
                    ┌──────────────────┐
                    │   Pensamientos   │
                    └──────────────────┘

   ┌──────────────────┐          ┌──────────────────┐
   │ Síntomas Físicas │          │     Acciones     │
   └──────────────────┘          └──────────────────┘
```
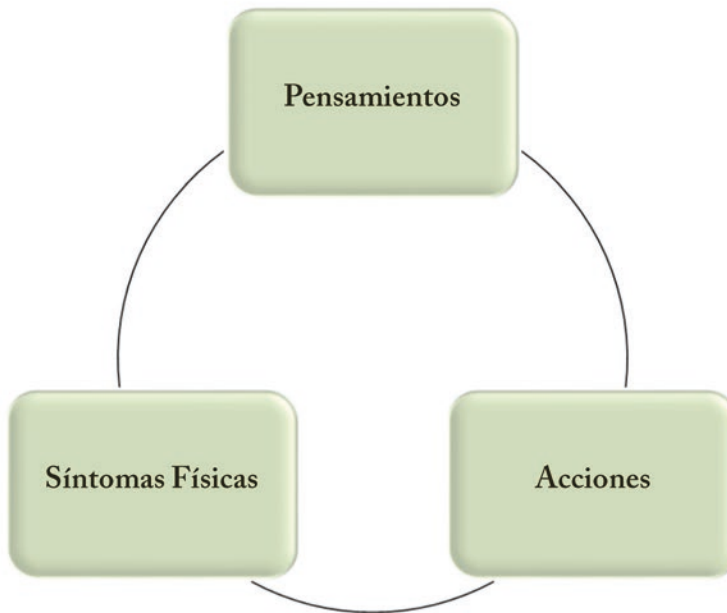
Diario de La Ansiedad

Fecha	Hora	Situación	Síntomas	Pensamientos	La intensidad de la ansiedad (0-10)	¿Trato de evitar la situación?

Respiración Relajada

Cuando estamos estresados o ansiosos nuestra respiración se acelera. Esto es parte de nuestro mecanismo defensivo. La reparación relajada manda un señal a todo el cuerpo que se debe de relejar y que uno esta seguro. La respiración relajada es mas lenta y mas profunda que la respiración normal. Cuando uno usa la reparación relejada usamos el estomago o barriga pare respirar y no el pecho.

Instrucciones:

1. Debe de sentarse o acostare para empezar el ejercicio.

2. Cierra los ojos si se siente a gusto haciéndolo.

3. Usa la nariz para respirar profundamente, contando a cuatro (**1….2….3….4**).

Respira
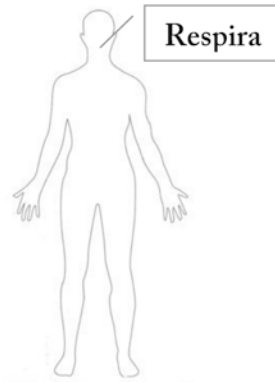
4. Pause (**1….**).

5. Expira, despacio contando a cuatro (**1….2….3….4**).

Expira
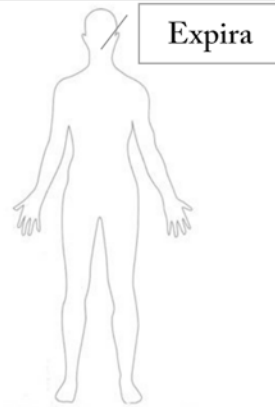
6. Si gusta, puede repetir el ejercicio después de un minuto. Practica durante el día.

Relajación Muscular

El cuerpo y la mente trabajan juntos, cuando estamos ansiosos o estresados nuestros cuerpos responden y se pone tenso. A veces el cuerpo empieza tenso y envía una señal que estamos en peligro y la mente se estresa o se pone ansioso. Entonces relajando el cuerpo nos ayuda eliminar el estrés o ansiedad del momento.

Un modo de relejar el cuerpo es usando relajación muscular. Con la relajación muscular cada grupo de músculos se tensa, y luego elimina la tensión.

Instrucciones

1. Siéntase en una silla, recuestase en una cama, sofá, o piso. Puede cerrar los ojos si gusta.

2. Empieza con 1) los dedos de los pies. Tensa los dedos de sus pies por unos 10-30 segundos, luego relájalos.

3. Repite paso 2 con todo los otros músculos: 2) Piernas, 3) Los dedos de su manos, 4)Estomago y pecho, 5) Los brazos, 6) Cuello y garganta, 7) La espalda, y 8) La Cara.
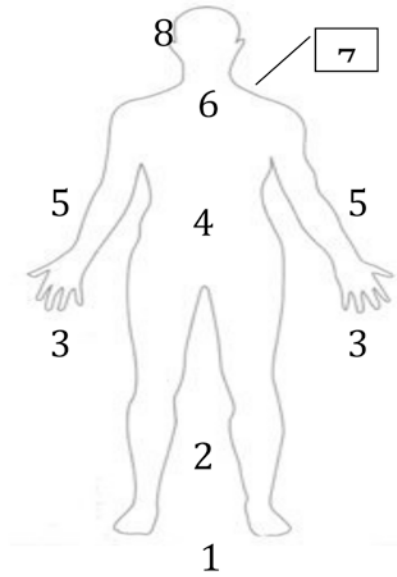
Recompensas

Cunado uno esta muy ansioso o estresado, a veces se nos olvida las recompenses por todo el trabajo y quehaceres que hemos hecho. Las recompensas son muy importantes para controlar la ansiedad. La recompensas vienen de diferente formas.

Unos ejemplos son:

* Salir a cenar   * Ir a campar

* Caminar en el parque
* Dibujar
* Visitar a Familia o Amistades
* Leer un libro o revistas
* Ir a nadar
* Ir a una fiesta
* Jugar deportes
* Cocinar una comida rica

* Cantar o Karaoke
* Ir a la playa
* Tejer
* Cuidar el jardín
* Ir a un concierto
* Bailar
* Ir de compras
* Aprender a tocar la guitarra

¿Cuales son sus recompensazas favoritas?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

¡Enfócate en el Presente!

Usando los cinco sentidos nos ayuda relajarnos y gozar el momento para reducir la ansiedad.

Sentido de Gusto:

¿Que pruebo en este momento?
¿ Es sutil o fuerte? ¿Es amargo, dulce o caliente? ¿Es frío o caliente?
¿Cuánto tiempo dura el sabor?

Sentido de Tacto:

¿Qué siento en mi piel?
¿Qué siento con las puntas de los dedos?
¿Que textura(s) siento?
¿Es suave o duro? ¿Es áspera o lisa? ¿Es caliente o frío al tacto?

Sentido de Olfato:

¿Qué olores noto?
¿Son fuertes o suaves?
¿Cómo cambia el aroma con el tiempo?
¿Cuánto tiempo dura el olor?

Sentido de Oír :

¿Qué es lo que oigo en este momento?
¿Hay sonidos cerca o lejos? ¿Son fuerte o suave?
¿Es en tono alto o bajo?
¿Cuánto tiempo dura cada sonido?

Sentido de la Vista:

¿Qué veo en este momento?
¿Qué objetos observo?
¿Qué colores miro?
¿Que son las texturas y patrones de lo que veo?
¿Qué figura o forma es lo que veo?

Actividades Para Utilizar lo Cinco Sentidos

Usar el perfume o las lociones favoritas

Ambientar la casa con una fragancia agradable

Hervir canela, hacer galletas o un pastel

Oler flores

Acariciar al perro o al gato

Que nos den un Masaje

Ponerse loción en el cuerpo

Abrazar alguien
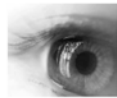
Comprar y arreglar flores

Ir a un museo de arte.

Contemplar la naturaleza

Mirar una fotos

Escuchar música hermosa

Escuchar la naturaleza

Saborear una comida buena

Probar diferentes sabores en una heladería

Mascar nuestro chicle favorito

Resolviendo Problemas

Para cada problema que esta ocurriendo en este momento, llena una hoja separada.

1. Identifica su problema con detallé.

2. ¿Que sentimientos siente con este problema?

3. ¿Cuantas soluciones hay para este problema?

4. Para cada solución lista las aventajas y desventajas.

	Aventajas	Desventajas
Solución 1		
Solución 2		
Solución 3		
Solución 4		

¿Que es la Terapia de Exposición?

La terapia de exposición es un tratamiento psicológico que fue desarrollado para ayudar a las personas enfrentar sus miedos. Cuando las personas tienen miedo de algo, evitan los objetos, actividades o situaciones temidas. Aunque esta evitación podría ayudar a reducir los sentimientos de miedo en el corto plazo, a largo plazo puede ser que evitando el miedo cause mas daño.

En la terapia de exposición, los psicólogos o terapeutas crean un ambiente seguro en el que uno "expone " individuos a las cosas que

temen y evitan. La exposición a los objetos, actividades o situaciones temidas en un entorno seguro ayuda a reducir el miedo y la evitación disminución.

Hay dos formas comunes de exposición:

La exposición en vivo: Situado frente a un objeto, situación o actividad temida en la vida real. Por ejemplo, alguien con un miedo a las arañas puede ser instruido a tocar una araña, o alguien con ansiedad social puede ser instruido para dar un discurso frente a una audiencia.

La exposición imaginal: Vívidamente imaginar el objeto, situación o actividad temido. Por ejemplo, uno debe de recordar y describir una experiencia traumática que tuvieron repetidamente para reducir la sensación de miedo.

Enfrentando los Pensamientos Negativos y Preocupaciones

Pensamiento Negativo/ Preocupación	Nivel de Ansiedad 0-10 Antes de enfrentarlo	¿Como voy a enfrentar el pensamiento o preocupación?	¿Pasara este momento?, ¿Voy a sobrevivir? ¿Si o no?	Nivel de Ansiedad 0-10 después de enfrentarlo	Recompensas

Diario: Practicando los Ejercicios para Reducir la Ansiedad

Fecha/Día	Hora	Causa de Ansiedad	Nivel de Ansiedad 0-10	¿Que Ejercicio uso? 1	¿Que Ejercicio uso? 2	Nivel de Ansiedad 0-10

Appendix

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Tools for Treating Trauma-Related Disorders Among Latinos

Aileen Torres and Melany Rivera-Maldonado

Overview of the Trauma

We all use the word "trauma" in everyday language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to extreme stress that overwhelms a person's ability to cope both psychologically and physiologically. Technically, trauma refers only to the event, not the reaction to it, and should be reserved for major events that are psychologically overwhelming for an individual. However, the term trauma for mental health practitioners refers both to negative events that produce distress and to the distress itself (Briere & Scott, 2006). The Diagnostic and Statistical Manual of Mental Disorders-5 (American Psychiatric Association, 2013) defines trauma with two necessary criterions:

1. Direct personal experience of an event that involves actual or threatened death or serious injury or other threat to one's physical integrity; witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate.
2. The person's response to the event must involve intense fear, helplessness, or horror (in children, the response must involve disorganized or agitated behavior).

The following is a list of the variety of potentially traumatic events a person may experience: combat, sexual and physical assault, robbery, being kidnapped or taken hostage, terrorist attacks, torture, natural disasters (i.e., earthquakes, tornadoes, etc.), severe vehicle accidents, life-threatening illnesses, witnessing serious death or serious injury, as well as childhood sexual and/or physical abuse (APA, 2013). Approximately one million cases of abuse and neglect are substantiated per year. Many thousands of children undergo traumatic medical or surgical procedures or are victims of community violence or suffer from system-induced trauma (multiple foster placements, separation from siblings, etc.).

Most research contends that the frequency, intensity, and duration of traumatic events are the main important factors in our assessment and treatment of trauma (Herman, 1992). Symptoms and diagnoses vary and depend on a person's developmental level, sources of support, and temperament/coping resources. Early experiences

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of trauma and stress have an impact not only in the cognitive, behavioral, and emotional development of a child but also their adjustment and personality along his/her adulthood. As demonstrated in a systemic literature review (Carr, Martins, Stingel, Lemgruber, & Juruena, 2013), early stress and traumatic experiences such as physical, emotional, and sexual abuse, as well as neglect, are associated with several psychiatric disorders during adulthood. It is also important to consider that a traumatic experience can be acute, chronic, or complex. There are different presentations for clients with extensive histories of severe childhood maltreatment differing from those who had experienced a single traumatic event as a well-adjusted adult. As such, it is helpful to classify the trauma reactions as acute, chronic, or complex. Acute trauma is generally limited in time. An earthquake, a dog bite, and a motor vehicle accident are all examples of acute trauma (National Child Traumatic Stress Network, 2008, p. 6). Chronic trauma generally refers to the experience of multiple traumatic events. For example, living in an unsafe environment as a result of poverty, homelessness, domestic violence, or abuse or witnessing violence. As van der Kolk (2005) sustained, the concept known as complex trauma is used to describe the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early-life onset. The length of treatment and the pace with which exposure is utilized should vary based on these types and several other factors to be discussed further in this chapter.

Impact of Culture

Laura Brown (2008) states "Trauma is trauma is trauma. The texture of pain, the color of fear, and the melody of cries are all human and shared. They are all, also, uniquely configured and ordered by human identities, cultures, heritages, and networks of relationships" (p. 258). Brown's work is seminal in the area of culture and trauma because it provides us a multicultural/ecological framework to consider. First, it addresses what scholars interested in minority psychology have been researching, such as the implications of privilege and oppression, cultural literacy, and the importance of the therapeutic relationship, all of which can be easily ignored or superficially considered in our new press for evidence-based techniques. Orozco, Chin, Restrepo, and Tamayo (2001) suggested that to fully understand the complexity of and impact of culture on trauma reactions, one must consider an ecological framework, which holds that human development involves the interchange between an individual and his multilevel environments/systems. Some of these systems include the nuclear and extended family, peers, school, neighborhood, and community. The importance of understanding the social ecology and its relationship to trauma for a diverse group such as that of Latinos required an 80+ page document full of references and recommendations created by the NCTSN and the Chadwick Center, which is clearly an example of the complexity of culturally informed work (The Workgroup on Adapting Latino Services, 2008). Attempts to utilize treatment adaptations do not necessarily make a practice culturally competent because clinicians can easily miss cultural nuances and err by making concrete overgeneralizations. Even well-developed treatment adaptations cannot be appropriate for all individuals or groups. Therapists must possess the clinical skills to recognize this and continually evaluate the appropriateness and effectiveness of their treatments. Achieving cultural sensitivity requires a combination of cultural and systems awareness training, clinical consultation, reflection and treatment evaluation, and adaptation.

The need for all of the abovementioned components of culturally sensitive practice is highlighted by the reports that several disparities in Hispanic mental health services have been noted in the literature. These include the underutilization of mental health services and very high dropout rates. Latinos with mental health disorders rarely seek services, and recent immigrants have even lower rates of service utilization (Acosta, 2006; Office of the Surgeon General, Center for

Mental Health Services, & National Institute of Mental Health, 2001). Studies have indicated that almost 70% of Latinos who access mental health care services do not return after their first visit, thus indicating a possible lack of trust in the mental health care system (Aguilar-Gaxiola, 2005). In response to mental health disparities, several authors have indicated that the two most important issues that need to be addressed are inadequate/inappropriate sources of treatment and insufficient Latino or bilingual service providers (Acosta, 2006; National Council of La Raza, 2005; NCTSN, 2007). Additionally, some traumatic experiences may be related to the process of immigrating without proper documentation. For example, a growing body of research has demonstrated wide-ranging consequences of sudden caregiver-child separation, one of the most damaging outcomes of raids (Rodriguez & Hagan, 2004; Suárez-Orozco, Todorova, & Louie, 2002). Some documented consequences include, among others, fear and anxiety, depression, and posttraumatic stress symptoms and reactions (Capps, Castaneda, Chaudry, & Santos, 2007; Chaudry et al., 2010; Pumariega & Rothe, 2010). Additionally, there are many children who are separated from their parents very early in their development due to piece-meal migration which can intensify the child's risk of exposure to other traumatic events as well as their general sense of safety (Suárez-Orozco et al., 2002).

Over 25 years of research studies has found that Hispanic adults are more likely than their non-Hispanic counterparts to experience severe symptoms of post-traumatic stress disorder (PTSD) (Escobar et al., 1983; Galea et al., 2004; Kulka et al., 1990; Lewis-Fernandez et al., 2008; Norris, Perilla, & Murphy, 2001; Pole et al., 2001; Schell & Marshall, 2008). Eisenman, Gelberg, Liu, and Shapiro (2003) mentioned that a third of the Latino population who have been exposed to traumatic experiences developed symptoms of depression and PTSD. A longitudinal study by Marshall, Schell, and Miles (2010) with over 600 participants replicated several study findings indicating that Hispanics tended to report higher levels of symptoms such as hypervigilance and flashbacks. In contrast, few differ-

ences were observed for symptoms characteristic of impaired psychological functioning such as difficulty concentrating or sleep difficulties (other than nightmares). This may suggest that the pattern of symptoms for Hispanics with PTSD may differ not only in prevalence and degree but also in the types of symptoms. A study by Pole, Best, Metzler, and Marmar (2005) comparing Hispanic police officers (*n* = 189) from their non-Hispanic Caucasian (*n* = 317) and Black (*n* = 162) counterparts found that greater peri-traumatic dissociation, greater wishful thinking and self-blame coping, lower social support, and greater perceived racism were important variables in explaining the elevated PTSD symptoms among Hispanics.

There are several other running theories for these differences such as the idea that there is a culturally based propensity to exaggerate or over-report mental health symptoms (Ruef, Litz, & Schlenger, 2000; Ortega & Rosenheck, 2000), a disposition toward acquiescent responding (Ortega & Rosenheck, 2000), and the tendency of Latinos to manifest suffering in physical rather than psychological form (Hough, Canino, Abueg, & Gusman, 1996). Some of the other explanations include disparity in the experience of traumatic life events (Frueh, Brady, & de Arellano, 1998), ethnic discrimination (Loo et al., 2001; Marsella, Friedman, & Spain, 1996), differences in coping resources following trauma exposure (Pole et al., 2005), and/or sociodemographic disadvantage (Pole, Gone, & Kulkarni, 2008). All of these studies warrant future research. At this point stating that Latinos experience a greater risk for PTSD does not need as much further study as it provides very little clinical utility. Future research will be required to disentangle the many constructs within Hispanic ethnicity that may contribute to the observed differences in reactions to trauma. Examples of these factors include education, income, culture, religiosity, family composition, employment type, self-concept, discrimination, and its historical link to colonialism (Brown, 2008). Additionally, understanding that symptom presentation may differ, it is important that these symptoms be directly assessed in this population. In general, many

general psychological screening measures do not focus much attention on hypervigilance, flashbacks, and dissociation. As such, clients' symptoms may be misdiagnosed as bizarre or thought disorder related which increases the risk of misdiagnosis. Further studies may consider how to incorporate these factors into general screening assessments.

Symptoms/Diagnoses

For the purposes of this chapter, we will mainly focus on the diagnoses of post-traumatic stress disorder (PTSD) and acute stress disorder acknowledging that there is likely to be other comorbidity involved in chronic and complex trauma responses. The DSM-5 (APA, 2013) lists the following categories as the ones necessary for a PTSD diagnoses: traumatic event/stressor, intrusion symptoms, persistent avoidance of stimuli associated with the trauma, negative alterations in cognitions and mood that are associated with the traumatic event, and alterations in arousal and reactivity that are associated with the traumatic event. Examples of intrusion symptoms include flashbacks, nightmares, and frightening thoughts. Flashbacks are when one is reliving the trauma over and over, and this includes physical symptoms like a racing heart or sweating. Reexperiencing symptoms may cause problems in a person's everyday routine. The symptoms can start from the person's own thoughts and feelings. Words, objects, or situations that are reminders of the event can also trigger reexperiencing symptoms; therefore, clinicians would need to help a client identify these triggers. Avoidance symptoms include staying away from places, events, or objects that are reminders of the traumatic experience, as well as avoiding thoughts or feelings related to the traumatic event. These symptoms may cause a person to change his or her personal routine. Arousal and reactivity symptoms include an increased startle response, feeling tense or "on edge," difficulty sleeping, and angry outbursts. Arousal symptoms are usually constant, instead of being triggered by things that remind one of

the traumatic events. These symptoms can make the person feel stressed and angry. They may make it hard to perform daily tasks, such as sleeping, eating, or concentrating. Additionally, there are thought- and mood-related symptoms such as trouble remembering key features of the traumatic event; negative thoughts about oneself or the world; distorted feelings like guilt, shame, or blame; and loss of interest in enjoyable activities.

The National Institute of Mental Health (n.d.) emphasizes that children and teens can have extreme reactions to trauma, but their symptoms may not be the same as adults. In very young children (less than 6 years of age), these symptoms can include wetting the bed after having learned to use the toilet, forgetting how to or being unable to talk (regression), acting out the scary event or related themes during playtime, and/or becoming unusually clingy with a parent or other adult. Older children and teens are more likely to show symptoms similar to those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge.

A diagnosis of acute stress disorder is given within the first month after a traumatic event. Symptoms are also classified into categories: intrusion, negative mood, dissociation, avoidance, and arousal. It involves the reexperience of the event in the present, which varies by individual, but commonly includes recurrent memories that include a sensory, emotional, or physiological component (APA, 2013). Acute stress disorder and PTSD differ in two fundamental ways. The first difference is that the diagnosis of acute stress disorder can be given only within the first month following a traumatic event. If posttraumatic symptoms were to persist beyond a month, the clinician would assess for the presence of PTSD. The acute stress disorder diagnosis would no longer apply. Acute stress disorder also differs from PTSD in that it includes a greater emphasis on dissociative symptoms. An acute stress disorder diagnosis requires that a person experience three symptoms of dissociation (e.g., numbing,

reduced awareness, depersonalization, derealization, or amnesia), while the PTSD diagnosis does not include a dissociative symptom cluster. Problems with sleep onset and maintenance, as well as panic attacks, are also often reported (Harvey & Bryant, 1998). After a month, it may also progress to PTSD.

Idioms of Distress

Nitcher (1981) defines idioms of distress as the ways in which distress is experienced and expressed in a certain culture, considering its values, norms, and health concerns. Hinton and Lewis-Fernández (2010) mentioned the *ataque de nervios* or "attack of nerves" as an example of idioms within the Caribbean-Latino populations that at times can be considered as a normal reaction to a stressful or traumatic event. Originally *ataque de nervios* was a pejorative label developed by US military psychiatrists in the 1950s and 1960s in regard to Puerto Rican military males. It was not viewed as a response to trauma but rather focused attention on the disturbing idea that there was some inherent defect in being Puerto Rican. These psychiatrists failed to analyze local cultural meanings and the social and political context of these expressions. Additionally they ignored the broader colonial process of treating Puerto Ricans as "others" (Guarnaccia, 2014). Nowadays it appears that the prevalence is higher in Puerto Rican females, although it is found in other Latino ethnic groups (Guarnaccia et al., 2010). Clinical knowledge of cultural idioms of distress is necessary in order to provide a culturally sensitive diagnosis and a treatment that fits the patient's beliefs and practices. This becomes more salient considering that Latinos comprise the largest minority group in the United States and 17.6% of the population in the United States (US Census Bureau, 2015). Latinos constitute a diverse population from 20+ countries with distinct ethnic and racial compositions, as well as unique histories of migration to the United States.

Ataque de nervios has the following commonly reported symptoms: shouting uncontrollably, crying "attacks," trembling, and becoming verbally or physically aggressive. Dissociative experiences, seizure-like or fainting episodes, and suicidal gestures are prominent in some *ataques* but absent from others. A central feature of an *ataque de nervios* is a sense of being out of control. *Ataques de nervios* frequently occur as a direct result of a stressful event relating to the family, such as news of a death of a close kin, a separation or divorce from a spouse, conflicts with family, or witnessing an accident involving a family member. After the *ataque*, people often experience amnesia of what occurred. However, they otherwise rapidly return to their usual level of functioning. *Ataques de nervios* have been shown to be associated with a range of affective, anxiety, conduct, and dissociative disorders in several epidemiological and clinical studies, as well as to be normative forms of expressing deep sadness and strong anger in stressful social situations (Guarnaccia et al., 2010).

While many people have associated *ataque de nervios* with anxiety disorders such as panic disorder, it should be noted that while trauma has been acknowledged to be a risk factor in the development of panic disorder, as well as many other anxiety disorders (e.g., Creamer, McFarlane, & Burgess, 2005; Goodwin, Fergusson, & Horwood, 2005; Lubit, Rovine, Defrancisci, & Eth, 2003), a distressing event is almost always a precipitant for *ataques de nervios*. However, previous studies that have examined this link between trauma and *ataques de nervios* have been mixed (Lewis-Fernandez et al., 2002; Schechter et al., 2000). Treatment manuals or even solid treatment guidelines that are specific to the *ataque de nervios* symptom presentation have not been found.

Trauma-Informed Care and Evidence-Based Techniques

Trauma-informed care refers to treatment that incorporates a thorough understanding of the profound neurological, biological, psychological, and social effects of trauma and violence on the individual, and care that addresses these

effects is collaborative, supportive, and skill based (Jennings, 2004). While we teach specific techniques, there is much more involvedness to the treatment than the specific evidence-based treatments we utilize especially when considering complex trauma. The gold standard treatments for trauma-related disorders are somewhat different for children/adolescents (CPP, TF-CBT, etc.) and adults (CPT, EMDR, exposure therapy), but it is also important to conceptualize treatment model and length of treatment based on type of trauma (acute, chronic, or complex). Several random clinical trials have confirmed that exposure therapies and to a lesser extent other cognitive behavioral techniques, such as cognitive processing therapy (CPT), have been effective in the treatment of PTSD in adults (Keane, Kaloupek, & Kolb, 1998; Suris, Linl-Malcom, Chard, & North, 2013). The greatest number of studies has been conducted on exposure-based treatments, which involve having survivors repeatedly reexperience their traumatic event. There is strong evidence for exposure and of the various approaches; prolonged exposure (PE) has received the most attention although many clinicians report preferring titrated, gradual exposure or the "relationship as exposure" (Briere & Lanktree, 2008). PE includes both imaginal exposure and in vivo exposure to safe situations that have been avoided because they elicit traumatic reminders (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Nonetheless, the outcomes of such approaches leave room for improvement, with approximately 20–50% of treatment completers continuing to be diagnosed with PTSD after treatment (Resick, Nishith, Weaver, Astin, & Feuer, 2002; Schnurr et al., 2007). This may be related to the experience of complex trauma and the need for more sessions than allotted for in manualized treatments or phase-oriented treatment for these individuals.

The International Society for Traumatic Stress Studies (ISTSS) suggested that a phase-oriented or sequential treatment is needed in order to provide a hierarchy of treatment needs that go beyond addressing the standard PTSD symptoms (Cloitre et al., 2012). Phase 1 would be stabilization and skills strengthening. This phase is focused on safety and reduction of symptom acuity. Interventions in this phase include psychoeducation about trauma, assessment of harm to self/others, and the introduction of emotion regulation techniques. The next phase, Phase 2, would directly focus on the review and reappraisal of trauma memories. This is where the exposure and processing techniques come into play. The purpose is to maintain emotional engagement with the distressing memory while simultaneously remaining physically, emotionally, and psychologically intact. This is where you would experience reorganization and integration of the traumas into the memory (Cloitre et al., 2012).

There are two primary mechanisms of change hypothesized for efficacious treatment of post-traumatic stress disorder (PTSD): (1) Improvement occurs through emotional processing of the trauma memory by way of repeated exposure, and/or (2) improvement occurs because the meaning of the event changes (Brewin, Dalgleish, & Joseph, 1996; Ehlers & Clark, 2000; Foa & Jaycox, 1999; Keane & Barlow, 2002; Resick, 2001). The main issues that need to be addressed in treatment are psychoeducation regarding trauma symptoms, trigger identification, and body awareness. Useful bilingual tools to enhance clinician's ability to work on the trauma symptoms such as extreme stress and flashbacks are included in this chapter. Some useful techniques for the treatment of PTSD are flashback halting, relaxation exercises, grounding, body scanning, and tracking of emotional intensity. However, these should not be considered more important than the therapist's skills and relationship with the client.

The therapeutic alliance has been said to be the main ingredient for successful treatment more than any evidence-based intervention (Cabaniss, 2012, May 31). As the therapeutic relationship (relationship as exposure) can be a key corrective experience in cases of interpersonal abuse, it is very important to establish a strong, positive relationship with these potential trauma victims (Briere & Lanktree, 2008). Furthermore, the significance of the therapeutic relationship is paramount in Latino cultures, as suggested by the concept of *personalismo*, and the documented

evidence that Latinos often do not return after their initial visits perceiving their therapists as "cold," (Aguilar-Gaxiola, 2005, February 16; Añez, Paris, Bedregal, Davidson, Grilo, 2005). Three meta-analyses (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Smith, Domenech-Rodriguez, & Bernal, 2011) have found culturally adapted treatments to be superior to unadapted control and bona fide treatments. Therapist-patient negotiation of cultural meaning accounts for the superiority of cultural adaptation which may reduce the benefit of fidelity to "techniques" in certain populations. The authors refer to this as the "illness myth." The fact that it is proven that Hispanics differ in rates and type of symptoms of PTSD warrants consideration for more specialized treatment. Additionally, more work needs to be done in providing guidelines for people who present with and/or report having "ataque de nervios," as the neurological component is a distinct presentation as well.

As illustrated above, Latinos experience high levels of PTSD-related disorders and may have culturally variable presentations. Despite this high prevalence rate, Latinos underutilize mental health services which is unfortunate as trauma-related disorders can be effectively treated. Also there are limited resources available to clinicians who work with this population (specifically Spanish-speakers). The purpose of this chapter was threefold. First, we provided an overview of trauma-related disorders as they pertain to Latinos. Second, we discussed evidence-based treatments that can be used with Latinos. Finally, we have created a series of handouts and tools (all based on evidence-based principles and derived from empirically sup-

ported treatments) that can be used with Spanish speakers who present with a trauma-related disorder. A detailed index of these handouts and tools follows proceeded by the tools and handouts themselves.

Index of Bilingual Handouts

Adapted and Translated by Karina Perdomo Below

(a) Psychoeducation
- Understanding PTSD/trauma
- Extreme stress symptoms

(b) Distress tolerance/arousal modulation
- The power of relaxation/deep breathing for stress relief
- Progressive muscle relaxation sequence
- Deep breathing for stress relief
- Progressive Muscle Relaxation
- Emotion intensity
- How do we feel emotions in our body

(c) Grounding techniques
- Safe place
- Body awareness
- Moving

(d) Flashbacks
- Dealing with flashbacks
- Ideas on how to cope with flashbacks
- Flashback halting protocol

(e) Triggers
- Trigger grid

(f) Exposure
- Avoidance & Gradual Exposure: Hydra & Hercules
- Exposure homework

Understanding Post-traumatic Stress Disorder (PTSD) downloaded from Psychology Tools https://psychologytools.com/understanding-ptsd.html

Traumatic event

Fragmented memories of the trauma

Changes beliefs about:

Your self

The world

Other people

Fear

Sense of threat

Avoidance means that the memories remain unchanged

Avoidance means that the beliefs go unchallenged

Avoidance
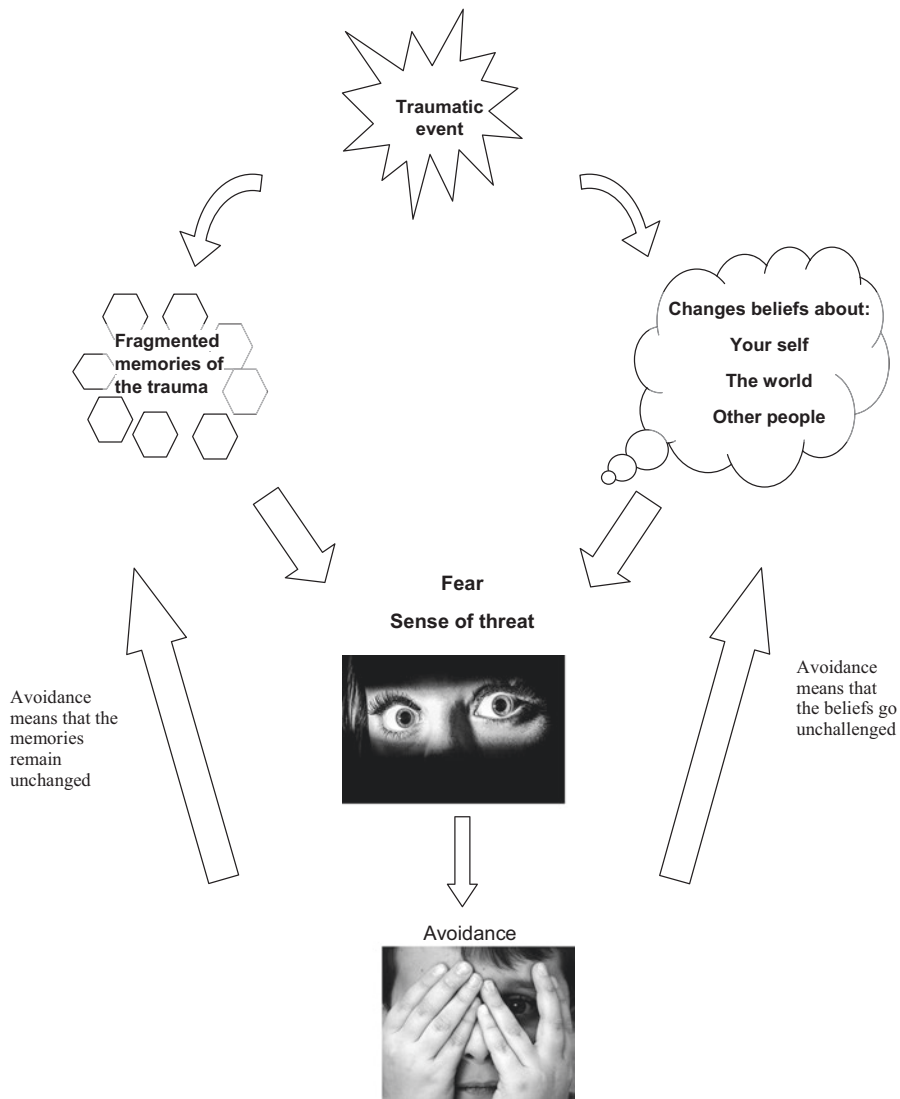
Entendiendo el trastorno de estrés postraumático (TEPT)

Entendiendo el trastorno de estrés postraumático (TEPT)

Evento traumático

Recuerdos fragmentados del trauma

Cambio de las creencias acerca de: tí mismo, el mundo y de la gente

Miedo, sensación de amenaza

Evitación significa que los recuerdos permanecen intactos

Evitación significa que las creencias no son retadas y/o enfrentadas

Evitacion
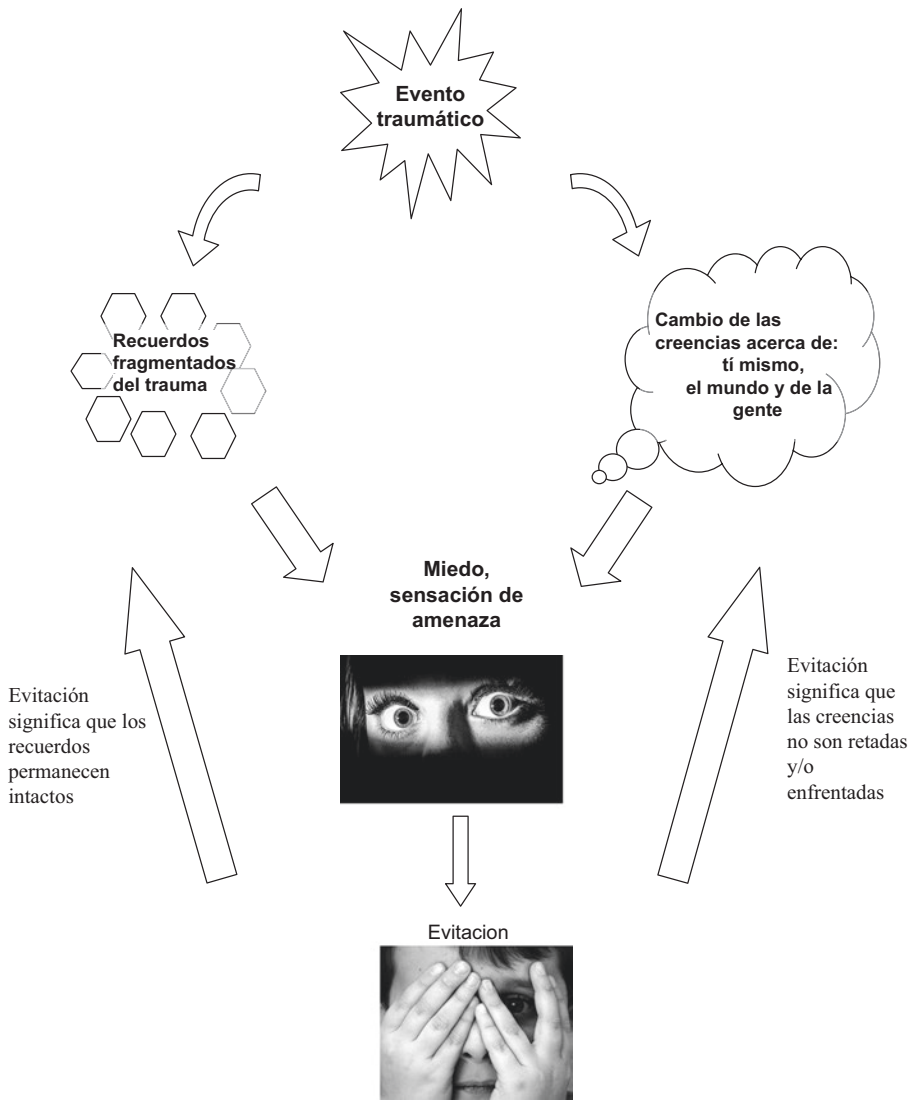
Síntomas de estrés extremo (Extreme Stress Symptoms)

Disociación (Mental shutdown)	
Mi mente se siente espaciada, como si estuviera aturdido	My mind feels spacey, like I'm in a daze
Me siento alejado del mundo que me rodea, como si las personas y las cosas no fueran reales, o como si todo fuera un sueño	I feel detached from the world around me, like people and things are not real, or like it's all a dream
Me siento como si no supiera quién soy y me estuviera viendo a mí mismo desde afuera, o como si hubieran partes de mí que toman el control de mi vida	I feel as if I don't know who I am, and I'm watching myself from outside, or like there are separate parts of me that take control of my life
Tratando de sentirse seguro/Comer en exceso como forma de control (Trying to feel safe/in control by extreme eating)	
No comeré o vomitaré porque tengo miedo de perder el control de mi forma de comer y aumentar de peso	I won't let myself eat, or I make myself throw up because I am afraid of losing control of my eating and gaining weight
Me encuentro comiendo grandes cantidades de alimentos para ayudarme a sentirme mejor	I find myself eating large amounts of food to help me feel better
Problemas con la sexualidad (Problems with sexuality)	
Me siento preocupado por mi sexualidad – pienso demasiado sobre sexo...	I feel preoccupied with sex – I think too much about sex…
Me encuentro evitando relaciones sexuales, sin querer pensar en ello o no queriendo que nadie me toque en absoluto	I find myself avoiding sex, not wanting to think about it or not wanting anyone to touch me at all
Soy más activo sexualmente que lo que realmente quiero ser	I am more sexually active than I really want to be
Asumir riesgos extremos (Extreme risk-taking or self-harm)	
Me encuentro en situaciones peligrosas, como conducir imprudentemente o estar en lugares o con personas con las que podría salir lastimado gravemente o incluso muerto	I find myself in dangerous situations, such as driving recklessly or being in places or with people where I could get hurt badly or even killed
Consigo alivio cuando me siento estresado cortándome, punzándome o lastimando mi cuerpo de alguna otra manera	I get relief from feeling stressed by cutting, punching, or hurting my body in some other way
Demasiada o muy poca participación en las relaciones (Too much or too little involvement in relationships)	
Centro mi atención en los demás, evitando mis propias necesidades y deseos	I focus my attention on others in my life, avoiding my own needs and desires
Siento que soy muy diferente a todos alrededor de mí – nadie puede entender lo que he pasado	I feel I'm really different from everyone around me – no one can understand what I've been through
Siento que no se puede confiar en nadie, que tarde o temprano todos te fallan, te usan, o te hacen daño	I feel no one can be trusted, that everyone lets you down or uses you and hurts you sooner or later
Desajuste de el cuerpo (Breakdown of the body)	
Dolor físico, enfermedades, y otros problemas de salud que los doctores no pueden explicar o ayudar	Physical pain, illnesses, or other physical health problems that doctors can't explain or help me with
Desesperanza y culpa (Hopelessness and self-blame)	
Pienso en la muerte como una forma de poner fin a la miseria que siento	I think about dying as a way of ending the misery I feel
Siento que la religión y los aspectos espirituales de mi vida no valen nada, o que están mal y dañan a la gente	I feel that religion and the spiritual aspects of life are worthless or that they are bad and hurt people
Siento que soy una mala persona- soy culpable cada vez que suceden cosas malas, aunque en realidad no sean mi culpa	I feel I'm a bad person – I'm guilty whenever bad things happen even if they really aren't my fault

The Power of Relaxation

Relaxation is our body's natural antidote to stress. When we feel stressed, our bodies can be flooded with chemicals which then prepare us for 'fight or flight'. In a real emergency situation where we really need to be alert, this is useful to us, but if someone is experiencing so much stress that these chemicals are always being activated, it wears down the body leaving you with some less energy and sometimes feeling less able to cope than you normally would.

Using relaxation techniques can bring your system back into balance. Relaxation techniques help you to deepen your breathing, reduce the stress hormones, slow down your heart and blood pressure rates and relax your muscles.

Research shows that relaxation can also increase energy and focus, help the body combat illness, relieve aches and pains, heighten problem-solving abilities, and boost motivation and productivity. Best of all - with a little practice – it is something we can all do for ourselves.

Deep Breathing for Stress Relief

Deep breathing is a simple, yet powerful, relaxation technique. It's easy to learn, and you can do it almost anywhere. It's a quick way to get your stress levels in check. Deep breathing is the cornerstone of many other relaxation practices, too, and can be combined with other elements such as aromatherapy and music. All you really need is a few minutes and a place to sit up straight or stretch out.

El poder de la relajación

La relajación es un antídoto natural de nuestro cuerpo al estrés. Cuando nos sentimos estresados, nuestro cuerpo puede inundarse de químicos que nos preparan para "luchar o huir", Durante una situación de emergencia real donde tenemos que estar alerta, estos químicos pueden ser útiles para nosotros. No obstante, si en la vida diaria alguien está experimentando tanto estrés que estos químicos siempre están activados, el cuerpo se desgasta dejándole con menos energía y, en ocasiones, menor capacidad para hacer frente a la situación.

El uso de técnicas de relajación puede llevar a nuestro sistema a estar balanceado nuevamente. Las técnicas de relajación ayudan a profundizar su respiración, reducir las hormonas del estrés, bajar el ritmo del corazón y la presión arterial, así como también a relajar los músculos.

La investigación muestra que la relajación también puede aumentar la energía y el enfoque, ayudar a combatir las enfermedades, aliviar dolores y molestias, aumentar la capacidad de resolver problemas y aumentar la motivación y la productividad. Lo mejor de todo -con un poco de práctica- es una actividad que todos podemos hacer para beneficiarnos a nosotros mismos.

La respiración profunda para aliviar el estrés

La respiración profunda es una técnica de relajación simple, pero potente. Es fácil de aprender, y se puede hacer casi en cualquier lugar. Es una forma rápida de obtener sus niveles de estrés bajo control. La respiración profunda es la piedra angular de muchas otras prácticas de relajación. Puede ser combinada con otros elementos como la aromaterapia y la música. Todo lo que realmente se necesita es un par de minutos y un lugar para sentarse con la espalda recta o estirarse.

Progressive Muscle Relaxation Sequence

Make sure you are sitting or lying comfortably, take off your shoes and make sure your clothing is nice and loose.

Take a few moments to relax and take some deep, slow, cleansing breaths, breathing in through the nose and out through the mouth.

When you feel ready to begin, focus your attention on your right foot, feel how it feels to you, slowly tense up all the muscles in your right foot, hold for a count of 10, or less if you can't manage to hold it to 10. Now relax your right foot, feel the tension flowing away and feel how your foot now feels more relaxed and loose.

Repeat this sequence for all the muscle groups in your body in an order similar to the example below:

- Right foot
- Left foot
- Right calf
- Left calf
- Right thigh
- Left thigh
- Hips and buttocks
- Stomach
- Chest
- Back
- Right hand
- Right arm
- Left hand
- Left arm
- Shoulders
- Neck
- Face

When you have gone through every muscle group, you will have an idea of where you were most tense and where you felt the most relief.

Complete the muscle relaxation by taking a few more deep breaths, and finish by ensuring you sit for a moment with your feet placed firmly flat on the floor to ground yourself.

Secuencia de Relajación muscular progresiva

Asegúrese de que esté sentado o acostado cómodamente, quítese los zapatos y asegúrese de que su ropa se sienta agradable y suelta.

Tómese unos minutos para relajarse y tomar algunas respiraciones lentas y profundas, inhalando por la nariz y exhalando por la boca.

Cuando se sienta listo para comenzar, centre su atención en su pie derecho; piense en cómo se siente. Poco a poco tense todos los músculos de su pierna derecha, resista y cuente hasta diez o al menos, hasta donde pueda resistir. Ahora relaje el pie derecho, sienta la tensión que se va y sienta cómo su pie ahora se siente más relajado y suelto.

Repita esta secuencia con todos los grupos de músculos en su cuerpo en un orden similar al ejemplo siguiente:

- Pie derecho
- Pie izquierda
- Pantorrilla derecha
- Pantorrilla izquierda
- Muslo derecho
- Muslo izquierdo
- Caderas y nalgas
- Estómago
- Pecho
- Espalda
- Mano derecha
- Brazo derecho
- Mano izquierda
- Brazo izquierdo
- Hombros
- Cuello
- Cara

Cuando haya pasado por todos los grupos musculares, usted tendrá una idea de dónde estaba más tenso y dónde sintió el mayor alivio.

Complete la relajación muscular realizando unas cuantas respiraciones profundas, y termine asegurándose que está con los pies bien asentados completamente en el piso para conectarse a tierra.

¿Qué tan intensos o fuertes son nuestros sentimientos?
(How intense or strong are our emotions?)

Muy fuertes/ Very Strong

10

9

8 Fuertes/Strong

7

6

5 Más o Menos/ So-so

4

3

2 Un Poco/ A little bit

1 Nada/Nothing

Fecha/Date:

Periodo de la sesión/ Session Time	Sentimiento/Feeling	Intensidad/Intensity
Al inicio de la sesión/ Beginning of session		
En medio de la sesión/ Middle of session		
Al final de la sesión/ End of session		

¿Cómo sentimos las emociones en nuestro cuerpo?

(How do we feel emotions in our body?)

Utiliza colores para mostrar los lugares de tu cuerpo en los que sientes esa emócion y explícale a tu terapeuta cómo te sientes.

(Please use colors to demonstrate the areas in your body in which you feel the emotion and explain to your therapist how that makes you feel.)
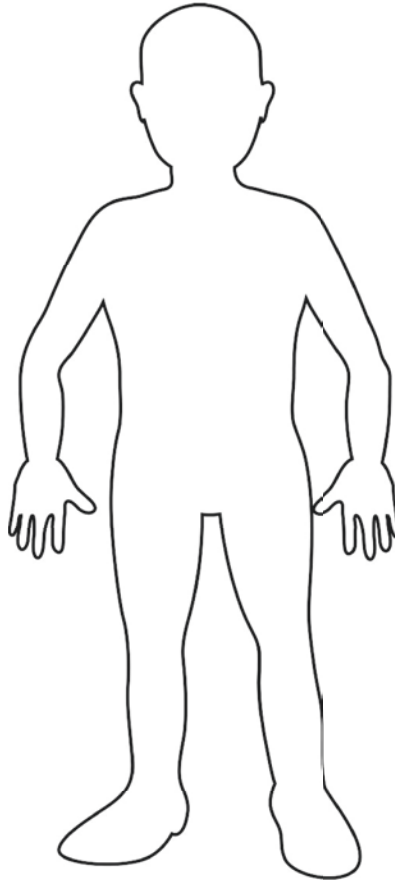
Grounding Techniques

There are a number of grounding techniques that can be learned to decrease hyperarousal and connect to the present. These include naming and listing things in the here and now and using as many senses as possible to reconnect to the present. What follows are some techniques that have proved useful to some survivors – it's important to find what works for you and you can adapt the techniques to fit you.

Técnicas de "grounding"

Existen un sinnúmero de técnicas de "grounding" que pueden aprenderse para disminuir la hiperexcitación y conectarse con el presente. Entre estas se encuentra el nombrar y enumerar las cosas que están presentes "aquí y ahora" utilizando la mayoría de tus sentidos (vista, tacto, audición, gusto, olor). A continuación se presentan algunas de las técnicas que han resultado útiles para sobrevivientes de algún evento traumático. No obstante,

es importante encontrar lo que funciona para ti, de forma tal que pueda adaptar estas técnicas de acuerdo a su preferencia.

Finding a Safe Place or Activity

A safe place is a form of anchor to reduce the stress of working with traumatic memories. Anchors can be used as "braking" tools when the going gets rough. A suitable anchor is one that gives relief (in body and emotion) and a sense of well-being. It is preferable that an anchor is chosen from real-life experience, so that positive memories in both body and mind can be accessed. It is useful to work with your counselor to establish in advance an anchor that can be sued when needed in trauma work. A safe place or activity is a current or remembered experience of protection. It should have associations of calmness and safety (as opposed to "relaxing," which can feel unsafe for people who have experienced trauma, or "pleasurable," which can be overstimulating). It is preferable for the safe place/activity to be something real that is known from life. This is because there will be somatic resonance in the memory – sights, sounds, smells, etc., which will be recorded as sensory memory traces and be highly accessible. It is helpful to imagine the safe place/activity during times of stress and anxiety, or it can be used as an anchor, to reduce hyper-arousal during a therapy session.

Encontrando un lugar o actividad segura

Un lugar seguro es una forma de ancla para reducir el estrés de lidiar con recuerdos traumáticos. Las anclas se pueden utilizar como un "freno" cuando las cosas se complican. Un anclaje adecuado es aquel que da alivio (tanto corporal como emocionalmente) y una sensación de bienestar. Es preferible que un "ancla" provenga de una experiencia de la vida real, de forma tal que los recuerdos positivos en el cuerpo y la mente se puedan acceder. En ocasiones resulta útil trabajar con su consejero para establecer de

antemano cuál es este lugar, de forma tal que le resulte fácil visualizarlo o acudir cuando lo necesite. De esta forma pudiera decirse que un lugar o actividad segura es una experiencia actual o recuerdo que produce un sentido de protección. Debe tener asociaciones con sentimientos de tranquilidad y seguridad (en oposición a 'relajante'-que puede resultar inseguro para personas que han sufrido traumas- o 'agradable'- que puede ser sobre-estimulante). Es preferible que el lugar/actividad sea algo real debido a que esto producirá resonancia somática en lugares de la memoria. Los sonidos, olores, etc., que se registran como huellas en la memoria sensorial pueden ser muy accesible. Es útil recordar o acceder a este lugar/actividad en momentos de estrés y ansiedad, o para reducir la sobre exaltación fuera o durante la sesión terapéutica.

Body Awareness

Employing our own awareness of the state of our body – our perceptions of the precise, coexisting sensations that arise from internal and external stimuli – is a very useful tool in trauma work. This is because consciousness of current sensory stimuli is our primary link to the here and now; it is also a direct link to our emotions.

Body awareness is about awareness of cues from the central nervous system. Body awareness (sensations) from exteroceptors originates from stimuli that have their origin outside of the body (touch, taste, smell, sounds, sights). Body awareness from interoceptors consists of sensations that originate on the inside of the body (connective tissue, muscles, and viscera).

Moving

Separating past from present can be accomplished on a body level. During a flashback or trauma work, getting up and moving (e.g., walking around or moving from one room to another) will help to reinforce the here-and-now reality that the trauma is no longer occurring. "I could not move then, but I can move now." Moving can

also help to complete a sequence of impulses that were blocked at the time of the trauma (e.g., the impulse to run or push away).

Conociencia de nuestro cuerpo

El empleo de nuestra conciencia sobre nuestro cuerpo, es decir, de nuestra percepción de las sensaciones precisas y coexistentes que surgen de estímulos internos y externos, es una herramienta útil en el trabajo con el trauma. Esto se debe a que la conciencia de los estímulos sensoriales son nuestro enlace principal al aquí y ahora; un vínculo directo con nuestras emociones. La conciencia del cuerpo se trata de reconocer las señales de nuestro sistema nervioso central. En términos externos, esta se origina a partir de los estímulos que tienen su origen fuera del cuerpo (tacto, gusto , olor, sonidos, imágenes) . Por otro lado, la conciencia del cuerpo de interoceptores consiste en sensaciones que se originan en el interior del cuerpo (tejido conjuntivo , músculos y vísceras) .

Moverse

Separar el pasado del presente puede llevarse a cabo a un nivel corporal. Durante un recuerdo repentino o trauma, levantarse y moverse (por ejemplo, caminar o trasladarse de una habitación a otra) es una forma de ayudar a reforzar "el aquí -y-ahora" de forma tal que le recuerda la realidad de que el trauma ya no está ocurriendo. "No me podía mover entonces, pero puedo mover ahora". Moverse también puede ayudar a completar una secuencia de impulsos que se bloquearon en el momento del trauma (por ejemplo, el impulso de correr o empujar hacia fuera).

Dealing with Flashbacks

What are flashbacks?

Anyone who has experienced a traumatic event can experience flashbacks. Flashbacks are a memory of a frightening or painful experience, which occurred either in childhood or adult life. It tends not to be like an ordinary memory but more of a sudden and unexpected intrusion.

Flashbacks can be experienced as a single slide from a slideshow, a snapshot, or photograph that flashes repeatedly or like a video clip. A flashback can feel almost as real as when it originally happened and can also be as frightening.

Not everyone's flashbacks are visual. Some take the form of words and phrases or sounds that were heard in the past. They can be accompanied by intense feelings, e.g., shame, sadness, anger, or physical sensations known as "body memories," which may have been felt at the time of the original traumatic event.

Flashbacks can happen at any time, anywhere, and often occur without warning. They can be triggered by the time of year or day, TV programs, films, smells, words, phrases, songs, places, someone who reminds you in some way of the traumatic event, pictures, tastes, a particular feeling such as fear or anxiety, having sex, or being intimate with your partner. These can occur instantly or sometime later.

Manejando recuerdos repentinos

¿Qué son los recuerdos repentinos?

Alguien que ha tenido alguna experiencia de un evento traumático puede sufrir de un recuerdo repentino. Los recuerdos repentinos o "flashbacks" son una memoria de una experiencia dolorosa o espantosa, que puede haber ocurrido en la infancia o en la vida adulta. No tiende a ser como una memoria ordinaria, sino más bien una intrusión repentina e inesperada.

Los recuerdos repentinos pueden ser experimentados como una sola diapositiva de una presentación, como una fotografía que parpadea repetidamente o como un clip de video. Se puede sentirse casi tan real o espantoso como cuando ocurrió inicialmente.

No todas las personas tienen recuerdos repentinos que son visuales. Algunos toman la forma de palabras y frases o sonidos que se escucharon en el pasado. Pueden estar acompañadas por sensaciones intensas -como por ejemplo vergüenza, tristeza, ira- o por sensaciones físicas, conocidas

como "memorias del cuerpo" que pueden haber sido sentidas en el momento del suceso traumático original.

Los recuerdos repentinos pueden ocurrir en cualquier momento, en cualquier lugar y con frecuencia ocurren sin previo aviso. Pueden ser provocados por: la época del año o el día, por programas de televisión, películas, olores, palabras, frases, canciones, lugares, alguien que le recuerda de alguna manera del evento traumático, fotos, gustos, una sensación particular, como el miedo o ansiedad, tener relaciones sexuales o tener intimidad con su pareja. Estos pueden ocurrir inmediatamente o en algún momento posterior.

Ideas on How to Cope with Flashbacks

- Let yourself know that what you are experiencing is a flashback and that this is a normal reaction to the traumatic event you experienced. It may be useful to look around you and take note of what is happening in the here and now.
- Try to associate to your immediate surroundings by feeling where your body makes a boundary with the chair and floor ("feel the arms of the chair against your arms and your feet on the floor"), and name things with your senses ("what can you hear that tells you are in the present?" "Name 5 things in this room that are green"). "Think of something that you know is real now that helps you to know that (event) is in the past, that you survived it and are safe now."
- You may find it reassuring or grounding to carry a stone or something familiar and comforting in your pocket that you can stroke, hold, or rub when a flashback occurs. Some people keep an elastic band around their wrist and "ping it" to try and bring them back to the here and now.
- Try to breathe from your diaphragm (put your hand just above your navel and breathe, so your hand is pushed up and down). This can help prevent a panic attack.
- If the flashback occurs while you are out and about, try to get yourself to somewhere that you feel safe and secure.
- If you are wakened by a flashback, also known as a "night terror," try to write it down, then go and have something warm to drink, watch some TV, listen to music, or do something else that you find relaxing. It's often best not to try and sleep until you have been able to relax for a while.
- Keep a list of people you can contact in the event of experiencing a flashback.
- It may be useful to write the flashback down or tell it to someone you trust – though it can be very painful to speak about, talking it over with someone can help your healing.
- If you self-harm/injure in response to a flashback, try to take some precautions to minimize the longer-term harm that you might do to yourself.
- Do something that helps you relax, e.g., have a bath, listen to your favorite music after you have had a flashback.
- Remember flashbacks are a normal response to what you have experienced.

Ideas sobre cómo enfrentarse con los recuerdos repentinos

- Recuérdate a ti mismo que lo que estás experimentando es un recuerdo repentino y que es una reacción normal al evento traumático que experimentaste. Mira a tu alrededor y toma nota de lo que está sucediendo aquí y ahora.
- Trata de conectarte con tu entorno inmediato sintiendo cómo y dónde tu cuerpo hace contacto con la silla y/o el suelo. (siente los brazos de la silla contra tus brazos, o tus pies en el suelo). Nombra las cosas con tus sentidos ("¿Qué puedes escuchar que te diga que estás en el presente?", "menciona 5 cosas en este cuarto que son verdes?'). Considera lo siguiente: "piensa en algo que sabes que es real ahora y que al mismo tiempo te ayuda a

saber que el evento está en el pasado, que lo sobrevivió y está a salvo ahora".

- En ocasiones puede ser útil y calmante cargar una piedra o algo familiar en tu bolsillo que puedas acariciar, mantener o rozar cuando un recuerdo repentino ocurra. Algunas personas llevan una banda elástica alrededor de su muñeca y lo halan para tratar de regresar al "aquí y ahora".
- Trata de respirar desde el diafragma (coloca tu mano justo por encima del ombligo y respira de forma tal que tu mano se mueva hacia arriba y hacia abajo). Esto puede ayudar a prevenir un ataque de pánico.
- Si el recuerdo repentino ocurre mientras estás fuera de casa, intenta ir por ti mismo a alguna parte donde te sientas seguro y protegido.
- Si despiertas por un recuerdo repentino, también conocido como "terrores nocturnos", trata de escribirlo, y a continuación, toma algo caliente, ver la TV, escucha música o haz otra cosa que encuentres relajante. Es mejor no intentar dormir hasta que haya sido capaz de relajarse un rato.
- Mantén una lista de personas a las que puedes contactar cuando tengas algún recuerdo repentino.
- Puede ser útil escribir el recuerdo repentino o decirle a alguien en quien puedas confiar. A pesar de que pueda ser muy doloroso hablar de este, esto ayuda en el proceso de sanación.
- Si te autolesionas o hieres en respuesta a un recuerdo repentino, trata de tomar algunas precauciones para minimizar el daño a largo plazo que pudiera ocurrir.
- Haz algo que te ayude a relajarte; por ejemplo, toma un baño, o escucha tu música favorita después de haber tenido un recuerdo repentino.
- Recuerda que los recuerdos repentinos son una respuesta normal a lo que has experimentado

Flashback Halting Protocol

- Right now I am feeling (describe your current emotion, e.g., "terrified").
- And I am sensing in my body (describe your current bodily sensations, e.g., "pounding heart, tight chest, shaky legs).
- Because I am remembering (name the trauma by title only – no details, e.g., "being hurt by my mother").
- At the same time, I am looking around where I am now in (the actual current year), here (name the place where you are).
- And I can see (describe some of the things that you see right now, in this place).
- And so I know (name the trauma by title only again, e.g., "being hurt by my mother") is not happening now or anymore.

Protocolo para detener recuerdos repentinos

- En este momento me siento (describa su emoción actual, por ejemplo: aterrorizado)
- Y estoy sintiendo en mi cuerpo (describa sus sensaciones del cuerpo, por ejemplo: el corazón acelerado, presión en el pecho, las piernas temblorosas)
- Por qué estoy recordando (nombra el trauma por título solamente- no hay detalles, por ejemplo: ser herido por mi madre')
- Al mismo tiempo, estoy mirando donde me encuentro ahora (el año en curso real), aquí (nombre del lugar donde se encuentra)
- Y puedo ver (describa algunas de las cosas que se ven en este momento, en este lugar)
- Y por lo que sé (nombre del trauma sólo por título otra vez, por ejemplo, " ser herido por mi madre ') no está sucediendo ahora o nunca más.

Flashback Halting Protocol Adapted and Translated from: Rothschild, B. (2000) *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*. New York: Norton.

Source: Adapted & Translated by Karina Perdomo from Appendix VI of J. Briere and C. Lanktree (2011), *Treating Complex Trauma in Adolescents and Young Adults.* Thousand Oaks, CA: SAGE Publications.

Fuente: Adaptado y Traducido por Karina Perdomo del Apéndice VI de J. Briere and C. Lanktree (2011), *Treating Complex Trauma in Adolescents and Young Adults.* Thousand Oaks, CA: SAGE Publications.

Developing a personal narrative (Adapted from Farrell, 2007)	Desarrollar un personal narrativa (Adaptado de Farrell, 2007)
Chapter One	*Capítulo uno*
What my life, my family's life, was like before the traumatic event?	Cómo era mi vida y mi familia antes del evento traumático
Chapter Two	*Capítulo dos*
The worst moment was…?	El peor momento fue cuando...
Something that I thought that I would never tell anyone?	Algo que pensé que nunca diría a nadie fue…
Other memories, thoughts, and feelings that I experienced?	¿Cuáles fueron otras memorias, pensamientos y sentimientos que experimenté?
If applicable: How I feel about the perpetrator/offender/event	Si es apropiado o pertinente: ¿Cómo me siento sobre el agresor, delincuente o sobre el evento?
Chapter Three	*Capítulo tres*
How I am different now?	¿En qué manera soy diferente ahora?
Advice that I would give others in my situation?	¿Qué consejos daría a otros que se encuentran en una situación similar a la que pasé?
How I have grown?	¿Cómo he crecido desde entonces?
What I want for myself and my family?	¿Qué quiero para mi y para mi familia?
Whenever possible, describe in detail how you felt, what your mind was doing?	Cuando sea posible, describe cómo te sentiste, qué pasaba por tu mente en esos momentos.
Which memories kept coming back to you?	¿Qué memorias continúan regresando a ti?

What Triggers Me? (The Trigger Grid)
(¿Qué es lo que me hace estallar?)

What is a Trigger?
(¿Qué es un "trigger" o detonante?)

_____

_____

_____

Times I have Been Triggered
(Ocasiones en las que algo me ha hecho estallar [Detonar])

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

What Kinds of Things Trigger Me? (What Are My Triggers?)
(¿Qué tipo de cosas son las que me provocan?)

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

What Happened After I Got Triggered?
(¿Que paso después que estallé?)

Trigger # (Número de Detonante)	What I Thought After This Trigger (Lo que pensé después del detonante)	What I Felt After This Trigger (Cómo me sentí después de este detonante)	What I Did After This Trigger (Lo que hice después de este detonante)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

How I Know I've Been Triggered
(Cómo yo sé que estoy a punto de estallar por algo que me provocó)

1._____
_____

2._____
_____

3._____
_____

4._____
_____

5._____
_____

What I Could Do So That I Wouldn't Get Triggered
(Lo que podría hacer para no estallar cuando algo me provoque)

1._____
_____
_____

2._____
_____
_____

3._____
_____
_____

4._____
_____
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5._____
_____
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6._____
_____
_____

7._____
_____
_____

8._____
_____
_____

What I Could Do After I Get Triggered That Would Make It Better and I Wouldn't Get So Upset or Mad
(Qué podría hacer después que me provocaron que podría hacer la situación más llevadera y no molestarme tanto)

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

4._____

_____

_____

5._____

_____

_____

6._____

_____

_____

Hercules and the Hydra: Explaining *Avoidance* and *Gradual Exposure* in Trauma

Hercules was a Roman/Greek hero who was given many hard tasks. One very difficult task was to slay the Hydra, a scary nine-headed creature. Someone who has experienced *trauma* is a bit like Hercules because the person has to face the scary thing that happened to him or her. How did Hercules do it? Well, Hercules first tried to cut one of the hydra's heads off, but it didn't work! Two heads would grow back instead of one. In trauma, people do the same thing when they *avoid* thinking or talking about the trauma. *Avoidance* works for a little while, but it ultimately gives the trauma more power over how the person feels—it's like the hydra growing another head.

Hercules did not give up though. He was able to defeat the hydra with the help of his nephew who used fire to prevent the hydra's heads from growing back. With trauma, the technique we use to keep the trauma from growing stronger is called *gradual exposure*, in which increasing exposure through talking or writing about the trauma decreases the trauma's ability to control our thoughts and feelings. Just like Hercules turned to his nephew for help in slaying the Hydra, someone who has experienced trauma can turn to a *therapist* (who might be a counselor, social worker, or psychologist) for helping overcoming the difficult thoughts and feelings linked to the trauma.

Hércules era un héroe romano / griego al que se le dieron muchas tareas difíciles. Una tarea muy difícil era matar a la Hidra, una criatura que da miedo y que tiene nueve cabezas. Alguien que ha sufrido un trauma es un poco como Hércules porque la persona tiene que hacer frente al evento aterrorizante que le ocurrió ¿Cómo Hércules lo hizo? Bueno, Hércules primero trató de cortar una de las cabezas de la hidra fuera, pero no funcionó. Dos cabezas crecerían hacia atrás en lugar de una. En el trauma, la gente hace lo mismo cuando no pueden pensar o hablar sobre el trauma. La evitación funciona por un tiempo, pero en última instancia le da al trauma más poder sobre cómo se siente la persona. Así es como la hidra sigue creciendo otras cabezas.

Hércules no se rindió. Él fue capaz de derrotar a la hidra con la ayuda de su sobrino quien utilizó el fuego para evitar que las cabezas de la hidra volvieran a crecer. Con el trauma, la técnica que usamos para evitar que el trauma continúe creciendo y haciéndose más fuerte se llama exposición gradual, en la que el aumento de la exposición a través de hablar o escribir sobre el trauma disminuye la capacidad del trauma, aumentando la capacidad de controlar nuestros pensamientos y sentimientos. Al igual que Hércules acudió donde su sobrino en busca de ayuda para matar a la Hidra, una persona que ha sufrido un trauma puede recurrir a un terapeuta (que podría ser un consejero, trabajador social o psicólogo) para ayudar a superar los pensamientos difíciles y sentimientos vinculados al trauma.

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Exposure Homework

Before performing the in vivo exposure, answer the following questions:

Antes de realizar la exposición en vivo, responda a las siguientes preguntas:

1. What's the worst that could happen in this situation?
2. What is the likelihood that this could happen?
3. Evaluate the evidence for and against the likelihood of this happening.
4. What is the safety plan if "worst thing" happens?
5. Identify skills (breathing, self-statements, relaxation) you will use during exposure exercise.

1. *¿Qué es lo peor que podría suceder en esta situación?*
2. *¿Cuál es la probabilidad de que esto pueda suceder?*
3. *Evalúa la evidencia a favor y en contra de la probabilidad de que esto ocurra.*
4. *¿Cuál es el plan de seguridad en caso de que lo "peor" pase?*
5. *Identifica las habilidades (respiración, enunciados para ti mismo, formas de relajación) que va a utilizar durante el ejercicio la exposición.*

Ratings before and after in vivo exposure:
Rangos antes y después de la exposición "en vivo"

Date	SUDS before exposure	Length of exposure	SUDS after exposure	Peak SUDS	Notes

Part of remembering what happened is being able to picture it in your mind. You would probably rather block it out of your mind, but that won't make it go away. Picture what happened, in your mind, then draw it on this page. It's hard to do, but try.
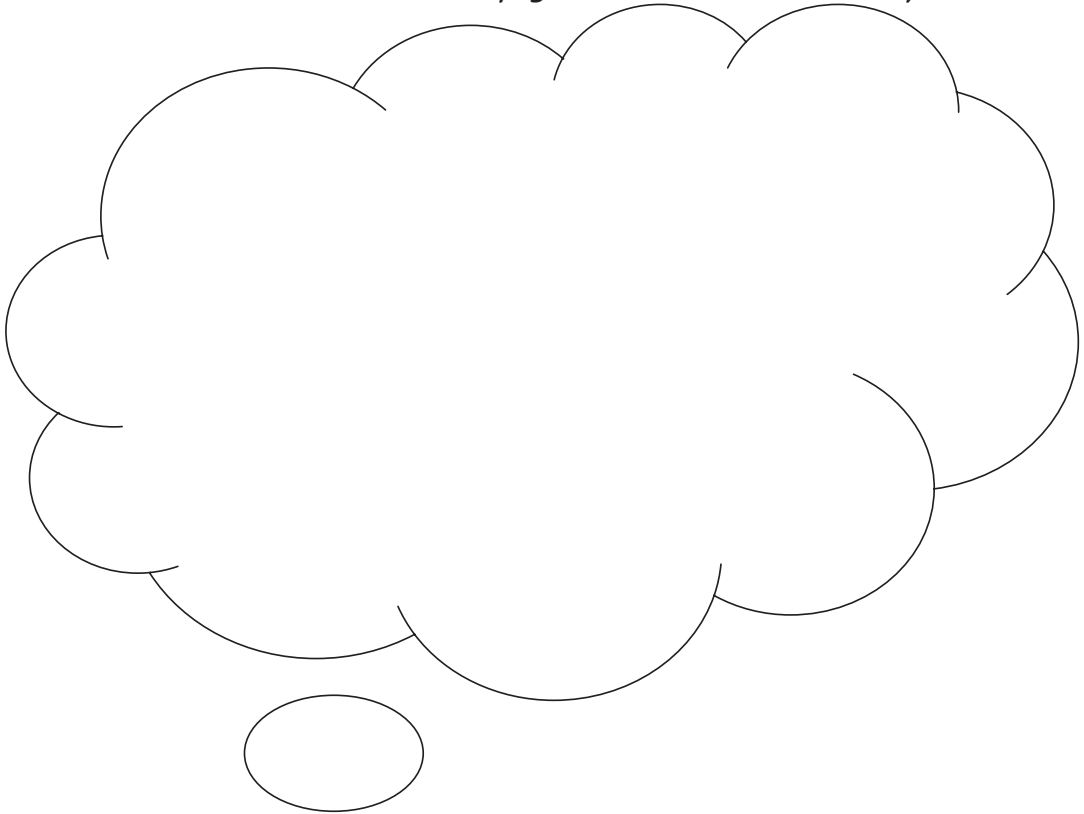
Parte de recordar lo que pasó es ser capaz de imaginarlo en su mente. Es probable que prefiera bloquearlo fuera de su mente, pero eso no hará que desaparezca. Imagínese lo que pasó, en su mente, y a continuación, dibuje en esta página. Es difícil de hacer, pero trate.

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Tools for Assessing Racism-Related Stress and Trauma Among Latinos

4

Monnica T. Williams, Adriana Peña,
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Overview of Racism-Related Stress and Trauma

The recent national debate and media-fueled political attacks on immigration have led to unfortunate harmful rhetoric and discriminatory actions toward Latinos (Constantini, 2011). There is heightened concern among Latinos about discrimination, with over six out of ten stating it is a "major problem" in 2007, and this rate has risen consistently since at least 2002 (Lopez, Morin, & Taylor, 2010). Racism and discrimination have strong negative consequences upon those who are oppressed, and this continually occurs as part of mainstream American culture. Racism creates barriers to health care, as well as negative physical and mental health outcomes among people of

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color (Penner, Blair, Albrecht, & Dovidio, 2014; Berger & Sarnyai, 2015). In African Americans, Hispanic Americans, and Asian Americans, there is a documented relationship between racial discrimination and increased psychological disorders (Chou, Asnaani, & Hofmann, 2012).

To note a few definitions that will be used in the chapter, race-based trauma consists of the mental health symptoms a person experiences as a result of racism or discrimination, which has often been compared to posttraumatic stress disorder (PTSD). Racism is defined as the use of power to act on the belief that racial differences make one group superior to another and should be given different privileges. According to a Pew Research survey, 67% of Latinos define their race as Hispanic/Latino (Gonzalez-Barrera and Lopez, 2015), and for the purposes of the current chapter, this definition is acceptable, and it is important to also consider how skin color may also impact vulnerability to racism in Latinos.

The progression of psychopathology among victims of racism is similar to what is experienced by victims of sexual harassment, domestic violence, and even rape (Bryant-Davis & Ocampo, 2006). All of these experiences attack an individuals' personhood, often leading to responses of shock and dissociation, followed by shame and self-blame. Survivors are often told if they act or dress in a certain way, they will not be targeted; however, when victims of racism continue to encounter racism despite following these rules,

symptoms of PTSD may begin or progress (Bryant-Davis & Ocampo, 2006). While there exists some research regarding the political, social, and economic impact of racism, there is less research available describing the psychological impact of racism on Hispanic Americans (Carter, 2007).

When considering the impact of racial trauma on Latino individuals specifically, it is important to be aware of the specific nuances and cultural factors associated with this population, such as acculturation and appearance. The way in which appearance influences discrimination toward Latino/as has proven difficult to study because US Census-defined racial categories do not adequately capture differences. According to the Census Bureau (2011), 53% of Latino/as self-reported their race as "White," while 36.7% marked "some other race." Furthermore, Latino/as experience discrimination not only based on visible, physical characteristics such as skin color but are also singled out as "other" due to language and culture. Having a lower level of English proficiency or having an accent were both identified as bringing about discrimination (Collado-Proctor, 1999).

While it seems intuitive to believe that first-generation Latino immigrants experience the most perceived discrimination, according to a national survey, perceptions of discrimination are actually more widespread in the US-born young Latinos (Taylor, Kochhar, Livingston, Lopez, & Morin, 2009). Similarly, it appears the emotional stress response to racial trauma is more salient among US-born Latinos due to the increased exposure to racism in mainstream American culture, which is consistent with the immigrant paradox (Torres & Vallejo, 2015). Perceived discrimination experienced by Latino immigrants and its negative effect on mental health can explain some of the increased risk of psychopathology among immigrants with more time spent in the USA (Cook, Alegría, Lin, & Guo, 2009). In order to prevent deterioration of mental health among Latino immigrants, interventions that can combat discrimination and limit family erosion are essential (Cook et al., 2009).

Data on the prevalence rates of race-related PTSD are "virtually nonexistent" (Helms, Nicolas,

& Green, 2012). While it is clear for researchers and clinicians to understand a discrete violent act as a precipitating event for PTSD, vicarious experiences and racial microaggressions are usually overlooked (Helms, Nicolas, & Green, 2012). Frequently, minorities experience cumulative racism, which can lead to a minor event triggering the PTSD reaction (Carter, 2007). Regarding prevalence rates, what can be said is Latinos have higher rates of PTSD, they may experience PTSD symptoms of greater severity compared to non-Latino Whites, and discrimination certainly plays a role in this disparity (Pole, Best, Metzler, & Marmar, 2005; Pole, Gone, & Kulkarni 2008). For these reasons, it is crucial for clinicians and researchers to develop a more comprehensive understanding of trauma in ethnic and racial minorities (Helms, Nicolas, & Green, 2012).

Symptoms of Racism-Related Stress and Trauma

Lee and Ahn (2012) investigated some of the possible mental health outcomes for Latinos who faced discrimination and found symptoms of anxiety were the most common, followed by symptoms of depression and poor academic and job performance/satisfaction. Other outcomes of the meta-analysis included significant and positive correlations between discrimination and both psychological distress and unhealthy behaviors (e.g., Cheng & Mallinckrodt, 2015). Psychological distress can be a daily reality for Latino victims of discrimination. They may present with nervousness, sadness, hypervigilance, suicidal ideation, and self-reported overall lower quality of life (Torres, O'Conor, Mejía, Camacho, & Long, 2011).

It is recommended that clinicians assess for race-based trauma in any client belonging to a stigmatized ethnic or racial minority group, especially if they are presenting for treatment due to other traumas (Scurfield & Mackey, 2001; Torres et al., 2011). Racist incidents may very well be contributing factors to the client's distress but are likely to not be seen as catalysts for treatment because of the high frequency of occurrences making it appear normal. However, trauma can

also be understood as a response to cumulative stressors (American Psychiatric Association, 2013), which is particularly salient in the case of persistent discrimination. A clinician can inquire about these experiences with questions such as, "Many Latino/as have had racist incidents or felt marginalized in this society, what has your experience been?" (Torres et al., 2011, p. 367).

Treatment for Racism-Related Stress and Trauma

Treatment for race-based stress and trauma has not been well researched: thus, there is not yet an empirically supported gold standard protocol for treatment. However, because of the similar development of pathology to other kinds of stress- and trauma-related disorders, good treatment options for Latino clients are probably culturally adapted variations of empirically supported treatments for PTSD. Please see Chap. 3 on PTSD for more information about PTSD-specific tools for Latinos and also Benuto (2012). When considering PTSD treatment for racial trauma, however, there are numerous steps the clinician can take to enhance the efficacy of interventions outside of what is recommended for PTSD generally.

While only few formal modifications to the treatment for PTSD may be necessary, some important considerations need to be taken into account to deliver effective services to Latinos with race-based trauma. Many PTSD treatments focus on singular events, and this is a major flaw when it comes to treatment of cumulative and collective traumas. Kira (2010) describes how in cumulative traumas there are core traumas and triggering traumas. He further describes how using a typical trauma-based approach may overlook the core traumas and treat the triggering traumas as the single traumatic event. Because of this, it is crucial to obtain a cumulative and collective history of experiences with racism and discrimination instead of focusing on just a single event (Malcoun, Williams, & Bahojb-Nouri, 2015).

Additionally, because racism and discrimination are generally collective and cumulative traumas, it can be important to treat race-based trauma from a collective standpoint. Most treatments for trauma focus on the individual's single identity and single traumatic event; however, when it comes to cumulative and collective trauma, it should not be limited to these aspects because it is related to a collective cultural identity (Kira, 2010). Thus, it is likely more effective to incorporate multiple systems such as the community and culture as well as provide a flexible approach to therapy (Kira, 2010).

Additionally, research has shown it is imperative for the clinician to have cultural sensitivity and cultural knowledge in order to adequately provide assessment and treatment for race-based trauma (Williams et al., 2014). Specifically, *familismo*, *respeto*, and *simpatia* are Latino cultural values that should be integrated into treatment (Antshel, 2002). Moreover, Chapman et al. (2014) emphasizes the importance of being open to a minority client's cultural context and uniqueness. By being knowledgeable about Latino culture as well as showing openness to the individual's experience, it can help the client identify the therapist as a safe person to discuss culturally relevant difficulties.

Ethnic/racial identity is also an important area to consider when conceptualizing a Latino client with race-based trauma. Positive and strong ethnic identity is positively associated with better coping skills, greater self-esteem, more optimism, and less psychological symptomology (Roberts et al., 1999; Smith, Walker, Fields, Brookins, & Seay, 1999; McMahon & Watts, 2002). However, racial self-identification is also associated with perceived discrimination among young Latinos, with 26% of young Latinos who identify as White endorsing that a friend or family member "has been the target of discrimination" compared to 36% among those who identify as Hispanic or Latino (Taylor et al., 2009). Similarly, Lee and Ahn (2012) found a small association between having a stronger connection to dominant culture and having decreased experiences of discrimination. Additionally, in

Latinos, ethnic identity exploration increases psychological distress, whereas ethnic identity commitment operated as a stress buffer (Torres, Yznaga, & Moore, 2011; Torres & Ong, 2010). Thus, becoming familiar with a client's ethnic identification and showing respect for their culture is crucial when it comes to adapting effective treatments for the needs of the minority client (Williams et al., 2014).

Clinicians must also recognize in themselves their own worldview and their biases. To effectively and genuinely treat a patient experiencing race-related trauma symptoms, the clinician needs to first acknowledge the implications of seemingly minimal but frequent race-based aggressions (Torres et al., 2011). Oftentimes, clinicians do not consider racism or discrimination as trauma, which can lead to misdiagnoses, further traumatization, poor conceptualization of the client, and ineffective treatment. Psychological distress associated with racist events is frequently minimized or questioned, negating the victim's reality. This only results in perpetuating their anxieties and exacerbating their distress (Carter, 2007; Torres et al., 2011). Many victims are faced with disbelief or avoidance from the clinician when recounting their experiences with racism. These racial microaggressions from the clinician can lead to further traumatization (Sue et al., 2007). Thus, it is imperative that all clinicians become familiar with their biases and work to reduce their own tendencies to stereotype and discriminate (Miller, Williams, Wetterneck, Kanter, & Tsai, 2015).

Moreover, many clinicians avoid discussing racially charged topics due to a lack of preparation in addressing cultural topics, and this can prevent open discussion of experiences with racism (Constantine, 2007). This is particularly problematic because minorities may be disinclined to volunteer experiences with racism to a person of a different race or ethnicity, and it is known most mental health providers are White (US Department of Labor, 2013). Latino patients may worry about how the clinician will respond (e.g., with disbelief, defensiveness, or invalidation). For these reasons it is important for the clinician to directly ask about the patient's experiences with racism or discrimination when evaluating traumatic history and to validate the client's experience (Hays, 2009). Minority patients may also have difficulty linking their PTSD symptoms to their experiences with racism if they are only asked about a discrete trauma. Thus, it is recommended the clinician ask about cumulative and collective experiences of racism as well (Malcoun et al., 2015). Examples of racial trauma can include racial harassment, microaggressions, discrimination, ethnoviolence, institutional racism, historical trauma, community trauma, memories of racism, or experiencing a perpetual threat of racism (Kira, 2010; Helms, Nicolas, & Green, 2012). Many people who experience constant subtle acts of racism develop "cultural paranoia," which is an adaptive response to racism developed to protect the victim from future discriminatory events (Whaley, 2001). It is important to ask about cumulative and collective experiences, because even the most subtle acts of racism can contribute to traumatization (Carter, 2007).

Further, there is some evidence to suggest focusing on empowerment, helping the client regain control, and preventing family erosion can be helpful for race-based trauma. Using cognitive interventions that can empower the client and enhance executive functions may be crucial for survivors of cumulative trauma (Kira, 2010). Kira (2010) also notes one common intervention that may not be effective with people who have been politically oppressed is encouraging forgiveness of the oppressor, and on the contrary encouraging positive anger against the oppressor but forgiving the collaborators may be more helpful. Survivors can give meaning to their suffering through activism or other pro-social activities.

Consistent with the recommendations from Kira (2010) about empowerment and involving the community, evidence is slowly accumulating for the use of photovoice as a community-based intervention to empower those who are oppressed and experience trauma. This may be particularly helpful for the Latino community facing race-based trauma, as it can foster community integration, empowerment, and positive identity among individuals with mental illness (Mizock, Russinova, & DeCastro, 2015). It also incorporates a collectivistic worldview in order to help people become

advocates and improve their self-identity. While limited research is available on the use of photovoice as a treatment intervention, it has been used to empower Latino adolescents who feel they do not have a fair chance to succeed at school (Streng et al., 2009). Further research should investigate more closely the mental health outcomes of using photovoice for victims of race-based trauma.

Tools for the Assessment of Racism-Related Stress and Trauma

Current psychological assessments used to evaluate trauma often fail to include racism and discrimination as trauma among the response choices (Malcoun et al., 2015). PTSD assessments tend to focus on a single traumatic event, which is limiting because many minorities experience recurrent racist events. This form of assessment and conceptualization may not be appropriate for ethnoracial minorities. In order to appropriately evaluate and conceptualize the nature of trauma in Latinos, it is important to specifically consider experiences with racism and discrimination as well as the associated psychological distress. Various measures have been developed in order to assess these areas and are described below. These measures can be used not only to evaluate the client but also as a way to facilitate open discussion about racism between the clinician and patient. While many of the measures described below are available only in English and will need to be interpreted, the Race-Based Traumatic Stress Symptom Scale (RBTSSS; Carter, Mazzula, Victoria, Vazquez, & Hall, 2013) and University of Connecticut Racial/Ethnic Stress and Trauma Scale (UnRESTS) are available in Spanish in addition to the English versions.

The Race-Based Traumatic Stress Symptom Scale (RBTSSS; Carter et al., 2013) is a measure which explicitly evaluates racist experiences and the associated psychological symptomology that may result. It has 52 items and 7 subscales which include low self-esteem, physical reaction, anger, avoidance, depression, intrusion, and hypervigilance/arousal. The measure begins with obtaining information from the examinee about racist experiences through an open-ended format followed by closed-ended questions about their reactions. It can be administered as a self-report measure, or a clinician can assist. The RBTSSS includes Latinos in the validation sample, however, is not validated for use with immigrants from other countries. Clinicians who use the measure with Latino immigrants should consider how the expression of U.S.-born Latinos race-based trauma may be different from U.S.-born Latinos (Carter & Sant-Barket, 2015). The RBTSSS has been translated into Spanish by two Latina English and Spanish speakers. First, it was translated into Spanish by one translator and then back translated into English by a second translator. The translators evaluated each discrepancy between the two versions and came to a consensus of the appropriate translation. This Spanish version is currently being validated among Spanish speakers and may be available upon request.

The General Ethnic Discrimination Scale (GEDS; Landrine et al., 2006) consists of 18 self-report items which measure the frequency of events of perceived racial discrimination. The subscales measure perceived ethnic discrimination appropriately across major ethnic/racial groups in the USA and use a structure similar to other stress inventories. The instructions for this measure have been simplified and shortened to make it easier for people whose first language is not English. It appears to be a helpful measure to use when there are limited time constraints.

The Racial Microaggressions Scale modified (RMAS; Torres-Harding & Turner, 2015) measures the frequency of racial offenses or slights faced by people of color and the distress associated with those experiences. It consists of 32 items which have a Likert scale format which inquire about 6 types of microaggressions. The distress subscales include criminality distress, low achieving/undesirable culture distress, sexualization distress, invisibility distress, foreigner distress, and environmental distress, which were derived from a previous version of the measure (RMAS; Torres-Harding, Andrade, & Diaz Romero, 2012). This measure included both foreign-born and native-born Latinos in their validation sample and may be

used with diverse racial groups (Torres-Harding & Turner, 2015).

The LGBT People of Color Microaggressions Scale (LGBT-POC; Balsam, Molina, Beadnell, Simoni, & Walters, 2011) considers the increased vulnerability which comes with the intersectionality of multiple minority identities. This measure is 18 items and includes 3 subscales: "racism in LGBT communities," "heterosexism in racial/ethnic minority communities," and "racism in dating and close relationships." This measure is the first of its kind and also included Latinos in the validation studies. Similar to some of the other measures, it queries about microassaults, microinvalidations, and microinsults.

The use of the Brief Symptom Inventory (BSI; Derogatis, 1993) has been recommended as a measure of current level of psychological distress when assessing Latino/as for race-related trauma (Moradi & Risco, 2006). It is a 53-item measure for which the reliability, factor structure, and validity has been supported in Latino samples (Martinez, Stillerman, & Waldo, 2005; Thoman & Suris, 2004). The BSI is particularly relevant for the Latino population because it captures both psychological and physical symptoms, which is important given that previous studies have shown Latinos have a tendency to somaticize (Gloria, Ruiz, & Castillo, 2004).

The Perceived Discrimination Scale for Latinos (PDSL; Collado-Procter, 1999) is a self-report measure that may be used to measure perceived discrimination and racism in Latinos. It specifically uses 34 items to ask about 34 experiences of racism, and the examinee indicates how often they experienced these using a Likert scale. While it is designed specifically for Latinos and has been validated in this population (Collado-Proctor, 1999; Moradi & Risco, 2006), it also has several drawbacks. The measure asks about specific experiences but does not ask about experiences not listed. Also, it only asks about frequency of the event and not about distress related to the event or symptomology. It is limited in scope, so another assessment would be needed to measure the distress or symptoms associated with the perceived discrimination.

The Experiences of Discrimination scale (EOD; Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005) is a self-report measure designed to ask about experiences of discrimination and the person's reactions or beliefs about why they were being discriminated against. It has been validated mainly with Latinos and is available in Spanish. Some strengths of this assessment are that it allows the examinee to provide other responses aside from race about why they were being discriminated against, it asks for reactions to discrimination, and it assesses whether the person has been concerned about being discriminated against since they were a child. However, some drawbacks are that it provides very little information about distress and psychopathology, and it does not obtain details about the events.

Very few of these instruments are available in Spanish, and none are designed to be administered by clinicians. In this chapter we would like to introduce a new semi-structured interview called the University of Connecticut Racial/Ethnic Stress and Trauma Scale (UnRESTS). This measure is offered in both English and Spanish and provides a more comprehensive assessment of race-based trauma relative to the existing measures. Because it is an interview, it can facilitate the conversation between the client and clinician regarding the client's experiences with racism and help the clinician build rapport with the client. This may be particularly helpful for clinicians who are unsure how or what to ask about racially charged topics.

The format of the UnRESTS is modeled after the DSM-5 Cultural Formulation Interview (APA, 2013). Unfortunately, neither the CFI nor its supplementary modules examine racism or discrimination despite that assessment is being intended as a cultural assessment. Therefore, it is important for clinicians to also have access to an interview specifically for the assessment of discrimination and its impact. Like the CFI, the UnRESTS is formatted into two columns, with one column describing instructions for the evaluator and the other column describing questions for the examiner to ask the examinee. The questions are not comprehensive, and it may be necessary to follow up to get more

details. The purpose of the interview is to help guide the examiner in asking about experiences of racism, and it is intended to be used in a flexible manner in order to build rapport with the client.

The interview portion of the UnRESTS is divided into various sections to obtain specific details from the examinee's life about various topics pertaining to race-based trauma. These sections include introduction to the interview, racial and ethnic identity development, experiences of direct overt racism, experiences of racism by loved ones, experiences of vicarious racism, and experiences of covert racism. The introduction section provides information regarding what the interview will be asking about and asks the client what race and ethnic group they identify with. The racial and ethnic identity development section focuses on the client's socialization to race/ethnicity and how the person feels about their racial/ethnic group. The interview goes on to ask about the person's experiences with explicit and obvious racism toward them, racism experienced by loved ones, being vicariously impacted by racist experiences that were learned about, and experiences with subtle forms of racism or micro-aggressions. Additionally, it also has a section in which symptoms and associated distress from racism are evaluated using yes/no response items to determine if symptoms meet DSM-5 criteria for PTSD. The items in this section were modeled after DSM-5 items and the PSSI-5 by Foa et al. (2015) and should be administered if any of the responses in the proceeding parts of interview meet the criteria for a trauma (single event or cumulative). A Likert scale of items that can be summed for a total score is currently being validated and is available from the authors by request.

The UnRESTS was translated from English to Spanish by bilingual English and Spanish speakers. The three translators had Spanish dialects from Venezuela, Mexico, Cuba, and Colombia. This resulted in providing the measure more utility with Latinos in the USA who come from a variety of Spanish-speaking countries with various dialects. Each section was translated from English into Spanish by one translator, and words/phrases with no direct translation were highlighted. A second translator reviewed the highlighted words/phrases and came to a consensus with the first translator. Later, the Spanish translation was back translated from Spanish to English by a third translator in order to help establish equivalence between the two versions of each assessment. The discrepancies between the two versions for the UnRESTS were noted, and all translators along with the primary developer of the measure met to discuss and agree upon the appropriate way to address each discrepancy.

Summary

It is vital for clinicians to consider the tremendous impact racism and discrimination can have when working with Latino clients. It has become a normative experience in the USA for ethnic and racial minorities to experience racism and discrimination, and among Latinos this is no exception. There are numerous negative health effects, particularly mental health effects, associated with racism and discrimination (Penner et al., 2014; Berger & Sarnyai, 2015). Various recommendations have been advanced to help the clinician identify and treat Spanish-speaking clients with racial trauma. It will be helpful for the clinician to consider time constraints, language, and the client's presenting concerns when selecting assessments and interventions for race-based stress and trauma to use with a Spanish-speaking client. Overall, it is crucial to screen and treat Spanish-speaking Latino clients for experiences of discrimination and racism as well as their reactions to those experiences.

Appendix

UConn Encuesta de Estrés Racial/Étnico
UConn RACIAL/ ETHNIC STRESS & TRAUMA SURVEY (UnRESTS)

Guía Para Entrevistador **Guide for Interviewer**		Preguntas de Entrevista *(Instrucciones para entrevistador están puestas en letra cursiva.)* **Interview Questions** *(Instructions for interviewer are italicized.)*
	A	***Introducción a la Entrevista*** ***Introduction to the Interview***
Note la diferencia entre <u>raza</u> *(el grupo que la sociedad pone una persona basada en su apariencia) y* <u>etnicidad</u> *(la cultura de una persona basada en su patrimonio). Pueden ser diferentes o la misma cosa.* *El Censo de los Estados Unidos reconoce varias categorías raciales específicas incluyendo Negro/Moreno, Blanco, Asiático, y Nativo Americano. Hispano es un grupo étnico, pero muchos consideran Hispano/Latino como una raza, y eso es aceptable para esta entrevista.* *Note the difference between <u>race</u> (the group society puts a person in based on their appearance) and <u>ethnicity</u> (a person's culture based on their heritage). They may be different or the same.* *The US Census recognizes several specific racial categories, including Black, White, Asian, and Native American. Hispanic is an ethnic group, but many consider Hispanic/Latino a race, which is acceptable for this interview.*	*A1*	A veces las personas tienen experiencias muy malas que causan sentimientos de estrés o hasta trauma. Algunas personas tienen varias experiencias difíciles durante toda la vida que son manejables individualmente, pero juntos pueden resultar en sentimientos de estrés o trauma. Yo quiero hablar con usted sobre algunos de sus experiencias de estrés o trauma en lo que se refiere a su raza o etnicidad. *Si el grupo racial y étnico del paciente no está claro:* ¿Cómo describiría su raza y etnicidad? Sometimes people have very bad experiences that cause feelings of stress or even trauma. Some people have several difficult experiences over a lifetime that are manageable individually, but together they lead to feelings of stress or trauma. I want to talk to you about some of your experiences of stress or trauma as it relates to your race or ethnicity. *If patient's racial and ethnic group is unclear*: How would you describe your race and ethnicity?
Asegure que la discusión solo incluya los incidentes en cuales por lo menos uno de los factores involucrados fueron raza o color. *Ensure that discussion only includes incidents where at least*	*A2*	Las personas pueden ser discriminadas o maltratados por muchas razones diferentes (p. ej., genero, orientación sexual, edad, discapacidad/dishabilidad, fe o creencia religiosa, etc.) pero yo estoy interesada en experiencias relacionadas con su raza- o su raza como esta percibido por otros. Sin embargo, si usted ha experimentado discriminación por una combinación de factores (i.e., genero

one of the involved factors was race or color.		+ raza, tal como siendo llamada una "Latina gritona" porque usted se defendió), podemos hablar de eso también. People may be discriminated against or mistreated for many different reasons (e.g., gender, sexual orientation, age, disability, faith, etc.) but I am interested in experiences connected to your race – or your race as perceived by others. However, if you have experienced discrimination due to a combination of factors (i.e., gender+race, such a being called "an angry Black woman" because you stood up for yourself), we can talk about that too.
	B	***Desarrolló de Identidad Racial y Étnica*** ***Racial and Ethnic Identity Development***
Si sí, pregúntele al paciente que elabore. *If yes, ask the patient to elaborate.*	**B2**	¿Hay otros grupos raciales o étnicos que personas asumen a que usted pertenece? Are there other racial or ethnic groups that people assume you belong to based on your appearance?
Pregúntele al paciente que describa esto. *Ask the patient to describe this.*	**B3**	¿Cuándo fue la primera vez que usted se dio cuenta de raza o etnicidad? When was the first time you became aware of race or ethnicity? ¿Cuándo fue la primera vez que usted se acuerda sintiéndose diferente o excluido, o singularizado por su raza o etnicidad aparente? When was the first time you remember feeling different, excluded, or singled out because of your apparent race or ethnicity?
Investigue por cosas como mensajes positivos de padres, socialización racial, mensajes negativos de otros, medios de comunicación, estereotipos, etc. *Assess for things like positive messages from parents, racial socialization, negative messages from others, media, stereotypes, etc.*	**B4**	¿Qué tipos de cosas, positivas o negativas, aprendió de su raza o etnicidad en su crecimiento? (Puede ser que no aplique a inmigrantes) What sort of things, positive or negative, did you learn about your race and ethnicity growing up? *(May not apply to immigrants.)*

	B5	

Investigue por sentimientos de orgullo y/o estigma/vergüenza racial/étnica
 	
Assess for feelings of ethnic/racial pride and/or stigma/shame.
 	
Valore cada pregunta (1-6) basada en la respuesta del paciente.
 	
Rate each question (1-6) based on response from patient.
 	
Por cada respuesta afirmativa, solicita un ejemplo.
 	
For each affirmative answer, solicit an example.
 	
Por cada respuesta negativa, pregunte "¿porque no?"
 	
For each negative answer, ask "why not?"
 	
Puntuacion de Identidad Racial/Etnica: Total (B5): _____
 	
Ethnic/Racial Identity Score: (B5) Total _____
		Quiero entender un poco más de como usted se siente siendo un/a persona (entra raza y etnicidad aquí). Voy a preguntarle unas cuestiones sobre eso.
		
		I want to understand a bit more about how you feel about being a(n) (enter race & ethnicity here) person. I'm going to ask you a few questions about that.
		
		1. ¿Usted diría que siente un apego fuerte a su grupo étnico (o racial)?
		  Muchísimo (2)- Un poco (1)- No (0)
		
		1. Would you say that you feel strong attachment to your ethnic (or racial) group?
		  Very Much (2) – Somewhat (1) – No (0)
		
		2. ¿Usted diría que tiene mucho orgullo de su grupo étnico y sus logros?
		  Muchísimo (2)- Un poco (1)- No (0)
		
		2. Would you say that you have a lot of pride in your ethnic group and its accomplishments?
		  Very Much (2) – Somewhat (1) – No (0)
		
		3. ¿Usted diría que es activo/a en grupos que incluyen más que nada miembros de su propio grupo étnico?
		  Muchísimo (2)- Un poco (1)- No (0)
		
		3. Would you say that you are active in groups that include mostly members of your own ethnic group?
		  Very Much (2) – Somewhat (1) – No (0)
		
		4. Usted diría que tiene un sentido fuerte de pertinencia a su grupo étnico?
		  Muchísimo (2)- Un poco (1)- No (0)
		
		4. Would you say that you have a strong sense of belonging to your ethnic group?
		  Very Much (2) – Somewhat (1) – No (0)
		
		5. ¿Usted diría que piensa mucho sobre como su vida es afectada por su membresía de grupo?
		  Muchísimo (2)- Un poco (1)- No (0)
		
		5. Would you say that you think a lot about how life is affected by your group membership?
		  Very Much (2) – Somewhat (1) – No (0)

		6. ¿Usted diría que ha hablado con otros frecuentemente de asuntos relacionados con su grupo étnico? *Muchísimo (2)- Un poco (1)- No (0)* 6. Would you say that you have often talked to others about issues related to your ethnic group? *Very Much (2) – Somewhat (1) – No (0)*
	B6	¿Cuánto de su tiempo libre pasa con personas de su propio grupo étnico/racial? How much of your free time do you spend with people from your own racial/ethnic group?
Investigue por un deseo de ser Blanco, no estigmatizado, y/o un miembro de un grupo privilegiado. *Assess for wish to be White, non-stigmatized, and/or privileged group member.*	B7	Muchas personas notan que puede ser difícil ser una minoría étnica o racial. ¿Usted ha alguna vez deseado que era un miembro del grupo mayoritario (i. e., una persona Blanca)? Many people note that it can be difficult to be an ethnic or racial minority. Have you ever wished you were a member of the majority group (i.e., a White person)?
Evalue la composición del lugar de trabajo/estudio y el clima racial. *Assess for composition of workplace/school and racial climate.*	B8	¿Cómo es el ambiente étnico/racial en su lugar de trabajo/estudio? ¿Qué cómodo se siente ahí como una persona (inserta raza aquí)? What is the ethnic/racial environment like in your place of work/school? How comfortable do you feel there as a (_enter race here_) person?

	C	Experiencias de Racismo Directo y Aparente *Experiences of Direct Overt Racism*
Dé ejemplos, si es necesario. Esto podrá incluir acoso en el trabajo, amenazas, persecución por agencia del orden público, etc. *Give examples, if needed. This may include harassment at work, threats, victimization by law enforcement, etc.* *Obtenga una descripción del evento.* *Elicit a description of the event.*	C1	¿Me puede decir de un tiempo cuando fue afectado por racismo? Esto puede ser algo que otra persona le dijo o le hizo. Estoy especialmente interesada/o en cualquier experiencia en que estuvo <u>preocupado de su</u> seguridad y el evento fue <u>muy perturbador?</u> Can you share with me a time you were impacted by racism? This could be something that someone else either said or did to you. I am especially interested in any experiences where you were <u>concerned about your safety</u> and the event was <u>very upsetting.</u> *Si es necesario:* Si no puede pensar de algún caso así entonces cualquier experiencia racista estará bien (i.e. ser seguido en tiendas, llamado insultos raciales, etc.). *If needed:* If you can't think of any instances like that, then any racist experience will be fine (i.e., being followed in stores, called racial slurs, etc.).
Determine cuando el evento ocurrió. *Determine when the event occurred.*	C2	¿Cuantos años tenía cuando esto paso? How old were you when this happened?
Ten cuidado de no comunicar duda que esto de hecho fue un evento racista. *Be careful not communicate doubt that this was in fact a racist event.*	C3	¿Que lo/la llevo a creer que este evento ocurrió debido a su raza? What led you to believe this event happened due to your race?
Investigue por el grado y tipo de angustia experimentada, por ejemplo, enojo, depresión, ansiedad. *Assess for degree and type of distress experienced, e.g., anger, depression, anxiety.*	C4	¿Cuán perturbado estuvo por esta experiencia? *Si angustia fue presente:* ¿Todavía está perturbado por eso? How upset were you by this experience? *If distress was present:* Are you still upset by it?
Determine si la experiencia fue un trauma. *Determine if experience was a trauma.*	C5	¿Tuvo miedo por su vida, salud, o seguridad? *Si sí:* ¿De qué modo? Did you fear for your life, health, or safety? *If yes:* In what way?

Investigue por estrategias adaptables en comparación a estrategias inadaptables de lidiar. *Assess for adaptive versus maladaptive coping strategies.*	C6	¿Cómo lidio con esta experiencia? How did you cope with this experience?
Investigue por la disponibilidad y el uso de sistema de apoyo. *Assess for availability and use of support system.*	C7	¿Cómo respondieron otras personas importantes en su vida cuando les dijo de esto? How did other important people in your life respond when you told them about this?
Pregunte de otras experiencias de racismo. *Ask about other experiences of racism.*	C8	¿Me puede decir de otra experiencia de racismo como ese? Can you tell me about another experience of racism like that? *Si es necesario: Esto puede ser cualquier otra situación donde se sintió temeroso, preocupado de su seguridad, o si el evento fue muy perturbador.* *If necessary:* This can be any other situation where you were fearful, concerned about your safety, or if the event was very upsetting.
Determine cuando el evento ocurrió. *Determine when the event occurred.*	C9	¿Cuantos años tenía cuando esto paso? How old were you when this happened?
Ten cuidado no comunicar duda de que esto de hecho fue un evento racista. *Be careful not communicate doubt that this was in fact a racist event.*	C10	¿Que lo llevo a creer que este evento ocurrió por su raza? What led you to believe this event happened due to your race?
Investigue por el grado y tipo de angustia experimentada, por ejemplo, enojo, depresión, ansiedad. *Assess for degree and type of distress experienced, e.g., anger, depression, anxiety.*	C11	¿Cuán perturbado estuvo por esta experiencia? *Si angustia fue presente:* ¿Todavía esta perturbado por eso? How upset were you by this experience? *If distress was present:* Are you still upset by it?
Determine si la experiencia fue un trauma. *Determine if experience was a trauma.*	C12	¿Tuvo miedo por su vida, salud, o seguridad? Si sí: ¿de qué modo? Did you fear for your life, health, or safety? *If yes:* In what way?

Investigue por estrategias adaptables en comparación a estrategias inadaptables de lidiar. *Assess for adaptive versus maladaptive coping strategies.*	C13	¿Cómo lidio con esta experiencia? How did you cope with this experience?
Investigue por la disponibilidad y el uso de sistema de apoyo. *Assess for availability and use of support system.*	C14	¿Cómo respondieron otras personas importantes en su vida cuando les dijo de esto? How did other important people in your life respond when you told them about this?
	D	***Experiencias de Racismo de Seres Queridos*** ***Experiences of Racism by Loved Ones***
Obtenga una descripción del evento. *Elicit a description of the event.*	D1	¿Me puede decir de un tiempo cuando usted fue afectado por racismo debido a algo que le ocurrió a <u>alguien cercano a usted?</u> Can you share with me a time you were impacted by racism as a result of something that happened to <u>someone close to you?</u>
Determine cuando el evento ocurrió. *Determine when the event occurred.*	D2	¿Cuantos años tenía cuando esto paso? How old were you when this happened?
Ten cuidado de no comunicar duda de que esto de hecho fue un evento racista. *Be careful not communicate doubt that this was in fact a racist event.*	D3	¿Que lo llevo a creer que este evento ocurrió por su raza? What led you to believe this event happened due to race?
Investigue por el grado y tipo de angustia experimentada, por ejemplo, enojo, depresión, ansiedad. *Assess for degree and type of distress experienced, e.g., anger, depression, anxiety.*	D4	¿Cuán perturbado estuvo por esta experiencia? *Si angustia fue presente:* ¿Todavía esta perturbado por eso? How upset were you by this experience? *If distress was present:* Are you still upset by it?

Determine si la experiencia fue un trauma. *Determine if experience was a trauma.*	D5	¿Tuvo miedo por su vida, salud, o seguridad? Did you fear for the life, health, or safety of that person?
Investigue por estrategias adaptables en comparación a estrategias inadaptables de lidiar. *Assess for adaptive versus maladaptive coping strategies.*	D6	¿Cómo lidio con esta experiencia? How did you cope with this experience?
Investigue por disponibilidad y uso de un sistema de apoyo. *Assess for availability and use of support system.*	D7	¿Cómo respondieron otras personas importantes en su vida cuando les dijo de esto? How did other important people in your life react to this?
Obtenga una descripción del evento. *Elicit a description of the event.*	D8	¿Me puede decir de otro tiempo cuando usted fue afectado por racismo debido a algo que le ocurrió a <u>alguien cercano a usted</u>? Can you share with me another time you were impacted by racism as a result of something that happened to <u>someone close to you</u>?
Determine cuando el evento ocurrió. *Determine when the event occurred.*	D9	¿Cuantos años tenía cuando esto paso? How old were you when this happened?
Ten cuidado de no comunicar duda de que esto de hecho fue un evento racista. *Be careful not communicate doubt that this was in fact a racist event.*	D10	¿Que lo llevo a creer que este evento ocurrió por su raza? What led you to believe this event happened due to race?
Investigue por el grado y tipo de angustia experimentada, por ejemplo, enojo, depresión, ansiedad. *Assess for degree and type of distress experienced, e.g., anger, depression, anxiety.*	D11	¿Cuán perturbado estuvo por esta experiencia? *Si angustia fue presente:* ¿Todavía esta perturbado por eso? How upset were you by this experience? *If distress was present:* Are you still upset by it?
Determine si la experiencia fue un trauma. *Determine if experience was a trauma.*	D12	¿Tuvo miedo por su vida, salud, o seguridad? Did you fear for the life, health, or safety of that person?

Investigue por estrategias adaptables en comparación a estrategias inadaptables de lidiar. *Assess for adaptive versus maladaptive coping strategies.*	D13	¿Cómo lidio con esta experiencia? How did you cope with this experience?
Investigue por la disponibilidad y el uso de sistema de apoyo. *Assess for availability and use of support system.*	D14	¿Cómo respondieron otras personas importantes en su vida cuando les dijo de esto? How did other important people in your life react to this?
	E	***Experiencias de Racismo Indirecto*** ***Experiences of Vicarious Racism***
Dé ejemplos según sea necesario, e.g., una redada de inmigración, un crimen de odio motivado racialmente, Guerra debido a limpieza étnica, etc. *Give examples as needed, e.g., shooting of unarmed Black teen, racially-motivated hate crime, wars due to ethnic cleansing, etc.*	E1	¿Me puede decir de un tiempo cuando usted fue afectado por racismo debido a algo de que usted aprendió- por ejemplo, en las noticias o en su comunidad- que involucro a alguien que usted no conoce personalmente? Can you share with me a time you were impacted by racism as a result of something you learned about – for example, on the news or in your community – that involved someone you did not know personally?
Determine cuando el evento ocurrió. *Determine when the event occurred.*	E2	¿Cuantos años tenía cuando esto paso? How old were you when this happened?
Ten cuidado de no comunicar duda de que esto de hecho fue un evento racista. *Be careful not communicate doubt that this was in fact a racist event.*	E3	¿Que lo llevo a creer que este evento ocurrió por su raza? What led you to believe this event happened due to racism?
Investigue por el grado y tipo de angustia experimentada, por ejemplo, enojo, depresión, ansiedad. *Assess for degree and type of distress experienced, e.g., anger, depression, anxiety.*	E4	¿Cuán perturbado estuvo por esta experiencia? *Si angustia fue presente:* ¿Todavía esta perturbado por eso? How upset were you by this experience? *If distress was present:* Are you still upset by it?

Determine si la experiencia fue personalmente traumática. *Determine if experience was personally traumatic.*	E5	¿Este evento lo/la hizo preocuparse de su propio/a bienestar, salud, o sentido de seguridad? Did this event make you worry about your own well-being, health, or sense of safety?
Investigue por estrategias adaptables en comparación a estrategias inadaptables de lidiar. *Assess for adaptive versus maladaptive coping strategies.*	E6	¿Cómo lidio con esta experiencia? How did you cope with this experience?
Investigue por la disponibilidad y el uso de sistema de apoyo. *Assess for availability and use of support system.*	E7	¿Cómo respondieron otras personas importantes en su vida cuando les dijo de esto? How did other important people in your life react to this?
	F	**Experiencias de Racismo Encubierto** **Experiences of Covert Racism**
Microagresiones incluyen intercambios breves, en la forma de comentarios que se parecen inocentes o inocuo, gestos sutiles o de rechazo, y tonos que mandan mensajes denigrantes a gente de color porque pertenecen a un grupo minoritario. *Microaggressions include brief, exchanges, in the form of seemingly innocent and innocuous comments, subtle or dismissive gestures, and tones that send denigrating messages to people of color because they belong to a minority group.*	F1	Frecuentemente minorías son blancos de experiencias racistas encubiertas o sutiles en la forma de algo que a veces llamamos "microagressiones." *Define si necesario.* Often minorities are the target of subtle or covert racist experiences in the form of what we sometimes call "microaggressions." *Define if needed.* ¿Cuán frecuente diría que experimenta esto? How often would you say that you experience these?
Obtenga una descripción del evento. *Elicit a description of the event.*	F2	¿Me puede dar un ejemplo reciente? Can you give me a recent example?
Obtenga una descripción del evento. *Elicit a description of the event.*	F3	¿Puede dar otro ejemplo? Can you give another example?
Obtenga una descripción del evento.	F4	¿Puede dar otro ejemplo?

Elicit a description of the event.		Can you give another example?
	F5	¿Cuán estresante es para usted cuando este tipo de cosas le pasa? How stressful is it for you when these sorts of things happen to you?
Investigue por estrategias adaptables en comparación a estrategias inadaptables de lidiar. *Assess for adaptive versus maladaptive coping strategies.*	F6	¿Cómo lidia con estas experiencias? How do you cope with these experiences?
	F7	¿Ha experimentado algún cambio en su habilidad de lidiar con microagresiónes? Have you experienced any changes in your ability to manage microaggressions?

Nota: Las Secciones C a F pueden ser duplicadas para capturar eventos adicionales.
Note: Sections C-F may be duplicated to capture additional events.

G Evaluación de Trauma Racial	
Racial Trauma Assessment	

Investigue por TEPT si alguna experiencia descrita anteriormente califica como el Criterio A evento del DSM-5.

Assess for PTSD if any experiences previously described qualify for DSM-5 Criterion A event.

Piense de todas las experiencias que hemos discutido acerca de racismo y discriminación cuando va respondiendo a las siguientes preguntas:

Nota: Para cada respuesta positiva, pida un ejemplo y apunte la frecuencia.

Think about all of the experiences we discussed concerning racism and discrimination as you answer the following questions:

Note: For each positive response, ask for an example and note frequency.

Re-experimentación (Necesita 1 para diagnóstico de TEPT)		
Re-Experiencing *(Need 1 for PTSD diagnosis)*		
G1. ¿Ha tenido memorias perturbadoras que siguen ocurriendo sobre las experiencias relacionadas con racismo?		
	SI	NO
Have you had reoccurring, unwanted distressing memories about racism-related experiences?	YES	NO
G2. ¿Ha estado teniendo sueños malos o pesadillas relacionadas con racismo o de sintiéndose impotente o excluido?		
	SI	NO
Have you been having bad dreams or nightmares related to racism, or about feeling powerless or excluded?	YES	NO
G3. ¿Ha tenido la experiencia de sintiendo como si algún evento pasado relacionado con racismo le estaba ocurriendo de nuevo (como una escena retrospectiva)?		
	SI	NO
Have you had the experience of feeling as if a past racism-related event was happening to you all over again (like a flashback)?	YES	NO
G4. ¿Se pone muy emocionalmente perturbado cuando es recordado de las experiencias relacionadas con racismo?		
	SI	NO
Do you get very *emotionally* upset when reminded of racism-related experiences?	YES	NO

G5. ¿Ha tenido reacciones negativas físicas cuando es recordado de las experiencias relacionadas con racismo (e.g., dolor de estómago, corazón acelerado, temblando)?

	SI	NO
	YES	NO

Have you had negative *physical* reactions when reminded of racism-related experiences (e.g., stomach ache, heart racing, shaking)?

Evitación *(Necesita 1 para diagnóstico de TEPT)*

Avoidance *(Need 1 for PTSD diagnosis)*

G6. ¿Ha estado tratando duro de no pensar de las experiencias racistas perturbadoras que ha tenido?

	SI	NO
	YES	NO

Have you been trying hard not to think about upsetting racist experiences you've had?

G7a. ¿Ha tratado de evitar actividades, lugares, cosas, o situaciones que le recuerdan de las experiencias relacionadas con racismo que usted ha tenido?

	SI	NO
	YES	NO

Have you tried to avoid activities, places, things, or situations that remind you of the racism-related experiences you have had?

G7b. ¿Ha tratado de evitar ciertos tipos de personas porque se preocupa que ellos se van a comportar de una manera racista (i. e., personas Blancas, agentes del orden público, jefes, etc.)

	SI	NO
	YES	NO

Have you tried to avoid certain types of people because you worry they will behave in a racist way (i.e., White people, law enforcement, bosses, etc.)?

Cambios Negativos en Cognición y Estado de Animo
(Necesita 2 para diagnóstico de TEPT – cuente solo uno de #9 y/o #10)

Negative Changes in Cognition & Mood
(Need 2 for PTSD diagnosis – count only one from #9 and/or #10)

G8. ¿Hay algunas partes importantes de sus experiencias con racismo de que usted no se puede recordar?

	SI	NO
	YES	NO

Are there any important parts of your experiences with racism that you cannot remember?

G9a. ¿Se ha estado viendo en una manera más negativa por el racismo (e.g., "Debo de ser una persona más fuerte")?

	SI	NO
	YES	NO

Have you been viewing yourself in a more negative way because of racism (e.g., "I should be a stronger person")?

G9b. ¿Ha estado viendo a otros en una manera más negativa por el racismo (e.g., "No puedo confiar en personas blancas")?

	SI	NO
Have you been viewing others in a more negative way due to racism (e.g., "I can't trust White people")?	YES	NO

G9c. ¿Siente como que el mundo es un lugar peligroso por sus experiencias con racismo?

	SI	NO
Do you feel as if the world is a dangerous place because of your experiences with racism?	YES	NO

G10a. ¿Se ha echado la culpa por sus experiencias de racismo, o por cosas que pueden haber ocurrido después debido al racismo?

	SI	NO
Have you blamed yourself for your experiences of racism, or for things that may have happened afterwards due to racism?	YES	NO

G10b. ¿Le ha echado la culpa a otros que no fueron involucrados por su experiencia o por cosas que pueden haber pasado después?

	SI	NO
Have you blamed others who were not involved for your experience, or for things that may have happened afterwards?	YES	NO

G11. ¿Ha tenido sentimientos negativos continuamente tal como miedo, horror, enojo, culpa, o vergüenza por su experiencia relacionada con racismo?

	SI	NO
Have you had ongoing negative feelings such as fear, horror, anger, guilt or shame because of your racism-related experiences?	YES	NO

G12. ¿Ha perdido interés en las actividades que antes disfrutaba?

	SI	NO
Have you lost interest in activities you used to enjoy?	YES	NO

G13. ¿Se ha sentido separado, distante, o alienado de otras personas?

	SI	NO
Have you been feeling detached, cut-off, or alienated from other people?	YES	NO

G14. ¿Ha tenido dificultad experimentando sentimientos positivos? ¿O siente entumecimiento emocional?

	SI	NO
Have you had difficulty experiencing positive feelings? Or do you feel emotionally numb?	YES	NO

Agitación & Reactividad Fisiológica *(Necesita 2 para diagnosticó de TEPT)*

Physiological Arousal & Reactivity *(Need 2 for PTSD diagnosis)*

G15. ¿Ha estado más irritable o (físicamente o verbalmente) agresivo/a?

Have you been more irritable or (physically or verbally) aggressive? — SI / YES — NO / NO

G16. ¿Ha estado tomando más riesgos o hacienda cosas que le pudieron haber causado daño a usted o a otros (e.g., manejando descuidadamente, tomando drogas, teniendo sexo sin protección)?

Have you been taking more risks or doing things that might harm you or others (e.g., reckless driving, taking drugs, having unprotected sex)? — SI / YES — NO / NO

G17. ¿Ha estado demasiado alerto/a o en guardia (e.g., chequeando a ver quién está alrededor de usted, sentándose en lugares donde puede ver a todos, etc.)?

Have you been overly alert or on-guard (e.g., checking to see who is around you, sitting in places where you can see everyone, etc.)? — SI / YES — NO / NO

G18. ¿Ha estado asustadizo/a o sobresaltado/a más fácilmente?

Have you been jumpy or more easily startled? — SI / YES — NO / NO

G19. ¿Ha tenido dificultad quedándose enfocado o concentrándose?

Have you had a hard time staying focused or concentrating? — SI / YES — NO / NO

G20. ¿Ha tenido dificultad yéndose a dormir o quedándose dormido?

Have you had a hard time falling asleep or staying asleep? — SI / YES — NO / NO

Síntomas Disociativos *(Necesita 0 para diagnóstico de TEPT)*
Nota: Estos pueden ser más probable cuando usted se pone perturbado o estresado, esp. cuando desencadenado por experiencias de racismo.

Dissociative Symptoms *(Need 0 for PTSD diagnosis)*
Note: These may be more likely when you get upset or stressed, esp. when triggered by experiences of racism.

G21. ¿Alguna vez ha tenido veces en que usted se sintió separada/o de su cuerpo, desconectado de su sentido de identidad, o se sintió como un robot? *(despersonalizacion)*

Do you ever have times that you feel detached from your body, disconnected from your sense of self, or like a robot? *(depersonalization)* — SI / YES — NO / NO

G22. ¿Alguna vez ha tenido veces en que todo se parece un poco irreal, como en un sueño, distante, o distorsionado? (*desrealizacìon*)

Do you ever have times that everything seems rather unreal, dreamlike, distant, or distorted? (*derealization*)

SI   NO
YES   NO

	Clínicamente significativo	No significativo clínicamente
Angustia e Interferencia (*Necesita 1 para diagnóstico de TEPT*)	Clinically significant	Not clinically significant
Distress & Interference (*Need 1 for PTSD diagnosis*)		

G23. ¿Estas dificultades han sido perturbadoras para usted? (*todos los síntomas discutidos hasta ahora*)

Have these difficulties been upsetting for you? (*all symptoms discussed so far*)

SI   NO
YES   NO

G24. ¿Han estas dificultades estado interfiriendo con su vida diaria? (e.g., relaciones, el trabajo, la escuela, crianza de los hijos, u otras actividades importantes?

Have these difficulties been getting in the way of your everyday life (e.g., relationships, work, school, parenting, or other important activities)?

SI   NO
YES   NO

	Un mes o mas	Menos de un mes
Duración de Perturbación (*Necesita 1 mes o más para diagnóstico de TEPT*)	1 month or more	Less than 1 month
Duration of Disturbance (*Need 1 month or more for PTSD diagnosis*)		

G25. ¿Por cuánto tiempo ha estado sintiendo estas cosas?

How long have you been feeling these things?

SI   NO
YES   NO

Para un diagnóstico de TEPT del DSM-5, el/la examinado/a debe de tener al menos 1 síntoma en la categoría de **Re-experimentación**, 1 síntoma en la categoría de **Evitación**, 2 síntomas en la categoría de **Cambios Negativos en Cognición y Estado de Animo** (cuenta solo uno de #9 y solo uno de #10), 2 síntomas en la categoría de **Agitación & Reactividad Fisiológica**, 0 síntomas en la categoría de **Síntomas Disociativos**, 1 síntoma en la categoría de **Angustia e Interferencia**, y **Duración de Perturbación** debe de ser una repuesta SI. Refiere al DSM-5 por criterio de exclusión.

For a DSM-5 diagnosis of PTSD, the examinee must have at least 1 symptom in the **Re-Experiencing** category, 1 symptom in the **Avoidance** category, 2 symptoms in the **Negative Changes in Cognition & Mood** category (count only one from #9 and only one from #10), 2 symptoms in the **Physiological Arousal & Reactivity** category, 0 symptoms in the **Dissociative Symptoms** category, 1 symptom from the **Distress & Interference** category, and **Duration of Disturbance** must be a YES answer. Reference the DSM-5 for exclusion criteria.

*DIAGNOSTICO PROBABLE:*_____

LIKELY DIAGNOSIS: _____

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Tools for Treating Social Anxiety Disorder Among Latinos

5

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Social anxiety disorder (SAD), formally known as social phobia, is mainly characterized by fear or anxiety of being negatively judged and evaluated by others and presenting intense crying, fear, and tremors when having a conversation, meeting with strangers in social events (e.g., eating or drinking), and speaking in public. SAD in children is characterized by problems speaking in public, asking for help at school or shops, and attending parties or events where they meet people of their same age (McEvoy, Rapee & Heimberg, 2016; Spence & Rapee, 2016). The prevalence of SAD among Latinos is similar to the global population, though epidemiological data in Spanish-speaking countries remain unclear. Research on treatment adaptation of empirically based treatments for social anxiety is still in progress. Based on the characteristics of the Latino population with social anxiety, this chapter will provide:

- An account of social anxiety and its epidemiology in the Latino population
- Cultural considerations when delivering treatment
- A description of the gold standard treatment for SAD: session vignettes and Spanish-adapted work sheets

Understanding SAD

Different models establish that social anxiety (SA) is impacted by biological markers and genetic factors (Bandelow et al. 2016); however, evidence suggests that SAD is also regulated by sociocultural factors and epigenetic processes that affect the way in which the environment influences on the development and adaptation of the individual to different contexts (Brockveld, Perini, & Rapee, 2014; Hofmann, & Hinton, 2014; Paniagua, 2014). These findings led to significant changes in the current classification of mental disorders (DSM-5), such as the inclusion of cultural factors and the establishment and maintenance of different psychological disorders, including SAD (Carter, Mitchell, & Sbrocco, 2012; La Roche, Fuentes, & Hinton, 2015; Woody, Miao, & Kellman-McFarlane, 2015). Cross-cultural studies indicate that cultures promoting interaction and support among members evidence lower levels of SA (Prina, Ferri, Guerra, Brayne, & Prince, 2011; Woody et al., 2015). For

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example, Latino culture is characterized by promoting closeness, friendship, and relationships among group members, leading to lower indicators of SAD compared to American and European groups (Benuto, & O'Donohue, 2015; Camacho et al., 2015; Polo, Alegría, Chen, & Blanco, 2011). In comparison, social anxiety indexes are higher in Anglo-Saxon countries where autonomy, personal achievements, and respect for the community are paramount (Woody et al., 2015).

The DSM-5 agreed that SAD is circumstantially determined; hence, they excluded the generalized subtype from its classification. Social anxiety is a specialized disorder, that is, individuals feel anxiety when speaking to a specific audience rather than a general public (Hofmann & Di Bartolo, 2014). This highlights the importance of environmental and cultural variables when diagnosing and treating social anxiety.

Epidemiology and Comorbidity

Epidemiological studies report that at least 13% of the global population has presented SAD symptoms once in their lifetime (Baxter, Scott, Vos, & Whiteford, 2013; Spence & Rapee, 2016). In the USA, 12% of the population has experienced SA at some point, and a prevalence rate of 0.4% and 6.8% is reported (Prina et al., 2011). Prevalence of SAD in Latin America is less clear. SAD prevalence during the first 12 months is 1.7% for Mexican, 6.4% for Chileans, and 1.2% for Colombians (Encuesta Nacional de Salud Mental, 2015; Hofmann, & Di Bartolo, 2014). The report of SA symptoms is slightly different between Latino females and males. In this population, SAD is more frequent when individuals interact with people of the opposite sex, receive criticism, and speak to authorities (e.g., professors, bosses, etc.) (Caballo et al., 2014). One difficulty in establishing epidemiological data in Latinos is the absence of instruments that accurately assess the characteristics of SA in this population; most investigations have adapted instruments designed with White American samples. Additionally, questionnaires developed with Latinos still lacking of strong validity and reli-

ability (Antona, Delgado, García & Estrada, 2012; Brockveld et al., 2014; Caballo et al., 2014; Camacho et al. 2015).

The average age of onset for SAD is 11 years old for European Americans, while 13 years old is the average age of onset for Latinos living in America (Polo et al., 2011). However, the data for the onset of SAD symptoms in Latin America remains muddled. The DSM-5 reports that the prevalence in children and teens is similar to adults, between 2.3% and 7% (APA, 2013). Polo et al. (2011) found that in Latinos born in the USA, SAD commonly co-occurs with several psychological disorders, such as depression (48.7%), generalized anxiety (19.1%), panic disorder (16%), alcohol abuse (30.4%), drug addiction (11.3%), behavioral disorder (25.1%), and bulimia (7.1%). Interestingly, as time spent in the USA increases, so do rates of comorbidity with agoraphobia (48.6%) and post-traumatic stress disorder (22.8%).

Longitudinal studies have found that the presence of behaviors characteristic of SAD in adolescence increases the risk of depression in adulthood (Polo et al. 2011). Additionally, SAD symptoms increase the risk of alcohol consumption, marijuana use, and alcohol dependence during adulthood, especially in women (Spence & Rapee, 2016). Although data on the prevalence of SAD at the global level are relatively similar, it has been found that in the USA, 8.2% of Latin Americans present SAD compared to 12.6% of European Americans and 8.6% of African Americans. No gender differences have been identified between males and females in the Latino population living in the USA (Polo et al., 2011). Epidemiological data also show that the presence of SAD symptoms in Latinos living in the USA ranged from 18 to 34 years old. Additionally, married and employed people have higher risk to develop SAD.

Cultural Considerations

Therapists working with Latinos need to take into account certain cultural variables in order to treat SAD. Studies with the Latino population have

demonstrated that religious beliefs are an important part of Latino culture and can directly impact the client's perceptions about their psychological problems (Carter et al., 2012; Prina et al., 2011). *Familismo*, a value that embraces cooperation, closeness, respect for authority, and the importance of family bonds (Vega, 1990), is another key factor that supports therapeutic success; particularity, it plays an important role in overcoming family difficulties. Therapist-client relationships might be benefitted by sharing personal information with the client when appropriate, as well as shaking hands, or occasionally accepting hugs, as a sample of closeness and interest in the relationship. Although the APA code of ethics does not allow accepting gifts as part of the therapeutic process, given the characteristics of the Latino population, it is important to explain to clients that gifts can only be accepted in special occasions whether they want to share something with the therapist, such as Christmas or birthdays (Carter et al., 2012; Paniagua, 2014).

Some additional considerations when working with Latinos include:

1. Maintain a professional distance during the first session; however, as the sessions progress, it is recommended to increase the level of "closeness" with the client.
2. Talk, when necessary, about spiritual aspects that the client believes lead to emotional problems.
3. Provide any suggestion of behavioral change as long as they do not compete against cultural values (e.g., *machismo*, *familismo*)
4. Close the first session with some suggestions about the intervention, allowing the client to have the opportunity to make some changes in their current behavior and environment (Paniagua, 2014).

In general, it is desirable to accomplish some of these recommendations during the session by being mindfully respectful of clients' cultural values throughout therapy. Although protocols in evidence-based therapies for SAD have not been directly validated and adapted for Latinos, it would be useful to adopt a language as close as possible to the EBT language (Camacho et al., 2015; Hofmann & Hinton, 2014).

Empirical-Based Treatments for SAD in Latinos

Exposure-based therapy for social anxiety and cognitive behavioral therapy for social anxiety (CBT-SA) have gained the most empirical support in the treatment of SAD (Deacon & Abramowitz, 2004; Chambless & Ollendick, 2001; McMain, Newman, Segal, & DeRubeis, 2015). Moreno, Méndez, and Sánchez (2000) carried out a meta-analysis comparing both behavioral and cognitive behavioral treatments (CBT, skills training, exposure, and Ellis cognitive restructuring), including studies conducted in English- and Spanish-speaking countries. They found that CBT was the highest clinically significant intervention; however, CBT was not significantly different from other treatments. Recently, Labrador and Ballesteros (2011) extended the analysis of the previous study; they found that 64.1% of clients treated with CBT in Spain achieve their therapeutic goals.

Some researchers have adapted the CBT-SA manual developed for US population to the characteristics of Hispanos and Latinos. Olivares and García-López (2001) adapted the Protocol for Intervention in Adolescents with Social Phobia to treat adult population in Spain and young adults in Mexico (Antona et al., 2012). The treatment is composed of 12 sessions consisting of social skills training, cognitive restructuring, and exposure to social situations that trigger fearful responses. Additionally, CBT for social anxiety has shown positive effects in the treatment of children in Mexico (Gil-Bernal & Hernández-Guzmán, 2009) and college students with public speaking anxiety in Colombia (Kalil, 2012), Chile, and Brazil (Brockveld et al. 2014). The four therapeutic elements of the CBT-SA protocol that have been successfully utilized with both US population and Latinos include (1) psychoeducation, (2) cognitive restructuring, (3) exposure, and (4) relapse prevention (McMain et al., 2015; Hofmann & Otto, 2008). The duration of CBT-SA

varies between 12 and 16 sessions depending on the format utilized, with the individual modality requiring 1 h sessions and the groups 2.5 hours sessions. Group intervention can offer advantages over the individual, especially in the exposure process. One of the key elements of success in the group format is that the audience provides direct feedback in every session. At the end of each session, therapists assign homework that helps clients to master and generalize the new skills.

In the next section, each one of the components of the CBT-SA will be presented using a hypothetical case.

Andres' Case

Andres is a 22-year-old man who is worried about his academic performance. Specifically, he thinks that he will fail most of his courses since he could not meet the criteria required in the classes. He mentions that his academic performance is being affected by his difficulties in discussing his opinions with others (classmates and teachers) and doing public presentations. Andres says that this problem began after watching some classmates criticizing and mocking another peer, while she was doing a presentation during their first year in college. Currently, when he is assigned group presentations or must express his opinions to others, Andres thinks that he is going to crumble and get exposed. In such circumstances, he either asks others to complete his presentation or prefers to stay quiet during class. When he has been forced to do the presentation or talk to the group alone, he exhibits high arousal (he blushes, shakes, sweats excessively, and his heart rate increases); he thinks he is doing it wrong and that others will mock him when he finishes. Andres also speaks rapidly, stutters, or walks out of the room. As a result, he has stopped attending classes in which he is required to speak in public or to do group assignments.

Cognitive Behavioral Therapy for Social Anxiety: Treatment Description

Psychoeducation

At this stage, the therapist presents and discusses the rationale of the SAD model and the factors that maintain it. The first session covers the description of the model and the core elements of CBT-SA (Hofmann & Otto, 2008). Therapists should explain the *social phobia model* (Clark & Wells, 1995). It illustrates that the central element of the SA is the desire of the person to produce a positive impression of him- or herself onto others, which leads to social situations that trigger distorted perceptions about themselves and the world. The individual, thus, assumes that the audience (others) is dangerous. Such perceptions make people anticipate that their performance will be unacceptable to the public or that their behavior may cause them to lose their status. This leads to behavioral symptoms (i.e., avoidance of social situations), somatic symptoms (i.e., redness, trembling), and automatic thoughts (AT) (i.e., I'm inept; they're going to laugh at me). These symptoms provide a feedback loop to the perception of danger and reaffirm anxiety in social situations (Folleto A).

The Role of Avoidance and Escape in Social Anxiety Maintenance

Therapists need to address with the client the role of avoidance and escape in the maintenance of SA. Describing the function of avoidance and escaping is fundamental for decreasing anxiety responses and subsequently becomes the central issue during the exposure phase. It is important to describe to the client how the behaviors associated with SA are part of the avoidance/escape cycle. This vicious cycle usually prevents clients from contacting anxiety-provoking situations and immediately stops the occurrence of nega-

tive thoughts about these events. Contrary to expectations, avoidance responses increase over time generating even greater psychological distress (Folleto B).

Therapists need to explain to the client the importance of scheduling and performing exposure exercises consistently in order to break down the avoidance/escape cycle that produces SA. Therapists should inform the client that all responses associated with avoidance increase momentarily after the first exposure session; however, upon continuous exposure, these responses decrease over time in their frequency and duration (Hofmann, & Di Bartolo, 2014). During this phase, it is important that the therapist continues the exposure exercises, while anxious responses increase. Rather than reducing anxiety symptoms, an abrupt interruption during the exposure leads to counterproductive effects. That is, the frequency, duration, and severity of the anxious response could escalate (more details about the exposure procedure are found below).

Let's review this phase through Andres' case:

Terapeuta	Imagina que tu profesor te pide después de clase que expongas un tema en la siguiente sesión. ¿Qué tipo de respuestas tendrías ante tal petición? (*pedir descripción específica de las respuestas de ansiedad*).
Cliente	Le digo que tengo un viaje de trabajo importante, o el día anterior le digo que estoy muy enfermo.
Terapeuta	Exacto, el malestar sería intenso y para ello actualmente llevas a cabo una serie de estrategias para disminuir la ansiedad, como: dar excusas, dejar de asistir a clase… (*permitir que el cliente de otros ejemplos*). A esto le llamamos evitación. Estas conductas te permiten salir de la situación ansiosa y sentir un alivio inmediato. La evitación es muy poderosa y genera bienestar a corto plazo, y por tanto vuelves a engancharte en ella cada vez que una situación social que te genera ansiedad se presenta. Sin embargo,

la evitación también tiene consecuencias a largo plazo, como generar mayor ansiedad, y limita de manera dramática tu interacción con otros. Por ejemplo, tu has comenzado a evitar situaciones sociales que son importantes para ti como la asistencia a clases, esto te genera alivio inmediato al aliviar tu ansiedad, el problema es que la evitación se puede volver la única manera que encuentres para manejar tu ansiedad y puede comenzar a extenderse a más situaciones en tu vida social.

Cliente	Si, entiendo, eso es lo que he hecho desde que empecé a sentirme ansioso
Terapeuta	Parte de lo que haremos en la intervención es interrumpir este ciclo invasivo de la evitación para que la ansiedad disminuya, y así vuelvas a involucrarte en las actividades que has venido dejando progresivamente. Esto se logra a través de la exposición. Esta estrategia permitirá que te pongas en contacto con las situaciones que te producen temor hasta reducir la ansiedad de manera que sientas que tienes dominio sobre lo que está pasando a tu alrededor.

Cognitive Restructuring

An important part of the CBT-SA is challenging clients' cognitions. Cognitive restructuring is guided by three principles: (a) people's responses and emotions are caused by the interpretations they have of the world; (b) interpretations are often biased, leading to cognitive distortions; and (c) CBT focuses on identifying these distortions and reinterpreting them in terms of objective facts. It is important to begin the cognitive restructuring phase, describing what the automatic thoughts (AT) and core beliefs are. This process will allow the client to make sense of the connection between their thoughts and anxiety:

Ahora que vamos a iniciar el proceso de reestructuración cognitiva es importante que entendamos cómo los pensamientos distorsionados afectan la forma en que sentimos, pensamos y actuamos. Los pensamientos ansiosos son automáticos, sesgados y usualmente ilógicos. Interpretamos constantemente lo que está pasando basado en nuestras creencias nucleares acerca del mundo, nosotros mismos, y el futuro. Al tratarse de un proceso automático, no somos conscientes de lo que hacemos, pero los pensamientos tienen el poder de producir emociones positivas o negativas, como la ansiedad.

Recording AT is a fundamental step to establish the characteristics of clients' distortions and their "triggers" (first three columns of the thought record; Folleto C). Therapist should assist the client in identifying the automatic thoughts that maintain the problematic behaviors (i.e., all-or-nothing, overgeneralization, filtering, mind reading, magnification or minimization, emotional reasoning, "should" statement) by explaining the thought record in session. Frequently, clients struggle with keeping track of the occurrences of AT. It is highly recommended the therapist describe to the client that completing the thought record allows them to identify the causes of the SA, which will be targeted in session. In such cases where the client does not complete the thought record, the therapist should explore those factors that are interfering with its completion. The therapist might ask the client if they had problems identifying automatic thoughts, whether they set up specific times throughout the week to fill the thought record, or if external or personal events interfered with this activity.

With the purpose of initiating the process of restructuring AT and core beliefs, the therapist needs to examine along with the client the thought record (Folleto C). During cognitive restructuring sessions, the therapist formulates some questions about the social situations that triggered the AT. The goal is to reevaluate client thoughts by identifying the extent to which AT accurately describe "reality" and how they affect his/her performance in social circumstances. The therapist can modify AT through the following strategies:

1. Using Socratic dialogue (client reaches a conclusion based on the evidence)
2. Searching of evidence (contrasting thinking and objective reality)
3. Examining the advantages and disadvantages of AT
4. Designing behavioral experiments, acting "as if ..." (creating hypothetical scenarios of appropriate behavior during anxious situations)
5. Formulating alternative beliefs, using imagery techniques (i.e., creating images that modify thinking)
6. Using metaphors, asking others about their thoughts and beliefs, examining the origin of beliefs in childhood (Beck, 2011)

Subsequently, it is important that the therapist and client evaluate the level of believability of the AT and if these are useful to achieve his/her expectancies. At the end of each session, the therapist and client set up a behavioral experiment, which will allow challenging client's AT in his/her natural environment.

Cognitive restructuring ends when the client has learned to identify his automatic thoughts and core beliefs and how to modify them to produce accurate thoughts about social circumstances.

Exposure

Exposure is an essential part in the treatment of social anxiety. This phase must take between six and eight sessions, involving an ongoing and consistent practice in and out of the therapeutic setting. Exposure exercises require the cooperation of different individuals, who function as an audience to evoke anxious situations and to provide genuine feedback after client performance. The therapist must video record the client's performance in therapy to facilitate his/her practice at home, which allows him/her to generalize the effects of in-session exposure. Clients must accomplish two tasks: (a) completing exposure exercises in the natural environment and (b) watching the videos of the exposure exercises

performed in session. Here is an example of how to present the *exposure* to the client:

> Ahora que iniciaremos las sesiones de exposición es importante recordar el rol de la evitación y la extinción en el proceso de mantenimiento y cambio respectivamente. Como habíamos discutido, la evitación perpetua los patrones problemáticos en las situaciones sociales. El papel fundamental de la exposición es romper dichos patrones de manera que puedas volverte un experto enfrentando tales situaciones. Para ello es importante la práctica dentro y fuera de nuestra sesión. Al comportarte de forma diferente en la sesión, puedes empezar a aprender que la ansiedad cambia cuando te expones a situaciones temidas, aunque inicialmente haya un aparente incremento del temor. Por lo tanto, es importante que practiques estas estrategias afuera, para que puedas aprender que dichos cambios no sólo ocurren cuando lo intentamos en sesión, sino cuando lo realizas de manera similar en el ambiente natural. Es importante recordar que dejar de actuar en las situaciones sociales en las que experimentas ansiedad es otra forma de evitación, y no podemos darle la oportunidad a la ansiedad de tomar fuerza nuevamente.

Exposure exercises must be designed and adapted to the specific needs of the client. It is important that he/she understands what the expected outcome of this process is (Hofmann & Otto, 2008). The objectives of the exposure sessions are:

(a) Being aware that any social situation could be anxious provoking
(b) Attaining small goals, though the performance is not perfect
(c) Observing social situations, independently of expectations and judgments
(d) Being prepared to deal with destructive biases that may occur before, during, and after social interactions
(e) Predicting optimal levels of social performance in anxious-provoking circumstances
(f) Adapting clients' responses to the changes that may occur in those situations

Once exposure objectives are established, the therapist and client assess the different situations in which the client experiences SA. The exposure activities planner template (Hoja de Actividades para Planear la Exposición, in Spanish; Folleto

D), developed by Hofmann and Otto (2008, p. 193), is a useful tool to identify the characteristics of client anxious-provoking situations. The exposure activities planner contains a series of questions that provide specific descriptions of social circumstances and behaviors that will be targeted within the exposure phase.

A hierarchy of fear and avoidance responses should be used to monitor the changes in the avoidance/escaping cycle and emotion of the client during the exposure phase (Folleto E). This hierarchy assesses the Subjective Units of Distress Scale (SUDS), which measures the degree of distress caused by anxious situations. At the beginning of each exposure session, it is necessary to administer this scale to evaluate the current subjective level of fear and avoidance produced by anxious events. In order to decrease response reactivity by the client during the first session, it is important that the therapist selects an event that the client has rated at an intermediate level on the scale. In doing this, the therapist facilitates contact with a fearful social situation that is not comfortable but won't produce damage or treatment dropout.

Starting the second session, the client should be exposed to situations that have been rated as highly anxious (SUDS > 6). The client and therapist will agree on the minimal accepted criteria to compare the progress against (e.g., 0–10), and this score will serve as a criterion for the success of the exposure phase. During these sessions, the client should report when the SUDS decreases, so that the therapist can monitor the effects of the intervention (Folleto E). The client's scores will also help the audience provide accurate feedback when the client achieves the goals proposed for each exercise.

Clients should evaluate their fear to the anxious-provoking events (SUDS 0–10) before and after their performance. They should do a brief presentation to the therapist and audience of no more than 30 s about the symptoms of anxiety, what happened during the anxious situations, and the place where they occur. The assessment of the exposure performance (Formato para evaluar la ejecución del cliente durante las sesiones de la exposición; Folleto F) allows the therapist and

audience to rate the client's performance during the exposure session. It is required that the therapist trains the audience how to provide accurate and genuine feedback once the client finishes his/her presentation. Upon completing the presentation, it is important that the audience applaud and reinforce the client performance. When a member of the audience provides negative feedback, the therapist needs to paraphrase his/her feedback into a constructive comment, turning it into a beneficial statement. This shift needs to be supported by other members of the group. For example:

> Cuando estabas presentando mantuviste contacto visual con nosotros, eso me produjo confianza sobre lo que estabas hablando (retroalimentación positiva). No obstante, algunas veces bajabas mucho la voz y no se oía claramente lo que decías (retroalimentación negativa). Dado que es un tema muy interesante, es posible que la próxima vez trates de hablar un poco más alto, con ello podría entender mejor el punto central de tu discurso (parafraseo para mejorar la siguiente presentación).

At the end of the feedback, the therapist hands over the video recording of the session to the client so he/she can watch it at home. The therapist should provide a brief description to the client about the topic he/she will present in the next session and encourage him/her to practice in front of the mirror daily. It is recommended to encourage clients to record (audio or video) the home rehearsals to provide feedback of her/his performance during the next session. Exposure sessions follow the same format during the remaining sessions.

Last sessions are focused on conducting the exposure session in a natural environment such as restaurant, coffee shop, library, etc. At the end of this phase, the client should report SUDS before and after every exposure exercise. Before starting exposure, the client is encouraged to answer these questions: (a) What will be the average and maximum level of anxiety when exposed to the anxious situation? (b) What will be the result of the situation (how will others react to his/her performance)? and (c) How long will these consequences last? (Hofmann & Otto, 2008).

Relapse Prevention

As in many psychological interventions, it is important that the therapist and the client discuss what conditions are associated with social anxiety, how to identify them, and what to do in such circumstances to prevent relapse.

Therapist should familiarize clients with relapse language. Clients need to identify events that provoke anxiety symptoms and the skills to cope with them successfully. They should learn to detect a lapse before it turns into a relapse (returning to baseline levels, prior to intervention). For this purpose, therapists and clients need to examine possible circumstances in which anxiety occurs and how to address the automatic thoughts, core beliefs, and avoidance behaviors associated with such events. It is necessary to state that lapses are an opportunity, not a failing, to re-implement the skills learned during the treatment (Folleto G).

Folleto A: Modelo de Fobia Social en el Caso de Andrés

Historia previa de interacción social.
Observar a sus compañeros burlarse de otra persona.

Situación social.
Exponer en clase.

Activa supuestos acerca del mundo y de sí mismo.
"Cuando esté exponiendo voy a fallar, porque soy un total fracaso".

Percepción de peligro a nivel social.

Actuará de manera inaceptable.
"Lo que diga será inaceptable".

La actuación le hará perder estatus, lo devaluará, o lo rechazarán.
"Todos van a pensar que soy un perdedor".

Síntomas Conductuales.
Se va de la universidad antes de clase.

Síntomas Cognitivos y Somáticos.
*PA: "soy un inepto".
Síntoma somático: temblor, sudoración.*

Folleto B: Efecto de los patrones de evitación/escape en el mantenimiento de la Ansiedad Social.
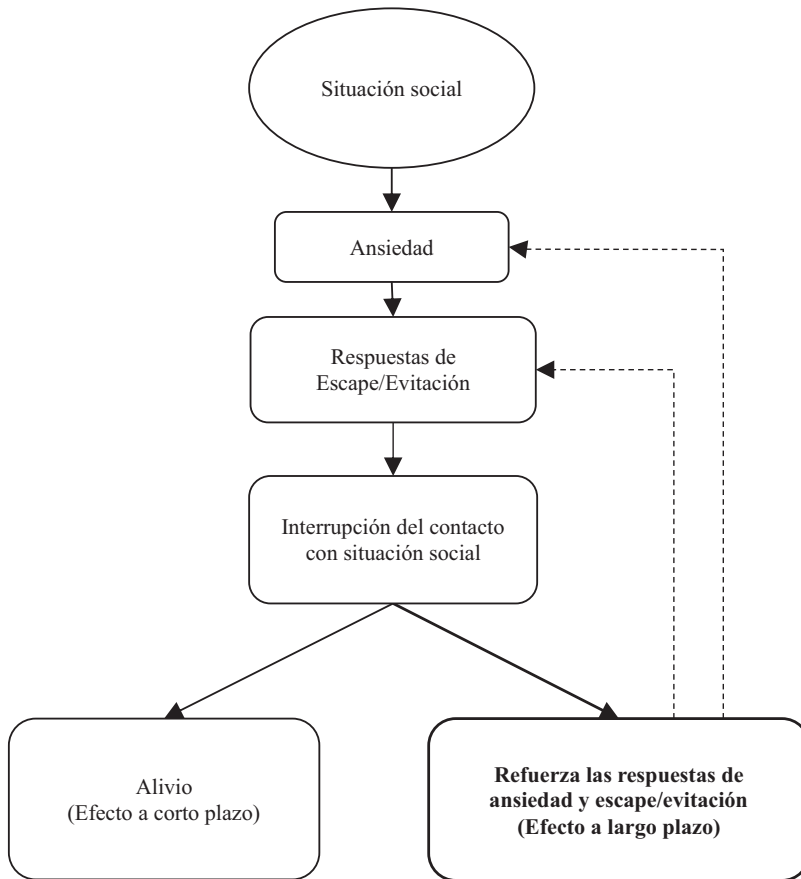
Folleto C: Autorregistro de Pensamientos Automáticos

Situación ¿Qué estaba haciendo cuando me sentía ansioso?, ¿Donde estaba?, ¿Con quien estaba?	Pensamiento Automático ¿Qué pensó inmediatamente antes de que se sintiera ansioso?	Emoción o Sentimiento Valore la intensidad de su emoción (0-10) Describa los síntomas fisiológicos	Desafiar el Pensamiento Automático ¿Cuál es la evidencia? ¿Cuál es la evidencia que la peor consecuencia ocurra?	Pensamiento Alternativo
Ejemplo *Reunirse con otras personas*	*"No soy suficiente", "Soy un tonto"*	*Temblor Sudoración (5)*	*No hay evidencia: Las personas nunca mencionaron que era un tonto o insuficiente.*	*"Soy capaz de interactuar con otros"*

Folleto D: Hoja de Actividades para Planear la Exposición

Hofmann & Otto (2008)

¿Cuáles son las situaciones que mejor caracterizan los miedos de humillación o vergüenza del cliente? ¿Estas son interacciones uno a uno, pequeños grupos, o grandes grupos; informales o formales, estructurados o no-estructurados; de trabajo o sociales; en relación con un rema especifico; etc.?

Pregunta: Descríbame algunos de los escenarios sociales que más teme.

_____

_____

_____

¿Cuáles son los miedos relacionados con la humillación? ¿Estos miedos se centran en errores sociales, la aparición de síntomas, creencias de incompetencia, etc.?

Pregunta: Muchas veces, los individuos con ansiedad social temen cometer ciertos errores sociales. ¿Puede decirme algunas de las cosas que teme puedan pasar en una situación social?

_____

_____

_____

¿Los miedos de tipo social dependen fuertemente de la aparición de síntomas (tasa cardiaca, sudoración, enrojecimiento, resequedad de la garganta, etc.)?

Pregunta: ¿hay algunos síntomas que intensifiquen el miedo a sentirse avergonzado(a) cuando están presentes (tasa cardiaca, sudoración, enrojecimiento, resequedad de la garganta, etc.)? ¿Por qué estos síntomas resultan tan molestos?

_____

_____

_____

¿Cuáles son las claves de seguridad que usa el cliente?

Pregunta: ¿cuáles son esas cosas que suele hacer para sentir menos ansiedad en las situaciones sociales?

_____

_____

_____

¿Cuáles son las formas en las que le paciente elimina las actuaciones adecuadas o en las que se auto-critica después de su ejecución social?

Pregunta: ¿Qué suele decirse a sí mismo(a) después de experimentar una situación social?

_____

_____

_____

Pregunta: ¿Cómo llenaría las siguientes afirmaciones?

No puedo creer que haya hecho… (en la situación social), Yo siempre…

_____

_____

_____

Lo eche a perder. Soy todo (a) un…

_____

_____

_____

Yo debería haber…

_____

_____

_____

Pregunta: y ¿cuándo se prepare para la siguiente situación social, cuales son las cosas que le preocupan o sobre las que quiere prestar atención?

_____

_____

_____

Folleto E: Escala de Ansiedad Social (SA) y Jerarquía de Miedo y Evitación

La escala de la AS	Situaciones sociales	Antes de situación de ansiedad		Después de situación de ansiedad	
		Miedo (0-100)	Evitación (0-100)	Miedo (0-100)	Evitación (0-100)
	Mi peor miedo:				
	Mi 2o. peor miedo:				
	Mi 3er. peor miedo:				
	Mi 4o. peor miedo:				
	Mi 5o. peor miedo:				
	Mi 6o. peor miedo:				
	Mi 7o. peor miedo:				
	Mi 8o. peor miedo:				
	Mi 9o. peor miedo:				
	Mi 10o. peor miedo:				

Folleto F: Formato para evaluar la ejecución del cliente durante las sesiones de exposición

Metas a alcanzar con la exposición		

Parámetros de logro		

	Antes de la exposición	Después de la exposición
Nivel de ansiedad (0-10)		
Descripción síntomas de los síntomas de ansiedad		
Descripción sí mismo en la situación		
Descripción el ambiente		
Descripción el discurso		

Ejemplo en el caso de Andrés

Metas a alcanzar con la exposición	*Expresar mi acuerdo con las políticas de vacunación como estrategia de prevención de enfermedades*	
Parámetros de logro	*Hablar durante 3-minutos sobre las ventajas de la vacunación en el país, mencionando los progresos y metas para el futuro de los programas de vacunación.*	
	Antes de la exposición	**Después de la exposición**
Nivel de ansiedad (0-10)	*8*	*4*
Descripción síntomas de los síntomas de ansiedad	*Sudoración*	*Sudoración*
Descripción sí mismo en la situación	*Soy incapaz*	*Soy capaz*
Descripción el ambiente	*Las personas afuera están en silencio, están esperando por mí.*	*Las personas están aplaudiendo y sonriendo ante lo que dije. Las personas dijeron que el tema fue claramente expuesto.*
Descripción el discurso	*Este contiene los pros de la vacunación, los avances hechos en los últimos años y que se necesita hacer*	*Mencione los puntos programados, sobre la importancia de la vacunación y lo que se requiere para lograr mayor cobertura.*

Folleto G: Plan para el manejo de caídas y recaídas

Situaciones asociadas a la ansiedad social		
	Habilidades para cambiar los patrones de evitación	**Habilidades para reestructurar los pensamientos y supuestos problemáticos**
Pensamientos y expectativas asociadas a la ansiedad social		
Conductas de evitación asociadas a la ansiedad social		

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Tools for Treating Panic Disorder Among Latinos

6

Andrew Ahrendt and Lorraine T. Benuto

Prevalence of Panic Disorder in the Latino Population

The Hispanic/Latino population is the largest and fastest-growing ethnic minority population in the United States currently comprising 17.6% of the United States (US) population (United States Census Bureau, Population Division 2016). While panic disorder is less prevalent than other anxiety disorders among Latinos, panic disorder within this population is substantial. A recent epidemiological study indicates lifetime prevalence rates of panic disorder among Latinos to be 4.1% which is slightly lower than the lifetime prevalence rate among non-Hispanic White Americans (5.1%) but higher than the lifetime prevalence rate for both African Americans (3.8%) and Asian Americans (2.1%; Asnaani, Richey, Dimaite, Hinton, & Hofmann, 2010). Despite that a substantial number of Latinos are impacted by panic disorder, there is a dearth of research on epidemiological, phenomenological, and outcome-based treatment research with Latinos. This is problematic as symptomatology can differ across

and within this population (Carter, Mitchell, & Sbrocco, 2012; Hollifield, Finley, & Skipper, 2003; Katerndahl & Realini, 1998).

Mental Health Service Use

Despite the high prevalence of panic disorder among Hispanic/Latinos, many Hispanic/Latinos do not seek professional services. In fact, Katerndahl and Realini (1998) found that 46.3% of Hispanics who experience panic attacks did not seek medical care. While it is important to note that not all people who experience panic attacks go on to develop panic disorder, these statistics suggest that a large proportion of Hispanic/Latinos do not seek needed services for panic disorder. Such disparities in healthcare utilization can result from barriers to access including economic barriers and lack of health insurance (Andersen, 1995; Cabassa, Zayas, & Hansen, 2006; Lara, Gamboa, Kahramanian, Morales, & Bautista, 2005; Keyes et al., 2012). In addition to structural barriers, cultural factors also play a role in treatment-seeking behaviors.

Indeed, cultural factors and language have been found to greatly influence whether or not Hispanic/Latinos will seek services when barriers to access (e.g., limited income, insurance, financial resources) were controlled for (Keyes et al., 2012). Specifically, the shortage of Spanish-speaking mental health professionals

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(Institute of Medicine, 2004) and an overall distrust of the medical system as a result of unsuccessful or discriminatory historical transgressions may act as additional barriers in establishing rapport, accurate assessment, diagnosis, and treatment of mental health problems within Hispanic/Latino population (Armstrong, Ravenell, McMurphy, & Putt, 2007; Corbie-Smith, Thomas, & St. George, 2002; Finch, Kolody, & Vega, 2000; Keyes et al., 2012). Additionally, Hispanic/Latinos are more likely to seek help from informal sources (e.g., religious leaders or family), prior to or in lieu of, seeking professional or medical care (Cabassa, & Zayas, 2007; Pescosolido, Wright, Alegría, & Vera, 1998). Thus, community outreach and education that promote a positive relationship with the healthcare system may be a necessary step to increasing mental health service utilization among this underserved population. Additionally interventions that are more aligned with the cultural values of this group may also help to increase treatment engagement.

Cultural Conceptualizations and Presentations of Panic Disorder

Cultural Concepts

While the characteristics of panic disorder appear to be consistent across cultures (i.e., the vast majority include sudden onset of physical sensations such as dizziness or heart palpitations subsequently followed by a private misinterpretation of symptomatology), the phenomenology of these experiences may greatly differ. Such differences in phenomenology should be considered including the use of cultural idioms of distress among Hispanic/Latinos. These are discussed below:

Ataque de nervios *Ataque de nervios* ("attack of nerves") is a cultural concept of distress that is used among Hispanic/Latino populations (Guarnaccia, Canino, Rubio-Stipec, & Bravo 1993). Guarnaccia et al. (2010) found that 7–15% of Hispanic/Latino sample in the National Latino and Asian American Study had experienced *ataques de nervios.* This experience is character-

ized by symptoms of intense emotional upset that include episodes of anxiety, anger, or grief; this may include screaming and shouting uncontrollably, being physically or verbally aggressive, and/or experiencing dissociative episodes (Guarnaccia, Rivera, Ranco, & Neighbors, 1996). This experience can be conceptualized as an anxiety-induced panic attack that is influenced by specific cultural expectations (Mendoza, Williams, Chapman, & Powers, 2012). While these attacks are usually triggered by a significant stressful event (Lopez & Guarnaccia, 2000), they also may occur as a result of accumulated suffering (Guarnaccia et al., 1996; Lewis-Fernández et al. 2010).

Although much symptom overlap exists, it is unclear whether *ataques de nervios* should be considered panic attacks (LaBruzza & Méndez-Villarrubia, 1994; Liebowitz, Salmán, Jusino, & Garfinkel, 1994). Though this subject has been heavily debated, evidence has shown that they are similar, but not the same, as *ataques de nervios* consists mostly of panic symptoms (Barrera, Wilson, & Norton, 2010; Guarnaccia et al., 1996; LaBruzza & Méndez-Villarrubia, 1994; Liebowitz et al., 1994) and lacks the avoidance aspect that is present in panic disorder (Cintron, Carter, & Sbrocco, 2005). Despite these experiences being different, it is necessary that practitioners are aware of and sensitive to these differences when making diagnostic and treatment decisions.

Somatic Symptom Presentation Research is mixed on whether Hispanic/Latinos experience panic symptoms differently. While some researchers found that Hispanic/Latinos endorse more somatic symptoms than Caucasian Americans (Canino, 2004; Hollifield et al., 2003), others found no difference (Barrera, Wilson, & Norton, 2010). Per the body of literature that suggests that Hispanic/Latinos may endorse more somatic symptoms, this may be due to greater cultural acceptance of physical ailments as compared to psychological ones among Hispanic/Latinos (Varela et al., 2004). Barrera et al. (2010) hypothesized that acculturation may further influence symptom endorsement, as the familiarity of panic disorder within Caucasian culture may be viewed as a culturally

apposite expression of grief (Asnaani, Gutner, Hinton, & Hofmann, 2009). For this reason individuals who are more acculturated may not experience anxiety or panic through traditional expressions (Barrera, Wilson, Norton, 2010). While current research on the direct effects of acculturation is limited, practitioners should assess individuals' levels of acculturation in order to efficiently provide effective services on an ideographic basis. This is not to say that therapists should solely focus on a client's race, ethnicity, or culture as main guiding factors in their treatment selection but instead focus on building a therapeutic relationship with the client that is both unique and specific to the client.

Research on the Treatment of Panic Disorder

Treatment Outcomes for Anxiety Disorders and Panic Disorder

While several studies have examined the outcomes of interventions directed at depression with Hispanic/Latino populations (Cummings & Druss, 2011; Foster, 2007; Hahn, Kim, & Chiriboga, 2011), little research has been conducted on treatment of anxiety within this group (Carter et al., 2012). This lack of treatment outcome studies for anxiety disorders is further magnified in the study of panic disorder as we only identified one study on the outcomes of therapy for the treatment of panic disorder with Hispanic/Latinos. In this single case study, Alfonso and Dziegielewski (2001) found that a 9-week self-directed cognitive behavioral therapy (CBT)-based treatment and weekly panic-based support group significantly reduced the participant's anxiety levels which were maintained through a brief 1-week follow-up. Despite this study's limitations, the results from this study suggest that CBT may produce positive outcomes with Hispanic/Latinos who have panic disorder. This is consistent with research findings from other studies that have examined treatment outcomes for anxiety with this group (Benuto, O'Donohue, & Bennett, Under Review)

and also with a systemic review that noted that CBT can produce positive treatment outcomes for Latinos (Benuto & O'Donohue, 2015).

Cognitive Behavioral Therapy

While there is evidence that both CBT and medication have been independently found to be effective in the treatment of panic disorder (Hicks, Leitenberg, Barlow, & Gorman, 2005), given the focus of this book, this chapter is focused on behavioral interventions. CBT is considered an empirically supported treatment for anxiety disorders. Indeed, the Society of Clinical Psychology has classified the empirically supported treatment (EST) status of CBT for anxiety as having strong research support (Hajcak 2016). Meta-analyses have also concluded that CBT is an efficacious treatment for anxiety disorders including panic disorder (Cuijpers, Cristea, Weitz, Gentili, & Berking, 2016). CBT for panic disorder includes the use of cognitive restructuring, mindfulness, and exposure:

Cognitive Restructuring Cognitive restructuring involves helping people replace catastrophic cognitions with more reasonable ones (Vickers & McNally 2006). When people experience the fight or flight response, it is common that they believe they are in danger even if they are actually safe. These beliefs can act to further intensify the fight or flight response (Fight or Flight Response n.d), which leads to increased fear, catastrophic thoughts and predictions, avoidance, and escape behaviors (Vickers & McNally 2006). By replacing these negative thoughts with more adaptive ones, people learn how to accept feelings of panic without mislabeling them as catastrophic (Vickers & McNally 2006).

Mindfulness The process of mindfulness acts by having people accept the sensations and feelings that accompany them in the present (e.g., the fight or flight response) without judging or negatively labeling them (Brown & Ryan, 2003). In taking a mindful approach, people are able to pay attention to themselves (thoughts, feelings,

emotions, and sensations) and their experiences in the present moment and accept them nonjudgmentally so that they can respond to them more effectively and efficiently, as opposed to engaging in negative behaviors of avoidance or escape (Bishop, et al., 2004; Kabat-Zinn, 1994).

Exposure Our primal response to fear is to engage in avoiding or escaping from danger (Craske & Barlow, 2014). However, these responses are paradoxical as the more a person tries to avoid or escape from a situation the stronger the fight or flight response becomes (Craske & Barlow, 2014). This occurs because every time that a person engages in avoiding a feared situation, they do not learn that the experience of anxiety or fight or flight is not dangerous and will decrease on their own over time (Craske & Barlow, 2014). Exposure involves having people be in these situations of heightened arousal until their anxiety naturally returns to normal (Craske & Barlow, 2014). This process allows the person to learn that these feelings are not permanent nor dangerous. Repeatedly engaging in this behavior helps people diminish their panic response (Craske & Barlow, 2014).

The above treatment principals are part of a manualized treatment for panic disorder (Craske & Barlow, 2014). As discussed above, this treatment protocol is a CBT treatment protocol, and CBT is considered an efficacious treatment for panic disorder. Also as discussed above, Hispanic/Latinos may present with culturally specific presentations of anxiety. Thus, our first recommendation is that clinicians carefully assess for anxiety with working with this population (see Benuto, (2013a, 2013b) for a general overview of assessment with Latinos and Snipes (2013) for a discussion of the assessment of anxiety with Latinos). Our second recommendation is that clinicians consider the clinical utility of any intervention that is to be used with any client. This includes a consideration of available research evidence and clinical consensus about the generalizability, feasibility, and client acceptability of the intervention (APA Presidential Taskforce, 2006). This may include a consideration of the client's ethnic background, cultural level, attitudes toward therapy, personal conceptualization

of anxiety (i.e., while some Hispanic/Latino clients may use cultural idioms of distress, others may not), etc. The client's mental health literacy, general literacy, and level of education should also be considered. Many of the tools and worksheets included utilize language and terms that the average person may not understand. Thus, all worksheets and tools should be reviewed in session with the client to ensure that she/he understands the concepts and content therein. Worksheet 0 lists several terms or concepts and associated definitions, and there is space on the worksheet to add additional ones depending on the client's level of mental health literacy.

Our final recommendation is that clinicians use evidence-based interventions with Hispanic/Latino clients. There is research support to suggest that Hispanic/Latinos can benefit from evidence-based interventions. The final section of this chapter includes a sample session plan and corresponding tools and worksheets. While these are based on evidence-based principles (discussed above) and were trans-adapted (several clinicians who specialize in working with Latinos reviewed the session plan and tools and worksheets and provided feedback, and revisions were made based on that feedback), it is important to note that they have not been empirically tested in their current form. Nonetheless, the research supports that empirically supported treatments and evidence-based treatment principals can be used with Hispanic/Latino clients (Benuto & O'Donohue, 2015).

Sample Session Plan

(Based on Craske & Barlow, 2014)

Session 1
The goal of this session is to establish rapport with the client, provide psychoeducation regarding patterns of anxiety, and gather information relating to the client-specific patterns and presentations of anxiety and panic:

- In session one the goal is to build rapport with the client in order to create a beneficial

therapeutic relationship that will further guide treatment. This can include but is not limited to speaking to the client about their career or personal life, explaining the therapeutic process with the client, reviewing limits of confidentiality (especially if immigration status is a concern for the client), and addressing any of the client's questions. Specific to Latinos this may include an assessment and/or consideration of cultural idioms of distress, attitudes toward mental illness therapy, and conceptualization of anxiety.

- Describe anxiety and gather information about when the client first experienced panic attacks. Identify when the client first began experiencing anxiety, and examine patterns in which it is presenting (people, places, situations, etc.). This may also include an assessment of the client's own personal descriptors of what she/he is experiencing and psychoeducation about what the term "anxiety" (i.e., *ansiedad*) means (Worksheet 0/PD0).
- Once this information has been gathered, the therapist should provide the client with a rational and description of treatment (if this was not done during the building rapport aspect of the treatment).
- Introduce the client to several tools that they will use throughout their treatment. These tools include:

  What is anxiety? (Worksheet 0)

  Daily Mood Log (Worksheet 1 PD1):

    This tool is used to log the client's daily levels of anxiety, depression, and worry specifically related to having panic attacks.

  The Panic Self-Monitoring Record (Worksheet PD2):

    The client will carry this tool with them at all times. The therapist should instruct the client to complete the worksheet as soon as they are able following any experienced panic attack.

- These tools will be used throughout the majority of the therapy, so it is very important that the therapist takes their time explaining how each of these work and then answering any questions that the client has

regarding these tools. A good strategy to ensure that the client understands these methods is to ask them to explain how to use each of the tools a few minutes after you have explained it to them.

- *Homework*:
  - The therapist will assign the client the homework of using and completing each of the tools (listed above) during the following week prior to the next session.

Session 2

The goal of this session is to provide the client with psychoeducation regarding the role and relationship between physiology and anxiety/panic symptoms:

- This session (and each subsequent session) begins by having the therapist review the client's homework and gather information about the client's past week. The clinician should gather information about whether the client had any difficulties using the tools that were assigned to them as homework. This is important as verifying that clients are using the tools correctly early on will benefit overall treatment efficacy and efficiency by allowing the therapist to focus on current treatment goals rather than reteaching tool use during later sessions.
- Describe the evolutionary role of anxiety and panic in the fight or flight process (Worksheets PD3 and PD4). Worksheets PD3 and PD4 offer an overview of panic and the flight or fight response. The clinician should be mindful of the client's level of general and mental health literacy. Depending on these levels, the clinician may need to spend a time going through these worksheets with the client and explaining what the various concepts mean. During this time the therapist will relate how the physiological changes of anxiety and panic relate to the bodily sensations that the client experienced during their panic attack.
- Describe to the client how specific thoughts and thought patterns relating to stressors or fears can lead to panic attacks. For instance, emphasizing that while panic attacks may appear to

come out of nowhere, a pattern or trigger likely exists. If the therapist has determined a common pattern of thoughts, actions, or situations that lead to a panic attack, this is a good example to present to the client. Otherwise if this has not yet occurred, the therapist can create an example of this to present. The benefit of providing this information is twofold. First it is to reduce anxiety related to the uncertainty of the onset of panic attacks and second to provide more credibility and support for CBT.

- *Homework***:**
  - Instruct the client to read and reread the Biology and Psychology of Anxiety and Panic Handouts (Worksheets PD5 and PD6) (Biology & Psychology of Panic 2006).
  - Last of all the therapist should reemphasize that their panic will gradually decrease as they read the assigned material and engage in homework activities.

Session 3
The goal of this session is to educate the client on breathing, simulate ineffective breathing and symptoms of panic, and begin practicing breathing control:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will educate the client on breathing and the role that it plays in their experience of anxiety and panic. During this time the therapist will address any misconceptions (e.g., fear of overbreathing) or questions the client has regarding breathing and the physiological effects associated with it.
- The therapist will provide the client with information relating to the benefits of deep slow diaphragmatic (breathing from their diaphragm) breathing and have the client practice this by engaging in three continuous sets of the breathing pattern:

- Slowly inhale through their nose for 3 s, hold this breath in for 3 s, and then slowly exhale this breath for 4 s before repeating the cycle:
  - Note: It can be beneficial for the therapist to count while the client is practicing this routine so that they can establish the tempo without having to internally monitor time.
- Following breathing education, answering questions, and practicing, the therapist will instruct the client to engage in simulated hyperventilation by asking them to breathe quickly and shallowly for 1 min (or enough time to facilitate panic symptoms).
- Immediately following this the therapist will ask the client to breathe slowly while sitting with their eyes closed until the panic symptoms have decreased.
- Once their panic symptoms have decreased, the therapist then asks the client about their experience and how it compares to other prior panic experiences. A majority of the time, the client will report that while the exercise produced symptoms that were the same or similar to those experienced during a panic attack, it was not as anxiety provoking as they felt safe in the environment:
  - If this occurs the therapist should emphasize the experience of perceived safety and relate this back to their prior learning about how the environment, events, or situation relates to their anxiety.
  - If the client does not report this, the therapist may emphasize how this situation was different in that even if the client was unaware they noticed it, they felt safer in the current environment than during their real-life experiences with anxiety and panic. Following this the therapist emphasizes the effects that perceived safety has on prior learning specifically how the environment, events, or situations relates to their anxiety.
- *Homework:*
  - Assign the client to practice deep diaphragmatic breathing at least two times a day for nine to ten cycles each, and complete the Breathing Practice Record (PD7). Make sure to emphasize that at this time clients

should only engage in this breathing while they are in safe environments and not situations of panic or anxiety.

– Remind the client to continue to engage in completing the Daily Mood Log and Panic Self-Monitoring Record (Worksheets PD1 and PD2).

a day for nine to ten cycles (Worksheet PD7). Make sure to emphasize that at this time the client should only engage in this breathing practice while they are in safe environments and not situations of panic or anxiety.

– Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Session 4

The goal of this session is to begin active cognitive restructuring with the client:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will restate that there is no actual threat related to experiencing panic attacks (Fictional Fears Worksheet PD8), emphasizing that the client's thoughts may not be facts but rather guesses about the future. Additionally, the therapist will help the client in completing the downward thinking section of this worksheet emphasizing that the arrows do not necessarily go in order and that a lot of other consequences can occur rather than only the negative ones (e.g., panic-> faint-> embarrassment ->feeling of overwhelming shame).
- The therapist will ask the client about automatic thoughts and teach them to observe these thoughts from an objective and descriptive perspective:
  - An example of a not useful thought: I feel bad so something bad will happen now.
  - I am afraid if I get too anxious around tall flights of stairs that I will jump off or fall down them and die.
- *Homework:*
  - Complete the Thought Occurrence Likelihood Worksheet (Worksheet PD9).
  - Assign the client to continue to practice and log their deep diaphragmatic breathing twice

Session 5

The goal of this session is to educate and challenge client around catastrophizing:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will educate the client on the common cognitive error of catastrophizing (viewing a situation as treacherous, intolerable, insufferable, or disastrous) and the two parts which compose it:
  1. Predicting a negative outcome.
  2. Concluding that if the negative outcome occurs, it will be disastrous.
- This should be used to both make the client aware of both their thought patterns of catastrophizing and help them realize that other things can occur (and often are more likely to occur) other than their predictions.
- The therapist should emphasize that people are very bad at predicting, that situations are often not as bad as originally thought, and that catastrophizing situations or physiological experiences increases the severity of the situation or experience.
- *Homework:*
  - Have the client continue to practice their breathing on a daily basis but also engage in the breathing exercise outside of safe settings.
  - Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Session 6

The goal of this session is to begin interoceptive exposure (IE):

!!!!!!!!!!STOP!!!!!!!!!!

*** Prior to engaging in any interoceptive exposure exercises the therapist needs to ask ***

****the client that if she/he has any health problems of any kind they should consult with ***

*****their doctor to see if these exercises are acceptable before they attempt them. *****

- This session begins with the therapist reviewing the client's homework and gathering information about their past week.
- The therapist will then provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist should educate the client on the purpose of IE. The purpose of IE is to create and repeatedly create feelings and sensations the client fears so that the fear response associated with these feelings and sensations weakens. The therapist should educate the client that often people are not aware that they avoid or escape from specific stimuli (people, places, situations, or interactions) because of the physical sensations that come along with them, for example, not running or working out because you are afraid of experiencing an elevated heart rate. Additionally, the therapist should reemphasize that while the client may experience feelings that are unpleasant, they are not dangerous and that they will eventually dissipate.
- Following providing the client with psychoeducation, the therapist should educate and establish a scale of sensation intensity with the client that can be used while they are engaging in IE. The client will use this metric to rate the intensity of their experience during IE from 0 to 100 or 0 to 10 with 0 being the most relaxed they could feel and 100 or 10 being the worst feelings they can ever experience. It is important that in establishing this metric with the client, the therapist asks them for examples of

the endpoints 0 and 100 so that they have personalized context to reference during their statements.

- Once this metric has been established, the therapist should ask the client their current score on their sensation scale and then instruct the client to engage in one of the following activities:
  - Shaking their head back and forth for 30 s
  - Holding their breath for as long as they are able
  - Placing their head between their legs while they are sitting in a chair for 30 s to 1 min and then lifting it quickly up
  - Exercising as hard as they can for 1 min (e.g., push-ups, jumping up and down, sit-ups, clenching all of their muscles as tight as they can, or running)
  - Holding a push-up position with their arms bent for as long as they are able
  - Spinning in a swivel chair for 1 min
  - Breathing through a straw while having their nose plugged for a few minutes (either plugged by them holding it shut or with nose plugs)
  - Breathing as slow as possible for 2 min
  - Looking at a mirror for 2 min:
    - Note: The therapist should match the intensity of the activity to the client's ability. For example, if the client is in very good physical shape, the therapist increases the amount of strenuous activity that they engage in.
    - Also, in instances in which the client may be engaging in exercise to, the therapist will want to inform them to bring appropriate clothes so that they are able to engage in the activities without damaging their clothes.
- These activities are meant to simulate feelings and sensations that are feared, so it is important that the therapist asks the client immediately following the activity what their current score is on their sensation scale. If the score has increased from their prior score (before they engaged in the activity), then this is an indication that the activity worked in elevating their feared sensations. The therapist should

then instruct the client to notice their discomfort and not distract themselves from it but remind themselves that their discomfort is only temporary and will soon pass.

- During this time the therapist can ask the client about what they are thinking and experiencing and record this on the Interoceptive Exposure Worksheet (Worksheet PD10).
- Once the client's scores have diminished from their reported post-activity score, the therapist should praise the client for engaging in the task and then inquire about the client's experience and what thoughts they had during their elevated feared sensations.
- The therapist should discuss with the client what misassumptions can make naturally occurring panic symptoms frightening and difficult to engage.
- *Homework:*
  - The therapist will assign the client to continue to practice their breathing in response to experiencing symptoms of anxiety.
  - Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Sessions 7 and 8

The goals of these sessions are to engage in IE and hypothesis testing:

- This session begins by having the therapist review the client's homework and gather information about the client's past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will ask the client their current sensation score and then instruct them that they can apply breathing control strategies during times of anxiety (e.g., once they have completed the IE activity).
- Next the therapist will instruct the client to engage in the same or another interoceptive exposure activity (a list of potential activities is provided in session 8. The therapist is also free to use other strategies in order to evoke feared sensation as long as they are safe for the client).

- Following completion of IE (and reported elevated score), the therapist engages in hypothesis testing with the client. The purpose of hypothesis testing is to continue with cognitive restructuring of disconfirming the client's incorrect hypotheses.
- For example:
  - Will a person fall if they do not lean on a wall while they are feeling dizzy?
  - If someone feels uncomfortable at the grocery store, can they still get groceries and take their time at the store?
    - Note: During this hypothesis testing, you want to ensure that the client is safe (e.g., the client has the ability to catch themselves or lean on a wall to prevent them from falling), but simultaneously the therapist wants to challenge them from engaging in avoiding activities.
- After engaging in hypothesis testing, the therapist should emphasize how the client is already making progress (even if they are only able to stand while dizzy without touching a wall for a few seconds).
- The therapist should end the session by again asking the client about their thoughts during the exercise and analyzing any misconceptions they may have had during this time, making sure to emphasize how well the client is currently doing after the feared thoughts and sensations have passed.
- *Homework:*
  - The therapist will have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).
  - Have the client complete the Avoidance Hierarchy Worksheet (Worksheet PD11) Avoidance Hierarchy/Fear Hierarchy (n.d). Create a panic level scale in which 0 is no fear at all and 100 is the most afraid that you can possibly imagine. Help the client identify situations which cause them anxiety or panic, and then assign a panic rating to each.

Session 9

The goals of this session are to extend IE to daily tasks that the client has avoided or dreaded experiencing:

- This session begins by having the therapist review the client's homework and gather information about their past week.
- The therapist will provide an overview of the current session to the client in order to ensure that the client does not experience any feelings of surprise or distrust that could damage the therapeutic relationship that they have built.
- The therapist will inform the client that they are going to engage in an activity that the client has indicated is very difficult for them to engage in (the client finds this very horrible or they completely avoid this activity all together):
  – These activities can be selected from the Avoidance Ladder Hierarchy Worksheet (Worksheet PD11) which the client completed as homework during sessions 7 and 8.
- Prior to engaging in these activities, the client is instructed to identify any maladaptive cognitions they have surrounding the activity and then restructure them (by themselves or with the therapist's help) prior to engaging in the activity:
  – Note: The therapist should remove safety signals or trinkets (lucky charms, cell phone, and or any ritualistic or superstitious activities) that the client may attribute the success of the activity to (e.g., I was able to ride in the taxi because I wore my lucky wristband) or allow the client to escape from engaging in the activity (e.g., I was able to ride in the taxi because I was distracting myself on my phone by texting the entire time).
- Some examples of activities may include:
  – Going to crowded areas (e.g., the mall, the grocery store)
  – Sitting in a waiting room
  – Sitting in a steamy room
  – Exercising
  – Eating foods that have been avoided but are liked (e.g., filling or spicy foods)
  – Being in a taxi
  – Walking on a cracked sidewalk
  – Watching the news

- Following IE the therapist should inquire about the client's experience and again reiterate any progress that the client made no matter how small (e.g., I was able to sit in a taxi even though it did not take me anywhere).
- *Homework:*
  – The therapist will have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).
  – Assign the client to engage in two IE activities on their own in their home. These can include any of the IE activities from session 6.

Session 10–15
The goals of these sessions are to continue to engage in in vivo exposure:

- During each session continue to work with the client on in vivo exposure moving up their personalized avoidance hierarchy as they meet each goal.
- *Homework:*
  – Have the client continue to engage in self-monitoring (Worksheets PD1 and PD2).

Concluding/Final Session
The goal of this session is to review how much progress the client has made and praise them for this progress:

- Throughout this session the therapist will review the client's progress by referencing prior difficulties and how they have overcome them.
- The therapist will use the client's self-monitoring logs as data to support the client's progress.
- The therapist will indicate to the client that if they need any additional services or maintenance sessions, they are more than welcome to contact the therapist.

Que es ansiedad?

A lo largo de nuestro trabajo juntos, vamos a usar un varios palabras y frases que son psicológicas.

Ansiedad
Esto se refiere a los nervios, el estrés, la preocupación, etc. ¿Qué significa esto para usted? (Discuta con el cliente).

Animo-Registro diario
Este es un lugar donde usted va registrar sus sentimientos y síntomas.

Sensaciones corporales
Estos son sentimientos que usted tiene en su cuerpo. Por ejemplo, esto podría ser tener palmas sudorosas o el latido del corazón muy rapido.

Interpretación errónea
Esto significa que lo que usted cree que está sucediendo, no es correcto. Por ejemplo, usted podría creer que está teniendo un ataque de corazón cuando realmente está teniendo un ataque de pánico.

Consecuencia de su actuación
Esto se refiere a lo que sucede después de algo. Por ejemplo, si usted comienza a tener un ataque de pánico en la tienda y se va de la tienda, ¿qué sucede después de que se va de la tienda?

_____

_____

_____

_____

Estado de Animo-Registro diario

0--------------1--------------2--------------3--------------4--------------5--------------6--------------7--------------8

Ninguno   **Leve**   **Moderado**   **Fuerte**   **Extremo**

Califique su ansiedad, depresión y preocupación diaria en las siguientes casillas de acuerdo con la escala anterior.

	Mañana			**Mediodia**			**Noche**		
	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio	Ansiedad Promedio	Depresión Promedio	Preocuparse de tener un ataque de pánico-Promedio
Lunes									
Martes									
Miercoles									
Jueves									
Viernes									
Sabado									
Domingo									

Semana #___ Fecha de comienzo_____ Fecha de Termino_____

Registroauto de pánico - autosupervisado   **Worksheet PD 2**

Fecha & Tiempo	Situación ¿Que pasó? ¿Quien estuvo ahí? ¿Dónde ocurrió?	Sensaciones corporales ¿Cómo te sentiste? Por ejemplo: mareado y tembloroso, doloe de cabeza leve, debilidad, dolor en el pecho, etc.	Pensamiento Negativo Interpretación errónea de la(s) sensación(es) corporal(es). Por ejemplo: "Me voy a desmayar", "Estoy teniendo un ataque de corazón", "Voy a vomitar".	Acción tomada ¿Cómo respondió al pensamiento negativo? ¿Qué acción tomaste?	Resultado (s) La consecuencia de su actuación	Otra Opción de Pensamiento (s)¿Qué te podrias haber dicho a ti mismo que te hubiera ayudado?	¿Cuántos minutos duró el pánico?

Entendiendo el Pánico
¿Qué es?

 Los ataques de pánico se describen como una experiencia en la que una persona esta envuelta en una gran ola de miedo. Experimentar miedo es a menudo una experiencia muy desagradable, pero es importante recordar que la razón por la que experimentamos el miedo es para prepararnos para el peligro. El miedo es un sentimiento que es inducido por la percepción de peligro o amenaza que nos ayuda a sobrevivir. Cuando experimentamos el miedo, nuestros cuerpos se preparan para huir de la situación (hombre A abajo) o se prepararse para luchar por nuestras vidas. Por ejemplo, si nuestros grandes antepasados no hubiesen experimentaron miedo al ver a un oso hambriento (hombre B abajo) mientras caminaban por el bosque, tal vez hayan terminado siendo la comida de ese oso, y tal vez no estaríamos aquí hoy leyendo este folleto.
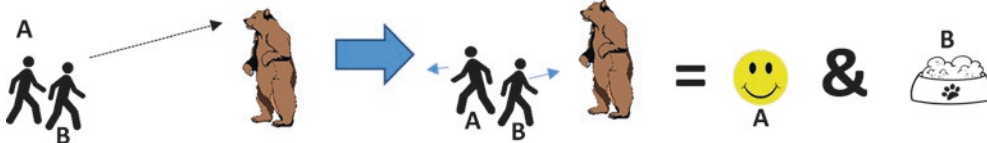
Si bien experimentar miedo puede ser de gran beneficio, también puede llegar a ser perjudicial cuando percibimos las cosas y situaciones mal, es decir, como peligrosas cuando en realidad no lo son. Estas experiencias son similares a un detector de humo que se prende cuando en realidad no hay ningun fuego. Esencialmente esto es lo que es un ataque de pánico. Es una falsa alarma. Los síntomas comunes de un ataque de pánico incluyen: (por favor marque todo aquellos sintomas que ha experimentado)

Sintomas de Ataques de Pánico

- o Corazon acelerado/ palpitaciones
- o Dolor de pecho
- o Siente asfixia
- o Dificultad para respirar
- o Sudor
- o Miedo de Morir

- o Siente que pierde el control
- o Mareos
- o Adormeciemiento
- o Nauseas
- o Siente que se sale de su cuerpo
- o Siente que pierde la razon

Los ataques de pánico pueden ser muy angustiosos y se puede sentir como si estuviera en una situación de verdadero peligro. Los síntomas pueden hacerle sentir como si se tuviera una condición médica, y es por eso, que muchas personas van a los cuartos de emergencia; pero luego descubren que no estaban enfermos. Un ataque de pánico pudiese ocurrir sola una vez o puede experimentar episodios repetidos. Los ataques recurrentes a menudo son provocados por una situación específica, como cruzar un puente o hablar en público, esto es más probable si esa situación ha causado un ataque de pánico antes. Por lo general, la situación que conduce al pánico es aquella en la que uno se siente inseguro e incapaz de escapar y le pueden llevar a retirarse de las actividades normales. Si no se tratan, pueden conducir al "Trastorno de pánico" y otros problemas. Los ataques de pánico pueden ser curados, lo mas pronto que lo haga lo mejor que será su resultado. El tratamiento le puede ayudar a reducir, manejar o eliminar los síntomas de pánico y le ayuda a parar de excluirse y asi poder disfrutar su vida.

Fisiología de Luchar o Huir   **Worksheet PD 4**

La mayoría de los síntomas angustiantes que experimenta una persona durante un ataque de pánico son los cambios físicos que se producen como resultado de la respuesta de lucha o huida. Esta respuesta se produce como resultado de nuestro cuerpo preparándose para luchar o huir de una amenaza. Estos cambios fisiológicos son útiles si nos encontramos con una amenaza (como un oso) con la que debemos luchar o huir, sin embargo no son útiles y nos sentimos incómodos cuando no existe amenaza.

A continuación se presentan ejemplos de aspectos positivos y negativos que resultan de la respuesta de lucha o huida. Por favor circule cada experiencia que se aplica a usted.

Pensamientos continuos y rapidos
+ Un pensamiento más rápido nos ayuda a evaluar el peligro y tomar decisiones más rápidas
- Puede ser difícil enfocarse en cosas que no sean el peligro

Cambios en la visión
+ La visión puede ser aguda para poder prestar más atención al peligro
- Puede experimentar la visión de túnel

Boca seca
+ La digestión se cierra durante situaciones peligrosas
- La boca se seca y comer se hace difícil

Cambios en la respiración
+ La respiración se hace más rápida y superficial para absorber más oxígeno a nuestros músculos
- Si este oxígeno no se usa, podemos sentirnos mareados o aturdidos

Aumento de la frecuencia cardíaca
+ Frecuencia cardiaca más rápida aumenta el suministro de nutrientes a los músculos para prepararse para participar o escapar a la amenaza
- La frecuencia cardíaca rápida puede conducir a un aumento de la presión arterialconducir a un aumento de la presión arterial

Siente náuseas
+ La sangre es desviada del sistema digestivo para prepararse para luchar o hui
- Esto puede conducir a náuseas, malestar estomacal o trastornos gastrointestinales

Incremento de Adrenalina
+/- La adrenalina aumenta la intensidad de los cambios fisiológicos

Manos y pies sudorosos
+El cuerpo suda para mantener los músculos frescos
- Las manos y los pies sudorosos pueden resultar incómodos

Enfriamiento de manos y pies
+ Los vasos sanguíneos se contraen para aumentar el flujo sanguíneo a los músculos principales
- Las manos y los pies pueden enfriarse

Aumento general de la tensión muscular
+ Músculos en todo el cuerpo se tensan para prepararse para confrontar o escapar de la situación
- Los músculos pueden temblar para poder usar el exceso de energía

Por favor liste cualquier otro síntoma de ansiedad que experimente:
_____
_____
_____
_____

La Biología de la Ansiedad y el Pánico

Una característica clave del "Trastorno de pánico" son los ataques de pánico. Los ataques de pánico pueden verse como una combinación de síntomas biológicos y psicológicos. Cuando nuestros cuerpos creen que estamos en peligro pasan por cambios fisiológicos que nos preparan para responder físicamente a una amenaza y nos preparan para pelear o huir de la situación.

Las reacciones biológicas de la respuesta "luchar o huir" pueden incluir pero no están limitadas a:

- Aumento en la fuerza y el numero de latidos cardíacos.
    - Estos cambios aumentan la cantidad de flujo sanguíneo y el transporte de productos químicos esenciales como el oxígeno en todo el cuerpo
- Aumento de la frecuencia y profundidad de la respiración.
    - Más oxígeno se introduce en el cuerpo para prepararlo para la actividad de supervivencia.
- Sudoración.
    - Un aumento de la cantidad de sudor ayuda a bajar la temperatura de la piel, lo que ayuda a enfriar el cuerpo preparando para las actividades que se necesitan para la supervivencia.
- La tensión muscular aumenta en todo el cuerpo
    - Aumento de la tensión muscular avisa a los grupos de musculos principales el prepararse para las actividades que se necesitan para la supervivencia.

Reacciones Biológicas de la Respiración Ansiosa y la Hiperventilación

Con cada respiración inhalamos oxígeno y exhalamos dióxido de carbono. Si bien es bien sabido que nuestros cuerpos necesitan oxígeno para funcionar, es menos conocido que necesitamos un equilibrio de oxígeno y dióxido de carbono para que nuestros cuerpos sean más eficientes. Cuando nos ponemos ansiosos, aceleramos la respiracion, lo que crea un desequilibrio entre estos dos gases esenciales. Para ayudar a regular este desequilibrio, nuestros cuerpos liberan una variedad de químicos que producen síntomas tales como sentirse mareado, confundido, sin aliento, con un aumento de la frecuencia cardíaca, visión borrosa o experimentando entumecimiento en las extremidades del cuerpo. Estos síntomas pueden ser angustiosos para cualquiera, pero para las personas con pánico estos sensaciones pueden ser especialmente angustiosos, ya que pueden ser vistos como un ataque venidero. <u>Es importante recordar que estos síntomas están en gran parte relacionados con el exceso de respiración, y no con un problema fisiológico.</u>

Psicología de la Ansiedad y el Pánico

En la hoja de trabajo PD5 "Biología de la ansiedad y el pánico", describimos los síntomas físicos que están asociados con el pánico (lea la hoja de trabajo PD5 antes de leer esta hoja de trabajo). Las personas que experimentan pánico son muy buenos observando y notando los síntomas físicos. Ellos continuamente se dedican a escanear y re-escanear sus cuerpos para identificar estas sensaciones físicas. Estas exploraciones se hacen continuamente, y se convierten en un hábito automático, en el que una vez que se perciben estas sensaciones se interpretan como un signo de peligro inminente. Esta manera de pensar puede dar lugar a interpretaciones equivocadas en las que se cree que hay algo que está mal con ellos, que están perdiendo el control, o que se están volviendo locos.

Tipos de pensamientos equivocados. Pueden incluir estos ejemplos pero no están limitados a:

- Sobreestimar la probabilidad de que ocurra un ataque de pánico.
  - Creyendo que si algo sucede o no sucede la probabilidad de un ataque de pánico aumenta drásticamente
    - "Voy a tener un ataque de pánico si hay un montón de tráfico en mi camino al trabajo".
- Sobreestimar el costo de tener un ataque de pánico.
  - Creer que el resultado de tener un ataque de pánico será extremadamente severo tive.
    - "Si tengo un ataque de pánico, mi fin de semana se arruinará".
- Tener pensamientos catastróficos sobre sensaciones físicas normales.
- Believing that the experience of anxious physical sensations are indications of nega health outcomes
  O Creyendo que la experiencia de las sensaciones físicas ansiosas son indicaciones de resultados negativos para la salud
  -
    - "Mi corazón esta acelerado, estoy teniendo un ataque al corazón"

Reacciones psicológicas que permiten que el pánico continue

Cuando las personas experimentan síntomas de ansiedad o pánico a menudo tratan de encontrar una manera de reducirlo o controlarlo. Una forma en que la gente hace esto es evitando cosas que les hacen experimentar las sensasiones de ansiedad o pánico. Esto puede incluir evitar situaciones donde una persona ha experimentado un ataque de pánico anterior, situaciones que provocan sensaciones similares de pánico (por ejemplo, tener relaciones sexuales, enfadarse, beber cafeína, actividad física) o situaciones en las que es difícil escapar o obtener ayuda Por ejemplo, conducir durante horas de tráfico pesado, usar el transporte público, áreas congestionadas). Esta acción se llama "Evadiendo" y si bien puede ser una estrategia exitosa en el corto plazo, los efectos a largo plazo puede ser muy perjudicial para el bienestar de una persona y la calidad de vida. Además de esto ultimo, estas personas, con frecuencia, se involucran en el uso de comportamientos que les permitan asegurarse que son capaces de hacer frente o escapar de una situación. Estos comportamientos,por ejemplo, pueden tomar la forma de estar de pie cerca de una pared para apoyarse en caso de que comienzan a sentirse débil o mareado, permaneciendo cerca de una salida por si surge un peligro, o distraerse de su ansiedad leyendo algo, escuchando música, cantando / tarareando, repitiendo un mantra, o tratando de asegurarse de que todo estará bien. Mientras que éstos comportamientos no parecer ser dañinos en el nivel superficial, pueden perjudiciales si la gente llega a ser dependiente de el uso de estos mismos. Ademas, la persona puede sentirse aún más angustiado si se encuentra en una situación en la que no puede utilizar estas estrategias.

Práctica de Respiración-Registro

0----------1----------2----------3----------4----------5----------6----------7----------
Ninguno   Leve   Moderado   Fuerte   Extremo

Después de cada práctica (dos por día) por favor evalue su concentración con respecto a su respiración, contando internamente durante el ejercicio, y su éxito con la respiración profunda diafragmática. Utilice el sistema de evaluacion anterior para evaluar su puntaje.

Fecha	Hora en que realize su session	Sesión de práctica respiratoria #	Concentración en Respirar y contar	Exito con su Práctica de Respiración
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		
		1		
		2		

<u>Miedos ficticios</u>

Este folleto le proporcionará una visión general de algunos malentendidos y malas interpretaciones que son comunes entre las personas que sufren de ansiedad y pánico. Las personas con trastorno de pánico a menudo malinterpretan las sensaciones físicas como algo que está seriamente mal con ellos. Dado que la mayoría de las personas no tienen una explicación clara de las sensaciones que están experimentando a menudo creen que están teniendo graves problemas mentales o físicos. Dado que estas sensaciones son interpretadas como algo peligroso, pueden desencadenar más ansiedad y respuestas de pánico. Con el fin de comprender mejor el "pánico" le explicaremos cuatro malentendidos que son comunes con respecto de los síntomas de ansiedad.

Desmayos, Caídas y Colapsos

Es común que algunas personas con pánico crean que en cualquier momento que experimenten mareos o aturdimiento, crean que se caerán, se desmayarán o se derrumbarán. Sin embargo, esta respuesta de ansiedad implica directamente un aumento en la presión sanguínea global que disminuye la probabilidad de que la persona se desmaye. Esto se debe a que el desmayo realmente implica una disminución o caída de la presión arterial. Esto tiene sentido ya que la respuesta de lucha o huida aumenta el estado de alerta de la persona, y no los hace más propensos a desmayarse ante el peligro.

Sentir como si se estuviera volviendo loco

Algunas personas creen que cuando experimentan pánico es una señal de que se están volviendo locos o fuera de su mente. Esto puede ser muy aterrador si estos síntomas se producen a menudo, ya que pueden aumentar el nivel de angustia general de una persona y aumentar la fuerza de su creencia. Mientras que los síntomas de la respuesta "luchar o huir" pueden ser aterradores y angustiantes, son muy diferentes de los síntomas de enfermedades mentales severas (por ejemplo Schizophrenia, desorden bipolar, depresión crónica)

Teniendo un ataque al corazón

Las personas que experimentan pánico pueden creer que sus sensaciones de pánico y sus experiencias son signos de un ataque al corazón. Esto se deriva de la creencia de que experimentar la falta de aire y tener dolor en el pecho es idéntico a la experiencia de tener un ataque al corazón. Dado que la mayoría de las personas no han experimentado un ataque al corazón no entienden las diferencias entre tener un ataque al corazón y tener un ataque de pánico. Experimentar dolor agudo en el centro del pecho que se extiende hasta el hombro o el brazo izquierdo es un signo clásico de experimentar un ataque al corazón. Además, el dolor que se asocia con un ataque al corazón no aumenta como resultado de la respiración excesiva. Además, una diferencia adicional es que las sensaciones de enfermedad cardíaca se correlacionan con el esfuerzo y disminuyen al descansar, mientras que los ataques de pánico pueden ocurrir durante los períodos de descanso o esfuerzo.

Es fácil ver cómo estas creencias pueden mantener y exacerbar los síntomas. Al aprender a desafiar estos conceptos erróneos y creencias falsas, las personas son más capaces de entender sus experiencias. Esto es de gran beneficio, ya que pueden empezar a vivir experiencias en lugar de evitarlas.

Frecuencia de Pensamientos

Registre su pensamiento negativo inicial y cheque el pensamiento equivocado que corresponde. Entonces,use la escala debajo de 0 a 100 indicando la probabilidad de que este pensamiento ocurrirá. Esto significaque una puntuación de 0 indica que el pensamiento imaginario negativo no ocurrirá, donde una puntuación de 100 indica que definitivamente ocurrirá. Después de esto, registre un nuevo pensamiento o pensamientos tomando en cuenta la evidencia real y las maneras de hacerle frente.

0------------------25------------------50------------------75------------------100

NO ES PROBABLE   **Moderadamente Probable**   **Definitivamente Probable**

Fecha	Hora	Situación	Primer Pensamiento Negativo	Pensamiento Equivocado		Probabilidad Realistica	Pensamiento Nuevo
				Conclusiones Automaticas	Actuando fuera de proporción		

Registro de exposición interoceptiva

Si tiene algún problema de salud o problemas de salud física, consulte a su médico para ver si estos ejercicios son aceptables antes de intentarlo.

FECHA	Actividad	Sintomas	Pensamientos	Anxiedad (0-100)		
				Antes	Punto mas alto	Despues
Ejemplo: 1/1/2017 Lunes	**Respirando Rapido** (Respiré rápidamente y superficialmente durante 1,5 minutos)	Casi no puedo respirar y mi corazon esta acelerado	Espero no tener un ataque al corazón, No, solo estaba hiperventilando	65	87	59

Evadiendo - Escalera de Jerarquías

Ahorra usted va construye una escalera de las cosas que le provoca panico y que usted evita. A cada situación que usted pone en su escalera usted va indicar que nivel de panico le causa.

0--50--100

Una vez que haz construido la escalera, trabajaras en enfrentar estas situaciónes empezando de la parte de abajo hacia la parte de arriba durante tus sesiones de terapia.

Situatión	Nivel de panico % (0-100)

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Tools for Treating Obsessive-Compulsive Disorder Among Latinos

Monnica T. Williams, Judy Mier-Chairez,
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Prevalence of Obsessive-Compulsive Disorder Among Latinos

Obsessive-compulsive disorder (OCD) is a severe illness that has been considered one of the top ten causes of disability worldwide, with a global burden comparable to that of schizophrenia (Ayuso-Mateos, 2006; Lopez & Murray, 1998). OCD includes the experience of intrusive distressing thoughts, urges, and/or images and accompanying behaviors done in an attempt to neutralize the resulting anxiety (American Psychiatric Association [APA], 2013). Individuals with OCD may struggle with obsessions and compulsions for up to 17 hours a day or more (Gallup, 1990). OCD is highly disabling, with

nearly two-thirds of those afflicted reporting severe role impairment (Ruscio, Stein, Chiu, & Kessler, 2010). People with OCD have much higher rates of unemployment (22% vs. 6%; Koran, Thienemann, & Davenport, 1996). The vast majority of individuals with OCD meet criteria for an additional mental disorder (90%), with 40.7% also suffering from major depressive disorder and 38.6% suffering from a comorbid substance use disorder (Ruscio et al., 2010). Lifetime prevalence rates for OCD are estimated at 1.6–2.3% (Kessler et al., 2005; Ruscio et al., 2010).

The National Latino and Asian-American Study (NLAAS) found that Latino/as experience equal rates for most major mental health issues compared to the overall population (Alegria et al., 2007); however, that study did not assess for the presence of OCD. The National Comorbidity Survey Replication (NCS-R; $N = 5424$) compared mental health prevalence rates in different ethnoracial groups (Breslau et al., 2006) and indicated that Latino Americans had three times the prevalence rate of OCD than European Americans, although this finding was not significantly different. Another study comparing OCD prevalence in European Americans and the Mexican American Latino subgroup found no significant differences (Karno et al., 1989). Thus, it may be most appropriate to report OCD prevalence at the subgroup level, but the extant literature is lacking as data is mostly unavailable. Lack of information is likely the

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result of difficulty recruiting Latinos for mental health research studies (Wetterneck et al., 2012) and cultural nonequivalence of OCD measures (e.g., Williams, Turkheimer, Schmidt, & Oltmanns, 2005).

OCD Symptoms in Latinos

OCD symptom differences in Latino Americans also remain widely unexplored compared to other groups. OCD is a heterogeneous disorder, and it is important to accurately understand symptom differences cross-culturally because patients without the most common presentations (i.e., compulsive washing and overt repetitive checking) may not be quickly identified by medical professionals. One study that did focus on symptom differences in a nonclinical sample found that Latino/a Americans demonstrated a higher rate of contamination symptoms than European Americans (Williams et al., 2005). Another study compared six symptom dimensions of OCD in a nonclinical sample and found equal rates among most dimensions (i.e., hoarding, obsessing, neutralizing, washing, and ordering), but European Americans were significantly higher on checking than Latino/as (Burgess, Smith, Cervantes, & Wetterneck, 2009). However, findings may differ in a clinical population; thus, it is important to examine these constructs in clinically diagnosed samples. There have been some studies on OCD in Hispanic countries, and overall findings appear to suggest a predominance of contamination, symmetry, and sexual obsessions, as well as washing, checking, cleaning, and repeating compulsions (Chavira et al., 2008; Nicolini et al., 1997). Findings from cross-national epidemiological research indicate differences in OCD symptomology across Latino and European American populations, particularly in the content of obsessions, which may be due to sociocultural influences (Chavira et al., 2008).

One large study comparing European American (N = 3986) and Latino American (N = 473) adults found that Latino/as may have higher levels of interpersonal functioning and

social support, but an OCD diagnosis was significantly related to problems with interpersonal functioning (Hernandez, Plant, Sachs-Ericsson, & Joiner, 2005). The resulting impairment could be particularly damaging in youth, who are still struggling to develop their identities. This may result in increased enmeshment with family, which may be more problematic in more collectivistic cultures, such as Latino culture. A recent study of young adults supported this need for investigation as they found that lower familial social support and higher familial stress correlated to higher OC symptoms in Latino, but not in European or African Americans (Sawyer et al., 2013). Given that acculturated adolescents are at increased risk for mental health issues than their less acculturated peers (Gonzales, Deardorff, Formoso, Barr, & Barrera., 2006), acculturation and parenting styles may be important variables.

Another important consideration for the Latino population is the evidence that individuals in this group often express symptoms related to mental health disorders, such as anxiety and depression, in the form of physical complaints (i.e., somatization; Chavira et al., 2008; Guarnaccia, Martinez, & Arcosta, 2005). A clinician without this knowledge may only look for cognitive and behavioral symptoms and potentially miss an OCD diagnosis. Religiosity in the Latino population is another factor clinicians should consider. Fifty-nine percent of Latino/as in the USA identify as Catholic, almost triple the percentage of European Americans (Kosmin & Keysar, 2009). Given that Catholics are more likely to have OCD than other religious groups (Himle, Taylor, & Chatters, 2012), religion may be an important factor in the phenomenology of OCD in the Latino population. Specifically, in Catholic individuals who are highly religious, a belief that thoughts are very important is predictive of OC symptoms (Sica, Novaro, & Sanavio, 2002).

Treatment for OCD in Latinos

There is a persistent mental health disparity among Latino Americans compared to European Americans. At approximately 16% of the US

population, the Latino population is expanding at a rate beyond the current research capacity necessary to understand the nature of their risks for psychiatric disorders. Although, the NLAAS epidemiological study did not assess participants for OCD, leaving a vast chasm in our knowledge of the disorder in this underserved population, the study did demonstrate that while U.S.-born Latinos were beginning to use more mental health services, they did so at a lower rate. Interestingly, Latino/as have demonstrated similar utilization of mental health services from social service agencies or general physicians compared to European Americans, but significantly less services from mental health professionals (i.e., psychologists, psychiatrists, and therapists; Alegria et al., 2002). Overall, less than 9% of those with a mental disorder contact a mental health professional and fewer than 20% of these individuals seek help through a general health care provider. The higher number seeking treatment from general health care providers is likely in part due to the tendency of Latino/as to somaticize mental health symptoms, as mentioned previously (Wetterneck et al., 2012). Recent immigrants are even less likely to seek out these services (U.S. Department of Health and Human Services [USDHHS], 2001), even though the very process of immigration may increase stress. An important additional barrier is that twice as many Latino/as are uninsured compared to European Americans (U.S. Census, 2015), although this may be changing with the enactment of the Affordable Care Act (Alexander, Billow, Bufka, Walters, & Williams, 2016).

Despite differences in the OC symptoms and service utilization reported between Latino/as and European Americans, no culturally specific assessment or treatment for Latino/a Americans with OCD has been developed. Research has noted an absence of Latinos being assessed or treated at OCD specialty clinics (Foa et al., 1995; Williams et al., 2015), which supports the epidemiological finding that these groups are undertreated and less likely to receive the most effective treatments for OCD. Based on current knowledge, exposure and response prevention (EX/RP) is the recommended course of treatment, as it has been shown to be efficacious in other groups (Abramowitz, 2006), though it should be noted that conceptualization of OC symptoms in ethnic minority groups using the cognitive-behavioral model remains in question (Wheaton, Berman, Fabricant, & Abramowitz, 2013).

A Treatment Plan

At the initiation of treatment, the client's language preference should be obtained. Though a Latino/a client may be bilingual, speaking in the client's *preferred* language has been shown to lower drop-out rates (Paris, Anez, Bedregal, Andres-Hyman, & Davidson 2005; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Latino/a clients should not only be matched with a clinician by language but also, when possible, with a clinician of a similar ethnic background, also keeping in mind that Latino/as are a heterogeneous group. Latino/as are similar to other ethnic minority populations in that they face a strong cultural stigma against mental health disorders. Being clear at the beginning of treatment about confidentiality could help push past some of the reticence to disclose. Clinicians may also choose to emphasize the directive, task-oriented, and generally short-term nature of EX/RP treatment because of the evidence that Latino/as prefer directive methods (Anger-Diaz, Schlanger, Ricon, & Mendoza, 2004; Santisteban et al., 2003). In addition to the exposure and response prevention protocol detailed below (based on Foa, Yadin, & Lichner, 2012; Yadin, Lichner, & Foa, 2012), the clinician should be aware of and incorporate cultural values held by many Latino/as such as religious faith and close family relationships. This is particularly important for establishing a therapeutic alliance. The treatment plan below lists names of measures, worksheets, and handouts in Spanish, shown in Table 7.1; however, their English counterparts are also available if the client prefers English.

Table 7.1 List of Spanish tools for OCD

List of work sheets and tools (provided)	Description
A. El Ciclo de TOC *The OCD cycle*	This handout describes the process by which obsessions are followed by anxiety, which then are followed by compulsions, and finally symptom relief.
B. Trastorno Obsesivo-Compulsivo Dimensiones de los Síntomas *Obsessive-compulsive disorder symptom dimensions*	This handout describes the various symptom dimensions of OCD, which include contamination symptoms, symmetry and organization, unacceptable/taboo thoughts, doubts, and harm. The work sheet also provides a list of associated disorders.
C. Pensamientos Inaceptables/ Tabú *Unacceptable/taboo thoughts*	This handout describes various types of unacceptable/taboo thoughts, which include sexual, scrupulosity, aggression, and other related thoughts.
D. Información Sobre el Trastorno Obsesivo-Compulsivo *Information on OCD* (Foa, Yadin, & Lichner, 2012; Yadin et al., 2012)	This handout describes some basic facts about OCD in order to help give the client some answers around common questions. The information provided describes symptoms of OCD, what causes OCD, how a person can get OCD, and two important associations in OCD.
E. Supresión de pensamientos y pensamientos intrusivos *Thought suppression and intrusive thoughts* (Psychology Tools)	This fact sheet describes the process of thought suppression and how trying not to think of something results in thinking more about it.
F. Exposición y Prevención de la Respuesta *Exposure and response prevention* (Psychology Tools)	This work sheet describes exposure and ritual prevention and how it requires the person to expose themselves to the trigger and resist completing the compulsion. It also provides a graph for the person to track their SUDS with the exposures.
G. Auto Monitorización de Rituales *Self-monitoring of rituals* (Foa et al., 2012; Yadin, Lichner, & Foa, 2012)	This work sheet helps the person track the rituals they perform each day. It consists of fill-ins that requests what ritual was performed, what time it was performed, what triggered it, the person's associated SUDS level, and how much time was spent on the ritual.
H. Dimensional OCD scale (DOCS; Abramowitz et al., 2010; López-Solà et al., 2014; Wetterneck, Siev, Smith, Adams, & Slimcowitz, 2015)	The DOCS is a self-report measure that assesses the four most common OCD symptom dimensions: contamination, responsibility for harm, unacceptable thoughts, and symmetry, completeness, and exactness. We also include a new supplementary subscale for sexually intrusive thoughts (DOCS-SIT).
I. Jerarquía de Evitación *Avoidance hierarchy* (Psychology Tools)	This work sheet has a ladder on the left side of it and two columns on the right. In the instructions it asks the person to create a hierarchy/ladder of situations or places they avoid and to also list the associated anxiety level.
J. Experimento de Comportamiento *Behavioral experiment planning* (Psychology Tools)	This work sheet helps the person process the various steps in a behavioral experiment. It is divided into four different sections: prediction, experiment, outcome, and learning. Each section has questions that prompt the individual to help them describe what they thought would happen, what they did, what ended up happening, and what they learned.
K. Hoja de Tareas Diarias *Daily homework work sheet*	This work sheet helps the person track and describe details of their exposure homework assignments. The work sheet consists of fill-ins where the therapist writes the type of exposure and then the client fills in how long it lasted, when it occurred, and the associated SUDS level for each exposure. This creates a record of the exposures clients have completed for homework and tracks how the SUDS level has changed.
L. TOC Prevención de Recaída: Consejos Rapidos *OCD relapse prevention handout*	This handout explains what to expect after treatment, including that occasional unwanted thoughts are normal, often brought on by stress. It reminds clients to keep resisting compulsions, practice exposures as needed, and how to identify a relapse.

Session Outline

Session 1: Treatment Planning – Setting the Stage
1. The Basics
   (a) Begin the session with introductions to help the client familiarize themselves with you. Describe the plan for the session explaining that it will consist largely of information gathering and laying the foundation for the treatment approach.
2. Psychoeducation and Information Gathering
   (a) Describe the "El Ciclo de TOC" (Appendix A) document to explain this model of the disorder and how compulsions strengthen the OCD.
   (b) Inquire about the client's experience of OCD including history and symptom description using "Trastorno Obsesivo-Compulsivo Dimensiones de los Síntomas" (Appendix B) as an aid. If the client has any taboo thoughts, then also review "Pensamientos Inaceptables/Tabú" (Appendix C).
   (c) Use the "Información Sobre el Trastorno Obsesivo-Compulsivo" form to define OCD and its components (Appendix D).
   (d) Guide the client to make a link between their obsessions and compulsions.
3. Why EX/RP? The Rationale
   (a) Provide a thorough explanation for the use of exposure/response prevention treatment, specifically its aim to disrupt the associations that feed OCD.
   (b) Recommended worksheet: "Exposición y Prevención de la Respuesta" (Appendix F).
4. What is EX/RP?
   (a) Outline the highlights of EX/RP treatment such as when you will build the exposure hierarchy, when exposures will begin, and the homework schedule.
   (b) Acknowledge that treatment may at times be taxing but also emphasize that substantial time and effort are necessary for positive outcomes.
   (c) Allow time for any questions the client may have.
5. Self-Monitoring and Homework
   (a) Describe, practice, and troubleshoot self-monitoring of rituals.
   (b) Assign the "Auto Monitorización de Rituales" (Appendix G) worksheet to be completed daily and brought to the next session.
   (c) The client is also to review the "El Ciclo de TOC" (Appendix A) document daily to reinforce this model of the disorder.
6. Measurement
   (a) Give the client the DOCS (Appendix H) to get a baseline of symptom severity by symptom dimension.

Session 2: Treatment Planning – In Depth
1. Review Homework
   (a) Go over the self-monitoring work sheets, providing clarifications, and making corrections as necessary.
   (b) Discuss "Información Sobre el Trastorno Obsesivo-Compulsivo" (Appendix D), answer any questions, and ask the client to identify two types of associations that occur in their experience of OCD.
2. Review the Rationale for EX/RP
3. OCD Symptom Information Gathering
   (a) Expand upon the discussion in session 1 on the client's OCD symptoms, gathering more details.
   (b) Introduce the subjective units of distress scale (SUDs) and instruct the client on how it is to be used.
   (c) Set SUDs anchor points (0, 50, 100).
   (d) Ask the client to describe specific situations, thoughts, and images that cause distress and have them rate SUDs for each.
4. Create a Treatment Plan
   (a) Use the information collected to select items for exposure based on SUDs ratings.
   (b) Build the exposure hierarchy using the "Jerarquía de Evitación" form (Appendix H).
5. Commitment
   (a) Revisit the conversation on the time and effort necessary for treatment and garner an agreement from the client toward this end.
   (b) Emphasize the importance of complying with the exposure plan (both in session

and at home) and the rules for ritual prevention.

(c) Answer any questions.

6. Homework

(a) Self-monitoring of rituals.

(b) Review OCD informational handouts for reinforcement of this model.

Session 3: Exposure and Ritual Prevention

1. Review Homework

(a) Go over the self-monitoring work sheets providing clarifications and making corrections as necessary.

2. Client Explanation of OCD Model

(a) Ask the client to describe the model of OCD, and how it is relevant to their treatment.

(b) Have the client provide the rationale for using EX/RP.

3. In-Session Exposure

(a) Recall the exposure plan, guided by the hierarchy, and do the exposure exercise (imaginal and/or in vivo).

(b) Therapist should demonstrate exposure to client before asking client to do it.

(c) Use the "Exposición y Prevención de la Respuesta" (Appendix F) to illustrate how the exposure and habituation work.

(d) If the client is unwilling to do an exposure, consider a behavioral experiment instead, using "Experimento de Comportamiento" (Appendix J).

4. Prepare for Exposure Homework

(a) Explain the importance of practicing exposure independently in between sessions with the therapist.

(b) With the client, select items from the hierarchy for exposure homework.

(c) Ensure the client is familiar with how to use the "Hoja de Tareas Diarias" (Appendix K) work sheet to track their homework.

5. Ritual Prevention

(a) Provide specific instructions for ritual prevention.

6. Homework

(a) Continue self-monitoring of rituals daily using the "Auto Monitorización de Rituales" (Appendix G) work sheet.

(b) Do the agreed upon exposure practice homework.

Sessions 4–15: Exposure and Ritual Prevention

1. Review Homework

(a) Go over the self-monitoring work sheets and, if necessary, bring attention to any problems with ritual prevention.

(b) Go over "Hoja de Tareas Diarias" (Appendix K) form to monitor exposure practice homework.

2. Review Progress

(a) Make time to review the client's progress regularly and also ask them to share any changes, struggles, or obstacles they have noticed.

3. In-Session Exposure

(a) Use the hierarchy to systematically continue with exposures in session.

4. Homework

(a) In session, assign exposure practice homework to be completed before the next session.

(b) The client is also to continue self-monitoring of rituals tracking daily for review in the following therapy session.

Sessions 16–17: Home Visits

1. Review Progress in New Setting

(a) It is recommended that the therapist conduct home visits during or after the office therapy sessions have ended. This allows the therapist to observe the home environment and the client's functioning in it as well as provide instructions for exposure exercises in this environment.

(b) The "home visit" does not have to be at the client's home and should be relocated if the client particularly struggles with OCD symptoms in another environment such as work, public places, etc.

(c) Note areas of concern to address during home visit.

2. Assess Progress

(a) Give the client the DOCS (Appendix H) to determine improvement for each symptom dimension.

Sessions 18–19: Relapse Prevention

1. Review Homework

(a) Go over the "Hoja de Tareas Diarias" (Appendix K) to monitor success with exposure practice homework.

2. Review Progress
   (a) Review the hierarchy to ensure mastery of all items.
3. In-Session Exposure
   (a) Ask the client to identify any areas of lingering difficulty.
   (b) Invite the client to devise his/her own exposure for managing the obsession.
   (c) Conduct the client-devised exposure during the session.
4. Homework
   (a) Advise the client to devise his/her own exposures for daily homework based on any current concerns using the "Hoja de Tareas Diarias" (Appendix K).
   (b) Ask the client to make note of any areas of difficulty.

Session 20: Final Session
1. Review Homework
   (a) Review the "Hoja de Tareas Diarias" (Appendix K) to monitor success with self-devised exposures.
2. Provide guidelines for normal behavior and discuss this with client (i.e., typical washing, cleaning, checking, etc.).

3. Assess Progress
   (a) Give the client the DOCS (Appendix H) to confirm improvement for each symptom dimension.
4. Review typical causes and signs of relapse and give the handout "TOC Prevención de Recaída: Consejos Rapidos" (Appendix L).
5. Make a plan for follow-up check in appointments in 3–6 months.

Spanish Language Tools for Assessment and Treatment of OCD

There are several psychological assessments that may be used when evaluating a Latino/a client for OCD symptoms. Various measures have been translated into Spanish, many of which have been validated with Latino/a clinical samples. Translated measurement tools include the Yale-Brown obsessive-compulsive scale (Y-BOCS), dimensional obsessive-compulsive scale (DOCS), and obsessive-compulsive inventory-revised (OCI-R). See Table 7.2 for a detailed list of preferred measures when assessing for OCD in Latino/as.

Table 7.2 Common validated measures for OCD

Measures for youth	Description
Mini-international neuropsychiatric interview for children/adolescents MINI-KID; Sheehan et al., 2010)	A semi-structured clinical interview, designed to aid in making reliable DSM-IV and ICD-10 psychiatric diagnoses, including OCD. The MINI-KID provides information about the participant's age of onset and comorbid conditions. It is available in Spanish
Children's Yale–Brown obsessive-compulsive scale – Severity Scale and Checklist (CY-BOCS; Scahill et al., 1997)	The CY-BOCS is a 10-item, semi-structured clinician-rated severity scale for OCD with subscales for obsessions and **c**ompulsions, and a total severity score. A Spanish version was found to have good psychometric properties (Ulloa et al., 2004). A checklist of 60 items assesses the presence of specific OC symptoms
Obsessive-compulsive inventory – Child version (OCI-CV; Foa et al., 2010)	This is a 21-item pediatric self-report measure of OCD severity, validated in youth aged 7–17. The OCI-CV includes subscales consisting of doubting/checking, obsessing, hoarding, washing, ordering, and neutralizing
Measures for adults	Description
Mini-international neuropsychiatric interview (MINI; Sheehan et al., 1998)	The MINI is a semi-structured clinical interview that provides information about the participant's psychiatric diagnoses, age of onset and comorbid conditions, including OCD. The measure is also available in Spanish
Yale–Brown obsessive-compulsive scale – Severity Scale and Checklist (Y-BOCS; Goodman et al., 1989)	The Y-BOCS is a 10-item clinician-rated scale that measures obsessions and compulsions. The psychometric properties of the Y-BOCS have been examined in a non-clinical sample of Latino Americans (Washington, Norton, & Temple, 2008). Available in Spanish
Yale–Brown obsessive-compulsive scale – Severity Scale and Checklist II (YBOCS-II; Storch et al., 2010)	The YBOCS-II is a revised version of the Y-BOCS (Goodman et al., 1989) that can provide a method of assessing symptom presence and severity
Obsessive-compulsive inventory-revised (OCI-R; Foa et al., 2002)	The OCI-R is an 18-item self-report measure that yields distress ratings over the past month for six symptom areas: washing, checking, ordering, obsessing, hoarding, and neutralizing. It is available in Spanish (Malpica, Ruiz, Godoy & Gavino, 2009)
Dimensional OCD scale (DOCS; Abramowitz et al., 2010; López-Solà et al., 2014; Wetterneck et al., 2015)	The DOCS is a 20-item self-report measure that assesses the four most common OC symptom dimensions: contamination, responsibility for harm, unacceptable thoughts, and symmetry, completeness and exactness. The sexually intrusive thoughts supplementary scale is also included (DOCS-SIT) in Spanish (Appendix H)
Florida obsessive-compulsive inventory (FOCI; Storch et al., 2007)	The FOCI is a new self-report questionnaire that has separate scales for symptom enumeration (the checklist) and evaluation of symptom severity (severity scale)
Clark-Beck obsessive-compulsive inventory (CBOCI; Clark, Anthony, Beck Swinson, & Steer, 2005)	The CBOCI is a 25-item measure developed to assess frequency and severity of obsessive and compulsive symptoms. Available in Spanish (Belloch, Reina, García-Soriano, & Clark, 2009)
Obsessive belief questionnaire – brief version (OBQ-44; Steketee, 2005)	The OBQ-44 contains three factors corresponding to empirically distinguishable belief domains: (a) the tendency to overestimate threat and perceived responsibility, (b) the need for perfectionism and certainty, and (c) overestimates of the importance of and need to control thoughts
Family accommodation scale (FAS; Calvocoressi et al., 1995)	The FAS is a 12-item semi-structured interview to assess the degree to which family members assist people with OCD in their rituals or avoidance behaviors. It has been validated in Spanish families and adolescents (Otero & Rivas, 2007)

Appendix A

El Ciclo de TOC

Obsesiones
Pensamientos, Impulsos, y imágenes mentales no deseados y angustiosos

Ansiedad
Puede ser angustia, miedo, preocupación, o asco. Es una falsa alarma. Siente la necesidad de hacer algo.

Compulsiones
Cualquier comportamiento realizado para ayudar hacer que la ansiedad se vaya.

Alivio
Solo es temporario. Obsesiones regresan mas pronto.

Appendix B

Appendix C

Pensamientos Inaceptables/Tabú

Pensamientos Inaceptables/Tabú: Rumiando, Repasando en la mente, Asegurándose, Chequeando

Escrupulosidad: Religion, Moralidad, Siempre hacienda lo correcto

Sexual: Orientación Sexual, Pedófilo/a, Violación

Preocupaciones Relacionadas: Se preocupa de la Salud y las Enfermedades

Agresión: Hacer un daño impulsivamente a otros o a si mismo cuando no esta enojado
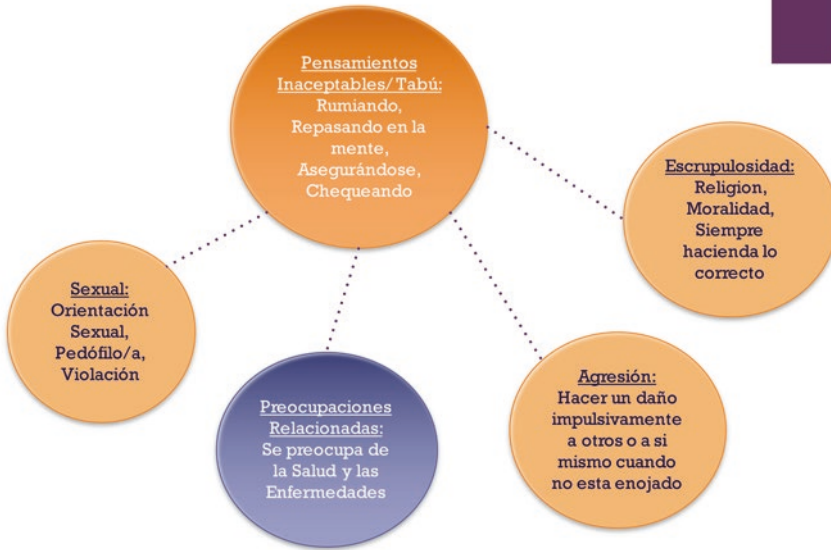
Appendix D

Información Sobre el Trastorno Obsesivo-Compulsivo

ESTA HOJA INFORMATIVA:

- SÍNTOMAS DE TOC
- ¿QUÉ CAUSA EL TOC?
- ¿CÓMO OBTUVO EL TOC?
- DOS ASOCIACIONES IMPORTANTES EN EL TOC

Síntomas de TOC

Esta estimado que 112 millones de personas en el mundo tienen trastorno obsesivo-compulsivo (TOC). Hombres y mujeres desarrollan TOC a velocidades similares y se ha visto en todos grupos de edad desde niñez hasta edad adulta. TOC típicamente empieza gradualmente, pero también puede empezar repentinamente. Síntomas pueden mejorar o empeorar a veces, y esto puede ser influenciado por eventos estresantes. Como los síntomas usualmente se empeoran a medida que las personas envejecen a veces ellos no se acuerdan cuando el TOC empezó. Las personas a veces se pueden recordar de un incidente especifico que lo desencadenó.

Así como el nombre insinúa, los síntomas de TOC incluyen obsesiones y compulsiones.

Obsesiones Comunes

- Dudas perturbadoras o no deseadas
- Pensamientos perturbadores sobre el daño, la contaminación, el sexo, temas religiosos, o la salud

Compulsiones Comunes

- Demasiado lavando, chequeando, rezando, y repitiendo actividades de rutina
- Pensamientos especiales diseñados a contrarrestar pensamientos negativos.

Puede ser que usted también note que ciertas situaciones, lugares, o objetos desencadenen pensamientos preocupantes y lo lleva a impulsos de realizar rituales (también llamado compulsiones). Rituales son acciones usted hace para tratar de sentir mejor después do que tiene una obsesión. Usted también podría encontrarse evitando situaciones, lugares, y objetos que lo molestan.

Causas del TOC

Las razones que muchas personas desarrollan el TOC mientras que otros no, no se ha comprendido en su totalidad. Algunos expertos han propuesto que ciertos "errores de pensamiento" sobre daños ocurren en el TOC.

Ejemplos de tales errores de pensamiento son:

- Pensando de algo malo es lo mismo que hacerlo, o querer hacerlo
- Las personas deben de poder controlar todos sus pensamientos todo el tiempo
- Si una persona no impide un daño, es lo mismo que causar el daño
- Una persona siempre esta responsable por un daño independientemente de las circunstancias

Aunque esto explica los tipos de erros de pensamiento que cometen las personas con el TOC, no explica porque algunas personas tienen el TOC y otros no.

Se ha descubierto que personas con el TOC tienen la química cerebral anormal que involucra la *serotonina*, un químico que es importante para el funcionamiento del cerebro. La química serotonina extraña ha sido observada en personas con el TOC, y medicamentos que alivian los síntomas de TOC también cambian los niveles de serotonina. Sin embargo, no se conoce si la química serotonina es en verdad una razón por el desarrollo del TOC. En este momento la investigación está en curso.

También hay evidencia que el TOC corre entre familias. Es difícil saber cuánto de esto es debido a lo que los niños aprenden de su familia mientras su crecimiento (crianza), y cuanto es genético (naturaleza). Sin embargo, personas con el TOC frecuentemente tienen otros familiares con el TOC o trastornos relacionados como la ansiedad, depresión, y el acaparamiento. Si aparece que el TOC tiene un componente genético muy fuerte.

¿Cómo obtuvo el TOC?

Muchas personas le gustarían saber que causa el TOC y como lo obtuvieron. Probablemente es una combinación de factores biológicos/genéticos y eventos estresantes de el vida que lo causan a ocurrir. A veces drogas recreacionales o de la calle pueden desencadenar la TOC en personas que son susceptibles al TOC. Pero usualmente no es posible saber exactamente que causo el TOC para cualquier persona en particular. Muchas personas gastan mucho tiempo tratando de describir como lo obtuvieron, pero esto no es muy útil. Afortunadamente, hay tratamientos efectivos para el trastorno que no requieren una explicación de porqué o como una persona desarrollo el TOC.

Científicos si entienden mucho de los *síntomas* del TOC y esto es muy importante para tratar el trastorno. Su terapeuta le ayudara aprender más de sus síntomas de TOC, el cual le ayudara a

mejorar. El TOC es una colección de hábitos que, como se mencionó anteriormente, involucra pensamientos, ideas, imágenes, o impulsos indeseados y perturbadores *(obsesiones)*. Junto con estos pensamientos, tiene sentimientos indeseados de incomodidad extrema o ansiedad y impulsos fuertes de hacer algo para reducir la angustia. Debido a esto, las personas se acostumbran a usar pensamientos o acciones especiales para tratar de deshacersen de la ansiedad (rituales compulsivos). Estas costumbres de pensamiento, sentimiento, y acción son muy desagradables, desperdician, y son difíciles de parar sin ayuda.

Dos asociaciones importantes en el TOC

Hay dos tipos de asociaciones o conexiones que son una parte importante del TOC y entendiendo las dos lo ayudara con su terapia. La terapia está diseñada para romper los dos tipos de asociaciones.

> Asociación 1: Primera es la asociación (conexión) entre ciertos objetos, pensamientos, o situaciones y la ansiedad/incomodidad. Por ejemplo, piensa en algo que usted trata de evitar o que usted aguanta con sufrimiento porque lo hace perturbado. Es probable que usted tiene una asociación entre esta situación y la perturbación que le causa.

> Asociación 2: El segundo tipo de asociación es la conexión entre haciendo un ritual/compulsión y disminuyendo la angustia. O sea, después de que realiza sus rituales obsesivos-compulsivos usted se siente un poco mejor temporariamente. Por lo tanto, usted continua a realizar el comportamiento más frecuentemente para obtener mas alivio.

Trate de identificar cuales situaciones aumentan su incomodidad (Asociación #1) y luego identifique los comportamientos o pensamientos que usted usa para reducir la incomodidad (Asociación #2). Haciendo esto le ayudara en su tratamiento.

Desafortunadamente, realizando rituales para sentirse mejor no sirve mucho a la larga. Su angustia baja por un tiempo corto y luego regresa otra vez. Frecuentemente, usted se consigue haciendo más y más rituales para tratar de deshacerse de la ansiedad. Pronto, ya está gastando tanto tiempo y energía en los rituales que no tiene tiempo o energía para otras cosas importantes en su vida, como el trabajo/estudio, la familia, las amistades, y la recreación.

Para tratar el TOC, las asociaciones describas arriba tienen que estar debilitadas o rotas. Su terapia está diseñada a hacer esto, y su terapeuta le va a enseñar ejercicios que le van a ayudar a llegar ahí. Estos ejercicios se llaman exposición y prevención de rituales, y va a aprender más sobre ellos de su terapeuta.

Adaptado de: Yadin, E., Lichner, T. K., & Foa, E. B. (2012). *Treating Your OCD with Exposure and Response (Ritual) Prevention: Workbook.* Philadelphia: Oxford University Press.

Appendix E

Supresión de pensamientos y pensamientos intrusivos

Cuando nos confrontamos con pensamientos o memorias dolorosas, es natural querer alejarlos. Lamentablemente, los seres humanos no son muy buenos en no pensar acerca de algo.

Puedes tratar esto contigo mismo

Por los próximos 30 segundos trata lo más que puedas en no pensar en un oso blanco

Cuenta cuantas veces pensaste en el oso blanco

Probablemente encuentres que es bastante difícil

Mientras más intentes en no pensar en algo, más vas a terminar pensando en eso (tenemos pensamientos intrusivos que no queremos acerca de los asuntos que tratamos de suprimir). Peor aún, una vez paramos el tratar de no pensar en algo hay una tendencia en pensar más de lo usual en ese asunto por un tiempo después. Esto se llama "efecto de rebote".

Este efecto es aún más fuerte cuando intentamos suprimir algo emocional y sabemos que las personas con ansiedad o depresión tienden a encontrar aún más difícil el suprimir pensamientos indeseables.

Appendix F

Exposición y prevención de la respuesta

Exposición y Prevención de la Respuesta tiene que ver con exponiéndose a una situación que desencadena sus obsesiones o compulsiones (exposición), y luego deliberadamente resistiendo el impulso a realizar la compulsión que normalmente le aliviaría su ansiedad (prevención de la respuesta)

Situación / Desencadenante
¿Cuáles situaciones desencadenan mi obsesion?

Obsesión
¿Cuál es el pensamiento, imagen, deseo, o impulso que me molesta?

Compulsión
¿Qué hago para hacerme sentir mejor cuando tengo la obsesión?

Instrucciones:
1. Expóngase al desencadenante
2. Resista a la realización de la compulsión
3. Anote cuan angustiado/a se siente con el tiempo usando el grafico abajo
4. Si realiza la compulsión, expóngase al desencadenante otra vez

Tan malo como se pueda lograr — 100

Unidades de Angustia Subjetivas

Ninguna angustia en absoluto — 0

Tiempo (minutos)

Exposición y prevención de la respuesta

Exposición y Prevención de la Respuesta tiene que ver con exponiéndose a una situación que desencadena sus obsesiones o compulsiones (exposición), y luego deliberadamente resistiendo el impulso a realizar la compulsión que normalmente le aliviaría su ansiedad (prevención de la respuesta)

Situación / Desencadenante	Obsesión	Compulsión
¿Cuáles situaciones desencadenan mi obsesion?	¿Cuál es el pensamiento, imagen, deseo, o impulso que me molesta?	¿Qué hago para hacerme sentir mejor cuando tengo la obsesión?
Viendo cosas sucias – las peores cosas son los pañales usados o las curitas	*Imagen de mi familia enfermándose – sería mi culpa*	*Me limpio y limpio cualquier cosa que mis familiares podrían tocar*

Instrucciones:
1. Expóngase al desencadenante *– Sostener un pañal usado*
2. Resista a la realización de la compulsión *– No lavarme las manos*
3. Anote cuan angustiado/a se siente con el tiempo usando el grafico abajo
4. Si realiza la compulsión, expóngase al desencadenante otra vez
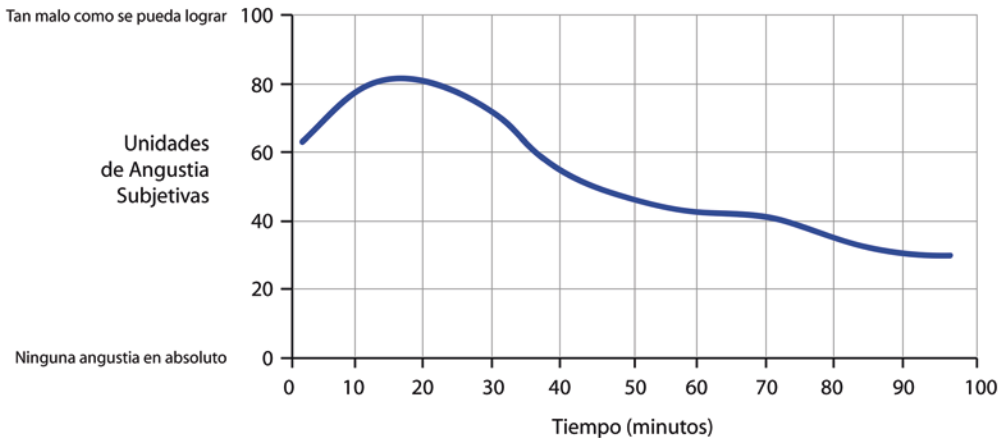
Appendix G

Auto monitorización de Rituales

Nombre		Fecha	

Tiempo de Día	Situación/Actividad/Pensamiento que evoca el ritual	SUDS[1] (0-100)	Descripción de ritual	Numero de minutos gastados en el ritual
6:00 – 6:30 A.M.				
6:30 – 7:00				
7:00 – 7:30				
7:30 – 8:00				
8:00 – 8:30				
8:30 – 9:00				
9:00 – 9:30				
9:30 – 10:00				
10:00 – 10:30				
10:30 – 11:00				
11:00 – 11:30				
11:30 – 12:00 P.M.				
12:00 – 12:30				
12:30 – 1:00				
1:00 – 1:30				
1:30 – 2:00				
2:00 – 2:30				
2:30 – 3:00				
3:00 – 3:30				

Tiempo de Día	Situación/Actividad/Pensamiento que evoca el ritual	SUDS[1] (0-100)	Descripción de ritual	Numero de minutos gastados en el
3:30 – 4:00				
4:00 – 4:30				
4:30 – 5:00				
5:00 – 5:30				
5:30 – 6:00				
6:00 – 6:30				
6:30 – 7:00				
7:00 – 7:30				
7:30 – 8:00				
8:00 – 8:30				
8:30 – 9:00				
9:00 – 9:30				
9:30 – 10:00				
10:00 – 10:30				
10:30 – 11:00				
11:00 – 11:30				
11:30 – 12:00 A.M.				
12:00 – 6:00				

[1]SUDS= Unidades de Angustia Subjetivas

Notas:

Appendix H

DOCS

En este cuestionario se le pregunta sobre 4 tipos de preocupaciones diferentes que puede que usted esté (o no esté) experimentando. Para cada tipo de preocupación, hay una descripción del tipo de pensamiento (a veces llamados obsesiones) y conductas (a veces llamadas rituales o compulsiones) que son típicas de ese tipo de preocupación en particular, seguida de 5 preguntas sobre sus experiencias en relación con estos pensamientos y conductas. Por favor, lea cada descripción detenidamente y responda a las preguntas para cada categoría basándose en las experiencias que usted ha tenido **durante el último mes**.

Categoría 1: Preocupaciones relacionadas con gérmenes y contaminación.
Ejemplos…

- Pensar o sentir que está contaminado/a porque estuvo en contacto con ciertos objetos o personas o estuvo cerca de ellos.
- Sentir que está contaminado/a porque estuvo en ciertos lugares (por ejemplo, un cuarto de baño).
- Pensar en gérmenes, enfermedades o en la posibilidad de propagar la contaminación.
- Lavarse las manos, usar desinfectante de manos, ducharse, cambiarse de ropa o limpiar objetos debido a preocupaciones sobre la contaminación.
- Seguir una rutina determinada (por ejemplo, en el cuarto de baño o al vestirse) debido a la contaminación.
- Evitar ciertas personas, objetos o lugares debido a la contaminación.

Las siguientes preguntas se refieren a sus experiencias con pensamientos y conductas relacionados con la contaminación <u>durante el último mes</u>. Recuerde que sus experiencias pueden ser diferentes de los ejemplos mencionados anteriormente. Por favor, rodee con un círculo el número junto a su respuesta.

1. Aproximadamente, ¿cuánto tiempo le han ocupado al día los pensamientos de contaminación y las conductas de limpieza debidas a la contaminación?

   0 Ninguno
   1 Menos de una hora al día
   2 Entre 1 y 3 horas al día
   3 Entre 3 y 8 horas al día
   4 Ocho horas o más al día

2. ¿ Ha evitado situaciones para no tener pensamientos de contaminación o para no tener que pasar tiempo lavándose, limpiando o duchándose?

   0 En absoluto
   1 Evitación leve
   2 Evitación moderada
   3 Evitación grave
   4 Evitación extrema de casi todas las cosas

3. Si ha tenido pensamientos de contaminación pero no ha podido limpiar, lavarse o ducharse (ni eliminar la contaminación de otra forma), ¿cuánto malestar o ansiedad ha tenido?

   0 Ningún malestar/ansiedad
   1 Ansiedad/malestar leve
   2 Ansiedad/malestar moderado
   3 Ansiedad/malestar grave
   4 Ansiedad/malestar extremo

4. ¿En qué medida se ha visto afectada su vida diaria (trabajo, escuela, cuidado personal, vida social) por los pensamientos de contaminación y por limpiar, lavarse o ducharse de forma excesiva o realizar conductas de evitación?

   0 Mi vida no se ha visto afectada
   1 Un poco afectada, pero en general funciono bien
   2 Muchas facetas de mi vida están afectadas, pero a pesar de ello me manejo bien
   3 Muchas facetas de mi vida están afectadas, y me cuesta funcionar
   4 Mi vida está completamente afectada y no puedo funcionar en absoluto

5. Cuando intenta ignorar los pensamientos de contaminación y abstenerse de conductas como limpiar, lavarse, ducharse u otros rituales para descontaminarse, ¿le resulta difícil?

   0 En absoluto
   1 Un poco difícil
   2 Bastante difícil
   3 Muy difícil
   4 Extremadamente difícil

Categoría 2: Preocupaciones relacionadas con causar daño, provocar lesiones o traer mala suerte.
Ejemplos…
-   Dudar de si ha cometido un error que podría hacer que sucediera algo horrible o perjudicial.
-   Pensar que pueda haber ocurrido un accidente, desastre o daño físico terrible u otra desgracia y que usted no fue lo suficientemente precavido para evitarlo.
-   Pensar que usted podía evitar algún daño o desgracia haciendo las cosas de una determinada manera, contando hasta cierto número o evitando determinados números o palabras "negativos".
-   Pensar que podía perder algo importante que es poco probable que pierda (por ejemplo, la cartera, papeles, documentos personales…).
-   Comprobar cosas como cerraduras, enchufes, la cartera, etc. más de lo necesario.
-   Comprobar repetidamente o preguntar a otras personas para asegurarse de que no ha pasado (o no va a pasar) algo malo.
-   Repasar mentalmente cosas del pasado para asegurarse de que no hizo nada malo.
-   Necesitar hacer las cosas en una secuencia determinada para evitar que ocurran cosas dañinas o desastres.
-   Necesitar contar hasta cierto número o evitar ciertos números negativos por miedo a que ocurra algo malo.

Las siguientes preguntas se refieren a sus experiencias con los pensamientos y conductas relacionados con causar daño o desastres <u>durante el último mes</u>. Recuerde que sus experiencias pueden ser ligeramente diferentes de los ejemplos mencionados anteriormente. Por favor, rodee con un círculo el número situado junto a su respuesta.

1. Aproximadamente, ¿cuánto tiempo le han ocupado al día los pensamientos sobre posibles daños o desastres y las comprobaciones o esfuerzos para que le tranquilicen asegurándole que esas cosas cosas no pasan (o no han pasado)?

> 0 Ninguno/
> 1 Menos de una hora al día
> 2 Entre 1 y 3 horas al día
> 3 Entre 3 y 8 horas al día
> 4 Ocho horas o más al día

2. ¿Ha evitado situaciones para no tener que comprobar si había algún peligro o para no tener que preocuparse por la posibilidad de haber causado algún daño o provocado algún desastre?

> 0 En absoluto
> 1 Evitación leve
> 2 Evitación moderada
> 3 Evitación grave
> 4 Evitación extrema de casi todas las cosas

3. Cuando ha tenido pensamientos sobre la posibilidad de provocar algún daño o desastre, o en el caso de no poder comprobar o pedir que le tranquilizaran, ¿cuánto malestar o ansiedad ha sentido?

> 0 Ningún malestar/ansiedad
> 1 Ansiedad/malestar leve
> 2 Ansiedad/malestar moderado
> 3 Ansiedad/malestar grave
> 4 Ansiedad/malestar extremo

4. ¿En qué medida su vida diaria (trabajo, colegio, cuidado personal, vida social) se ha visto afectada por los pensamientos sobre causar algún daño o provocar desastres, o por comprobar demasiado o pedir que le tranquilicen en exceso?

> 0 Mi vida no se ha visto afectada
> 1 Un poco afectada, pero en general funciono bien
> 2 Muchas facetas de mi vida están afectadas, pero a pesar de ello me manejo bien
> 3 Muchas facetas de mi vida están afectadas, y me cuesta funcionar
> 4 Mi vida está completamente afectada y no puedo funcionar en absoluto

5. Cuando intenta ignorar los pensamientos sobre daños o desastres y abstenerse de comprobar o de solicitar a otros que le tranquilicen, ¿le resulta difícil?

> 0 En absoluto
> 1 Un poco difícil
> 2 Bastante difícil
> 3 Muy difícil
> 4 Extremadamente difícil

Categoría 3: Pensamientos inaceptables/prohibidos

Ejemplos...

-Tener pensamientos desagradables sobre sexo, cosas inmorales o violencia que le vienen a la mente en contra de su voluntad.

- Pensar que podría hacer algo horrible, indecente o que le avergüence que en realidad usted no quiere hacer.

- Repetir una acción o hacer las cosas en una secuencia determinada debido a un mal pensamiento.

- Realizar mentalmente alguna acción o rezar para deshacerse de un pensamiento no deseado o desagradable.

- Evitar ciertas personas, lugares o situaciones que le provocan pensamientos no deseados o desagradables.

Las siguientes preguntas se refieren a sus experiencias con pensamientos no deseados que vienen a su mente en contra de su voluntad y a comportamientos dirigidos a afrontar este tipo de pensamientos durante el último mes. Recuerde que sus experiencias pueden ser ligeramente diferentes de los ejemplos mencionados anteriormente. Por favor, rodee con un círculo el número situado junto a su respuesta.

1. Aproximadamente, ¿cuánto tiempo le han ocupado al día los pensamientos desagradables no deseados y las acciones (físicas o mentales) que realiza debido a estos pensamientos?

     0 Ninguno
     1 Menos de una hora al día
     2 Entre 1 y 3 horas al día
     3 Entre 3 y 8 horas al día
     4 Ocho horas o más al día

2. ¿Ha evitado situaciones, lugares, objetos u otras cosas (por ejemplo, números o personas) que le desencadenan pensamientos no deseados o desagradables?

     0 En absoluto
     1 Evitación leve
     2 Evitación moderada
     3 Evitación grave
     4 Evitación extrema de casi todas las cosas

3. Cuando le han venido a la mente pensamientos no deseados o desagradables en contra de su voluntad, ¿ha sentido ansiedad o malestar?

     0 Ningún malestar/ansiedad
     1 Ansiedad/malestar leve
     2 Ansiedad/malestar moderado
     3 Ansiedad/malestar grave
     4 Ansiedad/malestar extremo

4. ¿En qué medida se ha visto afectada su vida diaria (trabajo, escuela, cuidado personal, vida social) a causa de estos pensamientos no deseados o desagradables o por las acciones (físicas y/o mentales) para evitar o afrontar estos pensamientos?

     0 Ningún tipo de alteración
     1 Un poco de alteración, pero en general funciono bien
     2 Bastantes cosas/aspectos están alteradas/os, pero todavía me manejo bien
     3 Mi vida está alterada en muchos aspectos y tengo dificultades para afrontarla
     4 Mi vida está completamente alterada y no puedo funcionar en absoluto

5. Cuando intenta ignorar los pensamientos no deseados o desagradables o dejar de realizar acciones (físicas o mentales) para afrontar estos pensamientos, ¿le resulta difícil?

     0 Nada difícil
     1 Un poco difícil
     2 Moderadamente difícil
     3 Muy difícil
     4 Extremadamente difícil

Categoría 4: Preocupaciones sobre simetría y la necesidad de que las cosas estén "bien" o "como tienen que estar".

Ejemplos...
- Necesitar que las cosas sean/estén simétricas, uniformes, equilibradas o exactas.
- Sentir que algo no está "del todo bien".
- Repetir algo del día a día hasta que tiene la sensación de que lo ha hecho "bien" o "equilibradamente".
- Contar cosas absurdas (por ejemplo, azulejos del techo, el número de palabras en una frase, etc.).
- Poner las cosas en un orden determinado cuando no es necesario.
- Tener que repetir algo de una manera determinada hasta que está "bien".

Las siguientes preguntas se refieren a sus sensaciones de que algo no está "bien" y sus conductas dirigidas a conseguir una sensación de orden, simetría o equilibrio <u>durante el último mes</u>. Recuerde que sus experiencias pueden ser ligeramente diferentes a los ejemplos mencionados anteriormente. Por favor, rodee con un círculo el número situado junto a su respuesta.

1. Aproximadamente, ¿cuánto tiempo le han ocupado al día los pensamientos no deseados sobre simetría, orden o equilibrio o las conductas dirigidas a conseguir simetría, orden o equilibrio?

      0 Ninguno
      1 Menos de una hora al día
      2 Entre 1 y 3 horas al día
      3 Entre 3 y 8 horas al día
      4 Ocho horas o más al día

2. ¿Ha evitado situaciones, lugares u objetos asociados con sensaciones de que algo no estaba simétrico o no estaba "del todo bien"?

      0 En absoluto
      1 Evitación leve
      2 Evitación moderada
      3 Evitación grave
      4 Evitación extrema de casi todas las cosas

3. Cuando ha tenido la sensación de que algo no estaba "del todo bien", ¿ha sentido malestar o ansiedad?

      0 Ningún malestar/ansiedad
      1 Ansiedad/malestar leve
      2 Ansiedad/malestar moderado
      3 Ansiedad/malestar grave
      4 Ansiedad/malestar extremo

4. ¿En qué medida se ha visto afectada su vida diaria (trabajo, escuela, cuidado personal, vida social) por la sensación de que las cosas no estaban "del todo bien", y por los esfuerzos para conseguir que las cosas estuvieran en orden o como usted sentía que tenían que estar??

      0 Mi vida no se ha visto afectada
      1 Un poco afectada, pero en general funciono bien
      2 Muchas facetas de mi vida están afectadas, pero a pesar de ello me manejo bien
      3 Muchas facetas de mi vida están afectadas, y me cuesta funcionar
      4 Mi vida está completamente afectada y no puedo funcionar en absoluto.

5. Cuando intenta ignorar los pensamientos sobre la falta de simetría y orden, y no ceder al impulso de ordenar las cosas o de repetir ciertas conductas, ¿le resulta difícil?

      0 Nada difícil
      1 Un poco difícil
      2 Moderadamente difícil
      3 Muy difícil
      4 Extremadamente difícil

Categoria 5: Pensamientos intrusivos sexuales

Ejemplos...
- Pensamientos desagradables acerca de alguien del mismo sexo si usted es heterosexual
- Pensamientos de hacer cosas horribles, indecentes, o penosas de carácter sexual que usted realmente no quiere hacer (incluyendo actos sexuales con niños o figuras de autoridad)
- Pensamientos de forzar a alguien que haga algo sexualmente o de ser forzado/a a hacer un acto sexual
- Repitiendo una acción o siguiendo una rutina especial debido a pensamientos intrusivos sexuales
- Realizando mentalmente una acción o rezando para deshacerse de un pensamiento desagradable o no deseado
- Evitación de personas, lugares, situaciones, u otros provocantes de pensamientos intrusivos sexuales

Las siguientes preguntas se refieren a sus experiencias con pensamientos sexuales que vienen a su mente en contra de su voluntad y a comportamientos dirigidos a afrontar estos pensamientos <u>durante el último mes</u>. Recuerde que sus experiencias pueden ser un poco diferentes de los ejemplos mencionados anteriormente. Por favor rodee con un circulo el numero situado junto a su repuesta:

1. Aproximadamente, ¿cuánto tiempo le han ocupado al día los pensamientos intrusivos sexuales y las acciones (físicas o mentales) que realiza debido a estos pensamientos?

    0   Ningún tiempo
    1   Menos de una hora cada día
    2   Entre 1 y 3 horas cada día
    3   Entre 3 y 8 horas cada día
    4   8 horas o más cada día

2. ¿En qué medida ha estado evitando situaciones, lugares, objetos, y otros recordatorios (e.g., números, personas) que provocan pensamientos intrusivos sexuales?

    0   Para nada
    1   Evitación leve
    2   Evitación moderada
    3   Evitación grave
    4   Evitación extrema de casi todas las cosas

3. ¿Cuándo pensamientos intrusivos sexuales vienen a mente en contra de su voluntad, que angustiado/a o ansioso/a se pone?

    0   Ninguna angustia/ansiedad
    1   Angustia/ansiedad leve
    2   Angustia/ansiedad moderado
    3   Angustia/ansiedad grave
    4   Angustia/ansiedad extrema

4. ¿En qué medida ha sido interrumpida su vida diaria (trabajo, escuela, cuidado personal, vida social) por pensamientos intrusivos sexuales y los esfuerzos para evitar o afrontar estos pensamientos?

    0   Ningún tipo de alteración
    1   Un poco de alteración, pero en general funciono bien.
    2   Bastantes cosas/aspectos están alteradas/os, pero todavía me manejo bien
    3   Mi vida está alterada en muchos aspectos y tengo dificultades para afrontarla
    4   Mi vida está completamente alterada y no puedo funcionar en absoluto

5. ¿Qué difícil es para usted ignorar pensamientos intrusivos sexuales y abstenerse de realizar acciones (fisicas o mentales) para afrontar estos pensamientos cuando intenta de ignorarlos?

    0   Nada difícil
    1   Un poco difícil
    2   Moderadamente difícil
    3   Muy difícil
    4   Extremamente difícil

Referencia original: Wetterneck, C. T., Siev, J., Smith, A. H., Adams, T.G., & Slimcowitz, J.C. (2015). Assessing Sexually Intrusive Thoughts: Parsing Unacceptable Thoughts on the Dimensional Obsessive-Compulsive Scale. *Behavior Therapy*, 46(4). doi: 10.1016/j.beth.2015.05.006

Appendix I

Jerarquía de Evitación

Construye una escalera de lugares o situaciones que evitas. En la parte de arriba de la escalera coloca los que te provocan más ansiedad. Abajo pon lugares o situaciones que evitas, pero que no te molestan tanto. En medio de la escalera pon los que están "entre medio". Dale a cada ítem una puntuación entre 0-100% según lo ansioso que te sentirías si tuvieras que estar en esa situación. Supera tu ansiedad abordando estas situaciones, empezando por la parte de abajo de la escalera.

	Situación	Ansiedad (0-100%)
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Appendix J

¿Cuándo tendría que pasar?

Predicción
¿Cuál es tu predicción?
¿Qué es lo que esperas que suceda?
¿Cómo sabrías si se hizo realidad?

Califica cuán fuerte crees que
esto va a suceder (0-100%)

Experimento
¿Qué experimientos podría pobar esa predicción? (dónde y cuándo)
¿Qué conductas de seguridad se necesitarían dejar de lado?
¿Cómo sabrías que tu predicción se hizo realidad?

Resultado
¿Qué sucedió?
¿Tu predicción fue precisa?

Aprendizaje
¿Qué fue lo que aprendiste?
¿Cuán probable es que tus predicciones sucederán en el futuro?

Califica qué tanto estás de
acuerdo con tu predicción
original (0-100%)

¿Cuándo tendría que pasar?

Predicción
¿Cuál es tu predicción?
¿Qué es lo que esperas que suceda?
¿Cómo sabrías si se hizo realidad?

Si hablo en público, temblaré tanto que la gente lo notará y se reirá de mí

Califica cuán fuerte crees que esto va a suceder (0-100%)

90%

Experimento
¿Qué experimentos podría pobar esa predicción? (dónde y cuándo)
¿Qué conductas de seguridad se necesitarían dejar de lado?
¿Cómo sabrías que tu predicción se hizo realidad?

Hablar alto en la siguiente reunión del lunes- Podría presentar alguna de la información que he querido mostrar
Necesitaría hacer gestos con las manos y no agarrarme a la mesa
Podría preguntar a mis amigos si ellos notaron que temblaba mientras hablaba

Resultado
¿Qué sucedió?
¿Tu predicción fue precisa?

Estaba realmente nervioso y estaba muy atento a mis manos
Mis amigos dijeron que hable bien y que ellos no pudieron notarme temblar

Aprendizaje
¿Qué fue lo que aprendiste?
¿Cuán probable es que tus predicciones sucederán en el futuro?

Aunque me sentí nervioso cuando hablaba no fue obvio para las otras personas

Califica qué tanto estás de acuerdo con tu predicción original (0-100%)

50%

Appendix K

HOJA DE TAREAS DIARIAS

Exposición: _____

Cantidad de Tiempo por Dedicar: _____

Día que lo hizo: _____ Hora de inicio: _____ Hora cuando lo termino: _____

SUDS (0-100): al comienzo: _____ punto más alto: _____ al final: _____

SUDS=(Unidades de Angustia Subjetivas)

Exposición: _____

Cantidad de Tiempo por Dedicar: _____

Día que lo hizo: _____ Hora de inicio: _____ Hora cuando lo termino: _____

SUDS (0-100): al comienzo: _____ punto más alto: _____ al final: _____

Exposición: _____

Cantidad de Tiempo por Dedicar: _____

Día que lo hizo: _____ Hora de inicio: _____ Hora cuando lo termino: _____

SUDS (0-100): al comienzo: _____ punto más alto: _____ al final: _____

Tareas por completar antes de la Próxima Cita:

1. _____

2. _____

3. _____

Traer a la Próxima Cita:

1. _____

2. _____

HOJA DE TAREAS SEMANALES

Exposición: _____

Cantidad de Tiempo de dedicar: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Exposición: _____

Cantidad de Tiempo de dedicar: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Día que lo hizo: _____   Hora de inicio: _____   Hora cuando lo termino: _____

SUDS (0-100):   al comienzo: _____   punto más alto: _____   al final: _____

Appendix L

TOC Prevención de Recaída : Consejos Rapidos

Pensamientos intrusivos son esperados y pueden persistir

- Acuérdese que hasta las personas sin TOC experimentan algunos pensamientos intrusivos, entonces está bien si usted todavía los siente hasta después de tratamiento
- Es posible que observe que la frecuencia de sus pensamientos intrusivos fluctúa durante el curso de terapia, está bien!
- Tiempos de estrés pueden causar que los síntomas de TOC aumenten- acuérdese de usar las herramientas que aprendió en terapia para manejarlos, hasta si se parece difícil.
- Nuevas situaciones como una nueva relación romántica, tener un hijo, o cambiar de trabajo pueden causar que los síntomas se regresen o que se empeoren.

Acuérdese que resistiendo compulsiones mantiene el TOC lejos

- Cuando usted note pensamientos intrusivos, préstele buena atención a su respuesta a los pensamientos
    - ¿Estoy evitando?
    - ¿Estoy actualizando rituales?
- Si respondió 'si' a las preguntas de arriba, acuérdese de hacer lo opuesto a lo que el TOC le está diciendo que haga: enfrenta los miedos y resiste los rituales!

Sea su propio/a terapeuta

- Hasta si no este experimentando ansiedad elevada, acuérdese de regularmente retarse a si mismo a practicar no evitar y a llevar a cabo exposiciones de "vida real"
- Mantenga una lista de estrategias útiles que aprendió en terapia para que pueda repasarlas después del tratamiento
- Antes de que termine el tratamiento, asegúrese de trabajar con su terapeuta para crear un plan para ayudarle enfrentar cualesquiera retos que queden cuando este solo/a

Lapso vs. Recaída

- Conozca la diferencia entre un 'lapso' y una 'recaída'
- Lapso- un regreso parcial de síntomas previos
- Recaída- un regreso de síntomas y un regreso del nivel de funcionamiento que tuvo antes de tratamiento
- Consiga grupos de apoyo localmente o en el internet
- Si su familia fue involucrada en el tratamiento, ellos pueden ser una fuente de energía durante tiempos difíciles
- Seguimiento: Póngase en contacto con su terapeuta cada 3 a 6 meses para asegurarse que el TOC no se está regresando.

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Cultural Considerations and Tools for Treating Chronic Pain Among Hispanics/Latinos

Eddie C. Erazo

Chronic pain (CP) is typically defined as pain persisting more than 3 months and beyond expected healing time from an injury or incident. In contrast to acute pain, CP is considered a chronic disease to be managed, as opposed to cured, because it is typically intractable and often reflects dysfunction in the nervous system rather than ongoing tissue damage. Example causes of CP include arthritis, fibromyalgia, injury, and peripheral neuropathy, yet CP rarely occurs alone. Common comorbidities of CP include anxiety, depression, insomnia, and obesity, which can both result from and exacerbate CP in a vicious cycle (Lunde & Nordhus, 2009). According to the Institute of Medicine (2011), CP affects an estimated 100 million Americans and exacts a price of up to $635 billion in the United States, including medical costs and economic costs of disability and lost wages and productivity.

A national survey revealed similar rates of CP among Whites, African-Americans, and Hispanics at approximately one-third of each group (Portenoy, Ugarte, Fuller, & Haas, 2004). However, of those with CP, fewer Hispanics (68%) reported visiting a physician for pain compared to Whites (82%) and African-

Americans (85%). Predictors of disabling pain (i.e., higher severity and functional interference) include low income and education, which occur more frequently in Hispanics than non-Hispanic Whites (Portenoy et al., 2004). While lack of access has been proposed as an explanation for the disparity in pain care (Mossey, 2011), pain treatment disparities remain even when comparing those who do seek treatment for pain. For example, Latino ethnicity predicted undertreatment of pain, including lower rates of prescription, lower dosages, and shorter prescriptions for analgesics, compared to non-Latinos (Campbell et al., 2009).

Although medication is not the only method of treatment for pain, negative attitudes toward medicine among Hispanics (e.g., side effects, addiction) appear to play a role in lower treatment seeking relative to other races and ethnicities. In one survey of Latino patients with CP, 76% endorsed the belief that pain medication should not be necessary if one is strong, 100% would wait until pain is severe to call a doctor, and 88% would wait until pain is 10/10 in intensity before calling for help (Zacharoff, Zeis, Frayjo, Chiauzzi, & Reznikova, 2009). Given that Latinos are the fastest-growing minority group in the United States (Vega, Rodriguez & Gruskin, 2009), they also represent the fastest-growing population of inadequately treated CP patients. Therefore, it is important to resolve this healthcare disparity by addressing cultural barriers.

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Cultural Factors Related to Pain in Hispanics/Latinos

In terms of functional interference, patients with CP range from harmful physical inactivity and severe impairment to overexertion and unhealthily pushing through pain (Murphy et al., 2014). On one extreme, lack of physical activity can compound and exacerbate pain via weight gain, weakness, and depression, which perpetuate inactivity. In contrast, there is the vicious cycle of ignoring pain cues and bodily limits, which leads to intensified and incapacitating pain that requires prolonged recovery time before being functional again.

Zacharoff et al. (2009) outlined core Hispanic cultural concepts that can interplay with these pain patterns. Overexertion may be especially problematic in Latino populations due to a heavy emphasis on *stoicism*o (enduring without complaint). For men, this stoicism may be exaggerated by the stereotypical value of *machismo* (strength and masculine pride), in which one endures pain to avoid appearing weak. Inability to provide due to pain can conflict with *machismo*, resulting in shame, anger, and depression. For women, *marianismo* (the female role of self-sacrifice and putting others' needs first, even when ill) can interfere with appropriate treatment seeking. Another commonly held belief among Latinos is *fatalismo*, which involves the view that pain is part of one's fate and predetermined by the gods or even punishment for immoral behavior. *Fatalismo* is closely related to *destino* (destiny) in terms of how health, including pain, is seen as chance or luck (Campbell et al., 2009). Combined, these beliefs are characterized by an external locus of control that may contribute to more passive or religion-based coping instead of medical or psychological treatment.

The extent to which Latinos hold these beliefs varies based on their degree of acculturation in the United States and should be appropriately assessed rather than assumed. Latinos who are foreign born, first generation, elderly, less educated, or speak Spanish as their primary language tend to be less acculturated and hold these traditional values and beliefs (Campbell et al., 2009; Duggleby, 2003). Interestingly, Spanish as a primary language predicted failure to attend pain clinic even when services were offered in Spanish (Shaparin, White, Andreae, Hall, & Kaufman, 2014), which suggests that speaking Spanish primarily may be a proxy for traditional beliefs and customs. As a result, many Latinos with CP resort to folk medicine and prayer rather than verbally expressing their pain and seeking medical treatment. For example, a common approach to folk medicine among Latinos is visiting a *curandero* (folk doctor), who uses candles, prayer, and herbs to heal (Campbell et al., 2009). Religious coping appears to be more commonly used among Latinos than other groups but is, unfortunately, associated with worse pain outcomes, including increased pain intensity and interference (Duggleby, 2003). Ironically, despite valuing stoicism, Latinos with CP who received instrumental and emotional support reported less psychological distress and greater psychological well-being (Campbell et al., 2009). This paradox exposes a valuable entry point for tailoring psychological pain treatment to Latinos in a culturally sensitive manner.

Fortunately, *familismo* (family closeness, loyalty, and contribution) is a strong cultural construct among Hispanics and holds potential to counter the social deprivation of stoicism through perspective taking. Indeed, Latinos who experienced recent pain have described their obligation and willingness to care for family members (Villarruel, 1995). Treatments for pain among Latinos may be strengthened by involving family members in decision making about pain management (Duggleby, 2003) and emphasizing perspective taking for the CP patient. It is important for the clinician to validate stoicism and religious coping efforts while also orienting the patient to supplemental treatment options, such as medicine and behavioral interventions, as a means of alleviating suffering and maximizing functioning toward other values (e.g., *familismo*-family, *salud*-health).

The cultural factors outlined above were used to create treatment resources presented in this

chapter with the intention of increasing cultural competence and treatment acceptability among Latinos while maintaining the integrity of extant empirically supported treatment for CP. However, these cultural factors and modifications may not be applicable to *every* Latino due to intraculture variance and acculturation. Therefore, appropriate assessment is necessary to determine the extent to which the patient holds these traditional beliefs and whether the tools specifically targeting religion and cultural values would, indeed, enhance treatment. Regardless, most of the treatment resources presented hold utility for the vast majority of Spanish-speaking clients with CP.

Evidence-Based Treatment for Chronic Pain

Although CP is a medical condition, the introduction of holistic conceptualizations of pain has led to more integrative theories of CP pathophysiology. Most notably, Melzack and Wall (1965) proposed the *Gate Control Theory*, in which pain signals ascend from the pain location to the brain and can be modulated by "gates" that are opened and closed, resulting in minimized or exacerbated pain. This theory fostered the creation of the *Neuromatrix Model of Pain* (Melzack, 1999), which asserts that pain is a multidimensional experience involving nerve impulses that can become a chronic stressor. In turn, stress contributes to greater tension and pain in a pain-stress cycle that must be disrupted using psychological interventions. As a result of theories such as these that acknowledge biological, psychological, and social contributions to pain, the biopsychosocial model of pain has generally been adopted as the most useful approach to CP (Gatchel, Peng, Peters, Fuchs, & Turk, 2007). Consequently, a multimodal treatment plan is strongly recommended for comprehensive pain care, including medicine (e.g., surgery, injections, analgesics, spinal cord stimulators, nonsteroidal anti-inflammatory drugs, etc.), physical therapy, appropriate social support, and psychological intervention (e.g., cognitive behavioral therapy

[CBT], acceptance and commitment therapy [ACT: Hayes, Strosahl, & Wilson, 1999], and mindfulness). Although this chapter will focus on psychological intervention and appropriate utilization of social support, which can be effective alone, these should be nested within the larger context of multimodal care provision. However, psychological interventions may be useful in promoting engagement in medical and physical treatments if there are psychological or cultural barriers, which will be discussed as they pertain to Latinos but may apply to other groups as well.

The two "gold standard" empirically supported treatments for CP are ACT and CBT (APA Presidential Task Force on Evidence-Based Practice, 2006). Both treatments effectively reduce pain intensity and interference in addition to improving mood for patients with CP (Morley et al., 1999; Veehof, Trompetter, Bohlmeijer, & Schreurs, 2016). CBT and ACT for CP are ultimately intended to reduce suffering and foster skillful behavioral engagement but use two diametrically opposed strategies. CBT aims to correct inaccurate and distorted thinking that contributes to unwanted experiences (e.g., anxiety, depressed mood, pain) and behavioral inactivation. ACT is mindfulness-based and seeks to promote acceptance of these unwanted experiences for the sake of valued action rather than coping using experiential avoidance (Hayes et al., 1999). Although these treatments are conceptually different in theory, elements from each can be extracted to enhance the other while still maintaining a cohesive treatment in real-world practice. For example, the values and mindfulness aspects of ACT are consistent with CBT and can be incorporated to enhance therapy (Lunde & Nordhus, 2009). Mindfulness is often defined as "paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally" (Kabat-Zinn, 1994) and can be used to inform and complement specific treatment modalities, such as CBT (Germer, 2005). It should be noted that mindfulness-based stress reduction (MBSR), which was developed by Jon Kabat-Zinn specifically for patients experiencing CP and other disorders associated with medical conditions

(Kabat-Zinn, 1990), is now an evidence-based intervention for CP, stress, anxiety, and depression (de Vibe, Bjørndal, Tipton, Hammerstrøm, & Kowalski, 2012; Morley, Eccleston, & Williams, 1999).

Treating Hispanics/Latinos with Chronic Pain

Unfortunately, there is a dearth of studies examining race and ethnicity as moderators of psychological pain treatment outcomes, and most have compared non-Hispanic White and Black patients to the exclusion of Latinos (Burton & Shaw, 2015). In one study, self-reported pain treatment outcomes in Veterans Affairs (VA) facilities were equivalent for Latinos and non-Latino Whites. Further, the limited extant research suggests that CBT is as effective for Latinos as non-Latino Whites for pain and depression but may require cultural tailoring of values and language (Beissner et al., 2012; Interian & Diaz-Martinez, 2007). Based on the information summarized, this chapter will primarily utilize a CBT for chronic pain (CBT-CP) protocol infused and supplemented with mindfulness, values from ACT, and cultural modifications (e.g., language, beliefs) germane to Latinos. Given the VA's emphasis on evidence-based practice and research, the VA's CBT-CP therapist manual (Murphy et al., 2014) is used as a framework for sessions, timeline, and tools. This manual was used in a nationwide study with significant improvements in pain catastrophizing, pain interference, and quality of life (Stewart et al., 2015). Given that (1) a substantial number of Latinos experience chronic pain, (2) many of those Latinos are Spanish-speaking, and (3) there are limited resources available for clinicians who work with Spanish-speaking Latinos, this chapter includes a session plan that outlines treatment goals and processes and associated resources, tools, and handouts for clinicians to use with Spanish-speaking clients. Given that experts in the field have indicated that CBT protocols may require cultural tailoring of values and language (Beissner et al., 2012; Interian &

Diaz-Martinez, 2007), all of the resources included are in Spanish and provide some minor cultural tailoring of values, but the core elements of CBT-CP have not been altered. Importantly, the treating clinician should maintain an idiographic conceptualization of each client and remember that these treatment resources should not be used in a blanket manner with Latinos. The clinician may wish to further tailor the values- and religion-based treatment tools to fit with the cultural values of the client.

Treatment Plan

This adaptation of CBT-CP involves a total of 13 sessions, including 1 for intake, 11 for treatment, and 1 booster session for maintenance. Each session is based on a 50-min hour. The treatment plan presented assumes that the therapist has at least basic knowledge of CBT. While familiarity with ACT would bolster the therapist's ability to explain acceptance and values, this is not required to be effective, and the tools provide sufficient detail about ACT principles. There are 16 tools included in Spanish to support the therapist in session and with homework, including handouts and worksheets. Refer to the session plan structure/timeline for a brief description of each session's theme, goals, and tools. The therapist should inform the client to keep a folder of the tools (handouts/worksheets) and bring the folder to each session.

Session #1: The Clinical Interview

Within CBT-CP, it is important to verify that the client is not experiencing emergent pain that requires immediate medical attention. Use clinical judgment to determine whether to refer to a medical doctor. Examples of this might include chest pain, open wounds, and severe head pain. It is helpful to confirm that the client has at least been seen by a medical doctor before presenting to therapy to rule out an acute cause of pain that can be treated.

During the intake, limits of confidentiality should be explained. As with any intake, the initial interview is an opportunity to assess the client's

Treatment plan timeline

Session #	Treatment component	Session/goals	Tools
1	Clinical interview Functional assessment	Confidentiality Rapport building Information gathering Case conceptualization Identify treatment goals	–
2	Orientation to CBT-CP	Rapport building Case conceptualization Psychoeducation Homework	1, 2, 3, 4
3	Values Costs of pain	Mood/pain assessment Review homework Cultural factors for pain Psychoeducation Valued behavior Homework	4, 5
4	Acceptance vs. avoidance/control	Mood/pain assessment Review homework Rationale for CBT-CP Medical treatment Homework	6
5	Pacing Physical activity Walking	Mood/pain assessment Review homework Activity scheduling Homework	7, 8
6	Relaxation training	Mood/pain assessment Review homework Psychoeducation Relaxation exercises Homework	9
7	Perspective taking Social support	Mood/pain assessment Review homework Psychoeducation Appropriate use of support Homework	4, 5 10, 11, 12
8	Pleasant activities	Mood/pain assessment Review homework Identify meaningful activities Activity scheduling Homework	13
9–10	Pain thoughts Cognitive coping	Mood/pain assessment Review homework Cognitive model Identify cognitive distortions Homework	14, 15
11	Sleep	Mood/pain assessment Review homework Psychoeducation Sleep hygiene Stimulus control Homework	16
12	Discharge planning	Mood/pain assessment Review homework Review treatment progress Maintenance of CBT-CP skills Schedule booster session	–
13	Booster session	Assess maintenance of skills Resolve problem areas	–

presenting complaint and current functioning. Key aspects to assess are:

(1)   Location(s) and typical level of pain on a 0–10 scale (0 = no pain, 10 = worst pain imaginable) and relevant variations
(1b) Factors that increase/decrease pain
(2a) How the client has attempted to resolve pain, including substance use or medication
(2b) What has been effective
(3a) How the client responds to pain (thoughts/emotions/behaviors)
(3b) Current level of functioning
(3c) Functional disability/impairment (inactivity/overactivity) and other costs of pain
(4a) Medical diagnosis/treatment
(4b) Pain history
(4c) Client's and family's belief about cause of pain
(5a) Social support availability/utilization
(5b) If bilingual and fluent in English, determine primary language spoken at home
(6)   Suicidal ideation, homicidal ideation, and self-harm
(7)   Mental disorder comorbidities, including psychosocial contributors and effects of pain, such as anxiety and depression
(8)   Sleep quality

Finally, the therapist should ask the client about goals for treatment.

Among Hispanics/Latinos, in particular, religious and spiritual causes of pain may be preferred over medical explanations. Therefore, a useful question to ask for (4c) is, "Can you tell me what you believe caused your illness?" This question can help to tap into any traditional beliefs that the client may hold as well as the family's attitude toward pain at home. From the intake session, a case conceptualization should be made to determine how pain is functioning in the client's life and determine the aspects of CBT-CP that will be most effective. During the intake, it is important to build a strong therapeutic alliance with empathy and validation of the client's pain and associated distress.

Session #2: Orientation to CBT-CP

• Begin by presenting the case conceptualization from the intake with the client to confirm that it "rings true."
• The primary goal of Session #2 is to educate the client about the difference between acute and chronic pain and the benefit of therapy. There are many misconceptions about chronic pain that clients may have.
• Present Tool #1 in session to discuss the client's beliefs and knowledge about pain with corrective education where necessary. An emphasis should be placed on how chronic pain does not involve damage to the body but rather pain that persists after the body has already healed.
• Introduce Tools #2 and #3 in order to explain the vicious cycle of pain with regard to both inactivity and overactivity. Emphasize the auxiliary effects of pain on mood, quality of life, and health. Maintain a theme of how the way people think and act affects pain throughout the session.
• Normalize and validate the client's responses to pain within the cycles because this can be a difficult realization for clients to accept.
• Explain how CBT-CP works to change the way the client thinks and acts to decrease pain and improve functioning, mood, and quality of life. Inform client that regular attendance and homework completion are critical to treatment progress. Ask client to keep all tools provided in a folder and bring them to session each week to support work in session.
• End Session #2 by briefly explaining the assigned homework (Tool #4) as an assessment of the costs of pain in the client's life. In particular, point out that pain often causes people to avoid activities they enjoy, which negatively affects thoughts and mood.

Sessions #3: Values and Costs of Pain

• Begin every session after Session #2 with a mood/pain check involving rating mood, pain

intensity, and functional disability/impairment on a scale of 0–10. Over the course of therapy, mood ratings should increase while pain intensity and disability decrease. Record these ratings to monitor progress and review during termination.

- Review homework from Session #2. Discuss the costs of pain unique to the client while eliciting client's emotional responses to the homework and realization of how pain negatively affects his life. Identify what is meaningful to the client about the activities he avoids and what experiences serve as obstacles.

- Use the end of homework review as an opportunity to introduce values with Tool #5. Present this worksheet using the instructions to explain how people can experience values conflicts between what they find meaningful and what they think they "should" value. Point out that these differences in values can lead to very different ways of acting, especially with regard to pain. Explain each example of how values lead to different behaviors with an emphasis on how common Hispanic/Latino "should" values may conflict with common Hispanic/Latino "want" values. Confirm whether traditional Hispanic/Latino values resonate with client. If not, modify values as necessary.

- Assign completion of the worksheet (Tool #5) as homework for the week to assess how each value influences the client's behavior.

Session #4: Acceptance vs. Avoidance/Control

- Mood/pain check.
- Review homework from Session #3 with special attention to how the "should" and "want" values conflict. Discuss which set of values the client believes will help him live the life he wants despite pain. Be aware there may be resistance to letting go of common values in the "should" category. Remind them of costs from Tool #4.
- Introduce Tool #6 to educate client about avoidance/passivity and control/resistance.

Explain how avoidance and control exacerbate pain and negative mood.

- Describe the middle path of acceptance with an active role in managing pain using strategies that are in the client's control. Emphasize the importance of acceptance given that chronic pain will likely never completely remit, even with treatment, to promote realistic expectations.

- Address any cultural beliefs that pain is inevitable, God's will, destiny, or punishment by presenting the serenity prayer to capitalize on factors that are in the client's control. Modify or omit as necessary if client does not hold religious beliefs.

- Respond to preference for religious or folk medicine with approval while also educating the client about the importance of multimethod treatment. Allow them to continue using preferred methods and encourage use of medical resources as courage to change. It is imperative that the therapist convey to the client that medical treatment, including physical therapy, is necessary for optimal pain management.

- Use the example of the baby crying to illustrate how caring for one's pain is an act of love that requires active engagement and help from others.

- Discuss the client's reactions to the idea of acceptance with an emphasis on how CBT-CP is intended to reduce pain and suffering rather than cure pain.

- Assign review of Tool #6 and scheduling a medical appointment (if not already receiving medical care) for homework.

Session #5: Pacing and Physical Activity

- Mood/pain check.
- Review completion of homework. Problem solve medical appointment scheduling, if necessary.
- Remind client about the costs of inactivity and overactivity from Tools #2 and #3.
- Use Tool #7 to describe the balance between inactivity and overactivity by using pacing. Use

the analogy of dancing to illustrate how to work with pain rather than against it or surrendering.

- Explain the activity schedule (Tool #8) with pacing by setting active and rest time goals.
- Complete Tool #8 with the client. Collaborate to determine appropriate active and rest time goals that will prevent severe pain. Explain how important walking is to everyday functioning and ensure one activity each day is walking.
- Give client Tool #7 and assign completion of the activity schedule (Tool #8) for homework.

Session #6: Relaxation Training

- Mood/pain check.
- Review completion of homework. Problem solve any obstacles. Discuss client's reactions to the homework, such as impact on mood/pain, perception of effectiveness, and productivity. Encourage maintenance of pacing strategy during and after therapy.
- Introduce Tool #9 by explaining the bidirectional relationship that stress and pain have on each other, which makes relaxation and stress reduction valuable skills.
- Briefly explain each of the exercises and lead the client through two with input from the client in choosing. Solicit reactions from the client after each exercise, including any effects on physical sensations, mood, or thoughts.
- Explain that the goal is to manage and respond to stress more effectively, not to get rid of stress. Educate client about the paradoxical effect of attempting to resist stress or pain.
- Give Tool #9 to client and assign practice of at least one exercise each day of the week for the rest of therapy.

Session #7: Perspective Taking and Social Support

- Mood/pain check.
- Review homework. Discuss client's reactions to the homework, such as impact on tension, pain, mood, or thoughts.
- Remind client about how "should" values affect behavior (from Tool #5) and how pain

interferes with valued activities (from Tool #4), which lowers mood.

- Introduce Tool #10 by validating how it can be difficult to share pain with others, and ask for physical or emotional support due to "should" values or feeling like a burden. Explain the importance of asking for support *when necessary* to break the pain cycle and improve quality of life and functioning. Emphasize that the client does not need to cope with pain alone. Present the idea of perspective taking by posing the questions from Tool #10 and explaining how our perceptions are biased.
- Lead the client through the perspective taking exercise in Tool #11. Discuss any differences between the first two and last two questions and how differently the client would perceive and respond to a loved one in pain.
- Give client Tools #10 and #11 and assign homework to ask a loved one to read Tool #12, followed by discussion of Tool #11 with the loved one to enhance communication and resolve distortions.

Session #8: Pleasant Activities

- Mood/pain check.
- Review homework assignment by discussing the loved one's reaction to Tool #12 and the client's discussion about Tool #12 with the loved one. Discuss client's reactions, including discrepancies between the client's and loved one's perceptions. Determine whether the client feels more comfortable requesting help when necessary.
- Remind client of the costs of pain with regard to avoiding activities (from Tool #4).
- Introduce Tool #13 by explaining how pain can prevent people from engaging in activities they enjoy, which negatively affects mood and pain.
- Using Tool #13, identify three values for the client. Use Tools #4 and #5 to aid in determining values.
- Identify two activities for each value that are pleasurable, meaningful, or provide mastery and write these down using Tool #13.
- Work with client to complete the activity schedule in Tool #13 with one pleasant/valued

activity scheduled per day for the next 2 weeks.

- Give client Tool #13 and assign completion of the scheduled pleasant activities for homework.

Sessions #9 and #10: Pain Thoughts and Cognitive Coping

- Mood/pain check.
- Review homework assignment by checking completion of daily pleasant activities and effects on mood.
- Explain the cognitive model (how automatic thoughts affect emotions and behavior) in basic terms and how pain can affect the way a person thinks and, therefore, feels and acts.
- Introduce Tool #14 to discuss the different types of cognitive distortions common to pain. Explain each distortion, each example of how it appears in a negative pain thought and, each example of how the thoughts can be more accurate. Discuss whether Tool #14 resonates with client and identify which distortions are most familiar to the client.
- Introduce Tool #15 and explain how to complete the basic thought record.
- Assign completion of Tool #15 for homework using situations that cause negative emotion.
- In Session #10, do mood/pain check and review Tool #15 from Session #9 and second week of Tool #13. Discuss client's reactions, including effect of pleasant activities on mood/pain and effect of accurate thoughts on emotion and behavior. Assign tool #15 again for Session #11.

Session #11: Sleep

- Mood/pain check.
- Review homework from week #10. Discuss effect of accurate thoughts on emotion and behavior, including engagement in valued behaviors and pleasant activities.
- Introduce Tool #16 by explaining how sleep problems are common among people with chronic pain and how poor quality sleep can worsen pain, health, and mood.

- Discuss the tips for sleep in Tool #16 one at a time. Explain the reason for each tip, and problem solve any obstacles to the DO and DON'T lists.
- Give client Tool #16 and assign compliance with the tips that appear to most problematic with client's sleep.

Session #12: Discharge Planning

- Mood/pain check. Record this last data point in chart/graph.
- Review homework and discuss effect of sleep tips on client's quality of sleep. Resolve any obstacles and encourage adherence to tips that were helpful.
- Show the client the chart/graph of mood/pain checks to illustrate treatment progress, and emphasize importance of maintaining cognitive and behavioral changes.
- Review the aspects of therapy that the client found most helpful in managing pain, reducing suffering, maximizing functioning, and improving mood. Have the client create a list in session of the skills that are most important to maintain.
- Celebrate the client's progress and praise the client for hard work and willingness to try new skills.
- Schedule booster session for 1 month later. Explain purpose of booster session is to monitor use of skills and maintenance of treatment gains.

Session #13: Booster Session

- Mood/pain check.
- Review use of skills from treatment, especially those identified as most important during Session #12. Problem solve obstacles to use of skills, and make recommendations from treatment based on any treatment loss. Determine whether further treatment is necessary.
- Ensure maintenance of medical treatment.

1) La Diferencia Entre Dolor Agudo y Dolor Crónico.

Todo el mundo experimenta dolor a veces de daño al cuerpo, como cortes, moretones, quemaduras, dolor de los músculos, e incluso la cirugía. Sentimos lo que llamamos "dolor" de estas lesiones porque el tejido dañado del cuerpo envía señales de dolor al cerebro. El dolor puede ser un recordatorio útil para limitar nuestro movimiento para que el cuerpo pueda sanar y no nos lastimemos otra vez. Por lo general, este tipo de dolor es temporal y dura de unos segundos a unos meses, dependiendo de la gravedad. Sin embargo, el dolor crónico es muy diferente de este "dolor normal" y no todo el mundo lo experimenta.

El dolor crónico implica dolor que continúa mucho tiempo después de que el cuerpo ha curado de una lesión, así como el dolor que no es el resultado de cualquier lesión. Generalmente, el dolor se considera crónico después de aproximadamente 3-6 meses y hay muchas diversas causas, incluyendo lesión, fibromialgia, artritis, y diabetes. Es importante saber que el dolor crónico es una enfermedad médica y refleja un problema en el sistema nervioso donde las señales de dolor se envían al cerebro a pesar de que no hay el cuerpo ya ha sanado. Mire a continuación en las formas en que el dolor agudo (normal) es diferente del dolor crónico. Un hecho importante a recordar es que el dolor crónico no es un signo de debilidad, es una condición médica.

 El dolor a menudo afecta negativamente la manera en que la gente piensa, siente y actúa. Además, la forma en que la gente piensa, siente y actúa puede empeorar el dolor. La terapia cognitiva comportamental para el dolor crónico ayuda a romper este patrón usando diversas maneras de pensar y de actuar para disminuir dolor y mejorar calidad de vida.

Dolor (Normal) Agudo	Dolor Crónico
• Menos de tres meses	• Más de tres meses
• El cuerpo está sanando	• El cuerpo ya ha sanado
• Se mejora con el tiempo	• Regularmente constante
• El descanso es bueno	• Es mejor moverse
• Causado por una situacion, como es una lesión	• Causado por una lesión o una condición medica
• El dolor disminuye con el tratamiento	• El dolor continúa a pesar del tratamiento
• Muy común y normal	• Menos del 30% en los EE.UU.; una enfermedad
• Se conoce la causa del dolor	• La causa del dolor puede ser desconocida

2) El Ciclo Vicioso del Dolor:

Desafortunadamente, el dolor crónico no puede ser curado, pero puede ser tratado, mejorado y manejado. Una de las cosas mas importantes cuando se desea manejar el dolor cronico es el mantenerse activo y en movimiento. Esto ultimo quizás le parezca confuse por que el dolor regularmente significa que debemos descansar y sanar y ademas tenemos dolor al movernos, pero recuerde que el dolor cronico no es debido a daño en el cuerpo. El dolor crónico puede engañarnos al pensar que estamos ayudando a nosotros mismos al ser menos activos. Sin embargo, la falta de movimiento puede realmente aumentar el dolor porque nos volvemos más débiles y rígidos.

El dolor crónico también es muy desagradable y podemos renunciar a hacer cosas que nos gustan y valoramos (cosas en las que somos buenos) porque duele demasiado, como pasar tiempo con la familia y los amigos, pasatiempos, trabajar para proporcionar y hacer ejercicio. Desafortunadamente, esto puede conducir a la tristeza oa la depresión, a la frustración, a las relaciones peores ya una menor autoestima y calidad de vida. Entonces, nos sentimos menos motivados para ser activos, lo que lleva a más dolor, menos actividad, sentirse peor, y así sucesivamente. Este es el ciclo peligroso del dolor crónico y es muy fácil quedar atrapado en él, pero hay maneras de salir y mantenerse fuera de él.
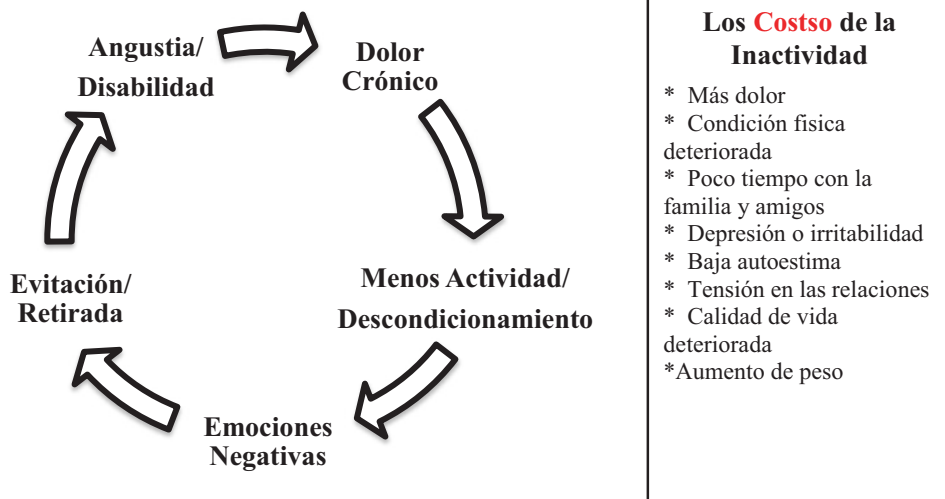
Dibujo del Manual de VA (Murphy et al., 2014)

3) Ciclo de la Hiperactividad

Es normal sentirse frustrado porque no puede hacer todo lo que solía hacer debido al dolor y lo mejor es seguir haciendo lo que todavía puede hacer. Sin embargo, hay un equilibrio importante entre hacer demasiado poco y hacer demasiado. A veces puede haber tentación de ser fuerte y empujar a través del dolor o hacer demasiado en días cuando se siente menos dolor. Similar al ciclo de inactividad, el ciclo de hiperactividad implica más dolor y emoción negativa. Empujar a través del dolor o el exceso de trabajo en un "buen día de dolor" conduce a un dolor intenso e incapacitante, que requiere unos días de descanso y la inactividad para recuperarse. Durante este tiempo, la irritabilidad y el estado de ánimo deprimido son más probables debido al dolor intenso, menos productividad, y falta de actividades agradables. En efecto, es normal tener un fuerte deseo de compensar el tiempo perdido y hacer mucho en un día cuando el dolor finalmente pasa. Entonces, el ciclo comienza otra vez. Esta es la razón por que es tan importante ir al paso en vez de hacer demasiado poco o demasiado.

4) Costos de Inactividad

El dolor puede interferir con nuestras vidas cuando evitamos las actividades que disfrutamos debido al miedo de sensaciones desagradables, perjudicarnos a nosotros mismos o afectar a otros. La inactividad también puede resultar de trabajar demasiado duro. Como se explica en el círculo vicioso del dolor, la inactividad puede aumentar el dolor y las emociones negativas, así como disminuir la felicidad, la fuerza, la autoestima y la salud. Durante la próxima semana, piense en las actividades más importantes que solía disfrutar pero dejó de hacer y ahora se pierda. También, piense porqué usted no los hace y el efecto de la inactividad en su vida. Rellene los espacios en blanco a continuación, siguiendo el ejemplo, para ver cuáles son sus costos únicos de inactividad.

La actividad que disfrutas pero evitas. ¿Por qué te gusta y por qué te lo pierdes?	¿Por qué evitas la actividad? ¿Qué te impide hacerlo? (Predicciones, miedos)	El efecto de evitar la actividad sobre usted y otros (Pensamientos, emociones, acciones)
Ejemplo: Jugar con mi hijo en el parque. Me encanta ver a mi hijo sonreír y la familia es importante para mí.	*Me duele moverme. Tendré que hacer descansos y mi hijo se aburriria. ¿Y si me lastimo?*	*Mi hijo está triste. Me siento avergonzado y deprimido. Creo que soy débil y un padre malo. Me paso todo el día adentro.*
1)		
2)		
3)		
4)		
5)		

5) Identificar los Valores de QUERER vs. DEBER
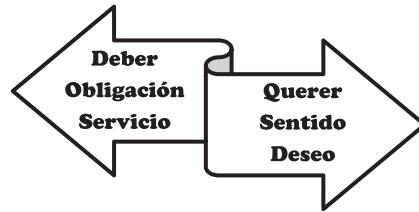
A veces, lo que creemos que debemos hacer y lo que queremos hacer nos atrae en direcciones muy diferentes. De la misma manera, lo que pensamos que se supone que debemos valorar y lo que realmente valoramos puede ser muy diferente y oponerse unos a otros. Un ejemplo común de esto con dolor crónico es ser estoico sin expresar dolor a otros en lugar de hablar con la familia y buscar apoyo. Piense en cómo cree que se supone que debe actuar y cómo realmente quiere vivir su vida. ¿Actuar de la manera en que piensa que "debería" interfiere con su salud, deseos, felicidad y vivir una vida significativa? Recuerde la página interacctive de costos de inactividad, las actividades que disfrutamos pero evitamos pueden ser útiles para identificar nuestros verdaderos valores y nuestra vida deseada.

"Deber" Valores   ¿Cómo se ve cuando vive con este valor?

| Estoicismo y Fuerza | •*Ejemplo: No le cuento a otros acerca de mi dolor e intento lidiar solo.* |

| Fatalismo, Destino, y Sufrir | •*Ejemplo: No visito a un médico. Pienso que no hay nada que puedo hacer.* |

| Machismo o Marianismo | •*Ejemplo: Trato de ser duro y proporcionar a otros aunque tengo dolor.* |

"Querer" Valores   ¿Cómo se ve cuando vives con este valor??

| Familismo, Amigos, y Relaciones | •*Ejemplo: Paso tiempo con mi familia y comparto mis sentimientos.* |

| Salud y Bienestar | •*Ejemplo: Como saludable, visito a mi médico y camino diario.* |

| Divertido y Placer | •*Ejemplo: Practico deportes, escucho música y bailo.* |

¿Qué conjunto de valores le ayudará a vivir la vida que desea a pesar del dolor?

6) Aceptación: La Línea Fina Entre el Control y la Resignación

Es muy común querer deshacerse del dolor porque es desagradable para la mayoría de la gente. El problema es que no podemos controlar directamente el dolor, de la misma manera que no podemos controlar la temperatura y el tiempo. La resistencia al dolor y el enfoque que ponemos en cómo queremos que desaparezca sólo aumenta el dolor y la angustia emocional porque no funciona y además conduce a una mayor tensión muscular y desesperanza. El deseo de controlar el dolor puede hacer que las personas busquen constantemente remedios para el dolor, incluyendo cirugías, medicamentos e inyecciones hasta que el dolor desaparezca por completo.

En contraste con el control, esta la aceptación y resignación. Hay una línea fina entre la aceptación del dolor y la resignación pasiva, o la inacción. Por un lado, la aceptación puede ser muy útil para reducir la angustia causada por el dolor y mantenerse activo en su vida. La aceptación es reconocer lo que está fuera de nuestro control, sin juzgar, y trabajar con habilidad para mejorarlo. Esto es lo contrario de resistir el dolor, que puede causar más tensión muscular, dolor, y emoción negativa. La aceptación del dolor es similar a cargar el dolor como si fuera un bebé en lugar de luchar contra un enemigo. Por otro lado, la resignación es similar a soltar completamente el control y no hacer nada, incluso cuando tenemos la capacidad de mejorar la situación. La resignacion puede impedirnos hacer cosas que mejorarían nuestras vidas y las vidas de otros.

Como un bebé, el dolor requiere el cuidado de los padres y el cuidado de un bebé requiere el apoyo de otros, como médicos y miembros de la familia. Por ejemplo, no podemos controlar cuándo llora un bebé, pero seguimos cuidando al bebé con amor y pidiendo ayuda cuando lo necesitamos, que es lo que sería la aceptación. No tratamos de encontrar una cura para el llanto (control) o ignorar por completo el hecho de que el bebé está llorando (resignación). De la misma manera, podemos cuidar el dolor crónico con la intención de reducir el dolor, el sufrimiento, y la interferencia con las actividades que valoramos. Esperar que el dolor desaparezca sólo se prolonga y aumenta el efecto que el dolor tiene en su vida.

El dolor, por ser complejo, requiere una variedad de métodos de tratamiento. Está bien si usted cree explicaciones religiosas del dolor y prefiere generalmente la oración y la medicina popular, tales como curanderos, para la salud. Sin embargo, debido a que el dolor es tan complejo, es mejor agregar otras estrategias de tratamiento para obtener el mejor resultado, como agregar ingredientes para una receta. Uno de los ingredientes más importantes para el dolor crónico es el tratamiento médico. La mayoría de los Hispanos/Latinos esperan hasta que el dolor sea severo para llamar a un médico. No esperes. Visite a un médico que puede recomendar diferentes opciones de tratamiento, incluyendo procedimientos médicos (cirugía, inyecciones) y medicamentos, basados en la evaluación de su dolor. Es importante destacar que el médico no puede hacer recomendaciones apropiadas a menos que sea completamente honesto acerca de la intensidad y duración de su dolor. Además, el tratamiento no será efectivo a menos que siga las instrucciones para cambiar el tratamiento médico si es necesario. Recuerde, el objetivo del tratamiento médico no es curar el dolor, que sólo llevará a la decepción y más sufrimiento. El objetivo es reducir el dolor, el sufrimiento, y la interferencia con su valiosa vida.

La psicoterapia es otro ingrediente muy importante para la receta de manejar el dolor. El tratamiento psicológico que recibe de su terapeuta también ayudará a prevenir los incrementos repentinos de dolor, maximizar la calidad de vida y cambiar su relación con el dolor. El tratamiento psicológico incluye niveles saludables de actividad física, viviendo con valores, reducción del estrés y uso adecuado del apoyo social. Estos son todos los factores en su control que pueden ayudar a reducir el dolor y el efecto que este produce en su vida, si los usa.

Si usted es religioso, la oración de serenidad es un gran ejemplo de aceptación y de manejo activo de su dolor, en lugar de control o resignación. "Dios, concédeme la serenidad para aceptar las cosas que no puedo cambiar, coraje para cambiar las cosas que puedo y sabiduría para saber la diferencia".

7) Despacio y Balanceado (Poco a poco): Bailando con el Dolor

Algunas personas son más propensas a forzarce a terminar un trabajo o actividad aun cuando tienen dolor severo (ciclo de hiperactividad). Esto es como tratar de combatir el dolor, lo cual puede ser agotador. Otros pueden estar preocupados por dañarse a sí mismos o temer al dolor tanto que evitan el movimiento por completo (ciclo de inactividad). Esto es como darle todo poder al dolor y renunciar. Ninguna de estas opciones es sostenible o saludable y ambas pueden llevar a emociones negativas, como la depresión.

La clave es dividir las tareas en partes más pequeñas y asegurarze que su actividad tenga un ritmo donde se incluya parar cada cierto tiempo y con descansos entre el medio. Si no ha estado muy activo, puede ser más fácil moverse si sabes que es sólo por 10 minutos. Si tiende a ser demasiado activa, entonces necesita mucho descanso, a la larga, puede lograr más en el largo plazo manteniendo un ritmo balanceado en lugar de tratar de terminar cada trabajo en un día.

La idea es simple, usted elige que tanto tiempo usted piensa que puede estar activo sin dolor severo, y así mismo, que tanto tiempo necesita para recuperarse antes de comenzar la actividad de nuevo. Puede reducir el tiempo de actividad y aumentar el tiempo de descanso al principio, si tiene mucho dolor, y puede aumentar el tiempo de actividad y disminuir el tiempo de descanso más tarde a medida que aumenta la fuerza y la resistencia. El objetivo es trabajar más inteligentemente, no más duro, y sentirse más productivo con menos dolor. En vez de la inactividad o la hiperactividad, bailes con el dolor tomando turnos para dirigir y seguir.

8) Su Agenda de Actividades con un Ritmo Balanceado

Piense en actividades que evita o hace durante demasiado tiempo. Escriba su meta de tiempo activa, tiempo de descanso y número de ciclos de trabajo y descanso. Cada día puede ser diferentes actividades. En el ejemplo siguiente, la persona pinta durante 10 minutos, luego descansa durante 15 minutos, 2 veces (10/15 x2). Llene los espacios abajo de la misma manera. Debido a que caminar es una parte tan importante de la vida cotidiana, asegúrese que caminar sea una de las actividades para cada día.

	Actividad 1	**Actividad 2**	**Actividad 3**
Ejemplo	Pintar Paredes 10/15 x2	Caminar Afuera 5/5 x3	Cocinar la Cena 15/20 x2
Día 1			
Día 2			
Día 3			
Día 4			
Día 5			
Día 6			
Día 7			

9) Ejercicios de Relajación

Debido a que el estrés puede aumentar el dolor y el dolor puede aumentar el estrés, es importante tener estrategias para reducir el estrés y relajarse. Algunas de las estrategias más comunes son la respiración consciente, las imágenes, la relajación muscular progresiva, el escaneamiento corporal y el movimiento consciente. A continuación se presentan breves descripciones e instrucciones para cada uno. Pruebe diferentes estrategias y encuentre lo que funciona mejor para usted, pero practique al menos una estrategia cada día.

Respiración consciente

En primer lugar, encontrar una posición cómoda estando sentada y cerrar los ojos si lo desea. Comience por centrar su atención en la respiración. Coloque una mano en su pecho y la otra mano en su vientre. Observe donde usted está respirando atravez de la sensación de que la mano se mueve más. Observe la profundidad y la velocidad de la respiración. Ahora, imagine llenar sus pulmones de aire causando que su vientre suba y baje. Deje que su cuerpo respire por usted. No es necesario controlar, analizar o cambiar la respiración de ninguna manera. Si lo desea, puede contar hasta 4 con cada inhalación y exhalación (1 ... 2 ... 3 ... 4) y hacer una pausa entre los dos. Siente la temperatura del aire cuando entra y sale por la nariz o la boca. Es normal que la atención pasee a veces a otras experiencias, como pensamientos, sensaciones corporales y sonidos. Simplemente traiga su atención de nuevo a la respiración cada vez que esto suceda. Continúe respirando unos 5-10 minutos antes de abrir los ojos.

Imaginando

En primer lugar, encontrar una posición cómoda sentado y cerrar los ojos. Imagínese en un lugar relajante, feliz o especial que disfrute. Esto puede ser un lugar afuera en la naturaleza, como una playa o las montañas, o en el interior, como una casa o un restaurante. Usando su imaginación, mire alrededor de este lugar y observe los objetos en su ambiente, quién está allí, y los colores. Escuche los sonidos de este lugar. Observe si hay algún olor que recuerde. Si este lugar implica comer o beber, imagina el sabor en tu boca. Alcanze y toque un objeto o persona y sienta la sensación. Utilice tanto detalle como sea posible al imaginarse estando en este lugar y utilice sus cinco sentidos. Por ejemplo, usted puede imaginar estar acostado descansando en la playa. Observe el calor del sol y la sensación de la arena en su piel, el olor del océano o su loción favorita, el sabor de una bebida tropical, el color del agua y el sonido de las olas que se estrellan.

Relajamiento Muscular

Elija un músculo o conjunto de músculos, como los dedos de los pies, las piernas, los abdominales, los brazos, las manos o la cara. Por ejemplo, usted puede empunar sus manos, doblar sus brazos, mover sus dedos del pie para arriba, apretar sus piernas, levantar los hombros a sus oídos, o apretar los dientes. Elija un músculo que pueda flexionar sin hacerse daño. Un poco de dolor es normal y está bien. Comience por flexionar lentamente el músculo y mantenerlo asi durante 5 segundos. Observe la sensación de apretar el músculo. Luego, suelte lentamente la tensión y sienta la sensación de relajarse durante 10 segundos. Repita esto con algunas 5 partes

diferentes del cuerpo. Sea creativo y pruebe diferentes músculos y formas de estirar o tensar su músculo.

Escaneando el cuerpo

En primer lugar, encontrar una posición cómoda acostado o sentado y cerrar los ojos, si lo desea. Ponga su atención en la parte inferior de sus pies y recorra todo su cuerpo hasta a la parte superior de la cabeza, paso por paso. Usted puede empezar a notar comezon, dolor, calor, frío, hormigueo, entumecimiento, sentir pesado, ligero, o nada. La intención es notar lo que está presente en cada parte del cuerpo con curiosidad y sin juzgar. Haga una pausa en cada parte del cuerpo durante unos 10-30 segundos. Un orden útil es pies / tobillos ... pantorrillas y rodillas ... piernas ... trasero y caderas ... vientre ... pecho ... espalda baja ... parte superior de la espalda ... manos ... antebrazos ... brazos ... hombros ... cuello ... mandíbula y boca ... nariz ... mejillas ... orejas ... La parte superior de la cabeza. Es normal que la atención se distraiga algunas veces a otras experiencias, como pensamientos, sensaciones corporales y sonidos. Simplemente traiga su atención de nuevo a la respiración cada vez que esto suceda.

Movimiento consciente

Elija un movimiento o actividad que funcione para usted. Esto puede ser caminar, rodar en una silla de ruedas, andar en bicicleta, o una tarea como lavar los platos, jardinería, o cepillarse los dientes. Traiga la mayor atención posible al movimiento de su cuerpo. Sienta la temperatura del aire o del agua contra su piel, la presión en sus pies, y cualquier sensación en sus manos si usted está sosteniendo algo. Observe la sensación de mover su cuerpo y cualquier cambio en los músculos. Tanto como usted puede, observe cada aspecto del momento sin juzgar. Si es posible, muevese más lento de lo normal y haga una pausa entre los movimientos. Es normal que la atención se distraiga a veces a otras experiencias, como pensamientos, sensaciones corporales y sonidos. Simplemente traiga su atención de nuevo a la respiración cada vez que esto suceda.

Autocompasión

El dolor te puede hacerte sentir como si estuvieras en una batalla con tu propio cuerpo. Te puede ayudar el sentir bondad y compasión hacia ti mismo tal como eres en lugar de pensar que necesitas cambiar tu cuerpo. Algunas expresiones sencillas, como las siguientes, pueden ayudarle a desear bienestar para usted mismo. Cuando usted intente esto, tenga presente que éstos son deseos o intenciones, no metas.

- Que yo esté protegido de daño interno y externo.
- Que yo esté feliz y reconozco que soy digno de la felicidad.
- Que yo sano y bien.
- Que yo me acepta tal como soy, incluyendo los aspectos agradables y desagradables.
- Que yo acepta las circunstancias de mi vida como son.
- Que yo esté libre del sufrimiento causado por querer escapar o controlar mi experiencia.
- Que yo viva confiado y relajado.
- Que yo esté en paz y viva con serenidad y liberación.

10) Tomando una Perspectiva Differente

Puede ser muy difícil hablar con otros sobre el dolor y pedirles ayuda, pero si lo hace, no tendría que lidiar con el dolor usted solo(a). Usted podría pensar que es un signo de debilidad, en su propia opinión, o tener el miedo de que otros piensen que usted es débil e incapaz de ayudarse a si mismo. Además, usted puede estar pensando que los demás no le creeran que usted tiene dolor crónico porque no hay evidencia visual, como una herida o moretón, para demostrar que está en el dolor. Una reacción común es ocultar su dolor y tratar de continuar como si usted no está en dolor sin pedir ayuda a los demás.

La mayoría de los Hispanos/Latinos esperan hasta que el dolor tenga una intensidad de 10/10 antes de pedir ayuda. Sin embargo, como se le mostro con los ciclos viciosos del dolor, el dolor puede causar inactividad, hiperactividad y emociones negativas. Es por eso que pedir apoyo cuando lo necesita puede ser una forma de fortaleza y sabiduría. Es importante pedir apoyo a los demás de dos maneras: 1) buscar apoyo social de otros para hacer frente a las emociones difíciles, y 2) pedir ayuda con tareas que son difíciles para usted y pueden causar más dolor. La manera más fácil de empezar es decirle a la gente a quien amas y confías.

Piensa en cómo te sentirías si alguien que amabas tuviera dolor y necesitara tu ayuda. ¿Quieres que te lo digan para que puedas ayudar o crees que son débiles y una carga? ¿Quieres que esperen hasta que su dolor es 10/10? A veces, la forma en que pensamos acerca de nosotros mismos puede ser muy diferente de la forma en que pensamos acerca de otros que están en la misma situación, como estar enfermo o cometer un error. Además, a veces lo que pensamos que los demás piensan de nosotros es muy diferente de lo que realmente piensan. Recuerde, usted no tiene que enfrentar al dolor solo.

11) Ejercicio: Adquiriendo Perspectiva

Echemos un vistazo a cómo piensa usted acerca de pedir ayuda a alguien cuando tiene dolor y lo compararemos con alguien que le pide ayuda cuando están en el dolor.

1) ¿Qué se preocupa que otros piensen si usted pide ayuda cuando tiene dolor?
_____

_____

2) ¿Qué hace usted en lugar de pedir ayuda a un ser querido?
_____

_____

3) ¿Qué pensaría usted si un ser querido necesitara su ayuda debido al dolor?

_____

_____

4) ¿Qué diría o haría si un ser querido necesitara su ayuda debido al dolor?
_____

_____

12) Adquiriendo una Nueva Perspectiva. Informacion para el Miembro de la Familia / Cuidador / Amigo

Puede ser muy difícil para las personas con dolor hablar con otros acerca de su dolor y pedir ayuda. Estas personas tienden a pensar que es un signo de debilidad o tienen temor que otros piensen que son débiles e incapaces de proveer o colaborar con la familia. Además, tienden a preocuparse de que otros no crean que tienen dolor crónico porque no hay evidencia visual, como una herida o moretón, para demostrar que están en dolor. Una reacción común es ocultar dolor e intentar continuar como si no estuvieran en dolor sin pedir apoyo de otros.

La mayoría de los Hiapnos/Latinos esperan hasta que el dolor tenga una intensidad de 10/10 antes de pedir ayuda. Sin embargo, como se le ha explicado, los ciclos viciosos del dolor pueden causar inactividad, hiperactividad y emociones negativas. Es por eso que pedir apoyo cuando sea necesario puede ser una forma de fuerza y sabiduría para las personas con dolor crónico. Es importante ayudar a las personas con dolor de dos maneras: 1) proporcionar apoyo social para ayudarles a lidiar con las emociones difíciles, y 2) ayudar con las tareas que son difíciles y pueden causarles más dolor. El dolor crónico es una condición médica muy real a pesar de que puede no haber signos visibles en el cuerpo.

Piense en cómo se sentiría si tuviera dolor la mayoría del tiempo y no fuera capaz de hacer todo lo que solías disfrutar. Por eso es tan importante asegurarse de que el ser querido con dolor se siente escuchado y entendido. Una estrategia útil en cualquier situación es imaginarte a ti mismo en su posición y cómo quisieras que otros te trataran. Recuerde asegurarle a su ser querido que no son una carga si necesitan apoyo emocional o físico. Sin embargo, también es importante que la persona con dolor haga lo que todavía puede hacer. Por eso, no trate de hacer todo por ellos o constantemente les pregunte si necesitan ayuda.

El objetivo es lograr un equilibrio entre el abandono y el refuerzo de la discapacidad fomentando la independencia, proporcionando apoyo sólo cuando sea necesario y fomentando la actividad física. A veces, usted puede sentir la necesidad de ayudarlos alentándolos a continuar a pesar de el dolor, pero esto sólo hace que el dolor empeore en el largo plazo. Debe confiar en que le pedirán ayuda cuando la necesiten y debe animarles a que mantengan las actividades que todavía pueden hacer para minimizar la discapacidad.

Por último, piense en las luchas o barreras que encuentra cuando cuida de su ser querido que esta con dolor. Puede experimentar un cambio de papeles, difícil en una relación, y es normal experimentar una cierta frustración porque usted no puede hacer que el dolor desaparezca. Tenga en cuenta que esta es una experiencia común y normal. Proporcione apoyo cuando sea necesario, recuerde que está haciendo lo mejor que puede, e imagine la situación invertida. Después de leer esto, discuta con su ser querido que sufre de dolor los pensamientos incorrectos que esta persona quizás tenga de lo que sucedería si le pidiera apoyo, y corrija cualquier preocupación incorrecta que su ser queirdo tenga sobre pedirle ayuda y apoyo a usted.

13) Programa de Actividades Agradables Basado en Sus Valores

Una trampa seria del dolor crónico es decirse a usted mismo que usted hará las actividades que le gustan cuando el dolor desaparezca. Sin embargo, el dolor crónico no desaparece y empeora con la inactividad, por lo que usted terminaría haciendo menos cosas que usted disfruta y ademas sentiria más dolor. De hecho, cuando usted se da cuenta que su dolor sigue ahi, usted puede ponerse triste, irritable, o deprimido. El dolor no tiene que hacerte esperar para vivir tu vida. En vez de esperar para hacer cosas que disfruta cuando no tiene dolor, puede hacer cosas aunque experimenta algún dolor. Hacer actividades que están en acuerdo con tus valores le dan a su vida más significado. Piense en cuáles son sus valores. Recuerde que los valores son una dirección no un destino.

¿Cuales son sus valores? Trate de pensar en 3 de ellos que son parte de quien usted es.

1. _____

2. _____

3. _____

¿Qué actividades puede hacer usted que sean placenteras o parte de sus valores? Puede ser útil pensar en lo que le gusta hacer, en lo que le hace sentir bien y en lo que sabe hacer bien. Trate de pensar en dos ejemplos para cada valor que indentifique.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Programe una actividad para cada día en las próximas dos semanas y anote cómo le hizo sentir.

Domingo	Lunes	Martes	Miércoles	Jueves	Viernes	Sabado

14) Pensamientos del Dolor

El dolor crónico y los "deber" valores pueden cambiar la manera que usted piensa de una manera negativa y los pensamientos negativos pueden aumentar dolor. Por ejemplo, los pensamientos negativos pueden conducir al aislamiento social, menos actividad física, tensión, y más emociones negativas. Por lo tanto, los pensamientos negativos no le ayudan a lidiar con el dolor de manera eficaz. A pesar de que no puede controlar los pensamientos porque son automáticos, puede responder a ellos de manera más eficaz mediante la identificación de la negatividad y la creación de un pensamiento más effectivo. Este es otro ejemplo de encontrar un equilibrio entre la resignación y el control. A continuación se presentan algunas categorías comunes de pensamientos negativos provocados por el dolor.

Tipos de Pensamientos Negativos del Dolor	Ejemplos de Pensamientos Negativos	Ejemplo de Pensamiento Efectivos "La Verdad"
Catastrofización: Creer que algo será mucho peor de lo que es en realidad.	Si trato de caminar, el dolor será insoportable.	El dolor nunca es extremo y por lo general mejora después de unos minutos.
Expresiones "debería": Pensar en términos de cómo deberían ser las cosas.	Debo soportar el dolor sin ninguna medicación o apoyo de otros.	Puedo maximizar mi funcionamiento y mi calidad de vida buscando la ayuda y siguiendo órdenes del doctor.
Pensamientos de Todo o Nada: Ver las cosas en categorías extremas de negro o blanco en lugar de gris equilibrado.	Tengo que terminar este trabajo o tarea completamente en un día. O tengo que descansar el día entero. La medicación para el dolor es mala, no usaré ninguna.	Está bien descansar cuando lo necesito y terminar el trabajo mañana. La medicación para el dolor puede ayudar y está bien usarla si realmente la necesito
Generalización excesiva: Creer en un patrón permanente basado en uno o pocos incidentes raros.	La terapia física y la medicación no ayudaron la última vez.	A veces la terapia física y la medicación no ayudan, pero en general, ayudan un poco.
Haciendo a conclusiones: Hacer conclusiones negativas de eventos que no se basan en hechos.	Me duele cuando me muevo, debe ser malo para mí para moverme.	El dolor crónico es diferente del dolor normal. Moverse ayuda a aliviar el dolor si lo hago con calma.
Razonamiento Emocional: Interpretar la realidad usando sus sentimientos en lugar de analizar los hechos.	Me siento solo. Otros no quieren pasar tiempo conmigo.	Mi familia me ama y tengo que hacerles saber cuando necesito apoyo.
Descontando lo Positivo: Centrándose sólo en lo malo y minimizando lo bueno.	Puedo trabajar otra vez, pero solamente 20 horas por semana.	Estoy trabajando más que el año pasado y finalmente puedo proporcionar a mi familia otra vez.

15) Pensamientos Negativos del Dolor: Página Interactiva

Piense en los pensamientos negativos provocados por el dolor que normalmente tiene y rellene las casillas de abajo como el ejemplo. Escriba la situación / evento, el pensamiento, el tipo de pensamiento negativo, y reemplaze por un pensamiento más preciso y effectivo. Escriba un ejemplo cada día. Con más práctica, será más fácil notar pensamientos negativos y pensar en pensamientos más precisos, effectivos, y balanceados. Identificando la negatividad en sus pensamientos y pensando en un pensamiento más preciso y positivo, puede prevenir que el dolor afecte negativamente sus emociones, dolor y acciones.

Situación/Evento ¿Que pasó?	Pensamiento/Interpretación ¿Qué pasó por su mente? ¿ ¿Cómo se sintió? ¿Que quería hacer?	Tipo de Pensamiento Negativo	Pensamiento, Exacto, Equilibrado "La verdad" ¿Cómo se sintió?¿Qué hizo usted?
Ejemplo: Mi familia me invitó a ir al parque.	*Estaré en mucho dolor para divertirme. Me sentí triste. Yo quería decir que no.*	*Catastrofización*	*Me dolerá un poco al principio pero luego me sentiré mejor y me divertiré. Me sentí menos triste. Fui con mi familia y estuvimos felices.*

16) Higiene de Dormir

Uno de los problemas más comunes con el dolor crónico es el problema de dormir. Los efectos comunes de la falta de sueño son dolor, dificultad para concentrarse, irritabilidad y falta de energía. En efecto, la falta de sueño puede empeorar las consecuencias del dolor. Aquí hay algunos consejos para aumentar la calidad del sueño que se aplican a cualquier persona que tenga problemas para dormir:

HACER (SI)

- ✓ Mantenga su cuarto oscuro, tranquilo y fresco.
- ✓ Limite las fuentes de luz y ruido.
- ✓ Utilice tapones para los oídos o una venda de ojos si es necesario.
- ✓ Sólo vaya a la cama cuando tenga sueño, no cuando esté cansado o con dolor.
- ✓ Sólo use la cama para dormir y la sexualidad. Salga de la cama después de 20 minutos si no puede conciliar el sueño. Haga algo aburrido hasta que esté cansado y luego regrese a la cama.
- ✓ Despertar a la misma hora todos los días, incluso si su horario es diferente.
- ✓ Limite la cantidad de agua que bebe después de la cena antes de acostarse para evitar el uso del baño.
- ✓ Use estrategias de reducción del estrés y relajación una vez al día.
- ✓ Haga ejercicio o haga algo físicamente activo durante el día.

NO HACER (NO)

- ✘ No vea la televisión ni use su teléfono en la cama.
- ✘ No consuma cafeína de refrescos, café o bebidas energéticas después de el lunche. La cafeína permanece en su cuerpo durante muchas horas.
- ✘ No come la cena, beba el alcohol, o fume 2 horas antes de ir a la cama.
- ✘ No tome siestas.
- ✘ No haga ejercicio antes de acostarse
- ✘ No utilice el botón de snooze
- ✘ No se preocupe en la cama. Levántese y escribe el problema para el día siguiente o antes de acostarse.

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Using Behavioral Activation and Cognitive Interventions to Treat Depression Among Latinos

Rebecca M. Pasillas
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It is estimated that the lifetime prevalence of major depressive disorder (MDD) in US population is 17% with higher prevalence rates in two adult age groups: 30–44 years (20%) and 45–59 years (19%) (Kessler et al., 2005). MDD is characterized by a single or recurrent depressive episode in which the person reports depressed mood or loss of interest in pleasurable activities along with five or more of the following symptoms: change in appetite or weight, change in sleep, loss of energy, feelings of worthlessness or guilt, lack of concentration, and suicidality. These symptoms must be present during a 2-week period and cause significant distress and impaired social, occupational, and educational functioning (American Psychiatric Association, 2013). According to the World Health Organization, MDD has been found to be the "leading cause of disability worldwide, and is a major contributor to the overall global burden of disease" (2016). Indeed, untreated MDD can negatively impact one's physical health resulting in poor health outcomes and, in severe cases, may lead to suicide attempts or death (e.g., Bolton, Pagura, Enns,

Grant, & Sareen, 2010; Cavanagh, Carson, Sharpe, & Lawrie, 2003; O'Neil, Williams, Stevenson, Oldenburg, & Sanderson, 2012). Additionally, factors such as gender and a history of childhood trauma have been associated with the development of depressive symptoms (Kessler et al., 2003; Kessler & Magee, 1993).

While there are several studies that examine the prevalence of MDD in Latinos, one meta-analysis found that Latinos have similar lifetime prevalence rates as non-Latino Whites (Mendelson, Rehkopf, & Kubzansky 2008). Despite similar lifetime prevalence rates between Latinos and non-Latino Whites, there is a difference in how MDD is clinically presented in Latinos. Specifically, a body of literature indicates that Latinas have higher rates of somatic symptoms associated with depression (e.g., Myers et al., 2002). Tailoring interventions to target both somatic and depression symptoms would enhance the psychosocial health outcomes of Latinas.

There are several evidence-based psychotherapies targeting depression identified by the American Psychological Association's Society of Clinical Psychology (DIV12). They include cognitive therapy, cognitive behavioral analysis system of psychotherapy for depression, interpersonal therapy, problem-solving therapy, self-management therapy, and behavioral activation. While many of these interventions have not been tested with Latinos, some of the interventions have been culturally modified and evaluated

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and demonstrated efficacy among Latinos experiencing depression. For example, a recent systematic review of psychotherapies for depression in a Latino population found that cognitive behavioral therapy (CBT) was the most evaluated intervention among Latinos, with a majority of the interventions provided in a group format, and found to improve outcomes on depression symptom measures (Collado, Lim, & MacPherson, 2016).

Given that behavioral activation is a component in CBT, very few studies have evaluated its efficacy as a stand-alone intervention among Latinos with depression, which is surprising considering that there is great promise for reducing depression symptoms using this intervention. In a seminal study by Comas-Diaz (1981), cognitive therapy and behavior therapy were examined against a wait-list control in Latinas with depression. Symptoms were reduced for both interventions, but, at 5-week follow-up, it was behavioral therapy that maintained reduction of depression symptoms. In evaluating recent studies examining the effectiveness of culturally modified behavioral activation in Latinos with depression, Collado et al. (2016) reviewed the results of one randomized control trial (Kanter et al. 2015) and two open trials (Collado, Castillo, Maero, Lejuez, & MacPherson, 2014; Kanter, Santiago-Rivera, Rusch, Busch, & West, 2010) and found that depression symptoms decreased. Based on these findings, behavioral activation is a promising, efficacious intervention for Latinos experiencing depression symptoms.

Behavioral activation (BA) is an idiographic intervention that incorporates behavioral principles such as positive reinforcement, shaping, and over-learning. The goal of BA is to alter environmental factors that may be maintaining depression symptoms. Treatment goals focusing on improving quality of life are identified, and pleasurable activities tailored to the consumer are scheduled in order to increase these types of activities in consumer's daily life. The idea is that by increasing pleasurable activities, the consumer is less likely to experience depressed mood or engage in depressive behaviors. Therefore, the behavioral activities selected and scheduled are personally relevant and always small, achievable

steps so as to improve the consumer's sense of mastery and provide the consumer immediate positive reinforcement. In addition to engaging in behavioral, pleasurable activities, consumers may also receive a dose of cognitive restructuring to attempt to change thoughts and moods that are maintaining depression symptoms.

Treatment Plan

Behavioral activation may be broken down into several phases over the course of treatment – initial/assessment, treatment, termination, and optional intervention of cognitive restructuring. Elements from various sources (i.e., Castro, Barrera, & Steiker, 2010; Kanter et al., 2010; Weisman, Duarte, Koneru, & Wasserman, 2006) were used to guide the treatment plan. Below is a description of each treatment phase. Although the sessions typically involve the therapist and the client, there may be cases in which a key support person such as a trusted family member or close friend will be enlisted to assist with client's implementation of the interventions. Sessions typically last 50 min to 1 h, and the duration of the treatment depends on client's treatment goals and clinical setting (e.g., outpatient community mental health clinic, primary care clinic, inpatient unit, etc.). For this chapter, a total of 11 sessions are presented, but therapists may be flexible with shortening or extending the number of sessions as this intervention may be tailored to meet the client's treatment goals.

Initial Phases of Treatment: Sessions 1 and 2

The first two sessions of the intervention incorporate several important elements that will impact the therapeutic relationship and adherence to treatment. Limits of confidentiality are described and discussed with the client during the initial session. Information gathering, rapport building, identification of treatment goals, psychoeducation about depression (see Tool #3), and the intervention are discussed with the client during this initial phase. Additionally, involvement of a key

person selected by the client to support the client's journey through treatment is introduced. Finally, activity scheduling is assigned during these early sessions as a way to get buy-in from the client to implement the intervention and to provide the client an early start with practicing behavioral activation.

As part of a thorough functional analysis, which will identify personally relevant specific behaviors to increase or activate, it is essential that the therapist get to know how the client's behaviors and environment contribute and maintain client's depression symptoms (see Tool #4). Assessing for secondary problems such as medical issues, somatic symptoms, history of childhood trauma, legal problems, or financial difficulties that could affect treatment progress is an important factor to also consider during information gathering. These secondary problems may become part of client's treatment goals, and the client will be encouraged to seek out assistance once the therapist makes appropriate community referrals. The therapist may have to coordinate client's care as part of the treatment plan.

Behavioral activation may be modified so that it is more culturally sensitive to the client. Therefore, assessment of cultural factors is also an important part of a thorough functional analysis. The therapist should make the effort to familiarize with the client's identified culture and how the client's cultural identity interacts with the client's understanding of depression and perception of treatment. The therapist should also assess how the client makes sense of their depressive symptoms from a cultural perspective. Based on the literature, there may be an intersection of depression symptoms, somatic symptoms, and cultural identity at play, which would be important information to consider when conceptualizing treatment. Relatedly, the therapist should also assess for literacy abilities of the client. If the client is unable to read or write in Spanish, then the resources offered in the tool kit will not be useful to the client. The therapist will have to be flexible and creative by modifying handouts and homework assignments; rather than providing written text, the handouts may be altered to include

symbols, figures, or drawings that may be understood by the client.

In addition to understanding client's cultural identity and its influence on depression and treatment, there is another advantage for assessing cultural factors – building rapport. It is important for the therapist to place emphasis on the therapist/client relationship. Working on the therapeutic alliance during the first session may help to increase engagement and retention. For instance, "personalismo," or strong personal connections, is a value that is often mentioned in the Latino literature (Chavez, 1979). If the therapist is comfortable with exhibiting the following behaviors with a client, then nonverbal gestures such as a handshake, a smile, or a pat on the back or shoulders can promote a friendly and welcoming environment. "Respeto" is another value used by Latinos and could be expressed in many different ways in the therapeutic relationship. One way in which "respeto" may lead to treatment-interfering behaviors is when the therapist is seen by the client as someone with power that deserves respect in the therapeutic relationship. In this case, the therapist must become aware that a client may abstain from asking the therapist questions or challenging treatment recommendations set by the therapist as the client may interpret such interactions as disrespectful. Conceptualizing each treatment case is dependent on the therapist working collaboratively with the client to explain client's current symptoms of depression using a behavioral perspective. Incorporating factors that may impact treatment goals and treatment progress such as culture, religion, spirituality, level of acculturation, English language proficiency, literacy levels, racism, prejudice, or discrimination should be considered.

The next element in this initial phase is to introduce behavioral activation as an evidence-based treatment for depression and to discuss the causes of depression from a behavioral perspective. The therapist educates the client about environmental causes of depression as a way to decrease client's self-blame and guilt and describes factors that exacerbate depression symptoms such as life stressors, biological factors, interpersonal relationships, and social

factors. At this point, the therapist discusses with the client how behavioral activation can decrease symptoms of depression and, therefore, secure treatment buy-in. It is imperative that the therapist receives feedback from the client about understanding the information discussed and consenting with receiving BA treatment.

An important component during this initial phase is the identification of treatment goals. The therapist works collaboratively with the client to develop measurable and realistic treatment goals. The goals should be personally relevant to the client and achievable. Examples of treatment goals may include engaging in one weekly social activity, learning at least one problem-solving skill, practicing daily relaxation exercises, or identifying at least three cognitive distortions that support the symptoms of depression. Some clients may identify one treatment goal while others may select more than one goal. If the client identifies more than one treatment goal, the therapist may work with the client to set a hierarchy of client's goals as a way to prioritize treatment goals and provide direction. Although identification of treatment goals is typically completed during the initial phase, there may be times in which new treatment goals are identified later in treatment. Therefore, the therapist will have to monitor and check in with the client to identify new or modified treatment goals that may occur in mid-treatment.

After treatment goals are identified, the therapist is ready to provide a tangible intervention – activity scheduling. It is important to start behavioral activation from the first session, especially if dropout after the first session is likely or the clinical setting allows for only one session (e.g., primary care clinic). The therapist works with the client to identify at least three responsibilities or pleasurable activities that the client can reestablish during the following week. The client may use the following handout in the tool kit: Tool #1. If a key support person has enlisted in assisting client, use their feedback to identify other activities (see Tool #5). The therapist should also encourage the client to attend the second session of treatment to target treatment motivation. Once a set of activation targets are identified and

scheduled, the client is tasked to complete the activities for homework; the client may use Tool #2 for this task. Alternatively, the use of smartphone applications may be encouraged if the client is familiar and/or interested in using this technology to complete and track their pleasurable activities.

Depending on the client, there may be an opportunity to involve a key support person in the client's treatment. In these cases, the client should be encouraged to bring a trusted family member, partner, close friend, or somebody who can provide support during the treatment process. The therapist should assess whether the key support person is an appropriate, safe, and trusted individual that will assist in client's treatment. Due to confidentiality issues, a release of information form should be completed if the client decides to bring the key support person to sessions. When the key support person is present during the sessions, the therapist will discuss limits of confidentiality, request consent from the key support person to take on the supportive role, reinforce the support person's effort of attending the sessions, and discuss how their support is beneficial for the client. If the key support person agrees to participate, the therapist gathers additional corroborating information about the client's behavior and symptoms of depression from the key support person and provides psychoeducation regarding the intervention and symptoms of depression. The therapist will also describe the key support person's role in the client's treatment. If the key support person cannot attend a treatment session, the therapist may ask the client to share the list of scheduled activities in order for the key support person to assist with completion of the activities.

Treatment Phase: Sessions 3 Through 7

The treatment phase – sessions 3 through 7 – of behavioral activation encompasses the bulk of the work that the client will engage in during the treatment process. Specifically, all sessions share a similar session structure in which each session

starts with homework discussion, an informal mood assessment conducted, followed by identification of treatment target, developing an activity schedule based on treatment target, and ending the session with assigning homework. These sections are described, along with what each session in the treatment phase entails, below.

Sessions start with discussing the homework assignment from the previous session. Any efforts to complete homework are positively reinforced. If homework was not completed, the therapist assists the client in resolving any barriers for homework completion and reassigns the homework, with modifications if necessary, for the following session. After homework review, an informal mood assessment is conducted with the client. This could be done in various ways such as using a mood thermometer or something as simple as asking the client to rate their level of depressed mood felt during the past week on a scale of 1 (signifying low depressed mood) through 10 (signifying extremely depressed mood).

Each session has a different treatment target or component, for example, session 3 targets avoidance behavior, session 4 targets clarification and implementation of values, session 5 targets decreasing somatic symptoms, session 6 targets increasing problem-solving, and session 7 targets relaxation skills. It is important to provide psychoeducation about these treatment targets and describe how these targets relate to symptoms of depression.

The activity schedule is an important element of behavioral activation. Activities chosen for completion are based on the treatment target discussed for that particular session. For example, the activity schedule for session 3 focuses on avoidance behaviors; for session 4, the activity schedule is on values clarification; and so forth (see Table 9.1). The therapist works with the client (and perhaps the key support person, if involved) to create a list of daily activities that are related to the treatment target. Finally, to generalize what was learned in session to the

Table 9.1 Treatment plan timeline

Session #	Treatment component	Session/goals	Worksheet
1	Therapeutic alliance Behavioral activation	Confidentiality Rapport building Information gathering Psychoeducation Case conceptualization Identify treatment goals Activity scheduling Homework	1, 2, 3, 4
2	Family support Behavioral activation	Rapport building Information gathering Case conceptualization Psychoeducation Identify new goals Activity scheduling Homework	1, 4, 5
3	Avoidance behavior Behavioral activation	Review homework Mood assessment Psychoeducation Activity scheduling Homework	–
4	Values work Behavioral activation	Review homework Mood assessment Psychoeducation Activity scheduling Homework	1, 6, 7

(continued)

Table 9.1 (continued)

Session #	Treatment component	Session/goals	Worksheet
5	Somatic symptoms Behavioral activation	Review homework Mood assessment Psychoeducation Activity scheduling Homework	–
6	Problem-solving Behavioral activation	Review homework Mood assessment Psychoeducation Activity scheduling Homework	8
7	Relaxation Behavioral activation	Review homework Mood assessment Reevaluation of goals Psychoeducation Activity scheduling Homework	9
8	Relapse prevention Behavioral activation	Review homework Mood assessment Psychoeducation Activity scheduling Homework	–
9	Termination Behavioral activation	Review homework Mood assessment Psychoeducation Activity scheduling Treatment summary	–
10	Cognitive restructuring	Review homework Mood assessment Psychoeducation Case conceptualization Homework	10, 11
11	Cognitive restructuring	Review homework Mood assessment Psychoeducation Homework	10, 11

client's life, homework is assigned. Homework assignments typically increase weekly or daily participation of activities related to the session's treatment target.

To further elucidate what each session in the treatment phase encompasses, specific details about each session's treatment targets are described. During session 3, the treatment target is on decreasing avoidance behaviors. The therapist educates the client on how avoidance behaviors contribute and maintain depression symptoms. For the activity schedule, the client's avoidance behaviors are identified, and the focus is on preventing client's avoidance behaviors to decrease depressed mood. Considering that avoidance can

be expressed through cognitions or behaviors, the client may deny or minimize problems as an attempt to confront the problem or reduce stress. Examples of behavioral avoidance behavior that could be targeted during the intervention include isolation, abusing drugs or alcohol, binge eating, or excessive work (Carvalho and Hopko, 2011). These activities could be used as a method to temporally escape from a problem.

For session 4, the treatment target is values clarification. The therapist educates the client on the importance of clarifying personal values and defining the difference between personal values (e.g., values are a direction) and personal goals (e.g., goals have an outcome). The therapist

explains how the client's personal values can provide life guidance and indirectly decrease symptoms of depression. A handout on values clarification is included in the tool kit and may be useful for the client to use; see Tools #6 and #7. If the client is struggling in identifying personal values, the therapist may provide examples such as valuing being a caring grandmother/grandfather, a faithful partner, a responsible mother/father, a sincere friend, or a reliable employee; becoming a more spiritual individual, a responsible citizen, emotionally healthy; staying connected with cultural roots; etc. If time does not allow for completion of the handouts during session, the client is directed to complete their topmost important valued domains and is assigned to complete the handouts for homework along with selecting a list of activities that are related to client's identified values.

Session 5 focuses on teaching problem-solving skills, which can be useful as Latinos are often present-oriented and open to advice giving (Santiago-Rivera et al., 2008). Clients learn how to implement problem-solving skills such as trial and error and brainstorm alternative solutions (see Tool #8). After the client has learned and practiced a problem-solving skill during session, the client is asked to put the skills into practice. For example, a client who is having financial difficulties may identify various solutions such as finding ways to reduce financial debt, develop a budget, or consult with a financial advisor. Finding an alternative solution or brainstorming different alternatives identified during session is listed as tasks assigned to complete in the activity schedule.

During session 6, the therapist may reevaluate the treatment goals with the client, as it is around the midpoint of treatment. It is important for the therapist and the client to discuss which goals the client has already achieved and if there are any goals that the client wants to work on. Treatment goals may be modified or updated to tailor the intervention to the client and continue with treatment progress. The treatment target for session 6 focuses on somatic complaints, which are common in the presentation of Latinos with depression. The therapist teaches the client different strategies to cope with physical symptoms so that somatic concerns do not interfere with treatment. The therapist may introduce some cognitive components by briefly educating the client on how certain thoughts and behaviors can increase pain and other physical symptoms. The activity schedule will consist of practicing behavioral strategies to cope with physical symptoms.

In session 7, the treatment target is relaxation techniques, which benefits most clients considering that a diagnosis of depression is often accompanied by symptoms of anxiety. Clients are taught to use relaxation strategies as a way to minimize anxiety symptoms and to incorporate the strategies in their daily life (see Tool #9). For example, if the client is reporting difficulty of sleeping, the therapist may suggest to the client to practice relaxation techniques every night for a couple of minutes before going to bed. A handout in the tool kit provides an example of a basic breathing exercise that a client could use as part of their scheduled activities; see Tool #9.

Termination Phase: Sessions 8 and 9

In sessions 8 and 9, behavioral activation is coming to an end. The session structure of the termination phase is similar to the session structure of the treatment phase, but now the treatment targets focus on preparing the client to become self-sufficient in implementing the techniques taught in previous sessions and in behaviorally activating one's self. Session 8 focuses on relapse prevention. After completing treatment, the client may confront a series of difficult life events that could trigger symptoms of depression. Therefore, it is important to help the client recognize these difficult events and implement strategies that decrease the chances of a relapse or, if symptoms are present, minimize the symptoms so they do not impact the client's quality of life. The therapist discusses relapse and relapse prevention from a behavioral perspective to assist the client and key support person recognize the signs and symptoms of a new depressive episode. Both the client and key support person, if participating, are also taught how to effectively respond to the relapse by formulating a plan.

The end of treatment occurs in session 9. The therapist reviews the client's treatment progress and uses the progress as part of the intervention. Activating behaviors are reinforced, and the activity schedule focuses on long-term changes the client plans to make in order to prevent a depressive episode. The continued use of behavioral activation treatment targets after treatment has ended is encouraged and reinforced.

Optional Intervention: Cognitive Restructuring

Sessions 10 and 11 are optional and may be included in the treatment if the therapist considers that client's cognitions are interfering with treatment progress. These sessions could be introduced at any time during the treatment plan. For the purposes of this chapter, we introduce cognitive restructuring after behavioral activation has been implemented. These two sessions will continue adhering to the session structure format of the treatment phase sessions (i.e., homework review, informal mood assessment, psychoeducation of treatment target, and homework assignment) except that there is no activity scheduling. The therapist introduces the concept of cognitive restructuring and educates the client on the cognitive triad. Automatic thoughts and how they can increase depression are described to the client. For homework, the client completes a thought record; see Tool #10. Cognitive distortions are also introduced. The therapist should be familiar with the different types of cognitive distortions that increase or maintain depression symptoms (e.g., unhelpful thinking styles, black-or-white thinking, mental filter, jumping to conclusions, emotional reasoning, labeling, overgeneralization, disqualifying the positive, the should; magnification or minimization; blaming). A handout focusing on challenging unhealthy thoughts is provided; see Tool #11.

Treatment Plan Timeline

This treatment timeline summarizes the various elements within each session of behavioral activation (BA). The therapist should keep in mind that factors such as gender, social class, level of acculturation, history of childhood trauma, and literacy abilities can create variations in how the treatment is implemented between clients. Other factors such as duration of treatment and client's treatment goals may need to be accounted for in order to tailor BA treatment components to the client's needs. It is recommended that the treatment outline be used as a guide.

#1   **Activación del comportamiento**

Planifica tus actividades semanales. Incluye responsabilidades diarias y actividades que disfrutes. Incluir tus responsabilidades te ayuda a sentirte útil una vez las completes. Las actividades diarias placenteras te ayudaran a aumentar las experiencias agradables en tu día.

	Domingo	Lunes	Martes	Miércoles	Jueves	Viernes	Sábado
8am							
9am							
10am							
11am							
12m							
1pm							
2pm							
3pm							
4pm							
5pm							
6pm							
7pm							
8pm							

#2 👣 **Lista de actividades placenteras**

Estas son algunas actividades a bajo costo. Planifica tu semana con alguna de estas actividades.

Puedes también hacer tu propia lista o pedir nuevas ideas a familiares y amigos.

- Llamar por teléfono a alguien con quien hace tiempo no hablas
- Hacer video conferencia con familiares o amigos
- Preparar una cena especial o cocinar una nueva receta
- Ir a tomar un café
- Jugar juegos de mesa o electrónicos
- Visitar un parque
- Ir a la iglesia/templo
- Rezar o practicar meditación
- Hacer trabajo voluntario
- Escuchar música
- Tomar un baño de sol
- Caminar, nadar, o hacer algún otro tipo de ejercicios
- Visita la biblioteca local o una librería
- Leer un libro, revista o página de internet de interés
- Llenar la tina de agua caliente
- Salir con un amigo(a)
- Ver un programa educativo o divertido en la televisión
- Tener relaciones sexuales
- Abrazar o besar a algún ser querido
- Hacer manualidades
- Arreglar el jardín
- Observar la naturaleza, los pájaros, la vegetación
- Ir a la playa, el bosque, el lago
- Conocer gente nueva

#3   **El comportamiento y la depresión**

La depresión es una enfermedad que puede afectar tu salud física, mental y emocional. Los siguientes son los síntomas más comunes de la depresión:

- Sentimientos de tristeza, vacío, soledad, deseos de llorar
- Cambios en el apetito – comer más o menos de lo usual
- Subir o bajar de peso drásticamente
- Cambios en el patrón de sueno - dormir más o menos de lo usual
- Pensamientos de muerte, suicidas o de autodestrucción
- Sentimientos de culpa o de baja autoestima
- Irritabilidad
- Falta de energía
- Perdida de interés en las actividades cotidianas
- Dificultad para concentrarse
- Baja autoestima

Estos síntomas físicos, mentales y emocionales pueden afectar la manera en que te comportas. Por ejemplo, la pérdida de interés o motivación pueden contribuir a que disminuyas la participación en actividades sociales y/o familiares.

Al mismo tiempo, este comportamiento puede contribuir a que los síntomas de la depresión aumenten. El disminuir la participación en actividades sociales o familiares, puede disminuir la probabilidad de tener experiencias agradables en tu día y de esta manera aumentar sentimientos de soledad o tristeza.

Por otro lado, un comportamiento saludable puede contribuir al mejoramiento tuyo. Aumentar la participación en actividades agradables (caminar, salir con amigos, visitar familiares, etc.), aumenta la probabilidad de tener experiencias agradables, lo que disminuye a su vez sentimientos de tristeza y soledad.

Describe como algunos de estos ejemplos aplican a tu experiencia. Discute con tu terapista como tu comportamiento afecta de manera positiva o negativa ti estado de ánimo.

#4 **Como el comportamiento afecta la depresión**

La manera en que nos comportamos y reaccionamos a diferentes situaciones en la vida, puede afectar de manera positiva o negativa nuestro estado de ánimo. Esta página contiene algunos ejemplos de esto. Discute esta la siguiente información con tu terapista e intenta aplicar la información discutida a tu realidad.

Comportamiento dañino
Quedarse en las casa y/o dejar de asistir a eventos
Sociales, familiares, y/o comunitarios para no ser visto llorando

Consecuencia inmediata
Pierde apoyo social y familiar
Pierde la oportunidad de tener pensamientos placenteros
Familiares y amistades cercanas no saben cómo se siente realmente

Respuesta
Disminuyen los sentimientos/pensamientos de alegria, esperanza, etc.
Aumentan los sentimientos/pensamientos de tristeza, desesperanza, etc.

Completa este ejercicio basado en la información previamente discutida con tu terapista

Comportamiento dañino

Consecuencia inmediata

Respuesta

#5   <u>**Nuevas Metas**</u>

Utiliza este ejercicio para facilitar la comunicación con un familiar o amigo que esté recibiendo tratamiento. Es importante para las personas de apoyo el entender cómo pueden ayudar a un ser querido.

- Haz una lista de los cambios que te gustaría ver en tu familiar luego de que termine el tratamiento.

- Identifica las similitudes que existen entre tus metas y las metas iniciales del paciente.

- Identifica como tú puedes contribuir al progreso del paciente.

- Identifica aquellos comportamientos del paciente, tuyos, y de otros miembros de tu familia, que son parte de las fortalezas de la familia.

- Identifica problemas familiares o relaciones familiares que incluyen o no al paciente, y como afectan estas interacciones al paciente. Por ejemplo, como discusiones entre un padre y un hijo pueden afectar el estado de ánimo del paciente.

#6   **Tus Valores**

Los valores son aquellas áreas de nuestra vida que son importantes para nosotros. Toma unos segundos en silencio y piensa cuales son las cosas que le dan valor y sentido a tu vida. El identificar nuestros valores nos ayuda a darle dirección a nuestra vida. Por ejemplo, si identificamos la familia como una de las áreas importantes de nuestra vida, podemos aumentar la cantidad y/o mejorar la calidad de actividades familiares. De esta manera, aumentamos momentos significativos en nuestra vida, y a su vez combatimos la depresión.

Todos los seres humanos somos diferentes y por eso valoramos diferentes cosas en la vida. Si actuamos en base a lo que es importante para los demás, corremos el riesgo de equivocarnos, ser infelices o sentirnos que no hemos vivido al máximo. En cambio, cuando actuamos en base a nuestros valores personales, aumentamos la probabilidad de vivir una vida plena. A continuación se describen algunas de las áreas que son de valor para las personas.

- Relaciones familiares- ¿Qué cualidades te gustaría tener como hermano(a), tío(a), primo(a), sobrino(a)? ¿Qué tipo de relaciones familiares te gustaría cultivar?

- Relaciones de pareja- ¿Qué cualidades valoras en una pareja? ¿Qué cualidades te gustaría tener como esposo(a), novio(a), pareja?

- Paternidad o Maternidad -¿Qué cualidades te gustaría tener como padre o madre? ¿Qué tipo de abuelo(a) te gustaría ser? ¿Cómo te gustaría contribuir a la crianza de algún niño(a) cercano a ti?

- Amistades y Relaciones Sociales - ¿Qué cualidades te gustaría tener como amigo(a)? ¿Cómo te gustaría que fueran tus relaciones sociales?

- Profesión, Trabajo o Carrera – ¿Qué cualidades te gustaría tener como empleado? ¿Qué tipo de relaciones te gustaría cultivar con tus compañeros de trabajo?

- Educación y Crecimiento Personal- ¿Qué cualidades te gustaría tener como estudiante? ¿Qué cosas nuevas te gustaría aprender? ¿Qué aspecto de la educación valoras?

- Recreación y Tiempo Libre- ¿Qué disfrutas hacer en tu tiempo libre? ¿Qué actividades disfrutas cuando estas a solo(a)? ¿Qué actividades te divierten o te relajan?

- Espiritualidad o Religión- ¿Cómo te gustaría profundizar tu relación con el ser supremo (Dios, la tierra, etc.)? ¿Qué tipo de conexión espiritual te gustaría tener contigo mismo(a)?

- Vida Comunitaria -¿Qué participación te gustaría tener en la comunidad? ¿Qué tipo de ciudadano(a) te gustaría ser? ¿Cómo te gustaría que fuera la relación con tus vecinos?

- Salud - ¿Qué significa para ti tener un estilo de vida saludable? ¿Cómo te gustaría cuidar de tu salud? ¿Qué aspectos de tu salud son importantes para ti?

- Cultura, raíces y herencia- ¿Qué aspectos de tu cultura te gustaría conservar? ¿Qué actividades culturales tienen valor para ti?

#7   **Tus valores**

Toma ahora un tiempo para identificar aquellos valores que le dan más sentido a tu vida.
Identifica además aquellas actividades relacionadas a tus valores.

Valores	Importancia (1-10)	Actividades relacionadas a tus valores
Relaciones de familia		
Relaciones de Pareja		
Paternidad o Maternidad		
Amistades y Relaciones Sociales		
Profesión, Trabajo o Carrera		
Educación y Crecimiento Personal		
Recreación y Tiempo Libre		
Espiritualidad y Religión		
Vida Comunitaria		
Salud		
Cultura, Herencia y Raíces		

#8 **Solución de problemas**

Utiliza este ejercicio para facilitar la solución de algún problema que afecte tu estado de ánimo.

Define el problema:			
Soluciones alternativas	Ventajas de esta alternativa	Desventajas de esta alternativa	Elige la mejor alternativa
Identifica el próximo paso a seguir:			

#9 Ejercicio de Relajación

- Elige un lugar donde hayan pocas distracciones

- Siéntate en una posición cómoda con la espalda derecha pero no rígida

- Comienza a respirar naturalmente siguiendo tu propio ritmo de respiración

- Coloca una mano en tu barriga y la otra mano en tu pecho

- Intenta mantener la mano encima de tu pecho sin mover, inflando tu barriga y no tu pecho

- Imagina que tienes un globo en la barriga que se infla con cada inhalación y se vacía con cada exhalación

- No hay necesidad de contar ni imaginar nada, solo presta atención a tu respiración

- Continua respirando naturalmente

- Se recomienda practicar este ejercicio todos los días, más de una vez al día

- Comienza practicando este ejercicio por un minuto y luego aumenta o ajusta el tiempo de practica

#10   **Registro de Pensamientos**

A menudo tenemos una charla interna con nosotros mismos. Esta charla interna pueden ser pensamientos positivos o pensamientos que afecten nuestro estado de ánimo. Piensa en la última vez que un amigo o familiar no contesto tu llamad. ¿Pensaste que ya no eres importante para esa persona? ¿Pensaste que la persona no contesto porque no tenía deseos de hablar contigo? Si estos o algún pensamiento parecido pasó por tu mente, es probable que te hayas sentido triste.

Durante la próxima semana identifica aquellas situaciones en las que te sentiste triste. El siguiente ejercicio te ayudara a entender cómo nuestros pensamientos se relacionan a nuestro estado de ánimo.

Situación Describe lo que estaba pasando en ese momento	Pensamiento ¿Qué fue lo primero que pensaste en ese momento?	Sentimiento ¿Cómo te sentiste?

#11   **El Dialogo Interno**

Nuestros pensamientos o la charla interna con nosotros mismos puede ser una herramienta positiva que nos ayude a mejorar nuestro estado de ánimo. Durante la próxima semana identifica aquellas situaciones en las que te sentiste triste. Luego identifica tus pensamientos y emociones. Reflexiona que otras posibles explicaciones existen para la misma situación. Haz un esfuerzo por identificar un pensamiento positivo o neutral. Tener pensamientos positivos te puede ayudar a sentirte mejor y a tener más control de tus emociones.

Situación Describe lo que estaba pasando en ese momento	**Pensamiento** ¿Qué fue lo primero que pensaste en ese momento?	**Emoción o Sentimiento** Tristeza, frustración, coraje, vergüenza, etc.	**Pensamiento alterno** ¿Qué otras posibilidades hay?	**Emoción o Sentimiento** Esperanza, alegría, calma, etc.
Cometí un error en el trabajo	*No ser hacer nada bien*	*Tristeza, frustración, coraje*	*Lo haré mejor la próxima vez*	*Tranquilo, esperanzado*

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Culturally Adapted Cognitive Interventions for Depression: Treatment Tools from Vida Alegre

Maria Pineros-Leano, Valerie Cintrón,
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Cognitive interventions (CBT) remain widely used in the general population. They are also among the most prescribed treatments for depression for Hispanics/Latinos (Collado, Lim, & MacPherson, 2016) and Hispanic/Latino immigrants (Antoniades, Mazza, & Brijnath, 2014; Pineros-Leano, Liechty, & Piedra, 2017). In addition, extensive modifications have been done to cognitive interventions to accommodate the cultural and linguistic needs of Spanish-speaking populations. This chapter describes best practices underlying *adapted* cognitive interventions used with Hispanics/Latinos struggling with depression. We begin with an overview of the Hispanic/Latino population, the prevalence of depression, and a discussion of some cultural manifestations associated with depression. Next, we provide an overview of cognitive interventions for changing depressive thoughts and special modifications for providers in communities with new Hispanic/Latino immigrants. Finally, we present a synopsis of a treatment plan designed for Hispanics/Latinos to help change problematic thinking associated with depression. In the appendix, we include tools *in Spanish* adapted from a cognitive

behavioral intervention, "Vida Alegre" (VA; "A Happy Life"; Piedra, Cintrón, Guardini, Marquez, & Sink, 2011), which was tested and found effective in alleviating depressive symptoms among Spanish-speaking mothers (Piedra & Byoun, 2012; Piedra, Byoun, Guardini, & Cintrón, 2012).

Hispanics/Latinos and Depression

Hispanic/Latino immigrants and their progeny constitute the largest and fastest-growing ethnically diverse group in the United States (U.S. Census Bureau, 2015). In 2014, there were 55.3 million people of Hispanic/Latino descent living in the United States, making up 17.3% of the population (Stepler & Brown, 2016). From this group Mexicans constitute 63% of the Hispanic/Latino immigrants in the United States, making them the largest ethnic Hispanic/Latino group (Ennis, Rios-Vargas, & Albert, 2011). However, as immigrants tend to be young, most of the population growth has come from natural increase rather than through migration. By 2050, Hispanics/Latinos are expected to reach 29% of the overall population (Passel & Cohn, 2008). As a result, this group is poised to play an important role in the future workforce, and, thus, their mental health needs warrant special attention. Among such considerations, service providers must keep in mind the role that the immigration experience

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has on families rearing native-born children, dual cultural and linguistic contexts, and the debilitating effects that depression has on families.

Among the mental disorders, depression ranks as the most common and is known to be highly treatable through medication, counseling, or a combination of both (U.S. Department of Health and Human Services, 2015). As a whole, Hispanics/Latinos, especially those of Mexican background, have lower levels of depression than the general population (Alegría et al., 2008). However, several national studies that examined a diverse sample of Hispanics/Latinos suggest a more complicated picture and underscore that many Hispanics/Latinos experience depression but fail to receive treatment. Alegría and her colleagues (2014) found high prevalence rates (28.1% and 28.6%, respectively) of elevated depressive symptomatology among Puerto Ricans in New York City and those on the island of Puerto Rico. When this study's sample was combined with subjects from the National Comorbidity Survey Replication, the investigation revealed that Hispanics/Latinos had lower rates of depressive disorders (15.4%) than non-Hispanic/Latino Whites (22.3%) but that those of Puerto Rican and Cuban backgrounds had higher rates than those of Mexican background (Alegría et al., 2008).

In the most comprehensive study of Hispanics/Latinos to date—Hispanic Community Health Study/Study of Hispanics/Latinos (HCHS/SOL)—investigators found an overall prevalence of depression of 27% (Wassertheil-Smoller et al., 2014). However, they also found that being US born or a second- or higher-generation immigrant was associated with higher levels of depression. Those of Puerto Rican background showed the highest levels of depressive symptoms; 38% reported high depressive symptoms, compared with 22% of those with Mexican background.

Although depression among Hispanics/Latinos can manifest in similar ways as in the general population, a few caveats are worth noting (Cabassa, 2007; Cabassa, Lester, & Zayas, 2007; Lackey, 2008; Martínez Pincay & Guarnaccia, 2007). Hispanic/Latino immigrants tend to define depression in ways that align with symptoms found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), but they also attribute such symptoms to situational conditions such as the hardships of migration, the acculturation process, and the loss of social networks (Karasz & Watkins, 2006; Martínez Pincay & Guarnaccia, 2007). For example, many Hispanic/Latino immigrants identify isolation as a main contributor to feeling depressed (Lackey, 2008) but normalize the sadness as a natural consequence of leaving family and community behind (Lackey, 2008; Martínez Pincay & Guarnaccia, 2007).

However, somatic manifestations of depression such as stomachaches and headaches are commonplace (Lackey, 2008). In some cases, the symptoms may appear similar to those of anxiety, such as chest and muscle pain (Cabassa, Hansen, Palinkas, & Ell, 2008). Hispanic/Latino immigrants also use idioms such as *nervios* (nerves) to refer to depressive-like symptoms (Cabassa et al., 2008; Guarnaccia, 1993). The presence of physical symptoms and the stigma associated with mental illness frequently means that a primary care physician becomes the first point of entry into mental health care.

Service Barriers

Unfortunately, there is a worrisome underuse of mental health services by Hispanics/Latinos (Alegría et al., 2008; Cabassa, Zayas, & Hansen, 2006). One study found that only 36% of Hispanics/Latinos obtained mental health treatment, compared to 60% of their White counterparts (Alegría et al., 2008). For those Hispanics/Latinos who accessed depression treatment, half receive it in a primary care setting, and fewer than 13% obtain adequate guideline-based care, which is half the rate when compared to non-Hispanic/Latino Whites (Lagomasino et al., 2005). In addition, immigrants experience greater obstacles to services. When immigrants seek out discretionary mental health care (i.e., preventive services), they access such care at a substantially lower rate

than Puerto Ricans and US-born Hispanics/Latinos (Alegría et al., 2007).

Language also plays a role in service disparities. Non-English-speaking Hispanics/Latinos are less likely to receive mental health services than those who speak English (Alegría et al., 2007; Sentell, Shumway, & Snowden, 2007). One study that compared Spanish and English speakers with similar mental health service needs found that 43% of the English speakers had received mental health services. In contrast, 8% of those who spoke only Spanish received such services (Sentell et al., 2007).

Other factors such discrimination, acculturation issues, family separation, and economic hardship compound language barriers (Aguilar-Gaxiola, Kramer, Resendez, & Magaña, 2008; Martínez Pincay & Guarnaccia, 2007; Mendelson, Rehkopf, & Kubzansky, 2008). On average, Hispanic/Latino immigrants have less education than the general population and tend to work in low-wage jobs without health insurance (Andrade & Viruell-Fuentes, 2011; Ennis et al., 2011). Those who continue to be underinsured or who do not qualify for coverage under the Affordable Care Act (Doty, Blumenthal, & Collins, 2014) experience a cumulative effect of heightened vulnerability to mental health problems (Beeber, Lewis, Cooper, Maxwell, & Sandelowski, 2009). In addition, limited English proficiency accentuates the risk of discrimination and constrains employment options. Across one's lifetime, these obstacles lead to lower earnings, higher exposure to occupational and environmental hazards, and low levels of service access (Andrade & Viruell-Fuentes, 2011; for a detailed review, see Vega, Rodriguez, & Gruskin, 2009). Moreover, these negative factors magnify adverse life events and contribute to chronic stress, increasing the risk of depression (Beeber, Perreira, & Schwartz, 2008). Consequently, despite having better health (Horevitz & Organista, 2013) and mental health than the general population (Breslau, Kendler, Su, Gaxiola-Aguilar, & Kessler, 2005), long stays in the United States are associated with worsening health and mental health outcomes for Hispanic/Latino immigrants (Stone & Balderrama, 2008; Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007).

Hispanics/Latinos in New Growth Communities

Although Hispanics/Latinos remain concentrated in urban centers and their surrounding metro areas, over the past two decades the population has spread to nearly 3000 of the nation's 3141 counties (Fry, 2008; Lichter & Johnson, 2006, 2009). Their relocation into small towns and rural areas of the Northeast, the Midwest, and the South has led to the emergence of "new growth" communities—those with small but rapidly growing Hispanic populations—in many states (Cunningham, Banker, Artiga, & Tolbert, 2006). This demographic shift has revitalized the economies in many of these communities (Partridge, Rickman, & Ali, 2008) but has also created new challenges (Lichter & Johnson, 2009). These new communities tend to have limited organizational capacity and a scarce bilingual workforce to meet the needs of their growing Spanish-speaking populations (Arroyo, 2004; Buki & Piedra, 2011; Cunningham et al., 2006). Although mental health service disparities for Hispanics/Latinos are well documented, Hispanics/Latinos in "new growth" communities face unique challenges. The rapid increase of Hispanic/Latino immigrants in communities unaccustomed to such populations adds additional complexity to the problem of service access. For instance, adapting interventions have proven more challenging for providers in new growth communities, compared to those with established enclaves (Pineros-Leano et al., 2017). These environments tend to lack bilingual/bicultural professionals (Lichter & Johnson, 2009), and thus, the first step in their adaptations included finding ways to overcome bilingual personnel scarcity (Dwight-Johnson et al., 2011; Hovey, Hurtado, & Seligman, 2014; Piedra & Byoun, 2012; Shattell et al., 2010). However, these might not be easy to

achieve. In these communities, where few professionals speak Spanish, bilingual staff can aid in the delivery of therapy.

Cultural Adaptations

Cultural adaptations enhance the therapeutic receptivity of cognitive interventions for people from other cultures (Kalibatseva & Leong, 2014). These adaptations range from simple language translations to deeper modifications that address core values such as the importance of family, respect, humility, and friendliness. Castro, Barrera, and Martinez (2004) provide a useful way to categorize different types of cultural modifications as (a) cognitive-informational adaptations, (b) affective-motivational adaptations, and (c) environmental adaptations (Pineros-Leano et al., 2017). Cognitive-informational adaptations address language and literacy barriers. Affective-motivational adaptations deliver content and activities congruent to the traditions and values of the population to improve the relevance of the intervention and minimize potential cultural conflicts. Environmental adaptations focus on ecological barriers for the population and community, such as the need for childcare and/or transportation (Castro et al., 2004). A recent systematic review of cognitive behavioral interventions adapted for Hispanic/Latino immigrants categorized the adaptations using the model in the following way (Pineros-Leano et al., 2017).

Cognitive-informational adaptations Although language translations and the engagement of bilingual facilitators were usually the first step in adapting a cognitive intervention, practitioners also took into account the amount of formal education and literacy of the participants. Many made changes to CBT manuals accordingly; in some instances, visual aids were used, and the reading level of translated manuals adjusted (Alegría et al., 2014; Camacho et al., 2015; Le, Zmuda, Perry, & Munoz, 2010; Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Muñoz et al., 2007; Piedra & Byoun, 2012; Shattell et al., 2010). For example, Camacho et al. (2015) drop

the provider checklist and homework review. Instead, they use 15–20 minutes of receptive listening and support based on the first two steps of the intervention.

However, for practitioners in new growth communities, delivering a cognitive intervention in a cultural and linguistically congruent manner needs a strategy for overcoming bilingual personnel scarcity (Dwight-Johnson et al., 2011; Hovey et al., 2014; Piedra & Byoun, 2012; Shattell et al., 2010). Although still a challenging endeavor, a number of successful tactics were employed. Some used bilingual (and not bicultural) facilitators to deliver the intervention (Piedra & Byoun, 2012; Shattell et al., 2010). Others used a "team" approach that made use of existing community resources (Beeber et al., 2009; Hovey et al., 2014). Hovey et al. (2014) employed *promotoras* (health promoters)—trained community members—to help co-facilitate sessions with a bilingual and bicultural professional who had a very different background from that of the migrant workers in the group. Because the *promotoras* shared common life experiences with participants, their engagement facilitated the accessibility of the intervention. Beeber and her group (2009) paired project-trained interpreters with advance nurses to deliver a home-based depression treatment (Beeber et al., 2009). This approach required a rigorous protocol for how the interpreters were used in the intervention to protect the integrity of the therapeutic interaction. Lastly, project-trained bilingual and bicultural social work and psychology graduate students were used to deliver the intervention (Dwight-Johnson et al., 2011; Piedra & Byoun, 2012). While difficult to coordinate, the diversity of these strategies suggests practitioners can find ways to deliver cognitive interventions even in environments with scarce human resources.

Affective-motivational adaptations Beyond language accessibility, other cultural adaptations actually modify the treatment manual to better align with the culture and language of the participants (Interian, Allen, Gara, & Escobar, 2008; Organista & Muñoz, 1996; Piedra & Byoun,

2012). Organista (1995) recommends simplifying Albert Ellis' A-B-C-D method for cognitive restructuring into a two-pronged approach called *Si, Pero* ("Yes, But"; Interian et al., 2008; Organista & Muñoz, 1996; Piedra & Byoun, 2012). Participants use this linguistic tool to replace unhelpful thoughts with helpful ones (Organista & Muñoz, 1996). They learn that thoughts that invoke depressive thinking patterns (i.e., "I don't speak English well") can be understood as "half-truths" that can be converted into "whole truths" (i.e., "Yes [*si*], I don't speak English well, but [*pero*] I am learning more every day"). This method facilitates cognitive restructuring for Hispanics/Latinos using everyday speech.

A notable affective-motivational adaptation specific to Hispanic/Latino immigrants involves the inclusion of discussion topics related to migration and its associated hardships in the cognitive intervention (Cardemil, Kim, Pinedo, & Miller, 2005; Dwight-Johnson et al., 2011; Hovey et al., 2014; Interian et al., 2008; Le et al., 2010; Muñoz et al., 2007; Piedra & Byoun, 2012). Such a perspective recognizes the potentially traumatic nature of migration and the unanticipated losses associated with acculturation. This adaptation anticipates that prolonged depressive feelings may reflect the hardships of the lengthy transition to life in a new culture.

Environmental adaptations For many Hispanic/Latino immigrants, the stigma associated with mental health problems can pose serious obstacles to treatment. To address this problem, some scholars have posited that it is not enough to provide information to the person; rallying the support of family members can help. For example, one group of researchers provided two family sessions to each participant and an adult of her choosing (Cardemil et al., 2005). During these family sessions, information about depression and the effects of chronic stress was provided. Although not everyone took advantage of the family session (52% attended at least one session), those who did reported greater symptom reduction compared to those who did not attend any of these meetings. Thus, family inclusion can

be a promising approach for those with significant others who are willing to lend support but may not understand how to do so (Pineros-Leano et al., 2017).

The use of technology to overcome environmental barriers such as the lack of transportation and childcare and the need for greater scheduling flexibility holds much promise. A recent study compared the usual care, which included a referral to a mental health provider and/or prescription antidepressants, to the effectiveness of two modes of CBT delivery with low-income Hispanics/Latinos who resided in either Boston or Puerto Rico (Alegría et al., 2014). The CBT intervention groups also received case management assistance for additional referrals and scheduling appointments. The study showed that both the telephone and face-to-face CBT interventions were more effective in reducing depressive symptoms than the usual care. In addition, the investigators found no differences between delivery modalities; both the telephone and face-to-face contact were effective in reducing depressive symptoms (Alegría et al., 2014). However, participants in the telephone intervention were more likely to schedule appointments compared those in the face-to-face intervention. It seems that for those who need greater flexibility or who struggle with transportation and childcare issues, delivering CBT by phone might facilitate the initiation and retention of treatment.

Technology can also be used to improve treatment adherence and enhance the experience (Aguilera & Muñoz, 2011). In one study, investigators sent daily text messages asking participants in a group intervention about a topic covered in treatment. For example, they might receive a message asking them how many people they interacted with or how many pleasant activities they did. The participants reported that these text messages strengthened their relationship with the group and with the therapists, making them feel closer. In addition to improving rapport between the therapist and the client, the text messages improved meeting attendance.

Table 10.1 List of sessions and activities

Title of the session	Session's goal
Treatment plan (Appendix 1)	In this session, we discuss the treatment plan and goals. As part of the therapeutic process, it is important to establish short- and long-term goals that can improve the client's mental health. Establishing goals will help the mental health professional and the client decide how they will work on the client's depression. In this treatment plan, we also emphasize the importance of homework as a useful method for the client to continue the therapeutic work outside of the sessions
What is depression? (Appendix 2)	In this session, the client learns about what depression is, some of its signals and causes, and how it addressed
Physical health and mental health go hand in hand (Appendix 3)	In this session, there is emphasis on the importance of taking care of the client's mental and physical health. We also include some guiding questions to help the client explore how she/he can maintain a general well-being
Working on the topic of immigration (Appendix 4)	In this session, we aim to address immigration as a source of strength. For many people, immigration is a difficult experience that can influence the development of depressive symptoms. In this activity, we use the "Strengths Perspectives" conceptual framework, favored by social workers. This perspective can help the client discuss his/her experience of immigration with an emphasis on his/her strengths and capabilities/skills
Introduction to cognitive therapy (Appendix 5)	In this session, we address what cognitive therapy is and how it works
Cognitive-behavioral therapy (Appendix 6)	In this session, we provide education about the connection between thoughts, feelings, and behaviors and their influence on the client's mood
Comparison between depressive and non-depressive thoughts (Appendix 7)	In this session, we focus on trying to distinguish between depressive and non-depressive thoughts
Thinking mistakes: Learn to recognize them (Appendix 8)	In this session, we introduce different categories of patterns of negative thoughts
Modifying negative thoughts: The "yes, but…" method (Appendix 9)	In this session, we introduce an innovative and culturally appropriate technique to modify negative thoughts
Working sheet for "yes, but…" method (Appendix 10)	In this appendix, we provide a worksheet to practice changing a negative thought to a positive or more realistic one
Mood and thought scale (Appendix 11)	This session provides a scale to monitor the client's mood and thoughts every day. First, this scale can help the client pay attention on how her/his thoughts and feelings influence his/her mood. Second, this scale can help the client and the mental health provider identify patterns of negative thoughts and the client's most frequent moods

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Treatment Plan and Related Activities from Vida Alegre

A cognitive treatment plan requires structure and activities to teach and reinforce positive thinking patterns (see Table 10.1). However, for new immigrants, such thinking patterns include adjusting to a new cultural environment. For many, this adjustment can be disorienting. Thus, any cognitive treatment plan for immigrants should include tools that will help with them make sense of their experience as newcomers. At the end of this chapter, we included a number of handouts *in Spanish* that focus on key strategies for implementing a cognitive intervention (see Appendices 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11). These worksheets have been adapted from a CBT intervention, "Vida Alegre" (VA; "A Happy Life"; Piedra et al., 2011), which was tested and found effective in alleviating depressive symptoms among Spanish-speaking mothers (Piedra & Byoun, 2012; Piedra et al., 2012). Because VA was developed for use in a new growth community, the worksheets assume low levels of Spanish

Table 10.2   Lista de Sesiones y Actividades

Título del Ejercicio	Explicación del Ejercicio
Plan de Tratamiento (Apéndice 1)	En esta sesión discutimos el plan de tratamiento y los objetivos. En el proceso terapéutico es importante establecer metas a corto y a largo plazo para mejorar la salud mental del cliente. El establecer metas ayuda tanto al profesional de la salud mental como al cliente a decidir cómo se va a contrarrestar la depresión. En este plan de tratamiento también recalcamos la importancia de las tareas como un método útil para que el cliente continúe el trabajo terapéutico fuera de las sesiones
¿Qué es la Depresión? (Apéndice 2)	En esta sesión el cliente aprende acerca de lo que es la depresión, cuáles son algunas de las señales y causas de la depresión, y cómo se puede superar
La salud física y la salud mental van de la mano (Apéndice 3)	En esta sesión se hace énfasis en la importancia de cuidar la salud mental y física del cliente. También, incluimos algunas preguntas para ayudarle a el/la cliente/a a explorar cómo se puede conservar un bienestar general
Trabajando el tema de la inmigración (Apéndice 4)	En esta sesión el principal objetivo es tratar el tema de la inmigración como una fuente de fortaleza. Para muchos, la inmigración es una experiencia muy difícil que puede influir en el desarrollo de los síntomas de la depresión. En este ejercicio, utilizamos el marco conceptual de la perspectiva de las fortalezas ("Strengths Perspective") preferido por los trabajadores sociales. Esta perspectiva puede ayudar al cliente a dialogar sobre su experiencia de inmigración con un énfasis en sus fortalezas y capacidades
Introducción a la terapia cognitiva (Apéndice 5)	En esta sesión se enfoca en qué es la terapia cognitiva y cómo funciona
Terapia cognitiva-conductual (Apéndice 6)	En esta sesión se provee educación sobre la conexión entre pensamientos, sentimientos y comportamientos y su influencia en el estado de ánimo del cliente
Comparación de pensamientos depresivos con pensamientos no-depresivos (Apéndice 7)	En esta sesión el cliente aprende a cómo distinguir los pensamientos depresivos de los no depresivos
Los errores en el pensamiento: Aprende a reconocerlos (Apéndice 8)	En esta sesión se hace una introducción a diferentes categorías de patrones modelos de pensamientos negativos
Modificar los pensamientos negativos: El método "sí, pero…" (Apéndice 9)	En esta sesión introducimos una técnica inventiva y culturalmente apropiada para modificar los pensamientos negativos
Hoja de trabajo para el método "sí, pero…" (Apéndice 10)	En este apéndice proveemos una hoja para practicar el cambio de pensamiento negativo a uno positivo o más realista
Escala del estado de ánimo y los pensamientos (Apéndice 11)	En esta sesión se provee la escala que se utiliza para monitorear los pensamientos y los estados de ánimo del cliente día a día. En primera instancia, la escala puede ayudar al cliente a prestar atención cómo sus pensamientos y sentimientos influyen su estado de ánimo. Y en segunda instancia, puede ayudar tanto al cliente como al profesional de la salud mental a identificar patrones modelos de pensamientos negativos y los estados de ánimos más comunes

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literacy and education in the participants. The simplified tools were also useful to novice clinicians, who consisted of project-trained graduate-level social work and psychology students.

In Table 10.1 (see Table 10.2 for a Spanish-language translation), we list the various tools and describe how to use them in the treatment process. The first three worksheets sequentially provide a way to create rapport between the clinician and the client (see Appendix 1), dispense psychoeducational information about depression (see Appendix 2), and help the client understand the link between physical well-being and mental health (see Appendix 3). This later point helps clients recognize some of the physical manifestations of depression (i.e., stomach or chest pains). These first three sessions help create a common language and a sense of familiarity

that will lay the groundwork for more difficult topics of conversation, such as immigration.

The next two worksheets open the discussion about immigration and its associated losses and gains (see Appendices 4 and 5). The immigration and acculturation experience will vary, and not all individuals will experience this process as traumatic and/or painful. It is important for the clinician to explore and discuss the experience with the client while being attuned to both verbal and nonverbal cues. The aim of this section is to determine whether some depressive feelings stem from this process and help reframe the meaning of difficult experiences. Appendix 5 is particularly useful in bringing a strength perspective to the immigrant experience.

At this point, the client is ready for solutions. The next worksheet introduces core tenets of cognitive therapy (see Appendix 6). This tool explains the concept of how experiences in a certain situation (A) will have a consequential feeling or reaction (C). This handout introduces clients on how to generate pleasant thoughts when negative ones arise. Appendix 7 describes the interconnection between thoughts, emotions, and behaviors and how they can reinforce depressive symptoms. In Appendix 8, we provide a comparison list between depressive and non-depressive thoughts to help clients identify what kind of thoughts occur more frequently. We provide examples for how depressive thoughts can be replaced with non-depressive ones. The worksheet in Appendix 9 helps clients identify errors in their thinking that generate their most prevalent depressive thoughts in order to challenge and change them.

The next two handouts provide an effective method of creating new schemas. First, the client is presented with an instructional guide on the *Si, Pero* ("Yes, But") method clients learn through the process of cognitive restructuring. The technique uses everyday Spanish language to convert half-truths into whole truths (see Appendix 10). Then the client is given an activity to practice the "Yes, But" method wherein she/he writes down a negative or depressive thought, such as "I am overweight," followed by describing how the thought makes her/him feel. Next, the client adds a positive truth that puts the negative thought into context: "But I am trying to eat healthier." Again, the person describes the associated feeling (see Appendix 11). Finally, we provide a mood scale for clients to monitor their feelings over time (see Appendix 12). This worksheet can be used from the beginning of therapy as a visual aid into the variability of one's feelings and the thoughts associated with particular moods.

Conclusion

Although many different cognitive interventions have been developed and adapted to work with the Hispanic/Latino population, many obstacles can hinder their effective implementation and/or reception by the intended population. First, the development and implementation of cognitive interventions can be more challenging in new destinations where there is a lack of human resources available. Second, the cultural adaptation of the intervention can range from the mere translation of materials to adaptations that adjust for low levels of literacy and education. This chapter provides examples of different forms of cognitive-informational, affective-motivational, and environmental adaptations (Pineros-Leano, Liechty, & Piedra, 2017). Although the inclusion of all these adaptations requires time, effort, and money, they can increase treatment attendance and even improve outcomes. Therefore, we include in the appendices of this chapter worksheets and activities that we have found useful when implementing Vida Alegre, an intervention tested in an emerging community in the Midwest with communities that are predominantly Mexican. Clinicians using these tools should modify them according to the needs of their client population, using the tenets mentioned here.

Apéndice 1. Plan de Tratamiento

Nombre: _____

Fecha de comienzo: _____

Problema o situación que contribuye a los síntomas de la depresión:

_____
_____
_____

Meta 1: _____

        Objetivo a: _____

        Objetivo b: _____

        Objetivo c: _____

Meta 2: _____

        Objetivo a: _____

        Objetivo b: _____

        Objetivo c: _____

Meta 3: _____

        Objetivo a: _____

        Objetivo b: _____

        Objetivo c: _____

Intervención (es): _____

Fecha límite: _____ **Fecha de revisión**: _____ **Fecha de terminación**: _____

Me han explicado y entiendo mi plan de tratamiento. Me comprometo a dialogar y a trabajar dentro y fuera de las sesiones terapéuticas para aprender a cómo manejar y/o superar mi depresión.

_____

Firma del Cliente

Apéndice 2. ¿Qué es la depresión?

La depresión es más que sentirse triste por unos días. Las personas con depresión suelen sentirse tristes, preocupadas o vacías. Estos sentimientos no desaparecen, incluso durante períodos felices. También, la depresión puede interferir en el cumplimiento de las tareas diarias. Sin embargo, lo bueno es que la mayoría de las personas superan la depresión al recibir ayuda psicológica y/o medicamentos.

¿Cuáles son algunas señales de la depresión?

• Sentirse inquieto o irritable
• Sentirse triste o desesperado
• Llorar mucho o fácilmente
• Falta de energía o motivación
• Comer o dormir muy poco o demasiado
• Problemas de concentración y de memoria
• Tener baja estima de sí mismo
• Pérdida de interés o placer en actividades que antes disfrutaba
• Aislamiento de amigos y familiares
• Tener dolores de cabeza, de estómago o problemas de salud que no desaparecen

¿Qué causa la depresión?

No existe una sola causa para la depresión. Es probable que sea debido a una combinación de factores que incluyen:

• Tener familiares que sufren o han sufrido depresión
• Eventos estresantes
• Problemas hormonales

¿Cómo se supera la depresión? Usted puede:

• *Trabajar con un profesional de la salud mental* para aprender a superar la depresión.

• *Tomar un medicamento* antidepresivo recetado por su proveedor de salud legalmente autorizado.

Apéndice 3

La Salud Física y la Salud Mental van juntos de la mano

La salud es un estado de bienestar general en cuanto a nuestro estado físico, mental y social, y no la ausencia o déficits de enfermedades.

Por lo general, visitamos al doctor una vez al año para cerciorarnos que nuestro cuerpo esté saludable. O quizás, vamos al doctor cuando nos enfermamos para obtener los tratamientos necesarios para aliviar nuestras dolencias.

Al igual que cuidar nuestra salud física es importante cuidar la salud mental en todas las etapas de la vida, en la niñez, en la adolescencia, en la edad adulta y en la vejez.

¿Qué es la Salud Mental?

Nuestras emociones, pensamientos y comportamientos influyen en nuestro estado de ánimo y, a la vez, estos determinan cómo enfrentamos las situaciones diarias en nuestras vidas. Una buena salud mental incluye sentirse tranquilo, contento y satisfecho con nuestra vida personal. Además, el tener una buena salud mental nos ayuda a enfrentar los retos de la vida de una forma adaptable.

El déficit en la salud mental puede causar enfermedades mentales como la depresión o la ansiedad. Y en otras ocasiones puede causar padecimientos físicos como por ejemplo dolores de cabeza, espalda o malestares estomacales.

Entonces, ¿Qué es tener una buena Salud Mental?

Tener una buena salud mental se define como un estado de bienestar en el cual el individuo es consciente de sus propias habilidades, se siente capaz de afrontar las tensiones de la vida cotidiana, tiene buenas relaciones personales con todos y trabaja en forma productiva. Además, nosotros podemos desarrollar destrezas de cómo manejar la depresión, relacionarnos de muy buena manera con otras personas y tomar buenas decisiones.

¿De qué manera podemos mantener una buena salud mental?

Tener una fuente de apoyo social tal como fuertes lazos familiares o amistades.

Tomar tiempo personal para dedicarnos a nuestros pasatiempos o para relajarnos.

Aceptarse a uno mismo reconociendo los defectos y virtudes propias.

Tener una actitud de gratitud a la vida por lo que tenemos y no en lo que nos hace falta

¿De qué otras maneras podemos cultivar una buena salud mental?

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Apéndice 4

Trabajando el tema de la inmigración

Hoy vamos a dialogar sobre su experiencia de inmigración con un enfoque positivo. Sabemos que para muchos es un recuerdo agridulce. Sin embargo, todos tenemos fortalezas que nos ayudan a sobrellevar las experiencias tristes. A continuación, le presento una serie de preguntas que le van a ayudar a reflexionar sobre su experiencia de inmigración de una manera más balanceada:

1) ¿De dónde sacó el valor para venir a los Estados Unidos?
2) ¿Qué esperanzas tenía al tomar la decisión de inmigrar?
3) ¿Qué cualidades tiene que le han ayudado a adaptarse a este país?
4) ¿Cómo ha logrado sobrevivir hasta ahora a pesar de los desafíos que ha encontrado?
5) ¿Cuál ha sido su actitud al enfrentar estos desafíos?
6) ¿Qué ha aprendido acerca de usted mismo durante estas luchas?
7) ¿Cuáles de estas dificultades lo han fortalecido como persona? ¿Qué habilidades ha desarrollado?
8) ¿Qué personas en su vida le han dado comprensión, apoyo y guía?
9) ¿Qué agencias, organizaciones o grupos le han sido de gran utilidad después de haber venido a los Estados Unidos?

Reflexione acerca de lo que se necesita para venir aquí y para hacer una vida nueva. Marque las casillas que reflejan sus experiencias.

- ☐ Inteligencia
- ☐ Trabajo duro
- ☐ Tomar riesgos
- ☐ Persistencia
- ☐ Responsabilidad
- ☐ Habilidad para aprender un idioma y una cultura nueva
- ☐ Habilidad para superar la pobreza
- ☐ Ser ingeniosa y práctica
- ☐ Creatividad
- ☐ Sacrificio
- ☐ Otros (por favor describir): _____

Apéndice 5

Perspectiva de las fortalezas

Hoy vamos a dialogar sobre cómo disminuir los pensamientos negativos al aumentar el enfoque positivo hacia las variadas circunstancias de nuestras vidas. Todos tenemos fortalezas que nos ayudan a sobrellevar las experiencias tristes y estresantes. A continuación, le presento una serie de preguntas que le van a ayudar a reflexionar sobre su vida de una manera más balanceada:

1) ¿De dónde sacó el valor para venir a la consejería?
2) ¿Qué esperanzas tiene al tomar la decisión de mejorar su salud mental?
3) ¿Qué cualidades tiene que le han ayudado a adaptarse a sus problemas?
4) ¿Cómo ha logrado sobrevivir hasta ahora a pesar de los desafíos que ha encontrado?
5) ¿Cuál ha sido su actitud al enfrentar estos desafíos?
6) ¿Qué ha aprendido acerca de usted mismo durante estas luchas?
7) ¿Cuáles de estas dificultades lo han fortalecido como persona? ¿Qué habilidades ha desarrollado?
8) ¿Qué personas en su vida le han dado comprensión, apoyo y guía?
9) ¿Qué agencias, organizaciones o grupos le han sido de gran utilidad durante su vida?

Reflexione acerca de lo que se necesita para sobrellevar la depresión y para mejorar nuestra salud mental. Marque las casillas que reflejan sus experiencias.

☐ Inteligencia
☐ Trabajo duro
☐ Tomar riesgos
☐ Persistencia
☐ Responsabilidad
☐ Habilidad para aprender un idioma y una cultura nueva
☐ Habilidad para superar la pobreza
☐ Ser ingeniosa y práctica
☐ Creatividad
☐ Sacrificio
☐ Otros (por favor describir): _____

Apéndice 6

Introducción a la Terapia Cognitiva

La terapia cognitiva conductual es un tipo de terapia basada en evidencia científica en donde se aprende a identificar, evaluar y cambiar pensamientos y conductas no saludables por otros pensamientos y conductas que lo son. Cuando hablamos de pensamientos también nos referimos a creencias, ideas, actitudes, percepciones, etc. El objeto es examinar estos patrones modelos de pensamientos y cómo, a su vez, éstos influyen en nuestros sentimientos y acciones.

La fórmula vieja acerca del origen de nuestros sentimientos y/o acciones:

A--------→ C

  (A) Situación
  (C) Consecuencias de esta situación (pueden ser sentimientos o acciones)

Por ejemplo: Daniela y Lisa han tenido un leve accidente automovilístico. Sin embargo, sus reacciones han sido diferentes.

A (Accidente de auto)-----→ C (Daniela siente enojo)
A (Accidente de auto)-----→ C (Lisa siente alivio)

¿Qué está pasando? ¿De dónde viene el sentimiento de enojo o de alivio? Es aquí donde se presenta una nueva fórmula acerca del origen de nuestros sentimientos y/o acciones:

A----→ B----→ C

Donde B- representa nuestros pensamientos

A (Accidente de auto) -----→ B (Daniela pensó: ¡Voy a llegar tarde a mi cita médica!   ----→
                                ¡Tanto trabajo que me dió conseguirla!)
C (Sentimiento de alivio)
A (Accidente de auto) -----→ B (Lisa pensó: ¡No pasó nada grave! Mi familia está bien.) ----→ C
(Sentimiento de enojo)

Otro ejemplo:
 (María se vio en el espejo) ------→ B (Pensó: ¡Qué fea me veo!) ----→ C (Se sintió triste)

¡Vamos a practicar!

A (_____) -------→ B (_____) ----→ C (_____)

Traduccion y modificacion del libro: Mc Mullin, R. E. (2000). *The New Handbook of Cognitive Therapy Techniques*. New York, N.Y.: W. W. Norton & Company.

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Apéndice 7

Terapia Cognitiva-Conductual

La palabra "Cognitiva" se refiere a nuestros pensamientos, creencias, ideas, imágenes, sueños, visiones, actitudes, recuerdos... En otras palabras, todo lo que sucede en nuestra mente. La palabra "Conductual" se refiere a nuestras acciones y comportamientos. Por tanto, en la terapia cognitiva-conductual nosotros vamos a trabajar en identificar esos pensamientos y conductas no saludables y reemplazarlas por pensamientos y conductas que lo sean.

Otro punto muy importante: a medida que crecemos, vamos desarrollando una perspectiva única sobre las situaciones que vivimos. Esta perspectiva es enriquecida por nuestras experiencias y nos lleva a interpretar situaciones de determinada manera. Por ejemplo, las personas optimistas, no importa lo que pase, siempre encuentran el lado positivo de las situaciones.

Los problemas e interpretaciones van a influenciar:
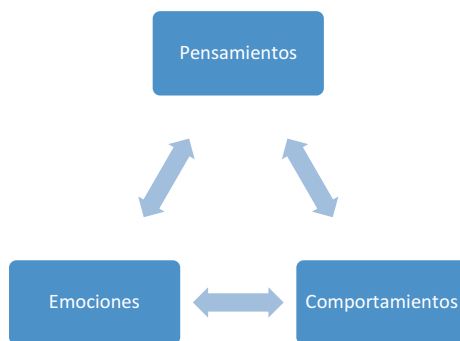
Como seres humanos, a veces tenemos pensamientos negativos y actuamos de manera negativa. Sin embargo, cuando estos pensamientos y comportamientos persisten por mucho tiempo y comenzamos a interpretar la mayoría de las situaciones de forma negativa, esto puede crear círculos viciosos de pensamientos y acciones que pueden llevar al desarrollo de la depresión.

Traducción y modificación del libro: Burns, D. D. (1999). *Feeling good: The new mood therapy*. New York, N.Y.: HarperCollins.

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Apéndice 8

Comparación De Pensamientos Depresivos Con Pensamientos No-Depresivos

Pensamientos Depresivos son:	Pensamientos No-Depresivos son:
Pensamientos <u>INFLEXIBLES</u>; es decir, son concretos y absolutos. Por ejemplo, una persona deprimida puede pensar: "Nunca me recuperaré de esta depresión" "Siempre fui y siempre seré un cobarde."	Pensamientos <u>FLEXIBLES</u>; nos llevan a reconocer que podemos cambiar nuestros pensamientos. Una persona flexible puede razonar: "Si salgo a caminar, por lo menos estoy tratando de sentirme mejor" "**A VECES** siento miedo de **ALGUNAS** situaciones**.**"
Pensamientos <u>CRÍTICOS</u> que lo hacen sentir como una mala persona. Por ejemplo, una persona deprimida puede pensar: "Soy un fracaso porque quemé la comida y no pude servirla a tiempo." "En realidad no me importa si las cosas están bien hechas, soy un fracaso."	Pensamientos de <u>ELOGIO</u> se concentran en lo que hacemos (comportamiento), no en quiénes somos (la persona). El pensador no-deprimido diría, "No estuve prestando atención a la comida y me hace sentir mal que la haya quemado." Un pensamiento menos crítico sería: "Sí, he cometido errores, pero eso no significa que yo soy un fracaso. Puedo aprender de mis errores."
Pensamientos <u>SIN ESPERANZA</u> te hacen sentir como si tratar de ser mejor no tuviera ningún sentido. Por ejemplo, la persona que tiene pensamientos depresivos diría, "Nací para sentirme mal, toda mi vida ha sido una tragedia tras otra." "Nada me ha ayudado."	Pensamientos <u>CON ESPERANZA</u>; es decir, implica pensar que las cosas van a mejorar. El pensador con esperanzas dice, "He sufrido mucho, pero puedo hacer las cosas mejor." "A veces las cosas resultan. Esto es una nueva experiencia y estoy segura de que aprenderé algo útil."

Apéndice 9

Los Errores En El Pensamiento: Aprende A Reconocerlos

Manera De Pensar:	Se Define Como:	Por Ejemplo:
Pensamiento Todo-O-Nada	Las cosas se ven como completamente buenas o completamente malas. Si comete un error, piensa que todo salió mal.	"Se me olvidó echarle sal a la comida, jamás seré buena cocinera".
Filtro Mental	Concentrarse en un sólo detalle negativo exclusivamente, hace que todo lo demás se vea negativo también.	Susana sólo se enfoca en su diabetes y en los niveles de azúcar que tuvo esta mañana. Y aún después de controlarla, no disfruta del bonito día.
Llegar a Conclusiones Precipitadas	Asumes lo peor a. **Leyendo la Mente** b. **Adivinando la Fortuna**	a. Cuando ve a alguien que no se porta amistosamente, usted asume que no le cayó bien a esa persona o que está enojado/a con usted. b. Usted cree que las cosas resultarán mal. Cree que desastres o cosas malas están "destinados a suceder."
Debería:	Intenta motivarse con: "debería". Se siente culpable cuando aplica este tipo de pensamientos porque ponen presión emocional.	"Yo debería ser mejor persona" o "debería dejar de comer hasta que baje de peso."
Poniéndose Etiqueta	Definirse bajo una categoría simplemente por un error.	Por un error, empieza a pensar que es un "fracaso". Si su niño se porta mal, usted piensa que fracasó como padre/madre.
Auto-Culpa	Se culpa así mismo por cosas sobre las cuales no tuvo control.	"Si hubiera hecho algo, esto no hubiera ocurrido." Si no hubiera llevado al niño a jugar, no se hubiera lastimado.

Apéndice 10

Modificar Los Pensamientos Negativos: El Método "Sí, pero…"

Cuando se siente deprimida, verdades a medias reciben más atención que verdades completas. Debido a que los pensamientos depresivos deforman la realidad; mantener una percepción precisa de sí mismo y de la situación puede ayudar. Aunque no se sienta mejor inmediatamente, las percepciones precisas impiden que uno se sienta peor. Esto es lo que debe hacer: primero, pare y tome en consideración lo que se dice así mismo. Si el mensaje lo hace sentir mal o lo hace enojar, es probable que sea una verdad a medias. Para luchar con el pensamiento negativo puede incluir una declaración que comience con "PERO…".

Por ejemplo, tome en consideración los siguientes pensamientos:
Antes: "Jamás voy a bajar de peso."
        "Jamás voy a poder aprender a hablar inglés".
¿Cómo la harían sentir estas declaraciones? Responda a estos pensamientos usando el método "sí, pero…".

Después: "Sí, estoy gordo, **PERO** trato de comer de la manera saludable."
Después: "Sí, no puedo hablar inglés, PERO estoy aprendiendo en mi nueva clase de inglés.

Ejercicio (use una tarjeta):
1) Por un lado de la tarjeta, escriba una frase que se diga frecuentemente y que le haga sentir mal.
 2) Pregúntese a usted mismo, ¿esta frase es completamente cierta? ¿Qué parte de la situación estoy ignorando?
3) Por el otro lado de la tarjeta use el método SÍ, PERO para hacer otra frase que sea más precisa y realista.
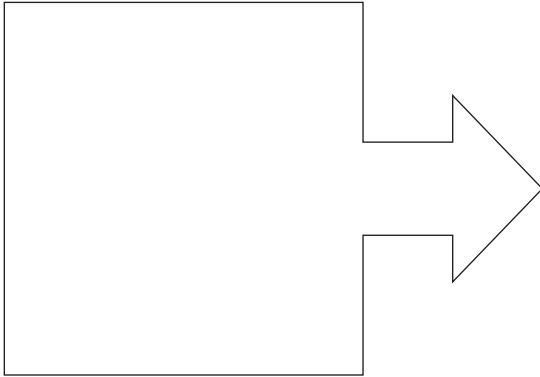
Traducción y modificación de Ellis' A-B-C-D method, esta adaptacion se encuentra en Organista, K. C. (1995). Cognitive-behavior treatment of depression and panic disorder in a Latina client: Culturally sensitive case formulation. *In Session: Psychotherapy in Practice, 1*(2), 53-64.
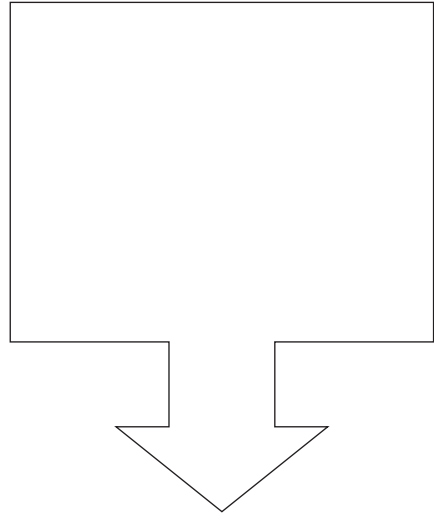
Apéndice 11

Hoja De Trabajo Para El Método "Sí, Pero…"
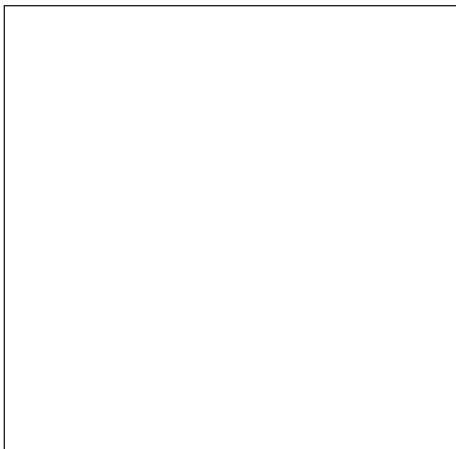
| Escribe un pensamiento negativo | ¿Cómo te hace sentir? |

| Ahora, ¿cómo te hace sentir? | Modifica el pensamiento negativo a uno positivo o más realista |
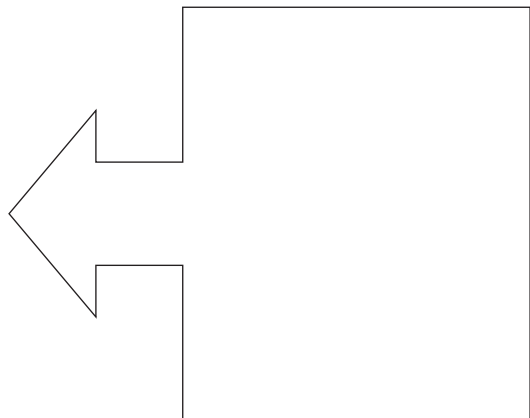
Apéndice 12: Escala Del Estado De Ánimo Y Los Pensamientos

Instrucciones: Cada día, identifique el o los estados de ánimo que sintió. Ennegrezca la intensidad del estado de ánimo. En adición, escriba algunos pensamientos que contribuyeron a su o sus estados de ánimo.

Lunes

	Feliz		Enojado/a		Nervioso/a		Cansado/a		Esperanzado/a
	Solo/a		Frustrado/a		Asustado/a		Aburrido/a		Apreciado/a
	Triste		Preocupado/a		Amado/a		Orgulloso/a		Decepcionado/a

Escribe tus pensamientos:

Martes

	Feliz		Enojado/a		Nervioso/a		Cansado/a		Esperanzado/a
	Solo/a		Frustrado/a		Asustado/a		Aburrido/a		Apreciado/a
	Triste		Preocupado/a		Amado/a		Orgulloso/a		Decepcionado/a

Escribe tus pensamientos:

Miércoles

	Feliz		Enojado/a		Nervioso/a		Cansado/a		Esperanzado/a
	Solo/a		Frustrado/a		Asustado/a		Aburrido/a		Apreciado/a
	Triste		Preocupado/a		Amado/a		Orgulloso/a		Decepcionado/a

Escribe tus pensamientos:

Jueves

	Feliz		Enojado/a		Nervioso/a		Cansado/a		Esperanzado/a
	Solo/a		Frustrado/a		Asustado/a		Aburrido/a		Apreciado/a
	Triste		Preocupado/a		Amado/a		Orgulloso/a		Decepcionado/a

Escribe tus pensamientos:

Viernes

	Feliz		Enojado/a		Nervioso/a		Cansado/a		Esperanzado/a
	Solo/a		Frustrado/a		Asustado/a		Aburrido/a		Apreciado/a
	Triste		Preocupado/a		Amado/a		Orgulloso/a		Decepcionado/a

Escribe tus pensamientos:

Sábado

	Feliz		Enojado/a		Nervioso/a		Cansado/a		Esperanzado/a
	Solo/a		Frustrado/a		Asustado/a		Aburrido/a		Apreciado/a
	Triste		Preocupado/a		Amado/a		Orgulloso/a		Decepcionado/a

Escribe tus pensamientos:				

Domingo				
☐ Feliz	☐ Enojado/a	☐ Nervioso/a	☐ Cansado/a	☐ Esperanzado/a
☐ Solo/a	☐ Frustrado/a	☐ Asustado/a	☐ Aburrido/a	☐ Apreciado/a
☐ Triste	☐ Preocupado/a	☐ Amado/a	☐ Orgulloso/a	☐ Decepcionado/a

Escribe tus pensamientos:				

Tomado de: Piedra, L. M., Cintrón, V., Guardini, L., Marquez, J., & Sink, L. (2011). *Vida Alegre: Cómo Lograr el Control sobre sus Emociones*. Manual de tratamiento -Versión en español (no publicado). [*Vida Alegre: How to Gain Control over Your Emotions*. Unpublished treatment manual-Spanish version]. University of Illinois at Urbana-Champaign. Urbana, IL.

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Tools for Cognitive Behavioral Treatment of Binge Eating Among Latinos

11

Marisol Perez

Symptoms

Binge eating is defined by the DSM-5 as an amount of food that is larger than what most people would eat in a similar period of time within a similar context. The binge eating episode must occur within a discrete period of time (e.g., within a 2- or 3-h period), with continual snacking throughout the day not considered an eating binge. In addition, three or more of the following symptoms must be associated with the binge eating episode: eating faster than normal; eating until feeling uncomfortably full; eating when not feeling physical hunger; feeling disgusted, depressed, or guilty afterward; or eating alone due to embarrassment. A binge eating episode that meets all of these criteria is considered an objective binge episode. Individuals can also report a subjective binge episode where loss of control over eating is experienced but the amount of food consumed is small or moderate (even though the client may perceive it as large). Recent research has

found that in comparing individuals who only report subjective binge episodes with loss of control to individuals who report objective binge episodes, there are no differences in eating disorder features or general psychopathology suggesting that subjective binge episodes are important to assess and treat (Palavras, Morgan, Borges, Claudino, & Hay, 2013).

Within the literature, there is no definition of what is considered a large amount of food for a binge episode. Research has found that individuals with bulimia nervosa tend to report large-size binges than individuals with binge eating disorder. The size of binges can range from 500 to 7000 kcal. The type of food can impact how clients view the eating episodes. Binge eating episodes that consist of sweets or forbidden foods tend to consist of smaller calorie sizes.

Among Latinos, no differences have been found when compared to White individuals on frequency of binge eating with loss of control, eating a small or typical amount of food with loss of control over eating, and eating unusually large portions of food with no loss of control (Azarbad, Corsica, Hall, & Hood, 2010; Lydecker & Grilo, 2016). In addition, no differences between Latinos and Whites have been found on level of eating disorder symptomatology associated with binge eating (Azarbad et al., 2010; Lydecker & Grilo, 2016).

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Prevalence and Course

Across the eating disorders, binge eating is the most prevalent among Latinos (Alegria et al., 2007) with rates being comparable to Whites (Alegria et al., 2007; Marques et al., 2011). In epidemiological studies within the United States, lifetime prevalence rates of binge eating have been found to be 5.8% for women and 5.43% for men (Alegria et al., 2007). Rates of binge eating tend to be comparable across gender and Latino subgroups (Alegria et al., 2007). Latino individuals under the age of 40 tend to have an elevated risk for binge eating when compared to older individuals (Alegria et al., 2007). Latinos report comparable rates of age of diagnosis and impairment due to their binge eating compared to White individuals (Marques et al., 2011). Specifically, Latinos report impairments in home management, ability to work, personal life, and social life, with severe impairment reported inability to work due to the binge eating (Alegria et al., 2007). However, there are slight differences in the course of the disorder. Among Latinos, binge eating precedes the dieting instead of coming after it as typically found in White samples (Lydecker & Grilo, 2016).

Differential Diagnosis

With recurrent binge eating, it is important to assess if individuals meet criteria for either binge eating disorder (BED) or bulimia nervosa (BN). In order to meet criteria for BED, binge eating episodes must occur at least once a week for 3 months and yield marked distress in individuals. Individuals with BED may report frequent attempts at dieting but do not engage in recurrent unhealthy compensatory behaviors as seen in BN. In order to meet criteria for BN, individuals must have binge eating episodes and recurrent unhealthy weight compensatory behaviors such as fasting, excessive exercising, vomiting, and laxative or diuretic use. The binge eating and weight compensatory behaviors must occur at least once a week for 3 months. It is important to note that among Latinos, BED is more prevalent

than BN (1.92% vs. 1.61%, respectively; Alegria et al., 2007).

Coexisting Conditions

Binge eating is associated with obesity. Individuals with a BMI greater than 30 are 5 times more likely to report binge eating than those with a BMI less than 30 (Alegria et al., 2007). According to DSM-5, individuals with obesity and BED report greater levels of over-evaluation of weight and shape than those who are obese without BED. In addition, when comparing Latinos who are nonobese with BED, nonobese without BED, obese without BED, and obese with BED, Latinos who are obese with BED report the most impairment in quality of life across all domains compared to the other groups (Perez & Warren, 2012). However, impairment in social interactions was related to diagnostic status more so than weight status (Perez & Warren, 2012). Another comorbidity associated with binge eating found in Latinos is depression (Lydecker & Grilo, 2016). Research examining predictors of binge eating has found that depression but not stress significantly predicts binge eating severity (Azarbad et al., 2010).

Since binge eating is associated with obesity, clients with binge eating can also present with significant medical conditions such as high cholesterol and blood pressure, diabetes, heart disease, sleep apnea, etc.

Treatments for Binge Eating

According to the American Psychological Association-Society of Clinical Psychology, cognitive behavioral therapy and interpersonal psychotherapy both have strong research support demonstrating that they are effective treatments for BED and BN (www.div12.org/psychological-treatments/disorders/). Both have been shown to significantly reduce binge eating among obese and nonobese individuals across several randomized controlled trials (Pike, Gianini, Loeb, & Grange, 2015). In a recent study examining

moderators and predictors of treatment outcome across clinical trials of BED, they found no differences in treatment outcome or treatment retention across education level, age, or when comparing Latino to White patients (Thompson-Brenner et al., 2013). Across the clinical trials, Latinos had a 74.9% reduction in objective binge episodes, a 27.3% reduction in eating disorder symptomatology, a 43.8% reduction in the cessation of objective binge episodes, and a 29.2% dropout from treatment. When comparing group versus individual treatments, Latinos had better treatment response to individual treatment.

Research has been mixed on the use of pharmacological treatments for binge eating. Some studies have found fluvoxamine to significantly reduce binge eating compared to a placebo, but others have not (Pike et al., 2015). A few studies have found that antiepileptic medication can reduce binge eating and weight loss when compared to a placebo, but further research is needed in this area. However, when clients present with comorbid depression, it is recommended to treat the depression with medication before starting CBT for binge eating (Pike et al., 2015).

Cognitive Behavioral Model for Binge Eating

The cognitive behavioral model for binge eating, graphically displayed in Fig. 11.1, hypothesizes that negative life events (i.e., life stress) lead to the experience of negative emotions, with binge eating as a way to cope. The binge eating itself can lead to emotional relief, or it can cause further negative emotions. Latino clients with binge eating tend to have a history of dieting after the onset of actual or perceived weight gain due to concerns about their weight and shape (Alegria et al., 2007). Dieting itself has been found to further trigger binge eating. Low self-esteem has been consistently found among individuals who binge eat. It is hypothesized that individuals with low self-esteem are more likely to be concerned and insecure with their weight and shape. Although my experience clinically with Latinas with binge eating is that the low self-esteem also impacts how they cope with negative emotions.

Research has found a variety of proximal and distal triggers for binge eating. Distal factors related to eating disorder symptomatology include low self-esteem and weight and shape concerns (Waller, 2002). However, these individual characteristics are hypothesized to be related to general eating disorder symptoms more than to binge eating per se (Waller, 2002). Research examining proximal antecedents for binge eating has found that negative affect consistently proceeds binge eating across retrospective studies, self-report questionnaires, and ecological momentary assessments (see Haedt-Matt & Keel, 2011 for a review). Research has also found that although negative mood is a stronger trigger of binge eating, hunger tends to be significantly higher before binge eating episodes when compared to nonbinge eating episodes (Stein et al., 2007). A recent study examined different dietary
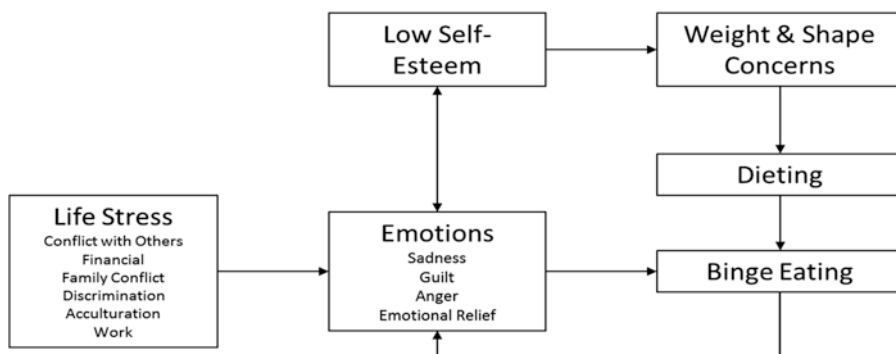
Fig. 11.1 Factors that maintain the binge eating cycle

restriction behaviors among adults with anorexia nervosa-binge/purge subtype, BN, and BED (Elran-Barak et al., 2015). Individuals with BN who reported higher frequencies of eating small and low calorie meals as their dietary restraint behaviors had lower frequencies of binge eating, suggesting that not all types of dietary restrictions trigger binge eating (Elran-Barak, et al., 2015). Research has also found that interpersonal problems predicted negative affect, which in turn, predicted momentary loss of control eating (Ansell, Grilo, & White, 2012; Ranzenhoefer et al., 2014). Similarly, interpersonal stressors, work/environment stressors, general daily hassles, and stress appraisal all predict binge eating through the increase in negative affect (Goldschmidt et al., 2014).

Research among Latinas who binge eat has found that acculturative stress (i.e., stress created from managing and balancing two cultures) and family disconnection predicted binge eating through negative affect (Higgins & Bardone-Cone, 2017). However, discriminatory stress directly predicted binge eating (Higgins & Bardone-Cone, 2016). Research examining meal patterns of Latinas who binge compared to Latinas who do not binge found greater frequency of binge eating during social contexts (Cachelin, Thomas, Vela, & Gil-Rivas, 2017). Qualitatively, Latinas who binge described family and peer pressure to eat large quantities of food as predisposing the consumption of larger meals (Cachelin et al., 2017).

Research examining consequences of binge eating has identified both proximal and more longer-term consequences. Research has found that negative emotional states are increased after a binge episode such as guilt, inadequacy, and sadness (Haedt-Matt & Keel, 2011). Binge eating also reduces hunger and starvation. Another hypothesized immediate consequence to binge eating is the distraction from or blocking of awareness of uncomfortable cognitive or emotional states (Waller, 2002). Among Latinas, it is hypothesized that binge eating satisfies pressure from family and peers to eat and demonstrates respect and likability of the food served (Perez, Ohrt, & Hoek, 2016). More longer-term conse-quences of binge eating include weight gain and dieting (Waller, 2002). In addition, the weight gain and dieting add to the unhealthy cognitions, emotions, and social situations that started the binge eating, thus becoming self-maintaining (Waller, 2002). Binge eating also adds to mal-adaptive cognitive beliefs related to self (e.g., incompetence, inadequate, defective), to eating (e.g., dysfunctional assumptions related to food, eating, and weight), and to environment (e.g., satisfying the family and being happy with self).

Rationale and Treatment Plan

Research on treatment of binge eating among Latinos is extremely limited. As previously mentioned, there is strong research support for CBT for binge eating among White samples. Morales and Norcross (2010) discuss how the clinician has three options when deciding how to apply a research-supported treatment to an ethnic minority client: adopt it, adapt it, or abandon it. They discuss how a clinician should adopt a research-supported treatment when the treatment has been tested on the target problem and found to be effective, *and* the clinician feels confident in using the research-supported treatment. Given that CBT for binge eating meets this criterion and the cognitive behavioral framework is a highly used and well-known framework for the treatment of diverse psychiatric conditions, this treatment plan will use the CBT framework for binge eating as developed for White samples. Throughout the treatment plan, a discussion of culture-specific issues and how to address them is provided to assist the clinician in tailoring CBT to the Latino client with binge eating. The following is not intended to be a detailed or comprehensive guide to CBT with binge eating but rather adjunctive tools and issues that may present with Latino clients. For a more thorough discussion of how to use CBT for binge eating and eating disorders, the following book is recommended:

Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountfourd, V. & Russell, K. (2007). *Cognitive behavioural therapy for eating disorders: A comprehensive*

treatment guide. New York, NY: Cambridge University Press.

CBT for binge eating involves self-monitoring, development of alternative responses to stress and emotions, regular eating, goal setting, self-reinforcement, problem-solving, behavioral experiments, and cognitive restructuring. Table 11.1 provides an outline of CBT for binge eating. Consistent with CBT, the assessment phase is important for a detailed understanding of the presenting problems, case formulation, and treatment planning. In general, the CBT program is intended to last approximately 18–24 sessions over a 6-month time frame. Individual therapy sessions are 50 min long. The goal of the first phase of treatment is to provide psychoeducation, establish a pattern of regular eating, and implement a mild exercise program. The goal of the second phase of treatment is to deal with situations, thoughts, and emotions that can trigger binge eating. During this phase, distress tolerance, problem-solving, and interpersonal problem-solving skills are taught. During the last phase of treatment, relapse prevention is addressed. The three phases of treatment can overlap over the course of the treatment program.

At each session, the client is routinely weighed. This is to assist in monitoring changes in weight during the course of treatment. Some clients are uncomfortable with being weighed, and this activity can also serve as exposure to this situation. It can also be used to assist the client in accepting and coming to terms with their weight and shape concerns.

Consistent with a general CBT framework, throughout treatment the clinician consistently identifies cognitive distortions the client says and challenges these thoughts using cognitive restructuring strategies. For example, a client may say "I can't win, no matter what I do my family criticizes me." A clinician can challenge this cognitive distortion by asking the client to list what evidence they have that supports this thought and what evidence they have that contradicts this thought. Another strategy is to question the client such as "Has there ever been a time when your family compliments you?" Common cognitive restructuring strategies include questioning the validity of the thought; using behavioral experiments to examine the accuracy of the thought; creating alternative explanations for other's behaviors, actions, or statements; and considering the implications of the cognitive distortion.

Table 11.1 Outline of cognitive behavioral treatment for binge eating

Assessment
In-depth interview and assessment of past and present eating disorder symptoms
Other psychopathology (depression, anxiety, trauma, personality disorders)
Stressors (occupational, financial, interpersonal, acculturative)
Familiarization with treatment
Goal setting
Phase 1 – eating and exercise change
Daily food records
Psychoeducation on healthy eating
Implementation of regular and consistent eating of healthier foods
Implementation of a mild exercise program
Phase 2 – identification of triggers and coping
Identifying the various triggers
Teaching coping strategies
Teaching interpersonal problem-solving
Phase 3 – relapse prevention
Identifying future pressures and stressors
Handling setbacks and relapses

Assessment

Important to CBT is a thorough in-depth assessment. Within the toolkit section at the end of this chapter, a semi-structured clinical interview and intake with a focus on binge eating are provided in both English and Spanish (handout 12.a). The intake begins with an assessment of the presence of binge eating and loss of control, which includes an assessment of the frequency of objective binge episodes and subjective binge episodes, and specifying the severity of the binge eating. The intake includes an assessment of current and past weight compensatory behaviors to assist the clinician in determining if the client meets criteria

for BED or BN. Given that clients who binge eat have a history of dieting, restrained eating, and food rules, there are sections in the intake that assist the clinician in assessing these constructs.

Evidence-based assessment is the "gold standard" to objectively quantify a client's presenting problems and assist in determining if they meet diagnostic criteria. The Eating Disorder Examination 16.0D (EDE; Fairburn, Cooper, & O'Connor, 2008) is the most empirically supported semi-structured interview for eating disorders. The EDE can take between 45 and 75 min to complete. It has been translated to Spanish within the United States, Spain, and Mexico. The English version of the EDE is available for free at www.rcpsych.ac.uk/pdf/EDE_16.0.pdf. A Spanish version of the EDE is available for free from the author of this chapter (please send requests via email). Clinicians who opted to use the EDE would not have to administer numerous sections of the semi-structured clinical interview (i.e., binge eating, weight compensatory behaviors, dieting, fasting, restrained eating, and food and body dissatisfaction) provided in the toolkit at the end of this chapter.

As previously discussed, binge eating can be comorbid with a number of other psychopathologies. Thus, it is important to assess a wide range of symptoms. Within the semi-structured clinical interview/intake provided in the toolkit section of this chapter is a section on comorbid symptoms that allows the clinician to write the score and severity level across numerous measures. For depression, the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996) is available in both English and Spanish. Scores on the BDI that range from 0 to 13 are considered minimal depression, scores between 14 and 19 are considered mild depression, and scores between 20 and 28 are considered moderate depression, with scores 29 or higher indicating severe depression (Beck et al. 1996). The Beck Anxiety Inventory (BAI; Beck & Steer, 1993) is also available in both English and Spanish. Scores on the BAI that range from 0 to 7 indicate minimal anxiety, scores from 8 to 15 indicate mild anxiety, scores from 16 to 25 are considered moderate anxiety, and a score of 26 or higher is considered severe

anxiety (Beck & Steer, 1993). For suicide risk assessment, there are a number of free resources available. The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) was a measure developed by the Suicide Prevention Resource Center and SAMHSA within the United States Health Resource Service Administration. The SAFE-T is available for free at http://www.integration.samhsa.gov/images/res/SAFE_T.pdf and categorizes suicide risk as low, moderate, or high with potential interventions outlined for each level of risk. For trauma, the PTSD Checklist-Civilian version (PCL-C) assesses feelings and behaviors commonly associated with trauma (Lang & Stein, 2005). There is an English version of the questionnaire available for free at http://www.integration.samhsa.gov/clinical-practice/Abbreviated_PCL.pdf. The Spanish translation of the PCL-C has also been published and is available within a peer-reviewed journal article accessible online (Miles, Marshall, & Schell, 2008). If there is endorsement of trauma-related symptoms and behaviors, then the Life Event Checklist (LEC) is recommended to determine the type of trauma that the client has experienced (Blake et al., 1995). The LEC is available at http://www.integration.samhsa.gov/clinical-practice/life-event-checklist-lec.pdf. Specific to Latino clients, it is important to assess for socio-political trauma. Recent data has demonstrated that trauma associated with war-related violence, drug cartel, and unstable governments is reported among Latinos living in Latin America and associated with eating disorder symptoms (Guarín, 2016).

Routine monitoring and assessment of treatment progress are also important in CBT. The Eating Disorders Examination-Questionnaire 6.0 (EDE-Q) is a self-report measure based on the EDE (Fairburn & Beglin, 2008). This measure assesses the frequency of eating disorder behaviors over the past 28 days. The measure also provides four subscale scores that assess restraint over eating, shape concerns, weight concerns, and eating concerns. An English version of the measure and scoring instructions is available for free at http://www.rcpsych.ac.uk/pdf/ede-q.pdf. The Clinical Impairment

Assessment (CIA) questionnaire is a self-report measure that assesses the degree to which eating disorder symptoms interfere with cognitive, interpersonal, and work domains (Bohn & Fairburn, 2008; Bohn et al., 2008). It is designed to be administered with the EDE-Q and focuses on the past 28 days. The English version of the CIA and scoring instructions is available for free at http://www.credo-oxford.com/pdfs/CIA_3.0_Instructions_for_users.pdf. A Spanish version of the EDE-Q and CIA is available upon request from the author of this chapter for free (please send all requests via email). Both of these instruments can be used monthly to assess treatment progress.

Familiarization with Treatment and Goal Setting

After the initial assessment and intake are complete, the first therapy session is used to familiarize the client to CBT. It is recommended to review the cognitive behavioral model of binge eating and apply Fig. 11.1 to the client's presenting problems. The individualized model of binge eating created based on the client's presenting problems is presented as our working hypotheses. Treatment will entail behavioral experiments and self-monitoring that will assist in examining the accuracy of our hypotheses with adjustments made to the model as we go along. The client is informed how each symptom in the model is addressed in the treatment program. The client is told what the expectations and requirements will be for both the client and clinician throughout treatment, and a verbal commitment is obtained from the client to actively participate in treatment. It is important that the client understand the length of treatment, structure of treatment, the importance of homework, and session attendance.

In addition to familiarization of treatment, the clinician should assist the client in developing treatment-related goals. Individuals who binge eat often have weight loss as a treatment target goal. It is important to discuss with clients that CBT for binge eating does not usually result in

weight loss. However, the cessation of binge eating can result in the prevention of future weight gain. It is important to discuss with clients that the cessation of binge eating should come first, before weight management interventions. In addition, weight management interventions can trigger binge eating making it important to have the binge eating under control. Common and appropriate treatment goals can include strengthening family relationships, cessation of binge eating, healthier eating, and improving mood.

Phase 1: Eating and Exercise Change

The goal of the first phase of treatment is to get the client monitoring their eating, healthier eating, and regular eating. During the second session of therapy, the daily record (provided in both English and Spanish within the toolkit section at the end of this chapter; handout 12.b) is introduced to the client. It is recommended that clinician complete a daily food record in session with clients. Clients should record all food and liquids consumed across each day (e.g., 1 cup of cereal with ¾ cup of milk, 1 diet coke 16 oz, 2 cups of rice and beans), binge episodes, loss of control over eating, exercise, and any additional comments. Within the comment section, clients are encouraged to report urges to binge, hunger levels, satisfaction levels, or any strong emotions before or after the food consumption. The importance of daily food records during the course of treatment should be emphasized. Daily records are used to identify eating patterns, binge triggers, and areas for healthier eating and assess treatment progress. It is important that clients do not use daily records to count calories or limit their intake to a fixed number of calories since restrained eating can contribute to binge eating. Clients have expressed concerns of the use of daily records making them obsessed with food and increasing their likelihood to overeat. To handle this concern, it is recommended to introduce a behavioral experiment. It is proposed that clients do the daily records for 2 weeks, and at the end of 2 weeks, we will assess together if

there has been an increase in overeating. It is important to note that this rarely occurs.

During the first phase of treatment, the clinician should introduce the importance of regular eating during the second or third session. The client should work toward a pattern of eating three regular meals and two to three snacks in between meals. It should be emphasized that all eating episodes should be planned and no eating should occur outside of the planned meals and snacks. The importance of not skipping meals should be reiterated. It is important that the rationale for regular meal patterns be provided. Regular eating will reduce hunger and starvation levels which can contribute to binge eating. In addition, regular eating allows retraining of the body to normal hunger and fullness sensations. A discussion of how the body uses food as fuel and energy, even when we are sleeping, and how regular eating also allows the body to become more efficient in converting food to fuel is recommended.

There are several issues with regard to eating that have been encountered with Latino clients and regular meals that should be noted. Latino clients highlight the importance of having meal plans that include cultural foods (Reyes-Rodriguez, Guilisano, & Silva, 2016). Among White individuals, research has demonstrated that individuals who binge eat tend to skip meals, have irregular meal patterns, and binge eat in social isolation. However, among Latinas research has demonstrated that those who binge eat tend to have regular meal patterns and the binge eating tends to occur during social situations (Cachelin et al., 2017). This distinction is important. Among White individuals, the institution of regular meal patterns significantly reduces the binge eating and contributes to significant treatment gains during the first phase of treatment. However, for Latinos, the institution of regular meal patterns will not lead to the same significant reductions in binge eating. Indeed, the majority of treatment gains are observed during the second phase of treatment when triggers and skill training are implemented (Reyes-Rodriguez, Baucom, & Bulik, 2014). Another significant issue that can arise with regard to regular eating is food insecurity. Clients that are experiencing financial stress and food insecurity may skip meals or reduce the food intake during a meal. In these situations, it is helpful for the clinician to connect clients with local resources such as food banks, the US Supplemental Nutrition Assistance Program, and/or other local resources.

Psychoeducation of what constitutes healthy eating is important. This education occurs over the span of the first phase of treatment. Daily records are reviewed, and the clinician highlights areas where small changes to healthier eating can be made while contextualizing the recommendations within education of healthy eating. The United States Department of Agriculture has a website (www.choosemyplate.gov) that provides free handouts in both English and Spanish and resources for teaching about healthy eating styles. Within the toolkit section at the end of this chapter, the most common handouts used from the USDA website are provided (12.c). The first handout demonstrates how a meal should be divided by the various food groups on a plate, with the second handout outlining what foods constitute each category. The third handout from the USDA gives ten tips for making a meal healthier. At times, Latino clients may resist changes in their cooking or meals for fear that healthier eating is incompatible with cultural foods. For example, when cooking meat for a burrito, the clinician recommended eliminating frying the meat in oil and cooking the meat with a little water instead. The client was afraid that eliminating the oil would change the flavor of the food and "Americanize" the burrito. The clinician suggested a behavioral experiment, where the client would make burritos for dinner and cook the meat in water instead of oil. She was not allowed to tell her family of the cooking change and would assess during the meal if her family noticed any changes in the food. She returned to treatment happy that the food had tasted the same, no one had noticed the cooking change, and in turn the meal was slightly healthier.

An important aspect to the psychoeducation of healthy eating is what constitutes a serving size. Some Latino clients will report eating

three meals and two snacks. However, the daily records will reveal that the amount of food eaten during a snack is comparable to a regular meal. In this situation it is important to distinguish meal size during a snack versus a regular meal. To assist in teaching clients about portion sizes, a foam or plastic plate that is divided into three sections can be used. It is important to note that some Latino clients will use the plates and pile the food in each section of the plate into large mounds. For this reason, it is recommended that plates with the three divisions also come with a lid. There are numerous products available that can be used, such as Go Healthy Portion Control Plates, 3-Section with Lids by Precise Portions. Clients are instructed that when they place the food on the plate, the lid should easily close on the plate and should not squish the food. Concrete examples, like these, can assist clients in understanding what healthy eating looks like.

The daily record can also be used to assess the client's level of exercise. A mild exercise program should be started. Clients are often started on 10 min of walking at a moderate pace, ideally four times a week. However, the frequency and length of time of exercise are adapted to the client's schedule. It is helpful to problem solve and remove barriers to exercising with the client. The implementation of exercise can involve some creativity on both the client and clinician. For example, one female client had a very busy schedule. Collaboratively, a plan was created where the walking exercise was around her couch during the commercial breaks when she watched her telenovelas or Spanish soap operas. Clients have also responded well to ideas such as lifting a can of beans with each arm while cooking or putting more effort/movement while vacuuming and doing household chores.

In summary, throughout the first phase of treatment, the clinician will review the daily record noting eating and binging patterns, reinforce positive changes the client makes, and assist the client in further implementing healthier changes. In addition, the clinician will educate the client on healthy eating.

Phase 2: Identification of Triggers and Coping

The second phase of treatment focuses on maintaining the progress from the first phase of treatment, the identification of binge eating triggers, and the teaching of coping strategies and problem-solving skills. The clinician and client collaboratively complete the Binge Eating Trigger handout provided in the toolkit section at the end of this chapter (12.d). The clinician can assist the client in identifying triggers from the daily records in addition to the client's past experiences prior to therapy. The identification of triggers can assist the clinician in deciding what coping strategies and skills training to teach the client.

An important component to the second phase of treatment is the involvement of family members and extended family. Latino clients with BN or BED who have undergone psychosocial treatment reported one criticism to treatment was the lack of psychoeducation of family on the binge eating and its health consequences (Shea et al., 2012). Clients reported that family members tended to discount the binge eating as just a big meal that is normative in Latino culture (Shea et al., 2012). On the other hand, some Latino clients report viewing therapy as a personal matter and did not wish to involve family in treatment (Shea et al., 2012). It is recommended that the clinician explore with the client their preferences with family involvement in treatment. If clients wish to involve family, there are two options: the clinician can work with the client so that the client is the one to educate the family on binge eating, or the clinician can provide a family therapy session where psychoeducation on binge eating and its consequences is provided. Family members can also be involved in the coping strategies to assist clients in resisting the urges to binge and handling social gatherings.

Handout 12.e. within the toolkit section, Coping Strategies Card, is completed with the client. The client is instructed to create ten different alternative strategies to binge eating. A key component of these strategies is that they are pleasurable. For example, when clients get the

urge to binge, they can go for a walk, call a friend or family member, watch YouTube videos that will make them laugh, etc. It is important that this list of activities be suitable for the client's economic situation. Past research has found that one major criticism of CBT for binge eating is the lack of suitable alternatives to binge eating for individuals living in low-income economic sectors (Shea et al., 2012). It is recommended that client carry this coping card in their wallet or cell phone case so that the card is accessible wherever they travel. Clients are instructed that they are to start at the top of their list and try the first activity; if it does not work and they still have the urge to binge, then they move to the second activity. They continue down their list until the urge goes away.

Across the eating disorder treatment literature, Latinos consistently remark on interpersonal stress caused by family conflicts related to food, eating, and comments about weight and shape (see Perez et al., 2016 for a review). In addition, research among Latinos has found that interpersonal stress predicts binge eating through negative affect (Cachelin et al., 2017; Higgins & Bardone-Cone, 2017). Thus, it is important to assist Latino clients in handling negative interpersonal situations. The Interpersonal Events handout (12.f) in the toolkit section can be used to assist with social problem-solving. The clinician and client complete the first one together, and then the client does two to three for homework.

When completing the interpersonal event handout, ask the client to think of a negative event (i.e., an argument or conflict with someone else) that recently occurred. The clinician then asks the client to describe what happened in as much detail as possible. During the first time, the clinician usually has to interrupt the client repeatedly to ascertain the level of detail necessary. The clinician will want to know what was the client's mood prior to the event occurring, exactly what did the client say during the interaction including tone of voice and volume, and how did the other person respond. As the client is detailing what transpired, the clinician is paraphrasing what the client says and placing the information under the facts or assumptions box. After the client finishes describing the situation, the clinician will review why statements were placed under the facts vs. assumptions boxes. The clinician will then ask the client "What did you want out of this situation?" The clinician will write what the client says in the space provided. Finally, the clinician will ask the client "Did you get what you wanted?" Since this is a negative interpersonal event, the client almost always says no. The clinician then says to the client:

The goal of this exercise is to figure out a way to make it more probable that you get what you want out of situations. So we are going to go back through this situation and figure out why you did not get what you wanted.

It is recommended that the clinician start with what the client wanted out of the situation. Usually, the client wants an outcome that is outside of their control. For example, they will state they wanted their boyfriend to appreciate them or their partner to stop drinking. When this occurs, it is helpful to point out to clients how they set themselves up for failure by wanting outcomes of situations that they have no control over (i.e., we cannot control what other people do). The clinician then assists the client in creating more realistic outcomes such as "I want to express to my boyfriend how I feel unappreciated" or "I wanted to tell my partner in a calm way that they were drinking too much and becoming inebriated."

Following the creation of more realistic desires of the situation, the clinician will take the client step-by-step through each statement and action the client made during the interaction. At each step the clinician will ask "Did this action or comment help or hurt you in achieving what you wanted?" The clinician and client can discuss if each comment/action helped or hurt and why. For each statement or action that is deemed as hurting in obtaining the desired outcome, the client creates a more appropriate statement or action that is in line with the new more realistic desired outcomes.

It takes about 2–3 weeks (approximately six interpersonal event handouts) for clients to understand and value the utility of this social problem-solving technique. Once they

understand it, they can prospectively complete the handout for future events. This handout can be useful when assisting clients in navigating social gatherings or family meals where they will experience pressure to overeat and triggers for binge eating. The interpersonal event handout can also be used to handle situations related to discrimination and acculturative stress. Past research has found that Latino clients report needing assistance navigating the discrepant beauty ideals and norms of their culture and American culture and conflicts related to discrepant gender roles and expectations of both cultures (Shea et al., 2012). The interpersonal event handout can assist clients in navigating individual situations as they arise. The focus on the client's desired outcome, and the structure of this technique, also assists clients in building their self-esteem and ability to cope with negative situations.

Other coping strategies that can assist clients in better tolerating and coping with emotionality include relaxation techniques, exposure to intense emotions, distress tolerance, and emotion regulation skill training from dialectical behavior therapy (Safer, Telch, & Chen, 2009).

In summary, the goal of phase 2 is to identify binge eating triggers, develop coping strategies to resist the urge to binge, and increase coping skills for emotion, distress, and negative interpersonal situations.

Phase 3: Relapse Prevention

During the relapse prevention phase, treatment gains are highlighted and reinforced as are the skills learned throughout treatment. The goal of the final sessions is to think prospectively about future potential triggers. This is done by the clinician and client reviewing past triggers for binge eating including environment, places, people, comments, and mood that may make the client vulnerable again to binge eating. Clinicians and clients then review what techniques or coping strategies may work for each of the triggers discussed. In addition, a discussion of future setback and relapses also occurs. A plan of action is outline for the client if they lapse into a binge eating episode. In addition, a separate plan of action is outlined if the client relapses and their eating disorder symptoms return.

Tools for Cognitive Behavioral Treatment for Binge Eating

12.a. Semi-structured Clinical Interview/Intake

ID Number: _____   Client's Name: _____

Gender: M   F   Gender Identity: _____

Age: _____   Employment: _____

Date of Birth: _____ / _____ / _____   Language Preference: _____

- *What brings you in today? [¿Qué es lo que te ha traído aquí?]*
- *How long has this problem been going on? [¿Cuánto tiempo hace que este problema viene sucediendo?]*
- *Describe to me your eating habits throughout a typical day. How do these habits vary on the weekends? How often do you skip a meal? Are there days when you eat nothing at all? [Descríbeme tus hábitos de alimentación durante un día típico. ¿Cómo varían estos hábitos en los fines de semana? ¿Con qué frecuencia te saltas una comida? ¿Hay días en los que no comes nada?]*

Please note if eating patterns are chaotic, structured, or if there are food rituals, snacking or grazing throughout the day.

<div align="center">Binge Eating [Atracón de Comida]</div>

- *Everyone has a personal definition of what it means to eat too much or overeat. Can you describe to me an episode when you have eaten too much or overate? What did you eat and how much? [Todo el mundo tiene una definición personal de lo que significa comer demasiado o comer en exceso. ¿Puedes describirme un episodio cuando has comido demasiado? ¿Qué comiste y cuánto?]*
- *Did you have a sense of loss of control during the episode? Do you feel you could have stopped eating at any time? [¿Tuvo una sensación de pérdida de control durante el episodio? ¿Siente que podría haber dejado de comer en cualquier momento?]*
- *How many of these episodes have you had in the past month? How many would you estimate in the past 3 months? [¿Cuántos de estos episodios ha tenido en el último mes? ¿Cuántos de estos episodios ha tenido en los últimos tres meses?]*
- *Describe to me other episodes of overeating you have had in the past month. [Descríbeme otros episodios de comer en exceso que has tenido en el último mes.]*

Assess number of objective binge episodes and subjective binge episodes in the past 3 months.

_____ objective binge episodes

_____ subjective binge episodes

Specify Current Severity:
1-3 binge eating episodes per week = Mild
4-7 binge eating episodes per week = Moderate
8-13 binge eating episodes per week = Severe

14 or more binge eating episodes per week = Extreme

In relation to the binge episodes…..	√ if Present
Eat more rapidly [comer más rápido]	
Eat until uncomfortably full [Comer hasta que se sienta incómodamente lleno]	
Binges occur even when they aren't hungry [Atracones ocurren hasta cuando no tienen hambre]	
Eat until the food is gone [Comer hasta que se termine la comida]	
Eat alone due to embarrassment [Comer solo debido a la vergüenza]	
Feel guilty during/after binge [Sentirse culpable durante / después del atracón]	
Feel depressed during/after binge [Sentirse deprimido durante/después del atracón]	
Feel disgusted during/after binge [Sentirse decepcionado durante / después del atracón]	
Feel ashamed during/after binge [Sentirse avergonzado durante / después del atracón]	

<u>Extreme Weight Compensatory Behaviors [Conductas Extremas de Control de Peso]</u>

Assess if client engages in any of the following to compensate for the binge eating episodes If they are currently engaging in the behavior, write in the number of times per week or per month. If they are not currently engaging in the behavior, then leave blank. If they have engaged in the behavior in the past, write in the number of times per week or per month they ever engaged in the behavior.

Behaviors	Present Frequency	Past Frequency	Notes:
Vomiting [Vomitar]			
Excessive Exercising [Ejercicio Excesivo]			
Laxative Abuse [Abuso de Laxantes]			
Diuretic Abuse [Abuso Diurético]			
Diet Pills [Pastillas para adelgazar]			
Other methods:			

Dieting, Fasting, Restrained Eating [Dieta, Ayuno, Control sobre la Ingesta]

- *In the last 3 months, have you been dieting? Describe to me your past attempts at dieting. [En los últimos 3 meses, ¿has estado haciendo dieta? Descríbeme sus intentos pasados de hacer dieta.]*
- *In the past 3 months, have you ever gone 8 hours or more without eating? If so, how often have you done this? Have you done this in the past as well? [En los últimos 3 meses, ¿alguna vez ha pasado 8 horas o más sin comer? Si es así, ¿con qué frecuencia has hecho esto? ¿Has hecho esto en el pasado también?]*
- *In the past 3 months, have you tried to cut back or limit the amount of food you eat? In what ways do you do this? Do you do this after a binge episode? What about during times or days you do not binge, do you still cut back or limit the amount of food you eat? How many times have you done this in the past 3 months? What are some of the reasons you do this? [En los últimos 3 meses, ¿ha intentado recortar o limitar la cantidad de comida que come? ¿De qué maneras haces esto? ¿Haces esto después de un episodio de comer en exceso? ¿Qué sucede durante las épocas o días en que no come demasiado, todavía reduces o limitas la cantidad de alimentos que usted come? ¿Cuántas veces has hecho esto en los últimos 3 meses? ¿Cuáles son algunas de las razones por las que hace esto?]*

Food [Alimentacion]

- *Are there any food you prohibit yourself from eating because they might make you gain weight? How often do you do this? Are there any food you prohibit yourself from eating out of fear that you might lose control? [¿Hay algún alimento que usted prohíbe de comer porque podría aumentar de peso? ¿Con qué frecuencia haces esto? ¿Hay algún alimento que usted se prohíbe de comer por temor a perder el control?]*
- *Do you have any rules with respect to food? For example, setting guidelines about what you can or cannot eat. How often are you able to comply with these rules? [¿Tiene alguna regla con respecto a la comida? Por ejemplo, establecer pautas sobre lo que puede o no puede comer. ¿Con qué frecuencia puede cumplir estas reglas?]*
- *In the past month, how much time have you spent thinking about food or the calories in the food you eat? Has this thinking about food or calories made it difficult to concentrate? Does it occur even when you are doing things that you like such as watching TV or talking with others? In the past month, how often has this occurred? [En el último mes, ¿cuánto tiempo has pasado pensando en los alimentos o en las calorías de los alimentos que comes? ¿Este pensamiento sobre los alimentos o las calorías hizo difícil concentrarse? ¿Ocurre incluso cuando estás haciendo cosas que te gustan, como ver televisión o hablar con otros? En el último mes, ¿con qué frecuencia ha ocurrido esto?]*

Body Dissatisfaction [Insatisfacción de la Imagen Corporal]

Assess if there is a dissatisfaction of body shape [insatisfacción con la forma del cuerpo].
Assess if there is a dissatisfaction of weight [insatisfacción con el peso].
Assess if there is a fear of fatness or gaining weight [miedo a la gordura o engordar].

Menstruation

Are the periods: regular, irregular, absent, not applicable

Age of the start of menstruation: _____

Weight and Physical Health

Current Weight: _____   Ideal Weight: _____

Height: _____   BMI: _____

Lowest Adult Weight: _____   Age: _____

Highest Adult Weight: _____   Age: _____

Client's Ideal Weight: _____

Chronic Health Conditions (e.g., high blood pressure, high cholesterol, diabetes, asthma, etc.)

[Problemas Cronicas de Salud (e.g., La presión alta, colesterol alto, diabetes, asma, etc.)]

Comorbid Symptoms

BDI Score: _____ (Level: _____) BAI Score: _____ (Level: _____)

Suicide Risk Assessment Score: _____ (Level: _____)

Trauma Score: _____

Type of trauma experienced: Emotional, Physical, Sexual, Sociopolitical, Other

Current or past Alcohol Use (frequency, quantity, concerns):

Current or Past Drug Use (Marijuana, Cocaine, Amphetamines, Ecstasy, LCD, Heroin, Other):

Any Drug Use for Weight Control purposes?

Impulsive Behaviors (e.g., self-cutting, burning, hitting; or risky sexual behavior):

History of Diagnoses:

Past Treatments

Past history of medical treatment:

Past history of psychosocial treatment:

Current medical or psychosocial treatments:

Interpersonal Relationships

Who does the client live with:

Family Structure/Quality of Relationship:

Marital Status and Sexuality:

Social Network (extended family, friends, supports):

Want to involve family in treatment: Yes, No

Mental State

Note client's mental state, appearance, mood, presentation, orientation, speech, demeanor, and engagement with clinician.

Client's Strengths

Note client's strengths such as interpersonal strengths, ability to cope, insight, good social support network, motivation, etc.

12.b. Daily Record

DATE:

TIME	FOOD	DRINK	BINGE	LOSS OF CONTROL	EXERCISE	COMMENTS

12.b. Registro Diario

FECHA:

HORA	COMIDA	LÍQUIDOS	ATRACÓN	PERDIDA DE CONTROL	EJERCÍCIO	COMENTARIOS

12.c. Handouts on Healthy Eating
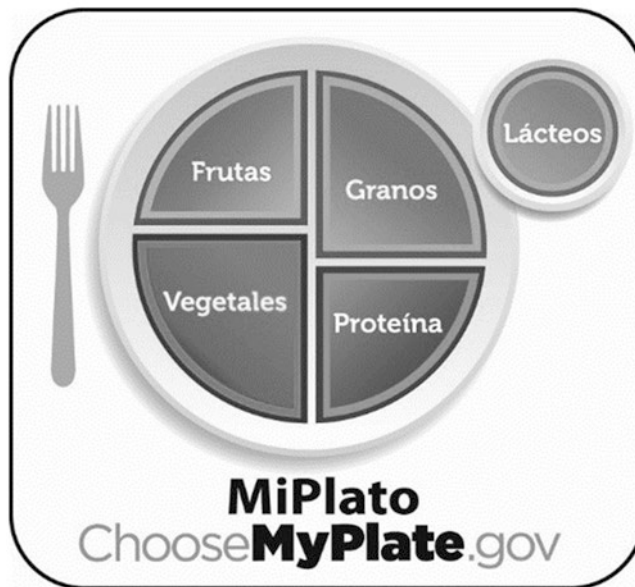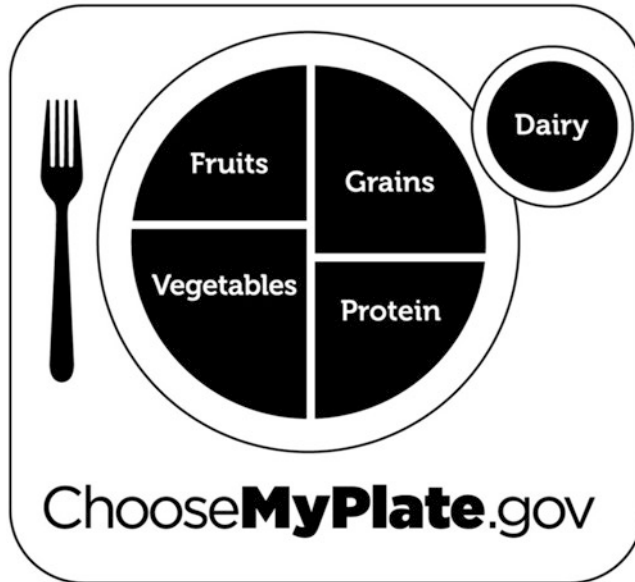
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10 tips
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MyPlate
MyWins

Based on the
Dietary
Guidelines
for Americans

Choose MyPlate

Use MyPlate to build your healthy eating style and maintain it for a lifetime. Choose foods and beverages from each MyPlate food group. Make sure your choices are limited in sodium, saturated fat, and added sugars. Start with small changes to make healthier choices you can enjoy.

1 Find your healthy eating style
Creating a healthy style means regularly eating a variety of foods to get the nutrients and calories you need. MyPlate's tips help you create your own healthy eating solutions—"MyWins."

2 Make half your plate fruits and vegetables
Eating colorful fruits and vegetables is important because they provide vitamins and minerals and most are low in calories.

3 Focus on whole fruits
Choose whole fruits—fresh, frozen, dried, or canned in 100% juice. Enjoy fruit with meals, as snacks, or as a dessert.

4 Vary your veggies
Try adding fresh, frozen, or canned vegetables to salads, sides, and main dishes. Choose a variety of colorful vegetables prepared in healthful ways: steamed, sauteed, roasted, or raw.

5 Make half your grains whole grains
Look for whole grains listed first or second on the ingredients list—try oatmeal, popcorn, whole-grain bread, and brown rice. Limit grain-based desserts and snacks, such as cakes, cookies, and pastries.

6 Move to low-fat or fat-free milk or yogurt
Choose low-fat or fat-free milk, yogurt, and soy beverages (soymilk) to cut back on saturated fat. Replace sour cream, cream, and regular cheese with low-fat yogurt, milk, and cheese.

7 Vary your protein routine
Mix up your protein foods to include seafood, beans and peas, unsalted nuts and seeds, soy products, eggs, and lean meats and poultry. Try main dishes made with beans or seafood like tuna salad or bean chili.

8 Drink and eat beverages and food with less sodium, saturated fat, and added sugars
Use the Nutrition Facts label and ingredients list to limit items high in sodium, saturated fat, and added sugars. Choose vegetable oils instead of butter, and oil-based sauces and dips instead of ones with butter, cream, or cheese.

9 Drink water instead of sugary drinks
Water is calorie-free. Non-diet soda, energy or sports drinks, and other sugar-sweetened drinks contain a lot of calories from added sugars and have few nutrients.

10 Everything you eat and drink matters
The right mix of foods can help you be healthier now and into the future. Turn small changes into your "MyPlate, MyWins."

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10 consejos
Serie de Educación en Nutrición

MiPlato
MisGanas

Basado en las
Guías Alimentarias para Americanos

Elegir MiPlato

Usar MiPlato para construir un estilo de comer saludable y mantenerlo para toda la vida. Elegir alimentos y bebidas de cada grupo de alimentos de MiPlato. Asegurarse que sus opciones sean limitadas en sodio, grasa saturada y azucares adicionales. Empezar con cambios pequeños para escoger opciones más saludables que puede disfrutar.

1 Encontrar su estilo de comer saludable
Crear un estilo de comer saludable significa comiendo una variedad de comidas para obtener los nutrientes y calorías que necesita. Los consejos de MiPlato le ayudan crear sus propias soluciones—"Mis Ganas."

2 Que la mitad de su plato sea de frutas y vegetales
Comer frutas y vegetales colorados es importante porque proporcionan vitaminas y minerales y la mayoría es baja en calorías.

3 Enfocarse en frutas enteras
Enfocarse en frutas enteras—frescas, congeladas, secas o enlatadas en jugo de 100%. Disfrutar fruta con comidas, como un refrigerio o como un postre.

Frutas

4 Variar sus vegetales
Probar echando vegetales frescos, congelados o enlatados a ensaladas, acompañamientos o platos fuertes. Elegir una variedad de vegetales colorados preparados en maneras saludables: al vapor, salteado, asado o crudo.

Vegetales

5 Que la mitad de sus granos sea integral
Buscar granos integrales enumerados primero o segundo en la lista de ingredientes—probar avena, palomitas, pan integral y arroz integral. Limitar los postres a base de cereales y snacks, como pasteles, galletas y pasteles.

Granos

6 Moverse a leche o yogur bajo en grasa o sin grasa
Elegir leche, yogur y bebidas de soya bajo en grasa o sin grasa para reducir grasa saturada. Reemplazar crema agria, crema y queso regular con yogur, leche y queso bajo en grasa.

Lácteos

7 Variar su rutina de proteína
Transformar sus alimentos de proteína para incluir mariscos, frijoles, arvejas, nueces y semillas sin sal, productos de soya, huevos y carne magra y carne de ave. Probar platos fuertes hechos con frijoles o mariscos como ensalada de atún o chili de frijoles.

Proteína

8 Consumir bebidas y comidas con menos sodio, grasa saturada y azucares adicionales
Usar la etiqueta de información nutricional y lista de ingredientes para limitar alimentos altos en sodio, grasa saturada y azucares adicionales. Escoger aceites de vegetales en vez de mantequilla y salsas basadas en aceite en vez de mantequilla, crema y queso.

Limitar

9 Tomar agua en lugar de bebidas azucaradas
Agua no contiene calorías. Soda, bebidas de energía y deportes y otras bebidas azucaradas contienen muchas calorías de azucares adicionales y pocos nutrientes.

10 Todo lo que come y bebe es importante
La mezcla correcta de alimentos le puede ayudar ser más saludable ahora y en el futuro. Convertir cambios pequeños a "MiPlato, MisGanas."

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Build a healthy meal

Each meal is a building block in your healthy eating style. Make sure to include all the food groups throughout the day. Make fruits, vegetables, grains, dairy, and protein foods part of your daily meals and snacks. Also, limit added sugars, saturated fat, and sodium. Use the MyPlate Daily Checklist and the tips below to meet your needs throughout the day.

1 Make half your plate veggies and fruits
Vegetables and fruits are full of nutrients that support good health. Choose fruits and red, orange, and dark-green vegetables such as tomatoes, sweet potatoes, and broccoli.

2 Include whole grains
Aim to make at least half your grains whole grains. Look for the words "100% whole grain" or "100% whole wheat" on the food label. Whole grains provide more nutrients, like fiber, than refined grains.

3 Don't forget the dairy
Complete your meal with a cup of fat-free or low-fat milk. You will get the same amount of calcium and other essential nutrients as whole milk but fewer calories. Don't drink milk? Try a soy beverage (soymilk) as your drink or include low-fat yogurt in your meal or snack.

4 Add lean protein
Choose protein foods such as lean beef, pork, chicken, or turkey, and eggs, nuts, beans, or tofu. Twice a week, make seafood the protein on your plate.

5 Avoid extra fat
Using heavy gravies or sauces will add fat and calories to otherwise healthy choices. Try steamed broccoli with a sprinkling of low-fat parmesan cheese or a squeeze of lemon.

6 Get creative in the kitchen
Whether you are making a sandwich, a stir-fry, or a casserole, find ways to make them healthier. Try using less meat and cheese, which can be higher in saturated fat and sodium, and adding in more veggies that add new flavors and textures to your meals.

7 Take control of your food
Eat at home more often so you know exactly what you are eating. If you eat out, check and compare the nutrition information. Choose options that are lower in calories, saturated fat, and sodium.

8 Try new foods
Keep it interesting by picking out new foods you've never tried before, like mango, lentils, quinoa, kale, or sardines. You may find a new favorite! Trade fun and tasty recipes with friends or find them online.

9 Satisfy your sweet tooth in a healthy way
Indulge in a naturally sweet dessert dish—fruit! Serve a fresh fruit salad or a fruit parfait made with yogurt. For a hot dessert, bake apples and top with cinnamon.

10 Everything you eat and drink matters
The right mix of foods in your meals and snacks can help you be healthier now and into the future. Turn small changes in how you eat into your MyPlate, MyWins.

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10 consejos
Serie de Educación en Nutrición

MIPlato
MisGanas

Basado en las
Guías Alimentarías para Américanos

Construir una comida saludable

Cada comida es un elemento en su estilo de comer saludable. Asegurarse de incluir todos los grupos de alimentos durante el día. Que frutas, vegetales, granos, lácteos y alimentos de proteína sean parte de sus comidas y refrigerios diarios. Además, limitar azucares adicionales, grasa saturada y sodio. Usar la Lista Diaria de MiPlato y consejos abajo para satisfacer sus necesidades durante todo el día.

1 Que la mitad de su plato sea de vegetales y frutas
Vegetales y frutas son llenos de nutrientes que apoyan la buena salud. Elegir frutas y vegetales rojos, anaranjados, y verdes oscuro como tomates, camotes y brócoli.

2 Incluir granos integrales
Aspirar de elegir por lo menos la mitad de sus granos integrales. Buscar las palabras "grano entero 100%" (100% whole grain) o "trigo integral 100%" (100% whole wheat) en la etiqueta de información nutricional. Granos integrales proporcionan más nutrientes, como fibra, que granos refinados.

3 Que no se olvide los lácteos
Completar su comida con una taza de leche sin grasa o bajo en grasa. Recibirá la misma cantidad de calcio y otros nutrientes esenciales como leche entera, pero menos calorías. ¿No toma leche? Probar una bebida de soya o incluir yogur bajo en grasa en su comida o refrigerio.

4 Agregar proteína magra
Elegir alimentos de proteína, como carne magra, cerdo, pollo, o pavo y huevos, nueces, frijoles o tofu. Dos veces a la semana, elegir mariscos para su proteína en su plato.

5 Evitar grasa adicional
Usando jugo de carne o salsas pesadas añade grasa y calorías a opciones sanas. Probar brócoli al vapor con poco de queso parmesano bajo en grasa o jugo de limón.

6 Que sea creativo en la cocina
Si está haciendo un sándwich, sofrito o cazuela, buscar maneras de hacerlos más saludables. Intentar usar menos carne y queso, que pueden ser más altos en grasa sólida y sodio y añadir más vegetales que contribuyen nuevos sabores y texturas a sus comidas.

7 Tomar control de su comida
Comer en casa más frecuentemente para que sepa lo que está comiendo. Si come afuera de la casa, leer y comparar la información nutricional. Elegir opciones que son más bajos en calorías, grasa saturada y sodio.

8 Probar nuevas comidas
Mantenerlo interesante por escoger nuevos alimentos que nunca ha probado, como mango, lentejas, quínoa, col rizada o sardinas. ¡Puede encontrar una favorita nueva! Intercambiar recetas divertidas y sabrosas con amigos o encontrarlas por el internet.

9 Satisfacer su diente dulce en una manera saludable
Disfrutar de un postre naturalmente dulce—¡fruta! Servir una ensalada de fruta fresca o un parfait de fruta hecho con yogur. Para un postre caliente, hornear las manzanas y cubrirlas con canela.

10 Todo lo que come y bebe cuenta
La combinación correcta de alimentos en sus comidas y refrigerios le pueden ayudar ser más saludable ahora y en el futuro. Convertir cambios pequeños en como come en su MyPlato, Mis Ganas.

12.d. Binge Eating Triggers

Sadness _____	Anger _____	Boredom _____
Frustration _____	Guilt _____	Happiness _____
Anxious _____	Jittery _____	Restlessness _____
Fear _____	Aroused _____	Stressed _____
Livid _____	Excited _____	Rejected _____
Insecure _____	Trapped _____	Misunderstood _____
Hungry _____	Full _____	Elated _____
Distressed _____	Pumped _____	Relaxed _____
Loved _____	Discriminated _____	Teased _____
Criticized _____	Embarrassed _____	Complimented _____
Uncomfortable _____	Proud _____	Accomplished _____
Successful _____	Inadequate _____	Worry _____

Desencadenantes De Atracones

Triste _____	Enfado _____	Aburrimiento _____
Frustración _____	Culpable _____	Felicidad _____
Ansiedad _____	Nervioso _____	Inquieto _____
Miedo _____	Estresado _____	Furioso _____
Emocionado _____	Rechazado _____	Inseguro _____
Atrapado _____	Incomprendido _____	Hambriento _____
Lleno _____	Exaltado _____	Afligido _____
Relajado _____	Amado _____	Descriminado _____
Criticado _____	Angustia _____	Incomodo _____
Orgulloso _____	Cumplido _____	Preocupado _____

12.e. Coping Strategies Card

COPING STRATEGIES CARD

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

TARJETA CON ESTRATEGIAS DE AFRONTAMIENTO

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

12.f. Interpersonal Events

Date of the event:

What happened:

FACTS	ASSUMPTIONS

What did you want out of this event? In other words, how did you want this event to end?

Did you get what you wanted?

12.g. Eventos Interpersonales

Fecha del evento:

Cuentame lo que pasó:

Hechos	Suposiciones

¿Qué deseabas de este evento? En otras palabras, ¿cómo querías que terminara este evento?

¿Consiguió lo que deseaba?

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Tools for Treating Sleep Disturbances Among Latinos

12

Ruth Gentry and Lorraine T. Benuto

According to the Centers for Disease Control and Prevention, sleeping problem, primarily insomnia, is a very common problem impacting nearly 60 million people with significant healthcare costs and burden. Persons suffering from insomnia are more likely to suffer from chronic health problems such as diabetes, obesity, chronic pain, heart disease, and gastrointestinal problems (Taylor et al., 2007). Women are more likely to report insomnia symptoms compared to men, and 50% of adults aged 65 and older report problems with sleep (Ohayon, Zulley, Guilleminault, Smirne, & Priest, 2001; Ohayon, 2002). Depression and anxiety disorders are also highly comorbid with insomnia along with other sleep disorders such as obstructive sleep apnea. Making the diagnosis of insomnia is based on patients' subjective report of the sleeping problem and the judgment of the clinician. Thus, it is important that clinicians can recognize the difference between acute sleep problems and insomnia as a disorder. Acute sleep problems may be caused by caffeine, napping, health problems, and recent life stressors with the sleeping problem improving once the stressor is resolved. Insomnia as a disorder is defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) (DSM-5; America Psychiatric Association, 2000), as difficulty falling or staying asleep along with perceived negative impact on daytime functioning not related to other sleep, medical, or mental disorders. The DSM-5 proposes a minimum frequency of at least three nights and a minimum duration of 3 months. In the "traditional" model of insomnia, the sleep disturbance is conceptualized as a symptom of a primary disorder coming from a medical or psychological problem; and once the primary disorder is treated, then the sleep disturbance disappears. However, recent research has shown this is not always the case that insomnia may not have some underlying problem to be treated but rather the sleep problem is what needs to be addressed. It is now recognized that in some cases insomnia presents first and is actually the risk factor for the first episode of depression and possibly leads to depressive relapses (Manber et al., 2008).

Spielman, Caruso, and Glovinsky (1987) presented the biobehavioral model of insomnia showing the factors that can be related in the development and maintenance of insomnia over

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time. First, there are predisposing factors such as a biological (i.e., hyperarousal brain physiology) or psychological predispositions that have been present prior to the onset of the disorder. The predisposing factors make people more vulnerable to sleeping problems that when combined with a triggering event maybe what causes the onset of the insomnia. The triggering event is the precipitating factor that often presents in the form of some biological or psychological stressor. For some individuals, the sleep disturbance improves once the precipitating factor is no longer present. However, for some, they start to engage in behaviors they feel may be helpful to their sleeping problem, but over time just complicate the problem. Behavioral examples include napping, staying in bed for long periods, caffeine in excess, and possibly taking sleeping aids. These behaviors are called perpetuating factors that when used over time continue to maintain the insomnia. Cognitions about sleep can also be perpetuating factors as it is common for people with insomnia to become anxious about their inability to sleep and worry how their sleeping problem is going to impact their daytime performance. As a result, these unhelpful sleep cognitions create more distress focused on their sleep again maintaining their chronic insomnia.

If left untreated, insomnia can be associated with significant healthcare costs such as work-related accidents (i.e., falling asleep) and indirect costs such as absenteeism. Thus, treatment of the disorder in the context of other mental and medical conditions is important not only for the individual but for society as well.

Treatment can include medication management, psychological treatment, or a combination of the two. Pharmaceutical companies continually report exponential growth in the number of sleep-aid prescriptions filled each year. The concern is not only the fact that sleep aids have side effects, such as memory loss, drowsiness, dizziness, and loss of coordination and balance (especially in elderly), but in some cases, they may only work slightly better than a placebo (Consumer Reports, 2015).

Sleeping aids should generally be used for short-term use (few weeks), but people are often using them for years, thus becoming dependent on them and increasing their risk for other health problems. Growing research is showing that people taking sleeping aids for long periods of time may have an increased risk for developing cancer and are far more likely to die prematurely than those who don't take sleep aids (Kripke, Langer, & Kline, 2012). Furthermore, there are alarming concerns for benzodiazepines (Ativan, Xanax, Valium, and Klonopin), which are associated with higher rates of emergency room visits due to falls, fractures, and auto accidents and also associated with higher rates of Alzheimer's disease (de Gage et al., 2014).

Their effectiveness is so limited that the American Academy of Sleep Medicine (AASM) no longer considers them a first-choice treatment. Instead, the AASM considers the use of cognitive behavioral therapy for insomnia (CBT-I) as the leading treatment.

CBT-I is a nonmedication approach that goes beyond general sleep hygiene such as avoiding alcohol, not watching television in bed, etc. and addresses the key behaviors and thoughts that can interfere with sleep. Treatment includes several behavioral interventions of sleep restriction, stimulus control, relaxation therapy, and cognitive therapy specifically aimed at insomnia. Recently, the American Academy of Physicians recommended CBT-I as the frontline treatment for insomnia compared to medications (Qaseem, Kansagara, Forciea, & Cooke, 2016). This recommendation is based on review of trials from 2004 to 2015 that compared CBT-I treatment to medications with CBT-I being found to be the more effective and safer treatment option. Research has shown that the use of CBT-I has equal or greater effectiveness when compared to medications in the short term, but over time CBT-I has been shown to be more effective and more durable effects (Morin, Colecchi, Stone, Sood, & Brink, 1999). There are few known side effects of CBT-I besides the possibility of increasing daytime sleepiness associated with sleep

restriction therapy. But compared to medications, the side effects are significantly less, and people often no longer need medications following treatment, thereby eliminating all potential drug side effects.

CBT-I can be delivered in an outpatient mental health setting, but also can be done within primary care clinics as well. A limitation to dissemination of CBT-I to a broader range of patients is the limitation of qualified clinicians trained in CBT-I. Furthermore, the limitation of Spanish-speaking therapists trained to provide treatment is even greater. Indeed the research on insomnia among Latinos is limited and resources related to insomnia for Spanish speakers are sparse. A PsycINFO search using the terms insomnia and Hispanic or Latino yielded only 52 publications. When the keywords treatment, intervention, and therapy were added, these results were further reduced to 28, and the majority of those publications were focused on psychotropic medication and/or are irrelevant to insomnia among Latinos; none of the manuscripts reviewed discussed the use of CBT-I with Latinos. Nonetheless, there is evidence to suggest that standard CBT generalizes to Latinos (Benuto & O'Donohue, 2015) indicating that the active ingredients in CBT-I may generalize to Latinos as well. Given the substantial prevalence rates of sleep-related difficulties among Latinos, interventions for treating these difficulties are needed.

Indeed, the prevalence rates of sleep-related difficulties among Latinos are substantial. While Ford, Cunningham, Giles, and Croft (2015) found similar prevalence rates of insomnia in the National Health Interview Survey among Whites and Hispanics (approximately 19% for both), other researchers have found higher rates for insomnia among Latinos. For example, Hispanic youth were significantly more likely to report insomnia symptoms (42.0%) than non-Hispanic white youth (30.4%: Blank et al., 2015). Pregnant Latinas are also substantially impacted by insomnia, and

insomnia symptoms have been noted to be particularly high among Latinas with depression (Manber et al., 2013). Moreover, Latinos have been noted to report poorer sleep practices relative to African American and Asian students (Gaultney, 2010). Loredo and colleagues (2010) reviewed the literature on Latinos and sleep and indicated that the high prevalence of risk factors in Hispanics (i.e., obesity, diabetes, living in the inner city, use of alcohol, poor sleep hygiene) suggests that sleep-related issues are high. The literature also suggests that acculturation to the US lifestyle is positively related to sleep difficulties among this group (Manber et al., 2013; Seicean, Neuhauser, Strohl, & Redline, 2011). This has been supported in research that has identified that US-born Hispanic/Latina immigrants were more likely to report sleep complaints than their first-generation ethnic counterparts (Hale, Troxel, Kravitz, Hall, & Matthews, 2014). This illustrates some of the complexities that we observe with this group.

Complexities aside, the literature clearly indicates that insomnia is a highly treatable condition via the use of CBT-I. While the research regarding the exact prevalence rate of sleep-related difficulties among Latinos is mixed, it is clear that Latinos need interventions targeted at sleep-related difficulties. Given the limited resources available for clinicians who work with Spanish speakers, this chapter attempts to fill a gap with regard to the resources that are available for clinicians who work with Spanish speakers. Specifically, below we provide an overview of CBT-I and associated resources and tools that can be used by the Spanish-speaking clinician with Spanish-speaking clients. While these specific tools have not been tested via a randomized clinical trial, the principles presented in the session overview (see below) and in the worksheets, resources, and tools were all derived from evidence-based principles as an attempt to fill a large gap in the resources available for Spanish speakers.

Treatment Plan Timeline

Session #	Treatment component	Session goals	Handouts
1	Assessment/evaluation Therapeutic alliance	Intake paperwork Confidentiality Information gathering Case conceptualization Introduction CBT-I	Sleep intake (see Appendix A) Sleep diary (Appendix B) Optional sleep and mood measures
2	Psychoeducation Stimulus control Sleep restriction Sleep hygiene	Review sleep diary Continue introduction CBT-I Information gathering Rapport building Identify new TIB Behavioral components	Sleep diary (Appendix B)
3	Stimulus control Sleep restriction Cognitive therapy	Review sleep diary Modify TIB Thought records Behavioral components Homework	Sleep diary (Appendix B) Thought record (Appendix C)
4–6	Stimulus control Sleep restriction Cognitive therapy	Review sleep diary Modify TIB Thought records (if needed) Behavioral components Homework	Sleep diary (Appendix B) Thought record (if needed) (Appendix C)

First Session/Intake

The initial appointment is the assessment of the sleep complaint and may need to be completed over two sessions depending on how much time is allocated. The goal of the first session is to provide a comprehensive assessment of the patient's sleep complaints that focuses on four essential areas: (1) sleep history and specific sleep complaints along with perpetuating factors, (2) medical history and current medications, (3) substance use, and (4) psychiatric or other mental disorders. It is common for clinicians to use a sleep history questionnaire (see Appendix A) to be completed prior to the initial interview. Another important clinical tool is the sleep diary that patients complete to monitor sleep pattern for a period of often 2 weeks (see Appendix B). The American Academy of Sleep Medicine has a standard sleep diary available in Spanish for download as well. If possible, it can be helpful to have the sleep diary completed prior to the initial appointment

as well with 2 weeks of sleep data. The sleep diary asks patients to record bedtimes, when they feel they went to sleep, wake up, and finally rise time from bed. Sleep diaries are the patients' subjective report of sleep so to ensure the greatest possible accuracy and consistency; the diary should be completed every morning immediately after getting out of bed. The patient will be provided with a blank sleep diary at the end of every session as homework to track progress.

Creating a structured intake interview focused on sleep is crucial to building rapport as often people with insomnia or other sleep complaints generally have not had any opportunities to talk about their sleep. Further, many patients suffer from sleeping problems for a long period of time, and going through a thorough history may be challenging for clinician to sort through. Therefore, developing a structured session that can still be conducted in an empathetic way that considers cultural factors that may contribute to the sleep disturbance is important for building the therapeutic relationship.

In structuring the intake, a good starting point is to find out the history of the problem in when it first started in the onset, duration, and severity of symptoms. For instance, "what was going on in your life when the sleeping problems first started? How long has your symptoms been going on? How do you feel this problem impacts your life?" Finding out the timeline of events for the sleeping problem is important to identify if the person meets criteria for insomnia disorder or another sleep disorder. By finding out contributing factors or precipitants, this will help the therapist set the stage for explaining the model of insomnia and conditioned arousal in later sessions. It regards to the patient's sleep schedule; it may be helpful to start by asking when the patient gets into bed compared to when he/she turns off the lights to try and go to sleep. These two times may be completely different suggestive of poor sleep hygiene if the patient gets into bed at 9 pm to read, but does not turn off lights till midnight to try to go to sleep. Often people with insomnia get into bed because they feel this is routine or what they "should" be doing, but do not know the difference between feeling tired and actually becoming sleepy. So it is important to ask how long it takes to fall to sleep and what does he/she do when cannot fall asleep? It is common for patients to stay in bed "trying" to fall asleep and getting into bed just because they feel fatigued, but not necessarily sleepy. It is also important to find out the timing for the beginning sleep period, middle and end of the night as well. For instance, "how many times do you think you wake in the middle of the night and how long does it take you to fall back to sleep? What time do you wake up in the morning and get out of bed?" The therapist would want to know if the patient's current sleep schedule is different than his/her premorbid sleep schedule. If the current schedule is dramatically different identifying why the patient changed the schedule may lead to clues to behavioral factors that have continued the ongoing sleeping problem.

Another important aspect of the clinical interview is gathering information on the patient's medical and psychiatric history. Gathering this information along with a thorough sleep evaluation is often why the first session may need to be longer or broken into two sessions. Providing a medical and psychiatric interview is beyond the scope of this chapter, but identifying untreated comorbid sleep disorders and psychiatric is crucial for successful treatment. For instance, chronic pain, sleep apnea, and insomnia in menopausal women along with depression and anxiety are common problems. Appropriate referrals may be needed such as referral to sleep medicine physician for further evaluation if sleep apnea is suspected. Further, prescription medications such as opioids can impact sleep, so identifying a full list of medications is also needed. Often insomnia patients have been on prescription sleeping medications for years and have become dependent on medication for sleep. It would be important to know when the patient started to take the medication, how often it is taken, and do they take the medication again in the middle of the night. Patients often become psychologically dependent as they view medication as the only hope and fear they have lost all ability to sleep without it. This may have to be addressed as treatment progresses if the patient's goal is to get off the medication at some point, and collaboration with the prescribing provider may be needed.

In evaluating comorbid medical problems, it is common that a medical problem or sleep disorder is present. One of the most common comorbid medical problems is obstructive sleep apnea (OSA), which requires referral to a sleep medicine specialist and overnight sleep study. In this case, it is not the job of the therapist to make the diagnosis but to know when to refer. Often sleep apnea patients when not treated feel very sleepy during the day, which may require modification to the standard CBT-I protocol. The prominent features of OSA are loud snoring, witnessed apneas by partner, waking gasping for air or choking, and significant daytime sleepiness. The patient may have also been previously diagnosed with OSA and stopped treatment with continuous positive airway pressure (CPAP). If the patient is no longer compliant with CPAP treatment, psychoeducation on OSA may be needed as the patient is going to continue to have problems staying asleep despite CBT-I treatment. Thus, it

should be made clear that treatment goals will likely not be met until the OSA is successfully treated. In regard to psychiatric problems, the therapist would want to assess for history of depression, bipolar disorder, PTSD, anxiety disorders, and substance abuse problems. If the patient is only seeking sleep-specific therapy and not long-term treatment, the focus will likely be on the current symptoms and how they impact sleep rather than focus on lifelong conditions. In regard to substance abuse, evaluating the patient's use of alcohol, nicotine, caffeine, stimulants, and illicit drugs is needed. It is important to know when the patient is ingesting relative to bedtime as many of the substances interfere with sleep. For instance, people may not know the half-life of caffeine and that the energy drink they had a few hours ago may be continuing to impact their ability to fall asleep. Further alcohol is a depressant and the patient may use it to "unwind" or relax before bedtime, but alcohol withdrawal may be contributing to the middle of the night awakenings. Ask questions about smoking as nicotine also causes sleep fragmentation. Other factors to evaluate for include the timing of physical activity in relation to bedtime as strenuous physical activity immediately prior to bed may impact sleep. Eating a heavy meal prior to bed may also impact sleep so assessing eating behaviors and if the patient eats in the middle of the night when unable to sleep.

Besides the sleep questionnaire and sleep diary, there are other helpful assessment tools that may be administered during the initial appointment to establish a baseline of sleep disturbance and also track changes. These include the Insomnia Severity Index (ISI), Dysfunctional Beliefs About Sleep Questionnaire (DBAS), and Epworth Sleepiness Scale (ESS). The ISI is a seven-item questionnaire (Morin, 1993) that provides a measure of perceived sleep disturbance and the patient's level of distress related to the symptoms. It takes less than 5 min to complete and can easily be administered in primary care setting or waiting room. The total score represents overall severity level with higher scores indicating more severe insomnia or sleep disturbance. The DBAS (Morin, Vallieres & Ivers,

2007) can be used to help identify unhelpful sleep-related cognitions. The therapist can note highly endorsed items to be addressed later in cognitive therapy. The ESS is a measure commonly used in sleep medicine clinics and is an eight-item self-report questionnaire that evaluates daytime sleepiness. Scores range from 0 to 24 with higher scores suggesting greater daytime sleepiness. Often insomnia patients do not score in the higher or sleepy ranges with higher scores being more common with untreated sleep apnea and should be referred to a sleep medicine specialist for more evaluation. Other psychological testing such as the Beck Depression Inventory-2 and Beck Anxiety Inventory may be helpful as supplemental information to identify comorbid psychological problems.

Session 2

Session 2 is the most challenging of all the therapy sessions because it requires the most psychoeducation and teaching on the part of the therapist. The patient may have questions about treatment and what cognitive behavioral therapy for insomnia is. Review of Spielman's 3-P model of insomnia and using examples from the patient's history to explain possible predisposing and precipitating events is useful. Good psychoeducation is very important as it will help lay the groundwork for the remaining sessions by helping patients better understand the treatment rationale and increase likelihood of adherence. Patients may have unrealistic beliefs about their sleep (i.e., "I need to sleep 9–10 hours per night") and can be helpful to educate what is average with adults sleeping 6–8 hours per night. Also starting to talk about the focus of CBT-I treatment is a quality not quantity. This may provoke some anxiety for the insomnia patient that is hoping to sleep 9 hours per night, but again the therapist will want to emphasize that treatment will focus on the patient's current sleep and trying to make it better.

Session 2 includes the behavioral components of treatment including stimulus control and sleep restriction. Stimulus control developed by Bootzin (1972) suggests repeated pairing of the bed with anxiety and frustration that over time

the bed becomes conditioned for arousal compared to sleep. Often insomnia patients say they get sleepy somewhere else than the bed such as the couch and when they get into bed they are wide-awake. This suggests that the bed has become a learned cue for wakefulness. Thus, explaining to the patient that continuous pairing of the bed with unpleasant or anxiety-provoking experiences becomes a cue for the body to become tense. An important point to make is this can be unlearned, but the patient will have to change behavior and routine. The instructions provided by the therapist should include the following: First, go to bed only when sleepy not when feeling fatigued or tired. As mentioned, patients may not know the difference between feeling tired and sleepy, so they may have to learn how to differentiate between the two. Second, do not spend excessive time in bed and only spend the amount of time that you need for sleep. This will become more clear when the therapist goes over the sleep restriction guidelines (see below), but patients are instructed not to try and force sleep by remaining in bed. This can be very challenging for some patients to follow such as the case of chronic pain because remaining in bed is comfortable and why get out of bed if you don't need to. Thus, it is important to explain the principle of conditioned arousal and that getting out of bed will allow for less chance for pairing of the bed with arousal. The therapist may have to provide the patient with non-stimulating activities to do when out of bed such as listening to audiotapes or reading. The question of computers may come up, but the use of computers is not recommended because they run the risk of causing more arousal. Further, computers impact melatonin, which is needed for restful sleep. Many activities (i.e., reading) can be done on the couch or another place prior to bed, but not in the bed because the bed must become a cue only for sleep. The only exception is sexual activity.

Other stimulus control components include the removal of naps and maintaining consistent wake times. Patients often have variable rise times and take naps in order to "catch" up or make up for sleep loss, but this inconsistency weakens the circadian clock and the drive for sleep. In the case of morning wake times, a good example is the concept of "jet lag" that having variable rise times feels like "jet lag" or that the body just flew cross-country. This only creates a burden on the body or the circadian clock to constantly make adjustments to the morning time changes. Similar is the case with napping in that naps also weaken the body clock. Often people with insomnia feel tired, but not sleepy, so they likely don't nap if even provided the time to do so. But often people with chronic pain and sleep apnea do feel sleepy during the day and may sleep for hours that only later impacts their sleep at night. Safety concerns for the patient should always be considered when suggesting the removal of naps. Drowsy driving is always a concern, and if a therapist is concerned that the patient is so sleepy that he/she may fall asleep while driving, then napping may be allowed, but it should be limited. If the patient is taking long naps in the afternoon, it should be explained that napping reduces the sleep drive and will impact the ability to fall and stay asleep. When safety is not a concern, napping should be eliminated, but if short naps are recommended for safety reasons, the patient should be encouraged to set an alarm and aim for a short scheduled nap. In regard to other safety concerns, there are times when stimulus control may need to be adapted in the case of frail elderly patients or chronic pain. In these cases, instead of getting out of bed when unable to sleep, the therapist may want to recommend to just sit up in bed when the patient can't sleep and engage in a relaxing activity. This helps lessen the pressure of forcing sleep or high sleep effort without the concern of the patient possibly falling when getting out of bed.

The other primary behavioral component is sleep restriction therapy introduced by Spielman and colleagues (1987). This chapter will briefly cover the principles of sleep restriction, but the therapist may want to gather more intensive training on the topic prior to implementation. Essentially, sleep restriction reduces the patient's times in bed to total sleep time (TST) in order to reduce awakening and improve sleep quality. Once this has been achieved, the time in bed (TIB) can be increased in small increments to

increase sleep quantity. It should be explained to the patient that sleep quantity is not the goal and not to focus on the numbers of hours per sleep but rather the sleep quality (i.e., number of nighttime awakening reduced, falling asleep faster). The first step is to take the sleep diary and determine the patient's total sleep time (TST), which is different than patient's time in bed (TIB). Some patients may be spending up to 10 h or more in bed hoping to get 6–7 h of sleep. For instance, the patient that gets into bed at 10 pm, but does not fall asleep till midnight, sleeps till 6 am. In this case the TST would be about 6 h, but TIB would be about 8 h. Using the sleep diaries, you calculate the average TST for 2 weeks. Next is the recommendation for the patient's new TIB based on his average TST. The general rule for the new TIB is to take the average TST and add 30 min. So in the case above with the TST of 6 h, the new TIB could be 12–6:30 or 11:30–6 or 12:30–7 or 11:00–5:30. Generally, the suggestion is to start from the rise time and work backward. So if the patient has to get up at 6 am for work, his/her new bedtime would be 11:30 pm and rise time 6 am. Again focusing on consistency in that, it is important to maintain the recommended rise time no matter what. Patients will often ask if they should keep the time if they have a "bad" night or sleep and maybe only slept a few hours. The therapist would want to encourage the patient to maintain the schedule, reinforcing the importance of stimulus control and the biological clock. Further, if the patient maintains the schedule after a "bad" night, the sleep drive or need for sleep will build and likely will have a better night of sleep the following night. In some cases, the therapist will have to guide the patient in choosing a realistic wake-up time. If the new TIB is 6.5 h and the patient wants to wake at 8 am, it may not be realistic for the patient to stay awake till 1:30 am. It may be more realistic to move the rise time up, so the patient does not have to stay up as late. In the following sessions, the TIB will likely be expanded so encouraging patient to stick with the schedule because it will get better in sessions to come. It may also be helpful to not use the word sleep restriction when presenting the rationale, but rather using the term sleep efficiency training suggesting you are trying to make your time in bed as efficient as possible.

Finally, if time allows in the session, the therapist may also want to introduce some basic sleep hygiene principles such as limiting caffeine and alcohol. Exercise can be helpful for the sleep, but vigorous exercise close to bedtime is not recommended. Also making sure the bedroom environment is comfortable with a comfortable bed, keeping your bedroom dark, having comfortable temperature, and limiting stimulating activities close to bedtime and lights such as blue light from computer are all helpful tips.

Session 3

The focus of third session will be to adjust patient's TIB and the cognitive components of CBT-I treatment. The session begins by reviewing the sleep diary and identifying any areas in which the patient had problems adhering to the schedule. For instance, if the patient slept past the recommended rise time or had a hard time staying up to the bedtime, the therapist will have to problem solve with the patient. A conversation can be had around what activities can be done to either stay up to the recommended bedtime or what activities can be done after the rise time. The next step will be to adjust the sleep schedule based on the patients' sleep efficiency (SE), which is the percentage of TIB that is actually spent asleep. Using the sleep diary, a calculation of SE is made by using the formula TST/TIB *100. If SE for the prior week is at least 85% than the TIB, it will be increased by 15 min for that week with the time increase given at the bedtime. For instance, if the initial recommended TIB in bed was 11:30 pm to 6 am, the new recommended bedtime would move up to 11:15 pm, but the rise time would remain the same at 6 am. If SE is between 80 and 84%, then TIB can stay the same. If SE is less than 80%, a new TIB will need to be calculated using the current sleep diary data as conducted in the previous session. The therapist will have to work through obstacles to adherence and work with the patient to develop a TIB that is realistic and one the patient can adhere to. In some cases, the new TIB may have to be curtailed by 15–30 min to increase adherence.

After the sleep schedule has been discussed, next is addressing arousal and sleep cognitions that impact sleep. Insomnia patients often experience high arousal and hypervigilance that impacts their ability to fall and stay asleep. Therapists familiar with relaxation strategies such as mindfulness meditation, diaphragmatic breathing, and progressive muscle relaxation can be helpful to teach as calming skills. Essentially, teaching the patient how to create a calming or wind down period prior to bed is essential. Over time the patient may have learned bad habits such as being on the computer and getting into bed trying to force sleep without letting their mind calm down prior to bed. The importance of setting side time to unwind before bed should be explained to the patient along with learning calming skills that works best for each individual. Intrusive thoughts such as worrying about future events and worrying about the next workday or what was not addressed during the day are common for all people. When asked, patients often say "I try to clear my mind and not think about anything," but trying to suppress thoughts does not help to create a state of relaxation. Explaining to the patient that worries only makes insomnia worse because it strengthens the conditioned arousal to the bed. Other techniques that can be taught include scheduling a worry time, one that is not to close to bedtime, in which the patient can allocate 30 min to worry daily. Thus, when bedtime comes along, patients can remind them that they can postpone their worries to the scheduled time the following day. At the end of the day, patients can also establish a "to-do" list for the following day, so these thoughts will not intrude when they get into bed to try to go to sleep.

The patient's beliefs about sleep may need to be adapted, and this is when cognitive therapy is used. The cognitive techniques used are similar to cognitive behavioral therapy for treatment of other psychological problems such as depression or anxiety. The focus is to teach patients to identify unhelpful thinking styles focused on sleep and come up with more balanced ways to modify unhelpful cognitions. Assuming the therapist already has some familiarity with cognitive therapy, the use of thought records is commonly used

and can be adapted for insomnia patient (see Appendix X). Some unhelpful beliefs common to insomnia patients include worrying that poor or not enough sleep will impact daytime functioning. The therapist may hear "If I don't get 8 or more hours of sleep per night I am a mess the next day." The therapist may want to use the downward arrow technique asking questions if the feared consequences were to come true. For instance, "what would happen if you (feared outcome) did occur?" Once the worry becomes clearer, the therapist can explore evidence for and evidence against the likelihood of that feared consequence that may actually happen. If the fear is around performance the next day often reminding the patient there has been nights he has slept poorly or less than 8 h and has been able to function during the day. This is also an example of unrealistic expectation about sleep that one must sleep 8 or a minimum set number of hours per night. This may be an unrealistic expectation on the part of the patient on his or her individual sleep needs, and using Socratic questioning or downward arrow technique, the therapist can help the patient question the usefulness of this expectation. Just as in traditional cognitive therapy, there are common unhelpful thinking styles that usually arise such as catastrophizing ("if I don't sleep well tonight I will not be able to get through my day tomorrow), overgeneralization ("I made a mistake at work because of my sleep"), and misattribution ("I am in bad mood today because I did not sleep well). Using the thought record, the therapist can work through these thoughts with the patient. At the end of the session, the patient should be instructed to continue with sleep diary tracking the new TIB schedule and also complete the thought record as homework for the next session.

Sessions 4–6 (If Needed)

Many patients just need to learn the behavioral and cognitive components of treatment to experience improvements in sleep and may not need additional sessions. In other cases, patients can benefit from one or more additional sessions with the focus of the remaining sessions depending on the needs of the patient. Some patients may need

more help with their sleep schedules, while others may need to focus on the cognitive components or learn more relaxation strategies. So having a strong case conceptualization on the factors that contribute to the patient's sleep problem will be helpful in driving treatment needs for the remaining sessions. The therapist will encourage the patient to continue with treatment recommendations including the behavioral components of sleep restriction and stimulus control despite any challenges that might have occurred. No materials are specifically needed for the follow-up sessions, but sleep diaries and thought records can continue to be used.

Other Treatment Considerations

Safety issues with the use of stimulus control were discussed above, but there are also other treatment considerations the CBT-I therapist will have to consider. Many patients seeing treatment may have become dependent on sedative medication and may also have serious comorbid medical and psychiatric issues. There are many medications used for insomnia ranging from benzodiazepine receptor agonists (BZRAs) such as ambien or lunesta that are FDA approved for insomnia and "off-label" for insomnia such as in the case of benzodiazepines (temazepam, clonazepam, etc.). Atypical antipsychotics such as quetiapine and the antidepressant trazadone are often used as well. Over time the patient may have developed tolerance, so abrupt withdrawal of the medications may result in distressing rebound insomnia symptoms. In these cases, patients have

become dependent on the medication nightly and feel they may have lost all abilities to sleep without it. Further, they may believe their sleep is only a "chemical" imbalance, so they need medications for the remainder of their life. Cognitive therapy may be needed to target these unrealistic or catastrophic beliefs. Further, relaxation strategies need to be strongly utilized, so the patient has some coping skills if titration takes place. Often patients want to get off their medications, and it will be important to work with the prescribing provider to have a treatment plan in place prior. Keep in mind titration is not suggested until the patient has successfully implemented CBT strategies and has experienced an improvement in sleep in order to build confidence that they may be able to sleep without the medications at some point.

In the case for the patients with comorbid medical problems, the therapist may have to help the patient seek appropriate medical care. As discussed earlier, patients with sleep apnea may need to follow up with sleep medicine for treatment. Many medications may have side effects like insomnia, and the patient may want to have a conversation about this with his or her treating physician. Besides insomnia, patients may also be experiencing depression, PTSD, or anxiety. The therapist may start with specific sleep-targeted treatment and may consider continuing with treatment for the remaining psychological problems if appropriate. If the therapist does not have training such as in the case of PTSD treatment, he/she may choose to refer the patient to another therapist for continuing treatment after CBT-I.

Appendix A

Heramientas Para la Evaluación del Sueño - Adultos

Nombre: **Fecha:**

Nombre de quien lo refiere:

Describa brevemente el/los problema(s) para dormir que está teniendo o la razón por la que desea tratamiento?

_____

_____

De la siguiente lista, marque su(s) problema(s):

_____ Dificultad para quedarse dormido   _____ Dificultad para mantenerse dormido

_____ Despierta en la madrugada   _____ Dificultad para despertarse a la hora planeada

¿Cuando fue la primera vez que se dio cuenta que estaba presentado problemas para dormir? Por favor identifique cualquier evento que haya contribuido a que se desarrollará su(s) problema(s) para dormir (ej., problemas de salud, un evento traumático, la muerte de un ser querido).

_____

_____

¿Qué es lo que usted piensa que esta contribuyendo a sus problemas para dormir ahorra mismo?

_____

_____

Historia Psico-social

¿cuando era niño o adolescente tuvo problemas para dormir o problemas psicológicos ? Si fue así, por favor explique:

_____

_____

_____

Historial familiar de insomnio y/o otros trastornos y/o problemas de el sueño (ej., Apnea obstructiva)? _____

_____

Historial familiar de salud mental y otros problemas relacionados (ej., depresión, esquizofrenia, ansiedad, etc.)?

_____

_____

¿esta experimentando algún conflicto familiar y/o problemas en el trabajo en la actualidad? Si No

 Si su respuesta es "Si" por favor explique: _____

¿Ha estado casado alguna vez? Si   No   ¿Cuantas veces?_____ _____

¿Cual es su estado civil? Por favor haga un círculo sobre la opción: Casado(a)   soltero(a)   viviendo con su pareja   separado(a)   divorciado(a)   viudo(a)

Cuantos hijos(as) tiene? _____Algún problema con la crianza de sus hijos? ____Si su respuesta es "Si" por favor explique:

_____

¿Cómo es su relación con sus hijos(as)? haga un círculo sobre la opción –   Buena   Mas o menos   Mala

¿Tiene familiares o amigos con quienes usted se relacione y pase tiempo? haga un círculo sobre la opción: Si   No

Abuso de Substancias y Otros Comportamientos Adictivos

Actualmente, consume usted alcohol?   haga un círculo sobre la opción   - Si   No

Con que frecuencia? (Una vez por semana, por mes, por año) _____

Si su respuesta es si, cuantas bebidas consume en cada ocasión? (ej., 1-2, 3-4, o 5+ bebidas) _____

En el presente, usa drogas ilegales (no prescritas) incluyendo marihuana? haga un círculo sobre la opción   – Si   No

Si su respuesta es "Si," que tipo de drogas (ej., marihuana, cocaína) y con que frecuencia las usa? (una vez por semana, por mes)? _____

¿Usa o ha usado alcohol y/o drogas ilegales (ej., marihuana) para poder dormir? Si su respuesta es "Si,"
Por favor escribe cuál(es)?
_____

¿Ha estado en tratamiento y/o ha tenido problemas legales (ej., DUI) relacionados con el uso de alcohol en el pasado?

_____
Escriba las fechas y los nombres de los centros de tratamiento (Si no recuerda con exactitud, sólo escriba una fecha estimada):
_____
_____

¿Fuma cigarros (circule) en la actualidad? Si No   ¿Cuantos por día? _____

Por favor indique si usted ha fumado cigarros en el pasado y la fecha en que paro de fumar? _____

¿Juega y/o apuesta en la actualidad? haga un círculo sobre la opción   –Si No   Si respondió "Si," ¿con qué frecuencia? _

¿Alguna vez ha estado en tratamiento debido al juego y/o apuestas? _____

¿Cuantas bebidas de cafeína (ej., café, soda, bebidas de energía) consume por día? Por favor indique el tipo de bebida(s)?

Historial Médico

Sí ha tenido alguno de los problemas médicos descritos en la siguiente lista, por favor haga un círculo sobre la opción,.
Indique cuando fue diagnosticado y cuando le dieron tratamiento:

Alergias _____

Asma _____

Artritis _____

Cáncer _____

COPD_____

Trastorno de Arteria Coronaria _____

CVA o Accidente Cerebro Vascular (Embolo) _____

Diabetes _____

Problemas Digestivos _____

Epilepsia _____

Lesión cerebral/TBI _____

Presión Alta/Hipertensión _____

Hepatitis _____

Trastorno del sueño/Apnea _____

Convulsiones _____

Tinnitus (Zumbido en los oídos) _____

Otros: _____

Nivel de dolor*** _____

**** Usando una escala de 0-10 (10 indica el dolor mas severo que usted pudiera imaginar y 0 nada de dolor) indique la severidad de su dolor en la actualidad), _____.

Por favor indique las cirugías que haya tenido (ej., cinturón gástrico (bypass), cirugía del corazón, etc.): _____

_____

_____

Medicinas para dormir que haya tomado en el pasado (prescritos y disponibles sin receta medica)?

Nombre	Dosis	Como las tomaba (antes de dormir, media noche; PRN)	Cuanto tiempo?	Le ayudaron?

Actualmente ¿Qué medicamentos para dormir se encuentra tomando (prescritos y disponibles sin receta medica)?

Nombre	Dosis	Como las tomaba (antes de dormir, media noche; PRN)	Cuanto tiempo?	Le ayudan?

Por favor indique cualquier otra(s) medicinas recetadas o prescritas por un médico (Use la parte de atrás de la hoja si necesita mas espacio): _____

_____

_____

Historial Psiquiátrico

Alguna vez ha sido diagnosticado o tratado por un problema de salud mental y/o psiquiátrico (ej., depresión, ansiedad, trastorno bipolar, PTSD/TEPT)? Por favor menciónelos: _____

En el presente, ¿Está siendo tratado por algún problema psiquiátrico?   Si No   Si su respuesta es "Si," ¿quién es su doctor, psiquíatra y/o proveedor de tratamiento médico, y cual es el enfoque de su tratamiento (Psicoterapia vs. medicina)? _____

Alguna vez, ha sido hospitalizado por problemas psiquiátricos/emocionales? Si su respuesta es "Si," ¿cuándo y donde? _____
_____

En la actualidad le han prescrito medicinas psiquiátricas (ej., antidepresivos, estabilizadores de ánimo, etc.)? _____

¿Tiene usted historial de intentos de suicidio? Si responde "Si," escriba las fechas aproximadas _____
_____

¿Ha tenido pensamientos relacionados con cometer suicidio, recientemente? haga un círculo sobre la opción Si   No

¿Ha tenido pensamientos relacionados, con hacer daño, asesinar y/o matar a otras personas? haga un círculo sobre la opción Si   No

Hábitos al Dormir (Enfóquese en la semana de actividad regular mas reciente):

¿A que hora suele ir a dormir, esto implica, estar con las luces apagadas? _____

En promedio, ¿cuánto tiempo le toma quedarse dormido? _____

¿Realiza actividades antes de ir dormir (ej., leer, bañarse, escuchar música)? Se encuentra acostado en su cama cuando realiza dichas actividades (leer, escuchas música, etc.)? _____
_____

¿Qué sucede cuando no puede dormirse (pensamientos/acciones)? _____
_____

¿Cuántas veces se despierta, en promedio, durante la noche? _____

¿Qué pasa cuando despierta en el medio de la noche (pensamientos/acciones)? _____
_____

Regularmente, ¿a qué hora se despierta? _____

¿A que hora se levanta de la cama para empezar su día? ¿Se levanta a la misma hora durante la semana que durante el fin de semana? _____

¿Cuantas horas cree usted que está durmiendo en realidad? _____

¿Toma siestas durante el día? De cuanto tiempo _____

Si usted tuviera la oportunidad de tomar una siesta, ¿la tomaría? _____

¿Cuantas horas de sueño piensa usted que necesita cada noche para sentirse descansado y poder funcionar? _____

¿Hay algunos aspectos, fuera de lo normal, que afecten y estén trastornando su ambiente durante su sueño (ej., compañero de cama, cuidado de niños, mascotas, incomodidad, ruido, luces, temperatura, se siente inseguro(a)? _____

Efectos durante el día:

Piensa usted que su problema para dormir le afecta en alguna de las áreas descritas en la siguiente lista? ¿cómo?

Energía/fatiga: _____

Memoria/Habilidad para concentrarse_____

Estado de ánimo (ej., irritabilidad, ansiedad, depresión): _____

Niveles de actividad durante el día: _____

Habilidad de trabajar: _____

Otras cosas por favor describa:_____

Comportamiento al dormir/Síntomas: por favor haga un círculo sobre la opción <u>Si o No</u>

¿Le han dicho alguna vez que ronca muy fuerte?	Si	No
¿Alguna vez su compañero de cama le ha dicho que deja de respirar cuando duerme?	Si	No
¿Le duele la cabeza por la mañana?	Si	No
¿Se siente con sueño aún cuando ha dormido 8 horas o cuando ha incrementado sus horas de sueño?	Si	No
¿Alguna vez ha sentido que se queda congelado(a) o paralizado mientras trata de dormir o cuando se despierta?	Si	No
¿Alguna vez ha vivido una situación donde siente como si estuviera soñando y como si tuviera una alucinación cuando se esta quedando dormido?	Si	No
¿Ha tenido episodios donde siente que no puede estar despierto(a) durante el día?	Si	No
¿Ha tenido episodios donde, de repente, siente que sus músculos están débiles y no le responden (ej., sus piernas cojean)? o ¿ha sentido emociones intensas como, por ejemplo, mucha ira o llorar?	Si	No
¿Camina dormido?	Si	No
¿Tiene pesadillas frecuentemente?	Si	No
¿Alguna vez le ha dicho su compañero(a) de cama que usted patea, golpea, y/o se pone violento(a) cuando esta dormido(a)	Si	No
Si respondió "Si" a la última pregunta,¿ recuerda usted esos episodios?	Si	No
¿Se despierta gritando durante la noche?	Si	No
¿Come usted durante la noche antes de ir a dormir?	Si	No
¿Rechina o aprieta los dientes mientras duerme?	Si	No
¿Le cuesta mucho trabajo quedarse dormido debido a la incomodidad de sus piernas?	Si	No
Si respondió "Si" a la última pregunta, ¿tiene que levantarse y mover sus piernas para sentirse mejor?	Si	No
¿Siente hormigueo y/o sensaciones como si insectos caminaran en sus piernas?	Si	No
¿Sus piernas se estiran de repente sin que usted lo controle durante la noche cuando trata de quedarse dormido(a)?	Si	No

Por favor escriba una lista de las metas que desea lograr en este tratamiento:

_____

_____

_____

_____

_____

Appendix B

Diario de el Dormir

Día de la semana	Lunes	Martes	Miércoles	Jueves	Viernes	Sábado	Domingo
¿A qué hora se acostó a dormir?							
¿A qué hora apagó las luces para dormirse?							
¿Cuánto tiempo le tomo quedarse dormido después de que apagó las luces?							
¿ Cuántas veces despertó por la noche aproximadamente ?							
Aproximadamente ¿ Cuánto tiempo duró despierto durante esas ocasiones que despertó?							
¿A qué hora despertó finalmente?							
¿A qué hora se levantó de la cama?							

Appendix C

Registro Adaptado a los Pensamientos para Casos de Insomnio

Situación ¿Donde? ¿Cuándo?	Intensidad de el estado de ánimo (O-100%)	Pensamientos con relacionados con dormir	Evidencia a favor de ese pensamiento	Evidencia Contra ese pensamiento	Pensamientos alternativos o para reemplazar	Nuevo grado sobre su estado de ánimo (0-100)

Adaptado de *Planes de Tratamiento e Intervenciones para el Insomnio* por Manber and Carney (2015)

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Improving Psychosocial Functioning in Latinos with Schizophrenia

13

Rebecca M. Pasillas and José A. Reyes-Torres

Schizophrenia is a debilitating, chronic serious mental illness that impacts 1.1% of the adult US population (National Institute for the Mentally Handicapped [NIMH], 2016). Schizophrenia is characterized with a variety of symptoms including hallucinations; delusions; disorganized thinking, speech, and movements; abnormal motor behaviors such as bizarre body posture; and negative symptoms such as flat affect, social isolation, and lack of pleasure in activities. Prevalence rates of schizophrenia in Latinos are unclear as there is limited research examining the lifetime prevalence of the disorder in this population.

Lopez and colleagues (2012) noted that due to the paucity of epidemiological studies, there is a disparity in providing mental health services to Latinos with schizophrenia as it is unclear how prevalent the disorder exists among Latinos. A few studies found that cases of schizophrenia are low, primarily due to under-identifying or under-reporting of psychotic disorder symptoms (e.g., Kendler, Gallagher, Abelson, & Kessler, 1996;

Lewis-Fernández et al., 2009). One of the reasons for the low cases of schizophrenia may be attributed to cultural factors in which unusual experiences or behaviors are classified as cultural expressions or cultural idioms of distress rather than psychotic symptoms; clinicians and researchers do not categorize these experiences as symptoms of a psychotic disorder, and, therefore, individuals are misdiagnosed (e.g., Vega, Sribney, Miskimen, Escobar, & Aguilar-Gaxiola, 2006).

Despite the limited research on prevalence rates of schizophrenia in Latinos, there is a need to provide evidence-based psychosocial interventions to improve psychosocial functioning in Latinos with schizophrenia. Social skills training (SST) is an evidence-based practice developed to directly address interpersonal skills deficits to enhance social functioning in individuals with serious mental illness (SMI) (Bellack, Mueser, Gingerich, & Agresta, 2004). The 2009 Schizophrenia Patient Outcomes Research Team project, Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices, and American Psychological Association's Society of Clinical Psychology (Division 12) recommend social skills training for individuals diagnosed with schizophrenia (Dixon et al., 2010).

While there is abundant data to support the effectiveness of skills training as a psychosocial intervention (Dixon et al., 2010; Kurtz & Mueser,

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2008), there are very few studies that have adapted and examined the effectiveness of the adapted versions of social skills training for use with Spanish-speaking Latinos with serious mental illness. One of those studies is by Kopelowicz, Zarate, Smith, Mintz, and Liberman (2003), which adapted skills training for use with Spanish-speaking Latinos with SMI by involving key family members to assist with skill practice outside of group. Participants in the adapted version of skills training reported improved functional outcomes (i.e., decreased symptoms and rehospitalizations, increased skill acquisition) compared to participants receiving routine care only.

Similar results were found in a randomly controlled study conducted in Mexico City; Valencia et al. (2010) compared an adapted version of skills training and family psychoeducation as additive treatments to routine care against routine care alone in individuals with SMI. Participants that received the adapted version of skills training and family psychoeducation reported fewer symptoms, number of relapses, and number of rehospitalizations as compared to participants who only received routine care. Finally, in a pilot study by Patterson et al. (2005), three clinics were randomly assigned to provide an adapted version of skills training or to provide a support group to older, Spanish-speaking Latinos with SMI. Results were mixed in that participants who received the adapted version of skills training reported improvement in daily functioning at 6 months post-intervention as compared to participants who were in the support group, but these improvements disappeared at 12 and 18 months post-intervention. No differences were found between the two types of groups on social functioning and symptomatology at 6, 12, and 18 months post-intervention. In sum, it appears that social skills training – whether modified or not – improves psychosocial functioning in Latinos with schizophrenia.

Treatment Plan Description

There are several models of social skills that one can follow. For this chapter, we will focus on the social skills training (SST) model by Bellack et al. (2004), and we encourage readers to become trained in the intervention and follow the SST manual to implement and maintain fidelity of this evidence-based intervention. SST groups teach a variety of interpersonal skills that improve communication by using basic behavioral principles such as role-playing, overlearning, shaping approaches, and providing positive feedback. It is a structured intervention in which each group session follows the same format: at-home practice of the previous social skills is reviewed; the purpose of the new social skill being taught is provided and discussed; steps of the new social skill are reviewed; group facilitators model the new social skill; group members review the modeled skill; group members role-play the new social skill with a group facilitator for a minimum of three times; after each role-play, group members are provided behaviorally specific positive feedback and suggestions for improvement by their peers and group facilitators; and at-home practice is assigned at the end of the group session.

SST groups may be open groups but closed groups are preferred although not required. There is an emphasis on behavioral rehearsal, hence a minimum of three role-plays for each group member during each SST group session. The level of skills training is geared and tailored to each group member. The social skills taught are linked to a group member's recovery-oriented goal as a way to improve psychosocial functioning. SST is primarily conducted in a group format that includes up to ten group members and offered twice a week for 60–90 min. The duration of an SST group primarily varies with content and clinical setting; an SST group may be as short as a few group sessions – if offered in an in-patient unit with a short stay – or as long as 12 weeks (24 sessions if offered twice a week), if offered in an out-patient community clinic. Although it is recommended that there be two group facilitators, one group facilitator may lead the group. Each week a new social skill is presented and taught to group members; at-home practice of the social skill is assigned to generalize learning. Positive feedback is always applied while negative feedback and criticism are highly discouraged, as SST group facilitators should create a warm, positive, and fun learning group atmosphere.

For the purposes of this chapter, we provide the phases of the intervention to consider when implementing a social skills training (SST) group along with handouts of the four basic skills to provide to Spanish-speaking group members. The treatment plan consists of a preparatory phase, individual goal-setting session, designing the SST group curriculum, and implementation of an SST group. Below are descriptions of each phase.

Preparatory Phase: Before Starting a Social Skills Group

As with the creation of any type of group intervention, preparatory work and planning are key factors that increase the likelihood for the group's success. Group facilitators should consider the following questions when developing their SST group with Latinos: Will the potential group members share cultural backgrounds? Do they have a common first language? Do potential group members live in the same community or group home? Do the group facilitators and group members share cultural and linguistic backgrounds? By considering these questions and understanding the makeup of the group and its group members, group facilitators will be better informed to develop an appropriate social skills curriculum and to enhance the group learning experience.

Another component in preparing for an SST group is the creation of recruitment materials such as flyers that can be posted in waiting rooms and distributed among the community or with mental health providers. Recruitment materials can assist leaders in finding appropriate candidates for the SST groups. The flyers may describe the purpose and goals of the SST group, contact information of the group facilitators, expected start date and location of the SST group, and other pertinent information that may help inform potential candidates or mental health providers about the SST group.

Other preparatory work includes securing a group room and supplies for the SST group. Group facilitators should secure a room that can comfortably accommodate up to ten (10) people seated in a "U" shape. There should be enough space for an easel and two chairs situated at the front of the group. Supplies for an SST group include an easel board with large notepad or whiteboard, different colored markers, and SST handouts of the social skill being taught for that session, which may also include the at-home practice, to provide to group members. Several materials must be prepared ahead of time for each SST group session. Group leaders must write the steps of each skill being practiced for that group session on the large notepad or whiteboard. Additionally, a separate large notepad detailing the group's rules may be posted on a separate easel board or the group room wall.

SST groups also serve as socializing opportunities in which group members may practice their social skills taught in previous SST group sessions. Thus, group leaders may want to provide coffee, tea, freshwater, healthy snacks, and/or pastries before and after each group session. These opportunities will allow group members to interact with each other and to practice their social skills with each other in an informal basis.

Identification of Potential SST Group Members

SST groups have been implemented in various clinical settings such as group homes, community outpatient clinics, or inpatient units. Potential SST group members may be self-referred or be referred by a provider. Depending on the clinical setting, it may be useful to contact mental health providers and educate them about the model and purpose of a social skills training group, especially if they are unfamiliar with this evidence-based intervention. The mental health providers can serve as referral sources for the SST group and may also be of help to group members learning these skills. For example, the group member may request the assistance of their mental health provider to complete an at-home practice of a social skill learned in a SST group session. In the tool kit, the *Social Skills Orientation for Professionals* was translated into Spanish to help group facilitators reach out and orient Spanish-speaking providers to the SST model and group.

Additionally, word-of-mouth referrals between SST group members and potential group members are common, especially if the clinical setting has previously offered SST groups. Many alumni or current members of SST groups speak highly of their experience and, therefore, encourage others to join an SST group for a similar experience. For potential group members unfamiliar with the format or purpose of SST groups, there is a handout that can orient them to SST. In the tool kit, the *Social Skills Orientation for Clients* document was translated into Spanish to help reach out to Spanish-speaking consumers interested in learning more about SST.

Individual Goal-Setting Session (IGSS)

To ensure optimal participation and adherence to an SST group, group leader(s) must first meet with each potential group member for an *individual goal-setting session (IGSS)*. The session lasts about 30 min and is completed before the start of an SST group curriculum. The IGSS serves as a formal orientation and introduction to SST group rules/expectations, and its structured format provides a setting for potential group members to ask questions about the SST group and its format and encourages buy-in to participate and engage in the SST group. It is recommended that group facilitators review the purpose and the format of the SST group before acquiring consent from potential group members to participate in the SST group, as it is a way to maintain "respeto" for the potential group member's willingness to engage in an SST group. The document *Social Skills Orientation for Clients* may be used during IGSS to guide this discussion.

The central objective of the IGSS is helping potential group members identify and outline a recovery-oriented SMART (i.e., specific, measurable, achievable, realistic, and time-bound) goal for their SST group. Sometimes, potential group members will need assistance with defining a SMART goal that is recovery-oriented and

related to SST. For example, a group member may initially state that his/her recovery-oriented SST goal is "to be happy at home." In this case, the group facilitator will need to help the potential group member define a SMART goal, which could be the following: "being able to talk with my children twice a week without yelling or cursing at them."

There will be times when group facilitators are not familiar with the potential group member. There are several assessment tools that group facilitators may use to help gather information about the potential group member's historical and current psychosocial functioning, social skill abilities, and other pertinent information that may be useful for identifying SST recovery-oriented goals. The *individual evaluation for goal-setting of SST* and the *social functioning interview* are two assessment tools included in the tool kit and translated to Spanish for use by Spanish-speaking group facilitators. Either one or both assessments may be used during the IGSS with the main objective of collecting enough information to identify the potential group member's SST recovery-oriented goal.

Overall, the IGSS incorporates the following elements:

- Introduction of group leader(s) to potential group member.
- Discuss the purpose of the SST group, plus the structured format and in-session activities (e.g., at-home practice review, skill introduction, review of the steps of the skill, modeling the skill, role-plays, positive feedback and suggestions for improvement, and assignment of at-home practice). The group facilitator emphasizes that all group members complete a minimum of three role-plays to practice the skill learned during that group session.
- Discuss the group's rules/expectations, plus the frequency of group sessions (e.g., twice a week for 12 sessions), group length of time (e.g., 60 min, 90 min), time and location of group, and limits of confidentiality.

- If you do not already know the potential group member, ask the potential group member questions from the *individual evaluation for goal setting of SST* or the *social functioning interview*.
- Review the components of recovery.
- Identify and select a recovery-oriented SMART goal that is related to interpersonal skills. Describe the meaning of a SMART goal with potential group member.

Designing a Social Skills Training Curriculum

SST group facilitators tailor the social skills training curriculum so that specific social skills based on group member's SST recovery-oriented goals are practiced during each session. Indeed, another main reason for completing IGSS with potential group members is to develop the SST curriculum for the cohort. After all potential group members complete their individual goal-setting session with group facilitators, a skills curriculum based on the collective SST recovery-oriented goals identified by the group members is developed. Depending on the number of SST group sessions being offered, the group facilitators will select social skills based on what the group members hope to achieve by participating in a SST group. For example, if there is an overlap of SST recovery-oriented goals – such as focusing on improving positive, respectful communication skills – among group members, then the skills selected to achieve those goals and included in an SST curriculum might include the following: "Expressing Positive Feelings," "Responding to Complains," "Disagreeing with Another's Opinion Without Arguing," "Compromise and Negotiate," or "Asking for help."

Only one skill should be practiced per session, as each group member will need to engage in a minimum number of three role-plays for the skill. An SST curriculum always includes the four basic skills (i.e., listening to others, making requests, expressing positive feelings, and expressing unpleasant feelings), as they are integral to every advanced social skill. For a list of

Table 13.1 Sample social skill training group curriculum

Session # 1	Listening to others
Session # 2	Making requests
Session # 3	Expressing positive feelings
Session # 4	Expressing unpleasant feelings
Session # 5	Asking for help
Session # 6	Leaving stressful situations
Session # 7	Making complaints
Session # 8	Responding to complaints
Session # 9	Compromise and negotiation
Session # 10	Disagreeing with other's opinion without arguing
Session # 11	Open session
Session # 12	Open session

additional and advanced social skills, please review the Bellack and colleagues SST manual (2004). The remaining SST group sessions will include social skills that would be of most help in achieving the recovery goals of the group members. A sample SST curriculum is shown in Table 13.1, which is an example of a tailored curriculum if the majority of SST recovery-oriented goals from group members were related to improving effective communication with others. Note that the "open sessions" are included to allow for participants to decide which skills they might want to practice a second time near the end of the group experience or for group facilitators to teach a new skill based on group member's abilities or interests.

Implementation of an SST Group

Now that an SST group curriculum is developed, group facilitators are almost ready to start their SST group. Prior to each SST group session, group facilitators should prepare for their group by completing the following tasks: make copies of the SST handouts to disseminate to all group members (see tool kit for Spanish versions of the basic social skills, which also includes an at-home practice section); review the new social

skill with each other and select an appropriate scenario for modeling the new social skill; assign primary and secondary group leader roles, if there are two group facilitators; and prepare the group room by writing the steps of the skill on the flip board or dry-erase board and moving chairs in a semicircle facing the board. If beverages and snacks are offered before or after the group session, group facilitators also set out the food.

As noted before, to fully learn the intricacies of implementing an SST group with fidelity to the model, we encourage you to receive training in SST and use the SST manual by Bellack et al. (2004) as a guide. The manual describes the SST model and implementation of the model in detail, includes a section on troubleshooting problems that commonly arise in SST groups, provides numerous social skill handouts to use in the group, and contains a variety of resources to support the implementation of SST groups. It is our hope that this chapter provided a general overview of SST groups for those somewhat familiar with the model and provided resources for mental health providers working with Spanish-speaking consumers diagnosed with schizophrenia to improve psychosocial functioning.

ORIENTACION PARA PROFESIONALES SOBRE EL ENTRENAMIENTO EN DESTREZAS SOCIALES

¿Qué son Destrezas Sociales?
Las destrezas sociales son las conductas específicas que usa una persona al interactuar con otros permitiéndole ser efectivo en alcanzar sus metas personales. Situaciones tales como tener una conversación casual, hacer amigos, expresar las emociones, u obtener algo de otra persona requieren el uso de destrezas sociales.

¿Cuáles son algunos ejemplos de Destrezas Sociales?
Unas buenas destrezas sociales incluyen tanto "*lo QUE se dice"* como el *"COMO se dice"*. Cuando nos comunicamos con otras personas, el contenido del mensaje, es decir, la selección de palabras o frases, es importante. La forma en *COMO* se comunica el mensaje puede ser tan importante como el contenido. Por ejemplo, expresiones faciales apropiadas, lenguaje corporal, contacto visual, y un buen tono de voz firme pueden ayudar a comunicar el mensaje. El Entrenamiento en Destrezas Sociales está dirigido hacia mejorar tanto lo que la gente dice durante las interacciones como la manera en que lo dicen.

¿Por qué son importantes las destrezas sociales?
Las personas con condiciones psiquiátricas usualmente experimentan muchos problemas en sus relaciones con otros, incluyendo a sus proveedores de tratamiento, miembros familiares y otros clientes. Estos problemas resultan en un pobre ajuste comunitario y el empobrecimiento de la calidad de vida. Para muchos clientes, su pobre funcionamiento social está relacionado con destrezas sociales inadecuadas. Por ejemplo, algunos clientes pueden confrontar dificultades comenzando una conversación, hablan en un tono de voz bajo y monótono o no establecen contacto visual. Ayudarles a los clientes a mejorar sus destrezas sociales puede realzar su funcionamiento social en la comunidad.

¿Cuáles son las causas de las deficiencias en destrezas sociales?
Existen muchas razones posibles para explicar las deficiencias en destrezas sociales de personas que experimentan enfermedades mentales. Algunos clientes se enferman antes de haber desarrollado cabalmente sus destrezas sociales. Otros pueden haberse criado en un ambiente donde no tenían buenos modelos para imitar. Incluso algunos pueden haber desarrollado buenas destrezas sociales, pero luego las perdieron al desarrollar su enfermedad y se retiraron del contacto con los demás. Los clientes que han pasado largos períodos de tiempo en hospitales donde existían expectativas bajas sobre su conducta, pueden estar faltos de práctica y necesitar ayuda para reaprender destrezas y saber cuando usarlas. Cualquier combinación en de estas posibilidades puede contribuir a las deficiencias en destrezas sociales.

¿Todos los problemas de funcionamiento social están relacionados con deficiencias en destrezas sociales?
No, la disfunción social también puede ser el resultado de otros problemas. Efectos secundarios de medicamentos pueden causar problemas de funcionamiento social. Además, si el ambiente social donde reside un cliente no conduce y promueve la conducta social apropiada y asertiva, el resultado será la disfunción social.

¿Qué es el Entrenamiento en Destrezas Sociales?
El Entrenamiento en Destrezas Sociales es un conjunto de técnicas psicoterapéuticas basadas en la teoría de aprendizaje social que se desarrollo para enseñarles destrezas sociales a individuos. El Entrenamiento en Destrezas Sociales usa los mismos métodos que se desarrollaron hace más de 25 años ara entrenamientos en asertividad. El Entrenamiento en Destrezas Sociales consiste en varios pasos. El primer paso es explicar la racional, es decir, explicarle al cliente porque es importante aprender la destreza. El segundo paso es demostrar (modelar) la destreza en un juego de roles ("role play"). El tercer paso es involucrar al cliente en un juego de roles y el cuarto paso requiere ofrecerle observaciones ("feedback") y sugerencias de cómo podría mejorar. Quinto, se motiva al cliente para que practique por su cuenta.

¿Cuán frecuentemente debe hacerse el Entrenamiento de Destrezas Sociales?
Tan frecuente como sea posible. Es preferible que el grupo de Destrezas Sociales se reúna dos veces por semana, pero se le debe recordar a los clientes que practiquen las destrezas frecuentemente, incluso de forma diaria. Mientras más oportunidades tenga el cliente de practicar la destreza social, más hábiles y más natural se torna la destreza.

¿Qué tipo de destreza social se puede enseñar?
Una gran variedad de destrezas se puede enseñar, dependiendo de las necesidades del cliente. Algunas de las destrezas más comunes incluyen el iniciar y mantener conversaciones, hacerles peticiones a los demás, expresar sentimientos, resolver conflictos, hacer amigos, y ser asertivos.

¿Cómo pueden los miembros del equipo ("staff") ayudar a los clientes para aprender estas destrezas?
Los miembros del equipo son tan importantes en el éxito del Entrenamiento de Destrezas Sociales como los líderes mismos. Los miembros del equipo ayudan a los clientes al saber las destrezas que se están enseñando, demostrar estas destrezas en sus propias interacciones con los clientes (y entre los propios miembros del equipo), sugerir y motivar a los clientes a usar las destrezas en situaciones especificas, y ofreciéndole refuerzo positivo cuando exhiben una destreza social adecuada. Más aun, los miembros del equipo pueden ayudar a los clientes practicando breves juegos de roles fuera de las sesiones regulares de grupo. Esta práctica adicional puede ayudar al cliente a sentirse más cómodo con la destreza aumentando la probabilidad de que la use por su cuenta. En resumen, los miembros del equipo juegan un papel vital en asistir a os clientes a mejorar sus destrezas sociales y son una extensión del equipo de Entrenamiento en Destrezas Sociales.

ORIENTACION DE DESTREZAS SOCIALES PARA CLIENTES

¿Qué es el Entrenamiento en Destrezas Sociales?
El Entrenamiento en Destrezas Sociales le enseña a las personas a comunicar mejor sus sentimientos, pensamientos y necesidades hacia los demás. También les enseña a las personas a cómo responder mejor a los sentimientos, pensamientos y necesidades de los demás. Las destrezas sociales le ayudan a las personas a conseguir lo que necesitan con mayor frecuencia y a evitar hacer cosas que no quieren hacer.

¿Cómo se diferencia el Entrenamiento en Destrezas Sociales de otros grupos?
El Entrenamiento en Destrezas Sociales es diferente a otras formas de grupos terapéuticos. Los miembros del grupo no se sientas en círculo para hablar de sus problemas. En lugar de eso, los miembros usan el tiempo tratando formas de resolver sus problemas. Ellos hacen esto practicando una serie de destrezas y luego intentándolas en situaciones de la vida real.

¿Qué se espera de los miembros del grupo?
Los miembros del grupo deben estar dispuestos a mantener la mente abierta. Deben estar dispuestos a intentar nuevas técnicas diseñadas para comunicarse los unos con los otros. Los miembros del grupo aprenderán sobre nuevas destrezas y discutirán como utilizarlas en su propia vida. Cuando estén listos, practicarán las destrezas dentro del grupo y en situaciones de la vida real.

¿Cómo aprenden y practican una destreza nueva los miembros del grupo?
Los miembros del grupo aprenden nuevas destrezas por medio de juegos de roles ("role playing"), primero junto a los líderes del grupo y luego los unos con los otros. Los juegos de roles son similares a practicar para una obra de teatro, pero es más relajado y divertido. Primero, los miembros del grupo reciben una hoja donde se describe la destreza que se va a discutir dividida en unos cuantos pasos simples. Después, se observa a los líderes del grupo hacer un juego de roles de la destreza (los juegos de roles son como actuar en situaciones fingidas). Cuando los miembros se sienten cómodos, se les da la oportunidad de hacer un juego de roles con la destreza. También se les pedirá que hagan tarea ara el hogar donde se les pedirá que practiquen la destreza fuera del grupo. Nunca se le fuerza a nadie para que participe en un juego de roles ni para que haga tarea si este/a no se siente cómodo/a.

¿Cómo me puede ayudar el Entrenamiento en Destrezas Sociales?
Las destrezas sociales le pueden ayudar a comunicarse mejor con sus amigos, familiares o jefes. Le podrían ayudar para hablarle a una persona a quien usted desea cortejar. Usted puede enfocarse en destrezas que lo ayuden a alcanzar mayor independencia. Las destrezas sociales podrían ayudarle a alcanzar prácticamente cualquier meta que usted se proponga. Antes de la primera sesión, cada participante del grupo se reúne individualmente con un líder del grupo. El líder le ayuda al participante a identificar cuáles son las metas personales con las que trabajara durante el grupo.

ENTREVISTA DE FUNCIONAMIENTO SOCIAL

Nombre: _____   Fecha: _____

Clínico: _____

Funcionamiento social Presente y Pasado

Rutinas diarias en el hogar

- ¿Donde vive actualmente?
- ¿Con quién vive actualmente?
- ¿Podría describirme un día típico en su casa?
- ¿Qué hace usted para mantenerse ocupado?
- ¿Hay momento en los que no está haciendo nada y se siente aburrido?
- ¿Qué tipo de situaciones de vivienda ha disfrutado usted más?

Actividades de trabajo y educación

- ¿Está usted tomando clases o estudiando alguna materia en este momento?
- ¿Trabaja usted a tiempo parcial o tiempo completo?
- ¿Hace usted trabajo voluntario?
- ¿Participa de algún programa de rehabilitación vocacional?
- ¿Ha trabajado en el pasado? ¿Qué tipo de trabajos tuvo usted en el pasado?
- ¿Qué tipos de carrera le interesan a usted en este momento? ¿Qué carreras le interesaban en el pasado?

Actividades recreativas

- ¿Qué le gusta hacer en su tiempo libre?
- ¿Cuáles son sus pasatiempos?
- ¿En cuál deporte le gusta participar o le gusta observar?
- ¿Le gusta leer? ¿Le gusta escribir o mantiene un diario?
- ¿Le gusta escuchar música o toca algún instrumento?
- ¿Le gusta ver películas o algún programa de televisión?
- ¿Le gusta dibujar u observar algún tipo de forma artística?
- ¿Qué tipo de pasatiempo solía disfrutar?

Relaciones

- ¿Usualmente, con quien pasa usted el tiempo? ¿Familiares? ¿Amigos? ¿Compañeros de clase, de empleo, o de vivienda? ¿Alguna persona significativa? ¿Niños?
- ¿Se siente usted cercano a alguien? ¿Alguien con quien pueda hablar las cosas que son importantes para usted?
- ¿Hay alguien con quien querría usted pasar más tiempo?
- ¿Quiere usted tener mas relaciones cercanas?

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ENTREVISTA DE FUNCIONAMIENTO SOCIAL

Apoyo espiritual

- ¿Es la espiritualidad importante para usted?
- ¿Qué le reconforta espiritualmente?
- ¿Participa usted activamente de alguna religión?
- ¿Usted medita?
- ¿Mira usted hacia la naturaleza o las artes para encontrar espiritualidad?

Salud

- ¿Qué hace usted para cuidar su salud?
- ¿Cómo usted describiría su dieta?
- ¿Usted hace algún tipo de ejercicio?
- ¿Cómo es su patrón de sueño?

Situaciones Sociales que son Problemáticas

A veces existen situaciones sociales específicas que las personas no manejan tan bien como quisieran. ¿De los siguientes tipos de situaciones cuales son difíciles para usted? Por favor describa cada situación de la manera más específica que pueda, provea ejemplos si es posible. ¿Qué pasa en la situación? ¿Qué hace usted y que hace la otra persona?

Iniciar y mantener conversaciones

Manejar conflictos y evitar discusiones

Reafirmarse uno mismo, defenderse uno mismo

Vivir con otras personas

Tener buenas relaciones (amigos, familia, esposa/o, pareja significativa, niños)

Comunicarse con los doctores y otros miembros de equipo de tratamiento

ENTREVISTA DE FUNCIONAMIENTO SOCIAL

Trabajo o labores voluntarias

Metas Personales Identificadas durante la Entrevista

Metas a corto plazo (durante los próximos 6 meses)

1. _____

2. _____

Metas a largo Plazo (durante el próximo año)

1. _____

2. _____

Fortalezas y debilidades en destrezas sociales Observadas por el Clínico durante la Entrevista

Fortalezas

1. _____

2. _____

3. _____

4. _____

Debilidades

1. _____

2. _____

3. _____

4. _____

EVALUACION INDIVIDUAL DE METAS PARA ENTRENAMIENTO EN DESTREZAS SOCIALES

Nombre: _____

Fecha: _____

Educación (más alta alcanzada): _____

Ocupación actual: _____

Historial de trabajo: _____

_____

_____

_____

¿En qué actividades se involucra usted de forma diaria o semanal? _____

_____

_____

_____

¿Al momento, existe alguna actividad en la que usted no esté participando pero que le gustaría hacer? _____

_____

_____

_____

¿Quiénes son las personas con quien usted pasa la mayor cantidad de tiempo? _____

_____

_____

_____

_____

¿Al momento, hay personas con quienes usted no comparte pero le gustaría compartir? _____

_____

Identifique dos metas que desearía lograr en el próximo año (metas a largo plazo):

1. _____

2. _____

¿Cuál sería una meta en la que el grupo de destrezas sociales le podría ayudarle para alcanzar sus metas de recuperación? Escriba la fecha en que se planteó la meta.

_____

_____

EVALUACION INDIVIDUAL DE METAS PARA ENTRENAMIENTO EN DESTREZAS SOCIALES

Circule la categoría más relevante. *¿Cuál categoría se ajusta mejor a la meta para el grupo de entrenamiento en destrezas sociales? Aun cuando las categorías podrían coincidir, trate de seleccionar la que es más relevante.*

1. Mejorar las relaciones interpersonales
2. Mejorar la participación comunitaria
3. Mejorar el compromiso con los servicios de tratamiento
4. Mejorar el bienestar físico y/o emocional

Pasos necesarios para alcanzar la meta al finalizar el grupo de adiestramiento en destrezas sociales (ponga una marca de cotejo (√) una vez alcanzado los pasos) :

1.

2.

3.

4.

5.

Rueda de la Recuperación

Social Skills Handouts for Group Members

Nombre: _____

Hoja de Asignación

<u>Destreza</u> : Escuchar a otros

Practique la destreza usando los siguientes pasos

Paso 1. Mire la persona a los ojos.

Paso 2. Déjele saber que está escuchando señalando que "si" con la cabeza o diciendo cosas como "ajá" o "ya veo".

Paso 3. Repita lo que usted escuchó a la otra persona decir.

Día en que se practicó:_____ Hora:_____ Lugar:_____

Describa brevemente lo que pasó:
_____
_____
_____

¿Cuán efectivo fue usted al realizar la destreza durante la asignación? Por favor marque una de las siguientes:

___1. No del todo Efectivo
___2. Un poco Efectivo
___3. Moderadamente Efectivo
___4. Bien Efectivo
___5. Altamente Efectivo

Comentarios Adicionales:
_____
_____

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Social Skills Handouts for Group Members

Nombre: _____

Hoja de Asignación

<u>Destreza</u> : Hacer peticiones

Practique la destreza usando los siguientes pasos

Paso 1. Mirar a la persona.

Paso 2. Decir exactamente lo que usted desea que la persona haga.

Paso 3. Dígale a la persona cómo le haría sentir. Al hacer su petición, utilice frases como:

"Me gustaría que _____"
"Realmente le agradecería que usted _____"
"Es muy importante para mí que me ayude con ____"

Día en que se practicó:_____ Hora:_____ Lugar:_____

Describa brevemente lo que pasó:

_____
_____
_____

¿Cuán efectivo fue usted al realizar la destreza durante la asignación? Por favor marque una de las siguientes:

___1. No del todo Efectivo
___2. Un poco Efectivo
___3. Moderadamente Efectivo
___4. Bien Efectivo
___5. Altamente Efectivo

Comentarios Adicionales:

_____
_____

Social Skills Handouts for Group Members

Nombre: _____

Hoja de Asignación

<u>Destreza</u> : Expresando sentimientos positivos

Practique la destreza usando los siguientes pasos

Paso 1. Mire a la persona.

Paso 2. Dígale a la persona exactamente qué fue lo que le gustó.

Paso 3. Dígale a la persona cómo le hizo sentir.

Día en que se practicó:_____ Hora:_____ Lugar:_____

Describa brevemente lo que pasó:
_____
_____
_____

¿Cuán efectivo fue usted al realizar la destreza durante la asignación? Por favor marque una de las siguientes:

___1. No del todo Efectivo
___2. Un poco Efectivo
___3. Moderadamente Efectivo
___4. Bien Efectivo
___5. Altamente Efectivo

Comentarios Adicionales:
_____
_____

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Social Skills Handouts for Group Members

Nombre: _____

Hoja de Asignación

<u>Destreza </u>: Expresando sentimientos desagradables

Practique la destreza usando los siguientes pasos

Paso 1. Mire a la persona. Hable con un tono de voz calmado y firme.

Paso 2. Dígale a la persona exactamente qué fue lo que le disgusto.

Paso 3. Dígale a la persona cómo le hizo sentir.

Paso 4. Sugiera como la persona puede evitar que vuelva a ocurrir en el futuro.

Día en que se practicó:_____   Hora:_____   Lugar:_____

Describa brevemente lo que pasó:
_____
_____

¿Cuán efectivo fue usted al realizar la destreza durante la asignación? Por favor marque una de las siguientes:

___1. No del todo Efectivo
___2. Un poco Efectivo
___3. Moderadamente Efectivo
___4. Bien Efectivo
___5. Altamente Efectivo

Comentarios Adicionales:
_____
_____

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14

Tools for Treating Aggression, Substance Use, Abuse, and Dependence Among Latino Adults

José J. Cabiya

Drug Abuse Prevention Strategies and Interventions for Latino Adults

According to Burrow-Sánchez, Minami, and Hops (2015), the effectiveness of treatments for both mental health and substance abuse disorders has largely been established in randomized clinical trials (RCTs) with predominantly White samples, while this type of research with Latinos has been extremely limited and almost nonexistent. Burrow-Sánchez et al. (2015) argued that research on drug abuse treatment with White samples cannot be generalized to Latinos. Some meta-analytic analyses suggest that Latino clients can benefit from culturally adapted treatments (Benish, Quintana, & Wampold, 2011), while others are not too convinced that what has been claimed to be effective adaptations to treatments of substance abuse for Latinos have been that effective as claimed in some studies (Benuto & O'Donohue, 2015). Regardless of how these cultural adaptations have been implemented, all reviews conclude that effective treatments for Latinos with substance abuse and dependence have consisted mainly of CBT type of interventions the same as

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was with children and adolescents as described above. Burrow-Sanchez, Meyers, Corrales, and Ortiz-Jensen (2015) tested the effectiveness of CBT using the RCT model and that included cultural adaptations to their CBT manual by adding to their manual an ethnic identity component. Their intervention model was based on cognitive–behavioral principles directed at the development of positive identity as a Latino, a cultural relevance component by infusing content in Spanish, and a family component by including family meetings. Besides CBT, another type of intervention which has been applied and found to be effective in reducing substance use, abuse, and dependence of Latino adults with substance abuse disorders has been motivational interviewing as will be discussed next.

Motivational Interviewing Model

Prochaska and DiClemente (1983, 1984; Prochaska, DiClemente, and Norcross, 1992; Prochaska, DiClemente, Velicer, and Rossi 1993) have proposed a theory of change that has served as the basis for most current prevention strategies and interventions for drug abuse. According to Prochaska and DiClemente (1983, 1984; Prochaska et al., 1992, 1993), the initial stages of change include pre-contemplation, there is no intention of change in 6 months; contemplation, there is intention of change in

6 months; preparation, posing to undertake the action against the disorder between 1 and 6 months; action, have undertaken actions clear against the disorder in last 6 months; maintenance, I am working to keep the changes that have made against the disorder by more than 6 months; and recovery/termination, I have taken action against disorder. This theory of change has served as the basis for the intervention called motivational interviewing (MI). MI is one of the most widely used interventions with Latinos to treat substance use, abuse, and dependence in general (Hettema, Steele & Miller, 2015) and specifically to treat alcohol abuse (Lee et al., 2013) and smoking (Hettema & Hendricks, 2010).

Prochaska and DiClemente (1983, 1984; Prochaska et al., 1992, 1993) have proposed five stages for the behavioral change process. These five stages include developing helping relations where one starts sharing ones' problems, counterconditioning where new behavioral alternatives are rehearsed and used, reinforcement management where one uses self-reinforcements to facilitate change, stimulus control where one controls the stimulus that leads to the drug abuse, and finally social liberation where one develops more appropriate and socially approved adaptive behaviors. Using this model of behavioral change, Prochaska and DiClemente (1983, 1984; Prochaska et al., 1992, 1993) have proposed the prevention strategy which has been labeled motivational interviewing (MI). They also have demonstrated that MI is effective in initiating behavioral change. MI consists first of developing empathy where the interviewer or therapist develops an empathic relationship with the client and then one challenges the values of the client by demonstrating the discrepancies between current drug abuse and addictive behaviors and values and goals. Then, the model proposes a technique called rolling with resistance where one manages the resistance in order to provoke the desired change in the addictive behaviors and finally the therapist supporting patient self-efficacy through a series of techniques and strategies.

Several researchers have demonstrated the need for cultural adaptations of MI when administered to Latino adults (Field & Caetano, 2010; Lee et al., 2013). Some of the cultural adaptations found to be effective by these researchers are to expand the range of areas addressed in the treatment groups to the whole cultural context including the clients' families and address directly such issues as poverty, unemployment, and racial biases (Lee et al., 2013). Thus, cultural adaptations of MI to Latinos need to be applied at all stages of the intervention. More specifically, each MI technique needs to be culturally adapted to Latinos as will be shown in the following description of each technique proposed by the present author next, and at the end of the chapter, specific examples for each technique will be discussed.

The main aim of MI is to resolve the ambivalence of the client toward change experienced by most people that try to overcome a drug dependence. The first technique used by MI to reduce this ambivalence is the double-sided reflections where the therapist restates in his own words what the client appears to be feeling. An usual example is to say, "you state show want to stop using the drug but feels that there is nothing you can do." A cultural adaptation for this technique could involve stating to the client that "Even when it might be very difficult, you can overcome the addiction with the help of your family."

The second technique to reduce ambivalence in MI is the amplified reflections where you intensify the resistance heard within the client's statement. It is important to note that you need to try amplifying what the client says without recurring to sarcasm. The purpose of this technique is that the client starts making positive self-statements toward change ("I can do it.") rather than continuing with his resistant statements (this is too difficult). For instance, if a client says "I cannot talk about my feelings because men do not do this," an amplified reflection with cultural adaptation might be, "only women know how to share feelings and men do not know how to share their feelings." Most likely, the client will back off from what he said and reply, "I didn't mean

that. Men also know how to share feelings." Thus, therapists can increase positive attitude toward change through the use of this technique.

A third MI technique is intentional reflections where a therapist listens for self-motivated statements related to self-statements positive toward change and purposefully reflect back statements that favor that intent to change. In addition, leaders using MI rely heavily on the use of reflection to guide sessions, using empathy to reflect thoughts and feelings that were implied but stated out loud. For example, if a client were to make an ambivalent statement such as, "I'd kind of like to work on not feeling so anxious when I talk to people in this group, but that's a scary goal for me," therapists using intentional reflection would purposefully reflect only the self-motivated statement, "you would like to work on your interpersonal communication within the group." An appropriate cultural adaptation of this technique is to add to the last statement "but I am afraid that the group cannot understand me since I come from a different socio-economical (or ethnic) background."

Finally, other MI techniques are the use of open questions during the interviewing, affirming patient strengths and efforts by supporting patient assets and present or past attempts to make positive changes. Also summarizing extended reflections and eliciting change talk are techniques used in MI. All of these techniques can be culturally adapted taking into consideration the importance given by Latinos to families' support and bringing up to the open fears of ethnic rejection because of biases and other cultural and socioeconomic factors like poverty or scarce resources and managing daily living demands.

A set of examples demonstrating how to train with these techniques in Spanish is offered at the end of this chapter.

Other Resources for Treating Substance Use Among Latinos

The Substance Abuse and Mental Health Services Administration (SAMHSA) developed and tested a CBT treatment protocol titled *Anger Management for Substance Abuse and Mental Health Clients* (Reilly, Shopshire, Durazzo, & Campbell, 2002); thus, resources for the treatment of aggression and anger management are discussed here in this chapter. A more extensive overview of this treatment protocol can be found in the proceeding paragraphs. This treatment manual is available in Spanish and is in the public domain, and thus tools for this specifically are not included here in this chapter. The manual includes worksheets and tools in both English and Spanish. The English and Spanish versions of the manual can be accessed on the SAMSHA website:

English: https://store.samhsa.gov/shin/content/ SMA12-4213/SMA12-4213.pdf
Spanish: http://store.samhsa.gov/shin/content// SMA08-4189/SMA08-4189.pdf

Research on the Effectiveness of CBT Approaches to Anger Management and Aggression with Latino Adults

Much of the research in anger management and aggression has been done with adolescents, and little has been published on its effectiveness with adults (Lochman et al., (2004). Nevertheless, many anger management programs for adults have been developed based on the CBT approach similar to the one described above for adolescents in general, but its efficacy with Latinos has not been thoroughly tested, specially, using the randomized clinical trials (RCTs) model. Examples of these CBT approaches to anger management include the CBT developed for anger management in Mexico by Lopez et al. (2012) and in Spain by Sevillá & Pastor (2016) just recently. The therapy developed by Sevillá and Pastor (2016) consists of first teaching the client to identify the antecedents of behavior which are their own negative self-statements which lead to the consequences of their behavior. This model has been known as the ABC model first labeled as such by Albert Ellis (Sevillá & Pastor, 2016). Sevillá and Pastor (2016) proposed

that the next stage is to teach the client how to do his own internal verbal discussion on how this ABC model leads to the anger response. After the verbal discussion, the client is taught to do rehearsal of alternative behaviors to their anger response and to develop more appropriate self-statements combining this technique with a stimulus control technique by which they learned how to avoid places and situations that lead to anger and aggression. Another technique is to use response interruption where they are taught how to stop the anger response once it starts mainly through the use of relaxation, which is also taught thoroughly.

The specific session plan proposed by Sevillá and Pastor (2016) is as follows:

Session 1: Introduction of the therapist and of the methodology to be used through the therapy and "breaking the ice" exercises.

Session 2: Teaching of strategies and role-playing on how to initiate a conversation, the importance of nonverbal communication, and how to introduce yourself.

Session 3: Continue with strategies and role-playing on how to initiate a conversation and how to introduce yourself.

Session 4: Teaching of strategies and role-playing on how to maintain a conversation.

Session 5: Continue with strategies and role-playing on how to maintain a conversation.

Session 6: Didactics and strategies and role-playing on how to close conversations.

Session 7: Introduction to cognitive techniques including working with the ABC of behavior and how to develop an internal analysis (D) and alternative, more adaptive behavior (E).

Session 8: Teaching of strategies and role-playing on assertive response in relation to an aggressive and a passive response.

Session 9: Teaching of strategies and role-playing of anger management techniques and how to state sincere compliments to others.

Session 10: Continue with strategies and role-playing on anger management techniques and how to state sincere compliments to others.

Session 11: Teaching of strategies and role-playing on how to receive criticism.

Session 12: Continue with strategies and role-playing on how to receive criticism.

Session 13: Teaching of strategies and role-playing on how to make requests and to say "no."

Session 14: Continue with strategies and role-playing on how to make requests and to say "no."

Session 15: Teaching of strategies and role-playing on how to communicate and how to receive positive feelings.

Session 16: Continue on strategies and role-playing on how to communicate and how to receive positive feelings.

Session 17–18: At this point, one can add whatever role-playing activities that the therapist feels are needed including dating skills, job interview skills, etc. Also the use of other techniques like mindfulness and exposure techniques can be introduced here.

In addition to the protocol discussed above, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed and tested a CBT treatment protocol titled *Anger Management for Substance Abuse and Mental Health Clients* (Reilly et al., 2002). This treatment manual is similar to the protocol described above by Sevillá and Pastor (2016). The treatment manual described 12 sessions, which include:

Session 1: Overview of Group Anger Management Treatment

Session 2: Events and Cues: A Conceptual Framework for Understanding Anger

Session 3: Anger Control Plans: Helping Group Members Develop a Plan for Controlling Anger

Session 4: The Aggression Cycle: How To Change the Cycle

Session 5: Cognitive Restructuring: The A-B-C-D Model and Thought Stopping.

Session 6: Review Session #1: Reinforcing Learned Concepts

Sessions 7 and 8: Assertiveness Training and the Conflict Resolution Model: Alternatives for Expressing Anger

Sessions 9 and 10: Anger and the Family: How Past Learning Can
Influence Present Behavior
Session 11: Review Session #2: Reinforcing Learned Concepts
Session 12: Closing and Graduation: Closing Exercise and Awarding of Certificates

This treatment manual is available in Spanish and is in the public domain, and thus tools for this specifically are not included here in this chapter. The manual includes worksheets and tools in both English and Spanish. The English and Spanish versions of the manual can be accessed on the SAMSHA website:

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Structured Practice Examples for Motivational Interviewing/ Ejemplos de la Práctica Estructurada de Entrevistas Motivacionales
Práctica Estructurada Ejemplo 1: Aprendizaje No Verbal

1. Antes de comenzar a escuchar reflexivamente, puede ser útil aumentar la conciencia de la importancia y el valor de habilidades no verbales de escuchar ("pasivoamente"). El ejercicio de entrenamiento para este paso es relativamente simple.
2. Parea a los alumnos y hacerles decidir quién hablará y quien escuchará.
3. Asignar un tema específico para el orador hablar durante cinco minutos, u ofrecer un menú de opciones tales como:
   a. Cómo fue crecer en mi casa maneras
   b. En que he cambiado como persona con los años
   c. Las cosas buenas y cosas no tan buenas sobre mis años en la escuela secundaria

   d. Lo que espero y planeo hacer en los próximos diez años.
   e. Describir uno de tus padres o alguien cerca de usted.
   f. Cómo llegué a hacer el tipo de trabajo que estoy haciendo.
4. Instruir al oyente a no decir nada, ni siquiera "mm hmm" u otros sonidos vocales.
5. Silencio absoluto. En cambio el oyente es utilizar habilidades no verbales para comunicarse al orador le o ella es escuchar y comprender.
6. Permitir que los monólogos continuar durante 5-10 minutos, entonces pregunto los parlantes hasta el final.

Evaluación ¿Cómo fue esta experiencia como para los oradores? ¿Para los oyentes? Oyentes observan a menudo que eran conscientes de todas las cosas que habrían dicho. Pregunte a oyentes para indicar el tipo de cosas que podrían haber dicho había sido permitido. La experiencia es a menudo una mezcla de placer y frustración para ambos, que le da mayor interacción. Esto fija la etapa para la introducción de métodos reflexivos para escuchar "activamente".

Práctica Estructurada Ejemplo 2: Pensar Reflexionando

i. Explicar que hay una manera de pensar que acompaña escuchar reflexivamente. Incluye, por supuesto, interés en lo que la persona tiene que decir y el respeto por la sabiduría interior de la persona. El elemento clave en este punto, sin embargo, es un enfoque de prueba de hipótesis para escuchar - el conocimiento que lo que piensa una persona significa no puede ser lo que él o ella realmente significa.
ii. Una buena respuesta de escuchar reflexivamente prueba una hipótesis. Se le pregunta, en cierto modo, "es esto lo que quiere decir?"
iii. Dibujar el modelo de Thomas Gordon de escuchar en el tablero y explicar brevemente.

El punto es que hay al menos tres lugares donde puede fallar incluso una comunicación única.

Modelo de Thomas Gordon (padre efectividad Training):

Palabras, el orador dice	2	Palabras el oyente oye
1		3
Lo que significa para el orador	4	Lo que el oyente piensa que el orador quiere decir
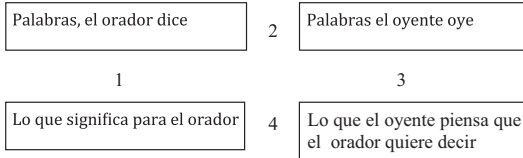
- Comunicación puede ir mal porque:
  1. el locutor no dice exactamente lo que significa
  2. el oyente no escucha las palabras correctamente
  3. el oyente le da una interpretación diferente a lo que significan las palabras
- El proceso de escuchar reflexivamente pretende conectar la parte inferior las dos cajas (4), para comprobar si "lo que el oyente piensa que el orador quiere decir" es lo mismo que "lo que el orador quiere decir."

Preparación:

- Que cada participante esté preparado para compartir por lo menos tres terminaciones personales de la frase "una cosa que me gusta de mí es que yo..."
- Estas declaraciones deberían hacer hincapié en las características personales relativamente abstractas (que se prestan a una mayor ambigüedad y discusión) en lugar de atributos concretos (por ejemplo, "una cosa que yo se, es que soy alta").

Comentario:

Este ejercicio enseña una aproximación a la escuchar reflexivamente y hace hincapié en cómo un oyente puede generar múltiples hipótesis en cuanto a lo que puede querer decir un orador en cualquier instrucción dada.

Actividades:

1. Participantes se constituirán en grupos de tres y, en cada tríada, cada miembro tomará turnos en rotación, diciendo una de sus oraciones a los dos otros miembros.
2. Cuando un orador ha ofrecido una oración, los otros dos sirven como oyentes y responder las preguntas de esta forma: "¿quieres decir que you___?"
3. El orador responde a cada pregunta tan solamente con "sí" o "no". Ninguna elaboración adicional está permitido. (Una alternativa es permitir que el orador diga "más tibio" o "frío").
4. Demostrar esto ofreciendo un ejemplo personal a la audiencia y los adiestradores le pregunten a usted: "¿Tú quieres decir que.....?" y usted solo responder con "sí" o "no".

Ejemplo:

Tú: Una cosa que me gusta de mí es que yo estoy organizada.

Aprendiz: ¿Quieres decir que mantener ordenado tu escritorio?

T: No!

A: ¿Significa que gestión tu tiempo bien?

T: Sí.

A: ¿Significa que usted siempre sabrá donde encontrar cosas?

T: No.

A: ¿Quieres decir que te las arreglas para conseguir un montón hecho?

A: Sí.

A: ¿Quieres decir que eres un buen planificador?

T: Sí.

A: ¿Significa que es difícil vivir contigo?

T: ... Sí.

5. Instruir a las triadas para iniciar este proceso, generando por lo menos cinco preguntas diferentes "quieres decir..." para cada instrucción que se ofrece. Cuando el cuestionamiento para una declaración parece haber llegado a su fin, gire a la siguiente persona, que se con-

vierte en el orador mientras que los otros dos generan preguntas. Circular entre los grupos para reforzar, aclarar, dar ejemplos y sugerencias. Espere unos 20 minutos para este ejercicio; Ajuste el tiempo según sea necesario, dependiendo del progreso.

Evaluación:

1. En un grupo grande, pida comentarios sobre esta experiencia. ¿Qué aprendió los participantes? ¿Qué sorpresas hubo? ¿Cómo se sentía ser el orador? Generalmente hay comentarios acerca el orador de querer fuertemente elaborar y explicar, que es una buena ilustración de cómo es el proceso reflexivo.
2. Pregunte: ¿Qué problemas se encontraron?
3. Destacar cuántos significados de una declaración aparentemente simple puede ser, así como el hecho de que muchas conjeturas tempranas están equivocadas.
4. Señalar cómo cada conjetura recibe retroalimentación inmediata ("Sí" o "No") en este ejercicio, que también desarrolla el escuchar reflexivamente.
5. Temas comunes durante el interrogatorio son:

Satisfacción. El orador se sintió bien entendido.

Frustración. Que es frustrante poder decir solamente "Sí" o "No" porque el orador quiere decir más. Este es un buen ejemplo de cómo incluso este simple nivel de reflexión provoca la auto-revelación.

Fascinación. Es increíble lo fácil que es perderse, y cuántas cosas distintas pueden significar. Oradores pueden tener la experiencia que me hizo pensar en cosas que no había considerado. Una vez más, es un efecto de reflexión, incluso en este nivel simplista.

- Con el fondo de pensar reflexivamente y generar hipótesis alternas sobre el significado, el siguiente paso es enseñar a los alumnos formar buenas declaraciones de escuchar reflexivamente.

Práctica Estructurada Ejemplo 3: Formar Relecciones

- Objetivo: Ayudar a los alumnos a aprender formar declaraciones reflexivas eficaces. Tiempo: 20 minutos más de discusión. Formato: Los participantes se organizan en grupos de tres.

  Prácticas de preparación:

- Las preguntas en el último ejercicio están muy cerca de escuchar reflexivamente, pero no del todo. El proceso, sin embargo, es la misma que en el ejercicio anterior: el oyente hace una conjetura sobre el significado del orador y esto ofrece al orador para respuesta.
- Explicar qué bueno escuchar reflexivo declaraciones son muy similares a, pero distinto, el "te refieres..." preguntas. Ofrecen una hipótesis sobre lo que significa para el orador, pero esto se hace en forma de una declaración en lugar de una pregunta (diferencia de inflexión al final de la frase). Una buena respuesta de escuchar reflexivamente es una declaración. Su inflexión da vuelta al final. (Ilustrar por descenso de la palabra "dijo" diferentemente en esta frase: "Estás enfadado por lo que he dicho?" (arriba) vs "Estás enojado por lo que he dicho."

Comentario:

- Es un paso corto de las preguntas de "pensar reflexivamente" a declaraciones reflexivas, pero a menudo parece más difícil y necesita algún entrenamiento y estímulo.
- El entrenador debe circular entre grupos, reforzar las respuestas de buena reflexión, sugerencias y ofrecer que algunas reflexiones tuyas sí parece que son apropiadas para el grupo.
- Asistir a la inflexión de la voz al final de declaraciones reflexivas y fomentar un descenso en la voz (declaración) en lugar de inflexión ascendente (pregunta).

Actividades:

1. Los participantes en cada tríada tomará turnos en rotación, diciendo una de sus frases a sus dos socios.
2. Cuando un orador ha ofrecido una oración, los otros dos sirven como oyentes y responden con declaraciones de escuchar reflexivamente.
3. El orador responde a cada declaración con elaboración que probablemente incluye pero no se limita a "sí" o "no". Escucha reflexivamente las instrucciónes, luego, toma esta nueva información en cuenta, añadiendo un grado de complejidad que no está presente en el Ejercicio 3.
4. Demostrar esto por al aprendiz de decirte un cambio de declaración; Puede responder sólo con declaraciones de escuchar reflexivamente y continuar este proceso varias veces. Por ejemplo:

Aprendiz: Algo sobre mí que quiero cambiar es mi mal humor.
Tú: Nunca sabes si vas a estar bien o mal.
A: No, no es eso. Te puedo decir cómo voy a sentir. Es solo que reaccionan de manera exagerada a las cosas.
T: Incluso pequeñas cosas pueden molestarle.
A: A veces, sí. Principalmente creo que me preocupo demasiado.
T: Te sientas y te preocupas demasiado por las cosas.
A: Uh-Huh. A menudo no hay nada que puedo hacer al respecto, pero todavía le sigo dando vueltas en mi mente.
T: Y que te pone cambiante en tu estado de ánimo.
A ¡Sí! Me siento agobiado y me quita el sueño.
T: Incluso de noche, es preocupante.
A: Sí. Eso es lo que deseo que yo pudiera cambiar.

5. Las tríadas comienzan este proceso designando a un miembro como el primer orador.
6. Los dos oyentes ofrecen sólo reflexiones a las respuestas (no hay preguntas u otros obstáculos), y elabora el orador.

7. Cuando una declaración se parece a otra, gire a la siguiente persona, que se convierte en el orador mientras que los otros dos responden al escuchar reflexivamente.
8. Circular entre los grupos para reforzar, clarificar y hacer sugerencias.
9. Espere unos 20 minutos para este ejercicio.
10. Ajuste el tiempo según sea necesario, dependiendo del progreso.

Evaluación:

Analizar el ejercicio desde el punto de vista de los oradores y oyentes. ¿Cómo sentiste los oradores en este ejercicio, en comparación con el Ejercicio 3? ¿Qué tan fácil es generar respuestas para escuchar reflexivamente? ¿Qué dificultades hubo? Generar declaraciones reflexivas individuales es más fácil que escuchar empáticamente en el contexto de la conversación. El reto aquí es la reflexión continua del nuevo significado que se ofrece como un tema explorado. Porque esto es difícil, los alumnos fácilmente caerán de vuelta en alternativas familiares de escuchar (por ejemplo, hacer preguntas). Este ejercicio está diseñado para desafiar a los alumnos a confiar más en escuchar reflexivamente.

Práctica Estructurada Ejemplo 4: Aprendizaje Sostenido Reflexivo

Objetivo: Dar a cada alumno una oportunidad practicar reflexiva escuchar como un estilo dominante en la conversación uno a uno.
Tiempo: 20 minutos más de discusión.
Formato: Los alumnos se organizan en pares.
Preparación del aprendiz:

• Algunos de los puntos más finos de la reflexión pueden ser discutidas en la preparación de este ejercicio. El concepto de niveles de reflexión puede ser útil:
1. Repetir. La Más Simple Reflexión donde simplemente repite un elemento de lo que ha dicho el orador.
2. Reformulación. Aquí el oyente se queda cerca de lo que el orador dice, pero sustituye

sinónimos o re-frasea un poco lo que se ofrece.

3. Parafraseando. Se trata de una reafirmación más importante, en la que el oyente infiere el significado de lo que se dijo y se refleja esto en palabras nuevas. Esto es que amplía lo que realmente se dijo. ¿En forma ingeniosa, es como sigue el párrafo que el orador ha estado desarrollando? diciendo la oración siguiente en lugar de repetir el último de ellos.

4. Reflejo de sentimiento. A menudo considerado como la forma más profunda de reflexión, se trata de un parafraseo que hace hincapié en la dimensión emocional a través de declaraciones de la sensación, metáfora, etcétera.

5. En general, reflexiones simples (1 and 2) se utilizan al principio, cuando el significado es menos claro y más profundas son reflexiones que se aventuran según la comprensión aumenta.

6. Saltar demasiado lejos más allá de lo que se dijo, sin embargo, puede convertirse en interpretación (un obstáculo). Usted también puede discutir aquí algunas de las variaciones de reflexión (p. ej., doble reflexión). Participantes deben estar preparados, como en el ejercicio de obstáculos, para hablar sobre cuando « me siento de dos maneras acerca de él o tal cosa».

• Discutir exagerar versus minusvalorar la declaración del cliente. Por ejemplo, hay una gran variedad de palabras que pueden usarse para capturar un sentimiento particular. Por ejemplo:

FELICIDAD	IRA	TRISTEZA	MIEDO
feliz	enfadado	infeliz	petrificado
alegre	disgustado	desdichado	horrorizado
encantado	molesto	desventurado	despavorido
contento	fastidiado	infortunado	horripilado
satisfecho	resentido	miserable	aterrado
contento	tirante	miserable	espeluznado
complacido	picado	desamparado	espantado
alborozado	irritado	apagado	asustado
gozoso	quemado	sombrío	entelerido

• Elegir una palabra que exagera la sensación del cliente y tiende hacer que la persona deje de hablar de la experiencia. Usando una palabra que subestima la intensidad de la sensación tiende a hacer que la persona a seguir experimentando y debatiendo.

Comentario:

• Participantes que son relativamente nuevos a la escuchar reflexivamente encuentran este ejercicio un paso difícil y necesitan estímulo. Este es un lugar donde individualizar entrenamiento es apropiado, si se trata.

• Algunos alumnos harán bien en esta etapa y están listos para seguir adelante; otros necesitarán apoyo y práctica adicional.

• Idealmente, los alumnos deben convertirse en experto en la escuchar reflexivamente antes de trabajar en aplicaciones más complejas. Esto es fácil de lograr en la formación individual y pequeños grupos que en talleres más grandes.

Actividades:

1. Los participantes en cada par decidan quién será el primer orador. Esta persona entonces habla al oyente sobre el tema elegido.

2. El que escucha debe responder sólo con declaraciones de escuchar reflexivamente. Aunque sería natural combinación de reflexión con otras formas (por ejemplo, preguntas), el oyente intencionalmente es prohibido utilizar nada más que reflexión. Esto se hace porque sin tal prohibición, los alumnos tienden a confiar en viejos hábitos. El orador responde a reflexión al elaborar.

3. Pida a los alumnos a permanecer en función, no discutir o romperse hasta que les interrumpa. Después de 10 minutos, instruya a los participantes en cada par para cambiar roles.

4. Modelo de este proceso. Tener un aprendiz de presentarles un tema de la ambivalencia y muestran cómo responder a escuchar reflexivamente 100%.

Evaluación:

• En un gran grupo, pida a los participantes a describir su experiencia como oradores y como oyentes. ¿Cómo se hizo "natural" se siente a los oradores y a los oyentes? Comparar la experiencia de los oradores con en el ejercicio 2, donde se utilizó la misma tarea. ¿Qué difícil tarea fue para los oyentes?

• Cuando un oyente tiene dificultad en la tarea, pregúntele a su pareja (orador) por su experiencia. A menudo el oyente percibe la experiencia mucho más positiva. Utilizar las experiencias de los oradores para ilustrar cómo los clientes pueden responder a escuchar reflexivamente.

• Antes de hacer la transición hacia la entrevista motivacional, puede encontrar útil para dar a los alumnos una oportunidad para una más extensa práctica, que inter-mezcla reflexiones con otras respuestas útiles. Si el tiempo es corto, este ejercicio puede ser una prioridad menor.

Práctica Estructurada Ejemplo 5: Escuchar Integrativo Reflexivo

Objetivo: Proporcionar a los alumnos práctica integración reflexiva con otras habilidades de consejería. Una cosa es enseñar a consejeros para poder generar una declaración de escuchar reflex-

ivamente aislada en comando. Lo que es otro para ayudarles a construir esta habilidad en su estilo de asesoría regular y sostener la escuchar reflexivamente en lugar de volver a caer en viejos hábitos (retenes). Este es un paso difícil y requiere enseñar a su público que es posible responder a un cliente, con eficacia y con gusto, usando casi nada salvo la escuchar reflexivamente.

Tiempo: 30 minutos.

Formato: Los alumnos se organizan en pares.

Preparación:

• Cada participante se le pide que se prepare para hablar sobre un tema determinado que se puede explorar durante al menos 15 minutos. Un ejemplo interesante: "Describe una experiencia que han tenido que crees que sería muy difícil para otra persona entender o aprender."

• El tema debe ser de suficiente complejidad y dejar 15 minutos de elaboración y exploración.

• Tener a un voluntario del público para presentarse y hablar con usted sobre un tema que él o ella está dispuesta a compartir. Algunas buenas opciones son:
  1. Algo que sientes de dos maneras.
  2. Cómo me sentí de crecer en casa.
  3. Lo que me gustaría hacer en los próximos cinco años.

• En respuesta al orador, use declaraciones de escuchar reflexivamente 100% si es posible. (La tentación es hacer preguntas).

Comentario:

Se trata de una práctica adicional que puede ser útil para experimentar cómo la habilidad de escuchar reflexivamente puede ser integrada con otras respuestas de asesoramiento (preguntas, afirmaciones, etcétera). Debe permitir un mínimo de 15 minutos por orador, que con el cambio de rol requiere de al menos 30 minutos. Recomendamos no circular entre pares durante este ejercicio, ya que interrumpe el flujo de la conversación.

Actividades:

1. Dejar que cada par decida quién hablará primero.

2. Tarea del oyente es tener escuchar reflexiva-mente y asistir al orador y tratar de entender la experiencia que describe el orador.
3. Otras clases de respuestas pueden utilizarse por el oyente pero sobre el 90% de las respu-estas deben ser declaraciones reflexivas.
4. Pida a los alumnos que no romper el rol o dis-cutir la experiencia antes de que terminen.
5. Debe permitir al menos 15 minutos antes de pedir a los socios que cambien roles.

Evaluación:

Pregunte a los alumnos para describir su experi-encia. Solicitar preguntas y reacciones que han surgido a través de este ejercicio.

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Tools for Treating Substance Use, Abuse, and Dependence Among Latino Adolescents

15

José J. Cabiya

Introduction

Evidence from the Youth Risk Behavior Surveillance Report for 2013 published by the US Centers for Disease Control and Prevention (CDC) found that Latino youths reported using more alcohol, marijuana, prescription drugs, and other illicit drugs than White and Black adolescents (Centers for Disease Control and Prevention [CDC], 2014). These results are consistent for those reported by the CDC's report on mental health surveillance among children in the United States (Centers for Disease Control and Prevention [CDC], 2013). This report demonstrated that Latinos living in the United States exhibited higher rates of alcohol use and abuse as well as abuse of illicit drugs than most other races including non-Hispanic Whites as well as a plethora of other mental health disorders (CDC, 2013). The CDC report (CDC, 2013) states that there is an urgent need for "increasing prevention and promotion activities, and supporting allocation of funding for services" (p. 146). Moreover,

Latino youths do exhibit more antisocial behavior the first generation living in the United States and especially when their parents lose their cultural ties to their country of origin (Duarte et al., 2008). These studies underscore the urgent need to develop an effective, culturally competent evidence-based therapy directed to meet the evident treatment needs of Latinos of all ages who exhibit behavior related to substance use, abuse, and dependence.

According to the National Institute of Drug Abuse (NIDA, 2003, 2014), effective programs preventing drug abuse in children and adolescents include focus on risk and protective factors, whereby risk factors lead to drug use and protective factors help the individual avoid the use of drugs. Risk factors associated with a greater probability that the youth will use drugs include poor family organization; poor parenting skills; approval by parents, peers, and the community of drug use; poor school achievement; poor social skills; and the presence of peers who abuse drugs and exhibit other socially deviant behavior. On the other hand, protective factors are those conditions that are related to low prevalence rates of drug abuse. They include positive family links, close parental checking of activities, consistent parenting, parental involvement in school activities, good school achievement, participation in outside school activities including sports and religion, and general rejection in their immediate environment to the use of drugs.

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Poor Anger Management and Aggressive Behavior Are Risk Factors for Substance Use

Poor anger management and aggressive behavior at an early age can stack over time and, without treatment, can cause a great deal of difficulty for the child and adolescent at risk, the community, and society at large. Furthermore, Barkley and Fischer (2011) found a direct relationship between socially aggressive behavior in children and the later development of delinquent behavior and drug abuse. Based on their longitudinal study of children called Fast Track, Bierman et al., (2013) and the Reid et al. (2004) concluded that early onset of conduct problems lead to "a subsequent extended and chronic pattern of antisocial behavior across a substantial period of development" (p. 650). Recently, research has confirmed that aggressive behavior and other behavioral symptoms of disruptive disorders including ADHD, ODD, and CD can lead to increased drug use in adolescence and other major impairments in adulthood (Bierman, et al. 2013; Granic & Patterson, 2006; Lahey, Loeber, Burke, & Applegate, 2005, Fothergill, and Ensminger, 2006).

Drug Abuse Prevention Strategies and Interventions with Latino Youths

Cognitive behavioral therapy (CBT) has proven to be effective for youths with drug use, abuse, and dependence behaviors (Lochman, Powell, Boxmeyer, & Jimenez-Camargo, 2011). Lochman and associates (Lochman, Wells, & Lenhart, 2008; Lochman, Powell, Boxmeyer, & Jimenez-Camargo, 2011; Lochman, Boxmeyer, et al. 2012; Lochman, Wells, Qu, & Chen, 2013; Lochman et al., 2015) proposed a socio-cognitive model for the treatment of aggressive and other disruptive behaviors which takes into consideration children's social cognition in terms of how they perceive their social environment and how they respond to the perceived problems of that

environment. The five stages of this model are discussed in the chapter of this text on anger management and aggression. Based on this model, Lochman and Wells (2002, 2004) developed the Coping Power Program (CPP). CPP is a school-based intervention delivered to moderate-to high-risk adolescents in elementary and middle schools. The theoretical model of CPP is also based on an empirical model of risk factors for potential substance abuse and addresses high-risk children's deficits in social competence, self-regulation, school bonding, and positive parental involvement. Lochman and Wells (2002, 2004) reported that the CPP with both child and parent intervention components produced lower rates of both covert delinquent behavior, substance abuse, and parent ratings of drug use at a 1-year follow-up evaluation. These prevention results were stronger than either the randomly assigned control group or the treatment group with no parent's component. The children in the dual intervention group also demonstrated improvement in teacher-rated school behaviors during the follow-up year evaluation.

Cabiya and his associates (2002, 2007) developed a 12-session intervention for Latino youths directed at improving anger management and reducing its concomitant risk for drug abuse. The intervention includes activities directed at improving anger control and reducing drug abuse. These activities have been culturally adapted to Latinos by emphasizing the Latino identity and using Spanish as the main language for its delivery. The complete treatment manual in Spanish for this intervention is provided at the end of this chapter, an example of a tool for treating substance use, abuse, and dependence in Latino youths.

In a more recent study, Cabiya and López-Córdova (2015) evaluated the effectiveness of the A-CPP culturally adapted for Latinos with Latinos in reducing both drug abuse and behaviors highly correlated with drug abuse in Latinos. The A-CPP was culturally adapted for Latinos by infusing Spanish language and Latino culture components into the program activities, particularly to the role-playing situations. The

participants were referred by their teachers for aggressive and disruptive behavior in the classroom. The therapy was administered in groups of 6 to 8 adolescents and consisted of 33 scheduled group sessions. The therapeutic intervention was conducted following the treatment manual developed by Lochman and his associates after it was translated directly into Spanish for the study. Trained doctoral students administered the therapy, and treatment fidelity was insured through several procedures including direct training and telephone conversations with the developer of the group intervention, Dr. John Lochman. The adolescents, their parents, and teachers were administered the experimental measures at pretreatment, posttreatment (33th session), and 3-month follow-up. This study used a differential treatment outcome design. Repeated measures analyses of variance were performed with each measure, with gender entered as a between-subject variable in the analyses of all measures except for the Irritability/Hostility subscale of the BSBI, which was analyzed separately for males and females. Findings indicate that the Irritability/Hostility subscale scores of the BSBI were significantly reduced in males following treatment F (1, 28) = 17.427, p = 0.001 with an effect size of 0.431 (partial eta square). The Activity/Impulsivity subscale scores of the BSBI were also significantly reduced in both males and females F (1, 28) = 14.157, p = 0.001 with an effect size of 0.336 (partial eta square). No significant reduction was found with the Distractibility/Low Motivation subscale. Also, end results show no substantial decline across time in the Activity/Impulsivity scale of the BSBI, and the gender by time interaction effect was not found to be significant. Repeated measures analyses were performed to compare the pre- and post-treatment scores on the alcohol, tobacco, and other drugs (ATOD) scales. No change in drug use was reported by the adolescents across time. However, the results demonstrate significant decrease in the levels of irritability and hostility, which are related to drug abuse throughout time. The results also show that the differences were maintained at the 3-month follow-up. Effect sizes at follow-up usually ranged from medium to large, indicating that, as a rule, adolescents assigned to treatment are much better off than at pretreatment. Cabiya and López-Córdova (2015) conclude that this study together with the study conducted by Cabiya et al. (2008) provides evidence that a manualized treatment can be successfully implemented and transported to clinical distressed Latino Puerto Rican children with high levels of comorbidity and applied in day-to-day clinical practice.

The A-CPP Parent Component

The A-CPP Parent Component adapted by Cabiya and López-Córdova (2015) for use with Latinos, based on the CPP Parent Component developed by Lochman and associates, consists of eight sessions offered to the parents during the same time frame. It focuses on supporting involvement and consistency in parenting, which also contributes to better child adjustment. Improvement in all these areas, particularly around times of change (such as going to middle school), can reduce the number of behavioral problems that arise during these transitions. The A-CPP Child Component, also based on the CPP Child Component developed by Lochman and associates, consists of 33 group sessions administered over a period of a year. Treatment sessions are held on average for 50 min, and the general content of the 33 session plan for Coping Power Program for Latinos is as followed:

- Sessions 1–2. The purpose of these sessions is that the participants get to know each other and the rules of the behaviors expected from the group members and to explain the basic principles of the reinforcement plan by which a system of points by which they will be able to exchange points for specific rewards. In these sessions, the participants will learn strategies directed at establishing effective short- and long-term goals. They will be taught how to set these goals in a practical and realistic manner.
- Sessions 3–4. These sessions are directed at teaching the participants how to improve their academic and organizational skills in school.

These sessions are also directed at developing the social skills necessary to respond effectively in social situations that provoke anger and aggression in them by providing them with specific examples of how to respond appropriately without a negative emotion.

- Sessions 5–6. The purpose of these sessions is teach and practice through role-playing prosocial behaviors specifically directed at anger management and avoidance of situations that lead to drug abuse by helping the participants to develop self-control through the teaching-specific techniques and self-statements in role-playing situations.
- Sessions 7–8. The purpose of these sessions is the development of self-control through relaxation. The deep breathing technique for relaxation will be taught.
- Sessions 9–11. The main objectives of these sessions were to further develop and reinforce all the learned skills and techniques through further role-playing, group discussions, and teaching of more advanced techniques directed

at developing more self-control and appropriate attributions.

- Sessions 12–22. To implement the problem-solving model known as PICC ("Problem Identification, Choices, and Consequences"). This model focuses in the recognition of social problems that youths have to deal with, including problems with peers, parents or family, and teachers and how to deal with these problems with problem-solving techniques.
- Session 23. The purpose of this session is to review all the concepts discussed in the past sessions.
- Sessions 24–27. Use of the video production by the youths is directed at developing skills in the management of problem-solving derived from conflicts with peers, parent, and teachers and mediating conflicts.
- Sessions 28–33. Continue practicing the PICC model with role-playing. The youths have to deal with different strategies, choices, possible solutions, and consequences of different social situations that can be present in any moment.

Manual para reducción de uso y abuso de substancias para jóvenes
Sesión 1

Selección de los participantes

Una vez sean identificados los jóvenes según los procesos escogidos para la selección de los mismos procure no tener un grupo mayor de 10 jóvenes o jóvenes. Los jóvenes que compongan el grupo deben tener de 10 a 14 años de edad. Cuente con al menos de dos (2) a cuatro (4) facilitadores para el grupo, dependiendo de la cantidad de participantes.   Si el grupo es muy demandante, violento y/o desorganizado en sus comportamientos, se necesitará ejercer más control sobre el grupo y es posible que uno o dos facilitadores necesiten ayuda en el manejo del grupo. Para facilitadores con vasta experiencia trabajando con grupos difíciles y grandes, es posible que no sean necesarios facilitadores adicionales.

Sesiones o reuniones

Reúnase con el grupo al menos una vez por semana, según lo permita las condiciones y la escuela. La duración de cada sesión o reunión debe ser aproximadamente una hora. Si decide realizar las intervenciones dos veces por semana no reduzca las horas de contacto con el grupo.

Informe a los padres o encargados, por medio de la trabajadora social, maestros, recordatorios o cartas escritas, sobre los días y horas en que sus hijos se reunirán en el grupo.

Lugar de reunión

Las terapias o reuniones deben llevarse a cabo dentro de la escuela. Solicite permiso para separar algún salón de clases o actividades de la escuela por un periodo de al menos tres horas para realizar las reuniones una o dos veces semanales. Debe ser un lugar amplio, ventilado, con buena iluminación y libre de objetos que puedan distraer demasiado la atención del grupo o que puedan resultar en "proyectiles" o amenazantes a la salud de los participantes y facilitadores.

 El realizar las reuniones dentro del escenario escolar, evita los problemas asociados a la pobre asistencia de los participantes a las reuniones (ej. transportación, tardanzas, entre otros).

Actividades "rompe hielo"

 Inicie cada sesión con el resumen de la sesión anterior para romper el hielo. Si usted estima que el tiempo de alguna sesión sobrará puede añadir alguna actividad o juego antes de comenzar la misma. Asegúrese que estas se lleven a cabo dentro del salón. También puede sacar unos minutos para conversar con los jóvenes sobre su día escolar o situaciones que los tengan muy exaltados.

Lenguaje

Puede que este manual, aunque se intentó desarrollarlo utilizando un vocabulario simple del español, no esté totalmente en un lenguaje familiar para los posibles diferentes grupos de participantes. Asegúrese modificar las instrucciones o vocabulario que se use con los participantes de modo que el grupo entienda a cabalidad lo que se le explica.

Participación de los jóvenes

Al inicio de la primera reunión se asignan tareas especiales a los participantes como la "persona reloj", la cual avisa el comienzo y el final de las reuniones, el historiador, que repasa lo hecho en la reunión anterior, el repartidor de las meriendas, entre otros. Esta asignación de tareas tiene doble intención: involucrar a los participantes dentro del grupo y asignarles alguna responsabilidad dentro del mismo. Es sumamente importante que, como facilitador, "facilite" que estas tareas se lleven a cabo por los jóvenes.

Recuerde al grupo en cada reunión sus responsabilidades, no espere que se acuerden de ellas inicialmente. Solicite cada día al grupo que lleven a cabo sus tareas dentro de la reunión y dé refuerzos por la labor realizada. **NO OLVIDE DAR SEGUIMIENTO A ESTO.**

Parafraseo

Este manual ofrece una guía estructurada y detallada de lo que consiste cada sesión del mismo. Por ningún motivo debe considerarse éste como una obra teatral o que, para hacer uso de este manual, deba el facilitador memorizar cada línea. Como antes dicho, es sólo una guía. Todo grupo participante y sus facilitadores tendrán unas necesidades particulares que requerirán posiblemente la modificación parcial de las sesiones para satisfacerlas. El desarrollar unos "parafraseo" específicos y tan detallados tienen como propósito evitar la improvisación total durante las reuniones y por consiguiente que el facilitador se aparte de la idea principal. Además puede ayudar a la estandarización del proceso para futuros estudios de efectividad.

L. *Consentimientos*

Asegúrese de que los padres o encargados, maestros (de ser necesario) y los jóvenes firmen los consentimientos para poder participar de los talleres. Estos consentimientos deben enfatizar la participación voluntaria en los mismos, asuntos de confidencialidad y lo que se pretende con la intervención.

Sesiones 2–5

Establecimiento del Programa de contingencias

Recuerde que cada programa debe ser hecho tomando en cuenta lo que puede ser o no ser reforzadores positivos para los jóvenes. Aunque todos tendrán un gusto particular, trate de llegar a un acuerdo de un reforzador común para todos. No olvide repasar las reglas y los puntos que se ganarán si respetan las mismas y llevan a cabo las actividades. Si promete dar un refuerzo a mitad del proceso, recuerde cumplir su palabra. Fallar en cumplir el acuerdo puede revertir totalmente el proceso y atentar la confianza de estos jóvenes que por sus sistemas de atribuciones y percepciones, será muy difícil revertir. **NO OLVIDE ENTREGAR LOS REFUERZOS O PREMIOS**.

Refuerce las conductas que estableció con los puntos, todo intento de participar, cooperar y el cumplimiento de las reglas, pero ignore aquellas conductas que no se desean fomentar (por supuesto si no se amenaza la salud o bienestar de los participantes en la reunión). **SI ESTOS/AS NIÑOS/AS SON DESAFIANTES, EN ESPECIAL HACIA LA AUTORIDAD, TRATARÁN DE PROBAR SUS LÍMITES DURANTE LAS REUNIONES, PREPÁRESE PARA ELLO E IGNORE SUS DESAFÍOS.**

Instrucciones a los participantes:

"Ahora bien, hemos creado estas reglas que debemos cumplir. Pero para asegurarnos de que no olvidemos de cumplirlas nosotros [facilitadores] *vamos a darles puntos por cada regla que cumplan y por realizar las actividades de cada reunión…si al cabo de ___ reuniones ustedes tienen ___ puntos se ganan un premio (p.e. si al cabo de 3 reuniones los jóvenes tienen 50 o más puntos se llevan el premio) Vamos a ver ¿qué cosas les gustaría ganarse, qué cosas les gustan a ustedes comprar o hacer?"*

Facilitador: Copie las reglas en una cartulina grande de modo que en cada reunión estén visibles para todo el grupo (Esta cartulina debe estar visible en todas las reuniones hasta el final de los talleres, de modo que los jóvenes recuerden las reglas establecidas para el grupo). En la parte de atrás de la cartulina o en otra, divida la misma en columnas (rotule todos los días de reunión esperados para el total de semanas a reunirse, por ejemplo, si se reúnen dos veces a la semana por un mes, debe haber 8 columnas, una por cada día) y en filas horizontales ponga al extremo izquierdo los nombres de cada uno de los participantes. Explíquele al grupo que en cada reunión hay que hacer una serie de actividades y que existen unas reglas a cumplir; por cada cosa que cumpla cada uno, recibirán un sellito. Al cabo de una cantidad determinada de puntos se ofrece la recompensa(usted como facilitador determina cada cuanto tiempo va a reforzar, tomando en cuenta la duración de la intervención y los recursos económicos disponibles para adquirir los refuerzos).

No olvide que para mayor efectividad los refuerzos deben ser ofrecidos consistentemente y lo más cercano posible a la manifestación de las conductas deseadas. En este caso, al cumplimiento efectivo del mínimo de tareas y reglas a cumplir. Usted llega a un acuerdo con el grupo de cuándo recibirán los refuerzos, cuál es el mínimo de puntos necesarios para recibir la recompensa y, lo más importante, qué refuerzos dar al grupo. Esto dependerá de las características del grupo y sus gustos. Algunas sugerencias, dependiendo la edad de los participantes, pueden ser, juguetes, rompecabezas, adornos para el cabello, "tokens" o fichas para jugar juegos electrónicos en centros de entretenimiento, un almuerzo o comida gratis, libretas con diseños o taquillas para el cine[1].

Cuando un participante falla en recopilar los puntos necesarios estimúlelo participar más en las reuniones, a cumplir con las reglas y provéale la alternativa de que si participa más o cumple determinadas reglas quizás pueda compensar y ganar los puntos necesarios para el premio.

NOTA: NO REGALE PUNTOS, PUEDE CREAR "RECELOS" ENTRE LOS/AS OTROS/AS PARTICIPATES. RECUERDE PREPARAR LA CARTULINA CON LOS NOMBRES DE LOS/AS PARTICIPANTES Y COLUMNAS PARA PEGAR LOS SELLITOS DE REFUERZOS PARA LA PRÓXIMA SESIÓN.

Ejercicio de Para y piensa

Reparta el Manual de Ejercicios a los jóvenes y dé las siguientes instrucciones. Esta ilustración se utiliza para trabajar el tema de solución de conflictos e introducir la técnica del "Para y Piensa". Suministre las siguientes instrucciones:

> *"Aquí en este dibujo hay un joven que le ofrecen vender una droga ilícita, pero no sabe cómo decir que no le interesa* (recuadro 2).

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[1] Muchos establecimientos cuentan con artículos de cortesía que ofrecen para dar a ciertos grupos. Explore esa posibilidad. También existen ofertas que a precios más reducidos ofrecen sus artículos si se les compra cierta cantidad de los mismos, como los cines o tiendas de helados, entre otros. Hay múltiples opciones que considerar, sólo tiene que ser creativo en sus ideas o preguntar a otros sobre sugerencias.

> *Aquí* (recuadro 3) *el joven piensa en varias alternativas. Pongan en esta burbuja lo que ustedes harían o que alternativas se les ocurre. No pongan sus nombres en el papel".*

Facilitador: Luego, se intercambian los papeles entre los jóvenes y se solicitan (o se escogen) voluntarios para leer los papeles en voz alta para el grupo. Discutir lo siguiente con el grupo:

- ❑ ¿En dónde piensan ustedes que ocurrió o que puede ocurrirles esto?
- ❑ De las soluciones leídas, ¿creen ustedes que fueron buenas maneras de lograr el objetivo o meta?, ¿Cuáles serían las consecuencias de las soluciones?

Facilitador: Modelen esta situación usando el "Para y Piensa". Prepare una cartulina con las siguientes preguntas para ilustrar el "Para y Piensa" a los jóvenes.

- ❑ ¿Cuál es el *problema*?
- ❑ ¿Qué *opciones* tengo?
- ❑ *¿Qué* voy a *hacer*?
- ❑ *¿Cómo* lo hice?

Reparta también estas preguntas a los jóvenes en un papel (Ver Manual de Ejercicios) e indíqueles que lo guarden para utilizarlo en las siguientes reuniones. Recalque las palabras ennegrecidas en la cartulina utilizando un color diferente o letras más grandes.

Modelaje 1:

> *"Imaginémonos ahora otra situación. A él o ella* [nombre facilitador, otro facilitador], *le llaman por un sobre nombre "BOCONA". Pero él/ella prefiere que le llame por su verdadero nombre. Para resolver ésto, vamos a demostrarles una manera más sencilla que les puede ayudar en ésta o cualquier otra situación parecida. A esta forma nosotros le llamamos "Para y Piensa" (Ver Manual de Ejercicios). Bien, ella/él* (Facilitador) *me dice bocona. Antes de salirle de atrás pa' alante yo me PARO y PIENSO*

Para y Piensa

	Definir	Pregunta	Preguntas para el grupo	Posibles respuestas
*	Definir el problema	*¿Cuál es el problema?*	*¿Cuál es el problema?*	*Me llamó Bocona:* ❑ *No permitir que me llame bocona* ❑ *Dejarlo pasar*
*	Acercamiento al problema	*Pienso en cuáles son mis alternativas, ¿Qué puedo hacer? ¿Qué opciones tengo?*	*¿Qué opciones tienen ustedes?*	✓ *Darle un golpe* ✓ *Gritarle* ✓ *Pedirle que no me llame así* ✓ *Quejarme con mi mamá o maestro*

*	Concentrar y focalizar en el asunto/ escoger alternativa	*Debo pensar bien lo que voy a hacer ahora y lo que estoy haciendo. Decido lo que voy a hacer. ¿Qué voy a hacer?*	*¿Qué pueden hacer?, ¿Qué sugerencias tienen?* [Escuche sus alternativas, refuerce las adecuadas]	*Me decidí, voy a hablar con él/ella y a decirle que no me gusta cómo se oye cuando me llama así": Oye, no me gusta cómo suena eso cada vez que me llamas. Por favor, no me llames así, porque no escoges otro nombre más bonito ya que me parece que no te gusta llamar a la gente por su nombre".*
*	Autorefuerzo	*Ahora pienso que no me salió tan mal ¿Cómo lo hice?*	*¿Cómo lo hicieron? ¿Cómo salió?*	*Lo hice, se lo dije. ¡Qué bien, bravo por mí!*
*	Manejo de situación.	*¿Y qué pasa, sí él/ella* (otro facilitador) *no me responde como yo quiero o se sintió insultado?*	*¿Qué creen qué es lo más importante?*	*Al menos lo intenté, no funcionó ahora, lo intentaré después. "Trataré de pensar mejor en otra forma de decirle que no me llame así."*

Modelaje 2: (Opcional si el tiempo lo permite)

> *"Pongamos esto en práctica. Él* (facilitador) *es mi amigo y se la pasa burlándose de mí porque no fumo marihuana. Yo quiero que deje de hacerlo porque no me gusta que insista y no me interesa la marihuana".*

Repase el "Para y Piensa":

* Ver problema
* Ver posibles alternativas de resolver el problema
* Concentrarse en lo que se está haciendo
* Decidir qué hacer y hacerlo
* Auto-refuerzo
* Manejo de las situaciones en caso de que no salga como esperado

O. ***Juego de papeles***

Facilitador: Introduzca la siguiente situación:

> *"Esta es la situación: Yo estoy haciendo una asignación con este compañero y cometo un error. Mi compañero me dice bruto.*
>
> Facilitador 1: *Mira pa' ya, lo dañaste. ¡Qué bruto eres!*
> Facilitador 2: *¿Por qué me dices así? Me haces sentir   mal.*
> Facilitador 1: *Bueno, pero es que lo hiciste todo mal.*
> Facilitador 2: *Un error lo comete cualquiera y eso no es excusa para hacerme sentir mal. Por favor, no me digas más que soy bruto por sólo cometer un error.*
> Facilitador 1: *Disculpa, no era mi intención herirte.*
>   *Tienes razón, todos cometemos errores.*

Es importante que veamos qué sucedió en esta situación y como se resolvió:

Primero: <u>El lenguaje no verbal</u>- esto significa que los gestos (o muecas) que la gente hace te dan a entender cómo se sienten, más allá de las palabras. Por ejemplo; al él/ella decirme bruto, si lo hubiera dicho calmado o sonriendo, se podía interpretar como broma. Pero al hacer gestos de estar furioso o molesto da a entender cuán fuerte era su emoción. Esto es bien importante cuando queremos expresar nuestras emociones. A veces no es lo que se dice lo que está mal, sino la manera (los gestos o muecas que se usan) al hablar. Si queremos decir lo que pensamos sin ofender o causar malas interpretaciones, tenemos que aprender a aguantar o regular nuestras expresiones faciales (de la cara) y del cuerpo, por ejemplo; hablar "manoteando" ó cerrar los puños o enseñar el dedo malo.

Segundo: Vieron cómo la otra persona expresó, de forma directa y clara cómo se sintió al ser llamado bruto. Lo de la técnica de "Para y Piensa" que hemos aprendido puede utilizarse en ésta situación. Al ser llamado bruto, la otra persona tuvo que PARAR y PENSAR en lo que estaba sucediendo, qué se suponía que hiciera, cuáles eran sus opciones, concentrarse, decidir qué hacer y expresar sus sentimientos. ¿Qué logró con la persona al expresar sus sentimientos?" (Se le pregunta al grupo).

Respuestas esperadas o para exponer al grupo:

- ❑ Decir lo que pensaba
- ❑ Tratar de prevenir (evitar) que le vuelva a suceder

Luego de terminado el ejercicio se repartirá y discutirá con los jóvenes un material sobre drogas.

Sesión 6–7

Orientación sobre drogas
Se ofrecerá la orientación sobre drogas (al final de esta sección). Luego se realizará el siguiente juego de papel:

"Veamos esta situación"

"Ustedes están jugando con sus amigos cerca de su casa y viene un muchacho que los llama y les ofrece drogas". Le dice "mira prueba este cigarrillito de marihuana, te va a gustar mucho". Si estuvieras en esa situación ¿qué tu harías?

*	Ver problema	Un muchacho te ofrece marihuana.

*	Ver alternativas u opciones	Ej.✓ informar a padres o maestros lo ocurrido
		  ✓ aceptar probar la marihuana
		  ✓ decirle que **NO** te interesa probar la droga

*	Concentrarse	Pensar en la situación actual y no actuar a la ligera.
*	Decir y actuar	Escoger alternativa; p.e. decirle que a ti no te
		interesan las drogas ya que eso no trae nada bueno
*	Refuerzo	¿Cómo te sentiste al decirlo?

Sesión 8–10

Modelaje de situación de resolución de conflictos

Facilitador: Introduzca el tema al grupo. Recuerde la cartulina del "Para y Piensa "y las preguntas del Manual de Ejercicios.

> *"Todos en nuestras vidas nos hemos encontrado con situaciones de conflicto. Esto es cuando las personas no nos ponemos de acuerdo. Por ejemplo, cuando tu primo está de visita en tú casa y quiere ver televisión y tú quieres ver un canal o programa diferente al que él está viendo. Como no saben llegar a un acuerdo se enojan y se dejan de hablar y tu primo se va de tu casa. Lo mejor hubiera sido tratar de llegar a un acuerdo entre ustedes. Esto puede ser muy difícil de resolver a veces, pero se puede lograr si aprendemos a "negociar". Es como cuando intercambiamos sellos o estampas que coleccionamos con otros amiguitos, así hay que tratar de hacer en esas situaciones de conflicto entre personas. Si no hablamos y nos quedamos molestos con los demás, cuando tenemos un desacuerdo, se puede poner peor y la otra persona nos va a responder con ira. Aprender a negociar significa que tenemos que pensar en alternativas o sugerencias que nos beneficien a todos. Otro ejemplo cuando tus amigos quieres que fumes marihuana y bebas alcohol cuando vas a una fiesta y debes negociar con ellos que no es necesario fumar marihuana ni beber alcohol para pasar un buen rato en la fiesta. Para eso tenemos que recordar lo siguiente:*

> * *"PARAR Y PENSAR"*
> * *Permanecer calmados, nunca tratemos de negociar si estamos demasiado molestos pues no llegaremos a nada y podemos hacer las cosas peor. Es mejor dejar pasar unos minutos y regresar a negociar cuando los "ánimos" estén más calmados.*
> * *Pensar las alternativas y sugerírselas a la otra persona*
> * *Tratar de ver los pro y contra de cada sugerencia*
> * *Llegar a una decisión que beneficie a todos de manera positiva*
> * *Felicitarnos por lo bien que lo hicimos*

Juego de papeles de situación de resolución de conflictos (Duración aproximada: 5 minutos)
    Facilitador: Llame a dos o tres voluntarios e introduzca lo siguiente:

> ***"Ahora vamos a practicar esto. Supongamos que ustedes están jugando pelota. Se forma una discusión porque uno de los jóvenes dice que deben dejar el juego y probar una marihuana que él obtuvo y les dice que son unos cobardes lo que no quieran probarla. ¿Cómo resolverían el conflicto?***

   Facilitador: Exhorte a los jóvenes a resolver el conflicto, destacando o guiándoles (si no lo hacen espontáneamente) a seguir los pasos de "Para y Piensa" y discutidos en el ejemplo anterior. Utilice la cartulina del "Para y Piensa" y las preguntas del Manual de Ejercicios.

Actividad figuras de autoridad (Durante aproximado: 10 minutos)
    Pregunte al grupo lo siguiente:
- ❑   ¿Cómo se siente tener un líder?
- ❑   ¿Cómo se sintió el líder estando a cargo del grupo?
- ❑   ¿Qué representa ser una figura de autoridad?
- ❑   ¿Cómo se sintieron los que formaron parte del grupo con el líder?

    Fomente la discusión en grupo y utilice ejemplos del ensayo de actividad de cierre para la discusión. Estimule a los jóvenes a usar "Para y Piensa" para discutir situaciones que se hayan dado mientras preparaban la actividad (Haga referencia a la cartulina del "Para y Piensa" y a las preguntas del Manual de Ejercicios).

Sesión 9–12

Practica de Ejercicios de Para, Respira y Piensa

Practique con los jóvenes la técnica de relajación del "Para, Respira y Piensa". Explique que esta técnica les ayudará a que se sientan más tranquilos en momentos de tensión o cuando estén muy enojados. Practique con los jóvenes el respirar profundamente por la nariz y exhalar el aire por la boca por tres ocasiones. Sirva usted de modelo y permita que los jóvenes practiquen.

Facilitador: Ahora haremos un ejercicio que nos ayudará a aplicar mejor la técnica de "Para y Piensa".   El facilitador debe hacer un ejercicio donde extiende los brazos y le pide al grupo que, cuando suene los dedos de una mano, estos deben mirar la mano contraria. Por ejemplo, si se suenan los dedos de la mano derecha los jóvenes deben mirar la mano izquierda. Haga este ejercicio por unos segundos y luego pregunte al grupo que observaron al hacer el ejercicio. Por lo general, las personas aguantan o detienen la respiración al hacer este ejercicio porque se encuentran en una situación que provoca tensión. Pregunte a los jóvenes si esto fue así y enseñe la técnica de "Para, Respira y Piensa".

Explique a los jóvenes que esta es una técnica que sirve para que nos relajemos cuando estamos en tensión, cuando tenemos ira o cuando vamos a actuar sin pensar. Practique con los jóvenes el respirar profundamente por la nariz y exhalar el aire por la boca por tres ocasiones. Sirva usted de modelo y permita que los jóvenes practiquen.

Utilizar el ejercicio de respiración controlada discutido en el capítulo anterior donde el facilitador ofrece estas direcciones:

"Te voy a pedir que te relajes. En unos minutos, voy a decir unas cosas que espero que te ayuden a crear una imagen en tu mente. También te voy a pedir que relajes diferentes partes de tu cuerpo.

Aprender a relajarse te ayudará a manejar sentimientos de coraje, tristeza, y miedo. Ponte en una posición cómoda en tu silla, sin tocar a otras personas, y respira profundamente varias veces. Cierra los ojos y relájate. Sacúdete un poco y ponte cómodo. Vuelve a respirar profundamente varias veces. Inhala y exhala. Inhala y exhala. Eso es, te estás sintiendo en paz. Si estuvieras molesto, puedes imaginarte a ti mismo moviéndote de caliente a frío en el termómetro. Te sientes más y más relajado, frío, pacífico. Ahora, con los ojos cerrados, pretende que estás en una nube blanca, alto en el cielo, en un día hermoso.
 Estás flotando pacíficamente en una nube mullida y blanca...Moviéndote bien suavemente. Estás tan liviano como una hoja. La nube mullida te aguanta con seguridad, flotando por el cielo. Ahora, mientras cuento del 1 al 3, imagina que estás sumergiéndote cada vez más profundo en la nube, hasta que la nube está a todo tu alrededor. 1...2...3 estás disfrutando la vuelta en la nube. Ahora, siente tus pies y los dedos de tus pies...siente lo relajado que están. Siente tus piernas.
Todos los músculos en tus piernas están livianos y relajados en la nube...siente tus brazos...siente tu cuello...siente tu cabeza...ahora estás totalmente relajado...flotando en la nube mullida...Recuerda que puedes volver a tu nube siempre que sientas que necesites calmarte y relajarte...En cualquier momento que necesites moverte de caliente a frío en el termómetro...Ahora, nos estamos preparando para parar nuestra vuelta en la nube. Pararemos cuando yo cuente hasta tres...1...2...3...Abre los ojos y estírate un poco.

Ejercicios de Autoestima y de Identidad Latina

 En cada sesión se trabajará con el desarrollo de una mejor autoestima e identidad con la cultura Puertorriqueña/Latina, proveyendo a los jóvenes con refuerzos sociales cada vez que finalicen una tarea donde expresan aspectos positivos de su autoestima e identidad. Expresiones como: *¡Bien hecho!* o *¡Buen trabajo!*, *¡Puedo hacerlo sin la ayuda de una droga!, ¡Puedo pasarla bien sin estar high!,* deben fomentarse entre los participantes. Evite expresiones como *¡Trata más duro la próxima vez! o ¡Pon más esfuerzo en lo que haces!* Seguramente estos jóvenes escuchan constantemente estas expresiones por parte de familiares y maestros.

Además, es posible que estos jóvenes ya hayan tratado lo más que podían y por sus dificultades cognitivas como sociales no logran hacer las actividades efectivamente. En estas sesiones se estarán continuando con ejercicios dirigidos a reforzar la autoestima y la identificación con la identidad como Latino.

Orientación sobre Drogas

Hay diferentes tipos de drogas, las recetadas y no-recetadas (legales) y las ilegales. Las recetadas se utilizan cuando una persona se encuentra enferma. Ejemplos de estas drogas lo son, Valium, Ritalín, Tylenol con Codeína, entre otros. Estas drogas son usadas para calmar el dolor o aliviar las enfermedades, pero si se hace abuso de ellas pueden causar molestias y problemas. Existen drogas no-recetadas (over-the-counter) que se pueden comprar sin recetas. Ejemplos de estas son medicinas para el catarro, pastillas de dieta, medicinas para músculos y el dolor de cabeza, entre otros.

Las drogas ilegales son aquellas que su uso no está permitido en el país. Ejemplos de estas drogas lo son:

Marihuana

La marihuana es la droga ilegal que más se utiliza en los Estados Unidos y es la que muchos jóvenes usan por primera vez para experimentar.

➢ Lenguaje callejero:
Blunt, Ganja, Pasto, Reefer, Gallito, Cucaracha, Mary Jane

➢ Apariencia: La marihuana tiene un color verde o marrón. Es como una hoja o pasto, estilo tabaco. Proviene de una planta llamada: "Cannabis Sativa", que crece dentro o fuera de los Estados Unidos. La marihuana contiene muchos químicos, uno de los más potentes es el THC. Mientras más alto es el contenido de THC, más fuerte y peligroso es el efecto de esta. La marihuana se puede fumar, tanto como masticar o comerse. Los efectos al fumarla se pueden sentir en par de minutos y puede durar de 3 a 4 horas.

➢ Efectos físicos y mentales:
Pérdida de memoria, dificultad para concentrarse, aumento en los latidos del corazón, paranoia, alucinaciones, debilita el sistema inmune, interfiere con las actividades diarias, comportamiento irresponsable, dificultad en el aprendizaje, pérdida de motivación mental o física.

Cocaína/Crack

La cocaína es un estimulante que supuestamente da energía y poder. Cuando se va el efecto, el usuario casi siempre se deprime y el cuerpo pide más. La cocaína es color blanco. Es mezclada con talco, polvo, "baking soda", azúcar o harina para hacer la droga menos pura y menos fuerte. Este proceso se conoce como cortar la droga.

La cocaína se puede inyectar, fumar o inhalar. Personas que comparten las agujas tienen más probabilidades de contraer el virus del VIH (SIDA). Los usuarios se inyectan o la fuman para que el efecto llegue más rápido al cerebro, arriesgándose a una sobredosis. La cocaína proviene en su mayoría de Sudamérica. Crece en una planta que se cultiva en Bolivia, Perú y Colombia. La hoja contiene 2% de cocaína y se extrae de un proceso químico. La cocaína pura es bien difícil de conseguir en las calles, ya que es bien costosa.

➢ Lenguaje callejero:
Coca, nieve, perico, Crack. Polvo. "Diablito": La mezcla de la marihuana con la cocaína se conoce como "diablito" alcohol con cocaína para que el efecto dure más.

➢ Efectos físicos y mentales:
Enojo, ansiedad, comportamiento violento, confusión, síntomas parecidos a la esquizofrenia, paranoia, alucinaciones, pérdida de peso, insomnio, aumenta el pulso y latidos del corazón, daño permanente al cerebro, derrame cerebral, convulsiones, alta presión, dolor en el pecho, SIDA, hepatitis, daño nasal a tejidos y "septum" (paredes de la nariz), hemorragia nasal, ataques y hasta la muerte.

Heroína

La heroína es una de las drogas más letales u adictivas que existen en el mercado. Este se ha convertido en el nuevo narcótico de preferencia del joven puertorriqueño que la consume fumándola. Los jóvenes están consumiendo la droga porque es menos costosa que la cocaína. La heroína no solamente se puede fumar, sino también inhalar o inyectar. Muchos jóvenes piensan que si fuman esta droga en vez de inhalarla o inyectarse no se van a volver adictos. Esto no es cierto. La heroína se produce de la morfina, que proviene de una planta que se llama "Opium Puppy". Se produce en laboratorios clandestinos, la mayoría proviene de Suramérica, Asia y Méjico.

➢ Efectos físicos y mentales:

Adicción, mal humor, felicidad o depresión extrema, difícil de dejar la adición, HIV/SIDA, hepatitis, nausea, vómitos, sueño, dificultad de respirar y hasta la muerte. El adicto a heroína puede comenzar a llevar una vida no agradable de vivir en callejones, inyectándose en hospitalillos con ratas y sabandijas, compartiendo agujas infectadas que causan enfermedades, pasando hambre y sueño, poco placer sexual, puedes robar y hasta matar para mantener el vicio.

Inhalantes

Magic markers, pintura de spray, pinturas para uñas, gas propano, pega, contact cement, liquid paper y otros. Estos productos le quitan el oxígeno al cerebro. Los mismos se pueden comprar en cualquier tienda o hasta hay de ellos en tu mismo hogar. Estos se hacen en fábricas.

➢ Efectos mentales y/o físicos:

Muerte súbita (de repente), comportamiento violento, pérdida de memoria, alucinaciones, nausea, dolor de cabeza, músculos débiles, hemorragia nasal, problemas con el hígado, páncreas y pulmones, daños al cerebro, hiperactividad y hepatitis.

Éxtasis

El éxtasis es una droga estimulante y alucinógena. Es una píldora que puede tener diferentes colores y formas. En la calle se conoce como Adam, droga del amor, etc.

➢ Efectos físicos y mentales:

Puede producir tensión muscular, nausea, visión borrosa, movimiento rápido de los ojos, elevación de la temperatura del cuerpo y elevación del ritmo cardiaco. Afecta la conciencia, produce confusión, ansiedad, pérdida de memoria, aún varias semanas después. El éxtasis mata las células del cerebro que necesitamos para el funcionamiento diario, causando daño cerebral y dificultades en el aprendizaje.

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Tools for Treating Anger, Aggression, and Disruptive Behavior Among Latino Adolescents

José J. Cabiya

Preliminary Studies with Aggression and Anger Management in Children and Adolescents

Aggressive behavior with early onset in childhood can lead to stable behavior patterns and serves as a predictor for substance use, delinquency, and other negative outcomes in adolescence and adulthood (Barkley & Fisher, 2011; Lochman et al., 2011, 2012, 2014, 2015). Thus, aggressive behavior serves as a high risk factor at an early age and if not properly treated can lead to great deal of difficulty for the individual, his/ her community, and society at large. The magnitude of the aforementioned concerns is further amplified when we consider that externalizing disorders among children are the disorders most frequently diagnosed disorders in community-based clinics (Kazdin & Weisz, 2010). Indeed several studies have documented the complexity of aggressive behaviors and the comorbidity across disruptive disorders among Latino children and adolescents.

In a preliminary study, Cabiya et al. (2001) examined the behavioral and cognitive factors that characterize impulsive and aggressive adolescents. Three groups were compared, namely, a group of aggressive adolescents, a group of adolescents with symptomatology of disruptive disorders who did not show aggressive behavior, and a normal control group. The group of adolescents with symptomatology of disruptive disorders who exhibited aggressive behavior included 28 children (22 boys and 6 girls) referred by their teachers and parents as impulsive and aggressive behavior. The second group included 28 children (26 boys and 2 girls) between the ages of 8–14 referred for symptomatology of disruptive disorders without aggressive behavior. The normal group included 34 children (16 boys and 18 girls) between the ages of 9 and 15 whose diagnoses did not fulfill the criteria for disruptive disorders. The Children's Depression Inventory (CDI), the Pier-Harris Self-Concept Scale, and the Youth Self-Report (YSR) were administered to all participants. The Bauermeister School Behavior Inventory (BSBI: Bauermeister, 1994) was administered to their teachers, and the Conners' Abbreviated Symptom Questionnaire for Parents was administered to their parents. A multivariate analysis of variance was performed to obtain mean scores of the total sample on all scales. The analyses revealed significant differences between the normal and the aggressive adolescents with symptomatology of disruptive

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disorders (p < .003) for the Conners' Abbreviated Symptom Questionnaire for Parents, BSBI Irritability-Hostility Scale, the Impulsiveness Scale, Distraction-Motivation Scale, and the Insufficient Control Scale. Additional differences were found between the Impulsive-Aggressive group and the normal group (p < .003) for the Irritability-Hostility and Depression Scales of the BSBI.

In a related study, Manzano-Mojica, Cabiya, Sayers, and Padilla (2005) examined the behavioral and cognitive factors associated with the diagnosis of ADHD in children who exhibited problems with anger management and aggressive behavior. Our aim was to assess the inattentive, impulsive, and hyperactive behaviors and predict aggressive behavior in ADHD children that according to many authors lead to several social problems like juvenile delinquency and drug abuse (Lochman et al., 2004; Shelton et al., 1998). One hundred seventy six students (127 males and 49 females) from 12 public elementary schools in San Juan area of Puerto Rico participated in this study. The participants classified into a group of ADHD children with aggressive behavior, a group of ADHD children without aggressive behavior, and a normal group without any diagnoses. Trained doctoral clinical psychology students using the DSM-IV criteria and established criteria for aggressive behavior diagnosed the children as ADHD-combined type with aggressive behavior. Several self-report measures were also administered to the participants and to the teachers. Our results indicated that the best predictor of aggressive behavior was hyperactivity and impulsiveness for both males and females with ADHD. Depressive symptomatology in both males and females was also a significant predictor of aggressive behavior in ADHD children. The best grouping ADHD variables to classify children as aggressive or nonaggressive were both activity/impulsivity and depression for both males and females. However, it is noteworthy that we found gender differences between ADHD children in the level of impairment as measured by a scale of social problems.

To further explore the comorbidity of disruptive disorders, Cabiya et al. (2007) evaluated and

diagnosed 620 children (436 boys and 184 girls), ages 9–13 (M = 10.10, S.D. = 7.1) referred by teachers for aggressive and other disruptive behaviors. Two hundred eight children (164 boys, 44 girls) were diagnosed with ADHD, 255 (178 boys, 77 girls) with ODD and CD, 120 (79 boys, 41 girls) with other nondisruptive disorder, and other 37 (15 boys, 22 girls) children referred for aggressive and other disruptive behaviors but were not diagnosed. The main finding of this study was that Puerto Rican ADHD children scored higher than other groups in depressive symptomatology, which is consistent with Treuting and Hinshaw (2001) finding a high comorbidity between ADHD and depressed symptomatology in White children. Thus, there appears to be a consistency across cultural boundaries in terms of the comorbidity of ADHD with depressed symptomatology. The finding that there is a correlation between depressive symptomatology and aggressive behavior also suggests that there is a high comorbidity in Puerto Rican children between ADHD and other disruptive behaviors including aggression and depression similar to the findings among North American children in general (Barkley, 1998). The studies described above illustrate the complexity of aggressive behaviors and the comorbidity across disruptive disorders among Latino children and adolescents. Fortunately there is a research that supports effective means of treating aggression; unfortunately this research is limited to mostly Euro-American samples. This literature is discussed below, and treatment recommendations for how these interventions can be applied with Latinos are discussed.

CBT as a Mechanism for Anger Management and Aggression with Non-Latino Children and Adolescents

Cognitive behavioral therapy (CBT) has proven to be effective for youths with aggressive behaviors (Lochman, et al., 2011). Lochman and associates (Lochman & Wells, 2004) proposed a CBT treatment approach of aggressive and other

disruptive behaviors based on children's social cognitions of their perceptions social milieu and their responses to the perceived threats from that social milieu. The five stages of the model include (a) encoding social cues, (b) making accurate interpretations and attributions about a social event, (c) generating a variety of adaptive solutions to the perceived problem, (d) deciding which of these solutions to enact based on the strategy consequences, and (e) skillfully enacting the chosen strategy. Based on this model, Lochman and his associates (2001) developed the Anger Coping Program (ACP). ACP is a school-based intervention delivered to moderate- to high-risk adolescents in elementary and middle schools with high rates of aggressive behavior and poor anger management problems (Lochman, 2001). The theoretical model of ACP is also based on an empirical model of risk factors for potential substance abuse as will be discussed in the chapter on Tools for treating substance abuse and addresses individual type of risks for drug abuse such as deficits in social competence and self-regulation as well as social type of risks such as school bonding and good parental involvement. The ACP, which has both a child and parent intervention component, is designed in an integrated manner to help children with the transition to middle school in multiple ways, such as teaching anger management, reviewing nonaggressive ways to interact with others, and practicing skills to resist peer pressure. The ACP also addresses some of the processes known to contribute to better adjustment and to prevent latter behavioral problems.

Jarrett, Siddiqui, Lochman, and Qu (2014) examined how a set of child-related risk factors with particular emphasis on symptoms of anxiety and depressive mood were related to the report of parents and teachers of externalizing problematic behaviors after the implementation of version of Coping Power (CP) without the emphasis in anger management with children at risk for externalizing problems. Participants included 112 preadolescent children (ages 9–12). Results indicated that a greater report by children of depressive mood symptoms (as reported by parent or teacher) was associated with a larger reduc-

tion in externalizing behavior problems based on parent or teacher report. This effect was found in the reports of parents and teachers and held after controlling for a number of child-oriented baseline variables including baseline aggression. The authors proposed that future research studies should examine whether co-occurring symptoms of depression relate to enhanced changes in externalizing problems as the result of interventions with these types of problems.

More recently, Lochman et al. (2015) reported a study directed at testing the differential effects of group versus individual CP with aggressive children. Three hundred sixty fourth-grade children were randomly assigned group CP or individual CP. Longitudinal assessments of reports by teachers and parents of the children's behavior were collected before the intervention and in a 1-year follow-up. The results revealed that teachers and parents reported less externalizing behavior problems and internalizing behavior problems in children in both conditions by the end of the 1-year follow-up. Moreover, the level of improvement in measures reported by the teachers was significantly greater for children receiving an individual version of the program. In addition, the authors found that the level of inhibitory control of the children did serve to moderate the intervention effects (Lochman et al., 2015). Specifically, Lochman et al. found evidence showing that children in the group condition that scored initially low in inhibitory control did respond poorly in the measures completed by the teachers compared to those that received individual interventions. These results suggest that CP can have significant effects on the comorbid internalizing problems among children with a history of aggressive behavior in school settings.

Coping Power with Latino Children and Adolescents

One of the original studies conducted by Cabiya and associates was directed at evaluating the effectiveness of the cognitive treatment directed at reducing disruptive and aggressive behavior

in children in Puerto Rico. The therapeutic intervention was based on a social/cognitive model based on Lochman's ACP and culturally adapted to Latinos by Cabiya and associates (2002) called Adapted Anger Coping Program (A-ACP). This cultural adaptation as will be discussed in more detail when the sessions are discussed consists of infusing the program activities including the role playing with Latino culturally sensitive situations. One hundred ninety nine children (144 boys and 55 girls) participated in the project. Forty children were diagnosed with attention deficit hyperactivity disorder (ADHD), 23 with oppositional defiant disorder/conduct disorder (ODD/CD), 52 with ADHD-ODD, 29 with ADHD-CD, and 55 with other types of diagnoses not mentioned above. The Children's Depression Inventory (CDI), the Piers Harris Self-Concept Scale (PHSCS), and the Youth Self-Report (YSR) were administered to the participants as a pre- and posttest measure of their conduct. The Bauermeister School Behavior Inventory (BSBI) was completed by the teachers as an additional measure. Children then were divided into groups and received 12 sessions of cognitive behavioral therapy. The results show that the social-cognitive treatment was effective with all groups of children, regardless of diagnostic classification, in reducing somatic complains, anxiety/depression, social problems, attention problems, and aggressive behavior.

In a more recent study, Cabiya and Sayers et al. (2008) evaluated the effectiveness of A-ACP in reducing aggressive behavior and anger control in Latino children. One hundred sixty seven children, ages 9–14 (M = 10.83, S.D. =1.6) participated in the project. Forty-one children (35 boys, 6 girls) were diagnosed with ADHD, 61 (43 boys, 18 girls) with ODD, and 65 (46 boys, 19 girls) with no diagnoses. The pre and post intervention mean scores for the two diagnostic groups and the normal group were compared for each scale administered to the children and their teachers. Repeated measures analyses of variance were performed for each measure with diagnostic

groups as the between subjects variable and the time of evaluation (pre and post treatment) as the within subject variable. The results of these analyses showed significant differences within subjects between the pre and post treatment in the scales of somatic complaints, anxiety, depression, social problems, attention problems, and aggressive behavior. Significant differences were found between the two diagnostic groups and the normal group, but no interaction effect between diagnostic group and time of evaluation was found to be significant. Cabiya et al. (2008) conclude that this study together with the study conducted by Cabiya and Lopez (2015) provide evidence that a manualized treatment can be successfully implemented and transported to clinical distressed Latino Puerto Rican children with high levels of comorbidity, and applied in day-to-day clinical practice.

Sample Session Plan of the Revised Anger Coping Program for Latinos

As mentioned above, the Adapted Anger Coping Program (A-ACP) was developed by Cabiya and associates (Cabiya et al., 2008) based on the ACP developed by Lochman and associates, and it consists of 12 group sessions administered either individually or in group manner. A description of each session is provided at the end of the chapter as a tool for treating Latino youths with anger management problems and who exhibit aggressive behavior. Treatment sessions are held on average for 50 min, and the general content of the 12-session plan for ACP for Latinos is as followed:

Sessions 1–2. The "stop and think" technique for the resolution of conflict will be introduced in these sessions. In this technique, the participants are presented a series of culturally relevant role-playing situations, where they teach them to (a) "stop" and define the problem, (b) "think" about possible alternatives to solve the identified problem, and (c) coordinate and select alternative appropriate behaviors for the

situation. In addition, the participating children are taught how to establish a program of reinforcements, where they themselves decided the appropriate behaviors which would be reinforced in the group or at home and the reinforcements.

Sessions 3–5. The objectives of these sessions were to teach the following techniques and basic skills: (a) relaxation training, (b) anger management training, (c) resolution of conflict, and (d) self-regulation and self-control. The activities included role-playing of specific culturally sensitive situations of their own experiences presented in a series of role-playing situations.

Session 6–8. The objectives of these sessions were to teach skills directed at (a) properly interpreting social signals, (b) making interpretations and attributions that are socially acceptable on social events, (c) generating socially acceptable solutions to problematic situations, (d) deciding which of these solutions carry out based on possible consequences of each alternative, and (e) demonstrating behavior appropriate in a series of culturally sensitive role-playing situations.

Session 9–12. The main objective of these sessions were to develop and strengthen even more all the skills and techniques learned in the workshops, through the role playing, group discussions, and the techniques aimed at the strengthening self-control and appropriate anger management skills.

Sesión 1
Estableciendo la estructura del grupo y el procedimiento para el establecimiento de metas conductuales

Metas principales:
- Discutir el propósito y la estructura del grupo
- Empezar a desarrollar la cohesión de grupo
- Comenzar la discusión del establecimiento de metas conductuales

Presentación:
En esta sesión se presentan a los facilitadores y asistentes del grupo a los miembros del mismo y se provee un vistazo de cuáles son las expectativas de los niños/adolescentes en cuanto a la experiencia que van a obtener durante el año
(Ej. Hablar del propósito general del grupo, proveer detalles sobre la duración y la frecuencia de las reuniones y las expectativas, etc.).

Generando las reglas del grupo:
- Cero contacto físico (no pelear ni jugar de manos)
- No utilizar sobrenombres
- No jurar, maldecir o hablar malo
- Llegar a tiempo
- Tener una actitud positiva
- No interrumpir a los compañeros
- Mantener confidencialidad (excepto en los casos pertinentes a la profesión)
- Seguir instrucciones
- Esperar turnos

Establecer Sistema de puntos:
- Los miembros del grupo pueden ganar **un punto (1)** por:
  - Seguir instrucciones
  - Participación positiva, etc.
- Los miembros del grupo pueden ganar **dos puntos (2)** por:
  - Completar las tareas asignadas
- Los miembros del grupo pueden ganar **cinco puntos (5)** por:
  - Cumplir su meta semanal.

Establecer Sistema de Tres "Strike":
- Este sistema debe ser utilizado para lidiar con problemas de conducta mostrados durante las reuniones o, si fuese apropiado, fuera de las reuniones (Ej. Romper la regla de confidencialidad).
- A los miembros del grupo se le dan tres oportunidades/advertencias antes de perder un punto por no seguir las reglas:
- Romper las reglas una vez "strike" uno; rompe las reglas por segunda vez – "strike" dos; rompe las reglas por tercera vez - "strike" tres y pierde un punto.
- El/la facilitador/a del grupo debe poner un cartel que describa el sistema de puntos y "strike".

Participación Positiva:
- Se pregunta a los niños/adolescentes: **"¿Qué ustedes piensan que significa participación positiva?"**
- Se elabora una definición que indique que conductas tales como responder de forma significativa a las preguntas de los facilitadores u otros compañeros, trayendo puntos

importantes relacionados a la discusión e involucrándose en actividades son ejemplos de participación positiva.

Rompiendo hielo/cohesión de grupo:

Se realiza una actividad por medio de un juego o dinámica para fomentar la cohesión de grupo y la integración.

- Pasa la Bola: Haga que los miembros del grupo se tiren una bola los unos a los otros. Pídale que identifique a la persona (por su nombre) que le tiró la bola, que identifique una cosa que tienen en común e identifiquen que es diferente de ambos.
- Tarea del Nombre del Grupo: Haga que los miembros del grupo decidan un nombre para su grupo (Ej. Utilizar la primera letra de su nombre para formar una palabra). Haga que los miembros del grupo generen varias alternativas de nombres y que voten por el más que les guste.

Establecimiento de metas:

Se comienza la discusión inicial relacionada al establecimiento de metas: **"¿Qué son metas? ¿Por qué nos proponemos metas?"**. Los facilitadores deben indicar que nos proponemos metas con el propósito de mejorar algo en nosotros o para tener una mejor idea sobre que nos gustaría lograr en el futuro.

HOJA 1.3

HOJA DE METAS

Para: _____   **Semana:** _____/_____/_____

Meta:_____

_____

- **Lunes**   S N _____
- **Martes**   S N _____
- **Miércoles**   S N _____
- **Jueves**   S N _____
- **Viernes**   S N _____

(Los estudiantes reciben 1 punto cada día que cumplen su meta)

Maestra/o: Por favor firme en la línea provista e indique si se cumplió la meta o no circulando *S* para Si o *N* para No. Si el niño/adolescente no cumple la meta, por favor explique brevemente el porqué. Gracias.

Yo, _____, escogí la meta de arriba y soy responsable por hacer lo más que pueda para cumplirla. También le daré la hoja a el/la maestro/a diariamente para que la firme.

Sesión 2

Estableciendo metas personales a corto y largo plazo

Metas principales:
- Ilustrar las diferencias entre metas a corto y a largo plazo y la importancia de ambos tipos de metas
- Ilustrar el proceso de establecimiento de metas personales
- Reforzar el establecimiento de metas como un proceso de vida
- Revisar el progreso de cumplimiento de metas
- Identificar barreras al establecer y llevar a cabo metas

Discutir el concepto de establecer y realizar una meta:
- Se genera una discusión sobre cómo establecer metas. Por ejemplo, pídale a alguien que conteste esta pregunta: **"¿Qué es una meta?".**
- Se discute el establecimiento de diferentes tipos de metas**,** tales como terminar las asignaciones a cierta hora para así poder jugar, aprovechar el tiempo para jugar Nintendo, ganar una insignia o rango en los/a Niños Escuchas o lograr un cierto número de canastos durante un juego de baloncesto.

Identificar las barreras hacia las metas y cómo alcanzarlas:
- ¿Qué tipo te cosas hacen difícil el alcanzar una meta que te hayas propuesto?
- ¿Qué es una barrera?
- ¿Cómo podemos sobrepasar cada una de las barreras identificadas?
- ¿Qué puedes hacer para prevenir que estas cosas se conviertan en barreras?

Introducir el sistema de "Pana":
- Se introduce el concepto de "panas" como asistentes en el cumplimiento de las metas. Los "panas" pueden recordarse el uno al otro las metas que están trabajando y pueden ayudarse mutuamente a lidiar con cualquier barrera que pueda aparecer. Paree a los participantes de manera que cada uno tenga un/a "pana".
- Introducir el sistema de "Pana":
- Se introduce el concepto de "panas" como asistentes en el cumplimiento de las metas. Los "panas" pueden recordarse el uno al otro las metas que están trabajando y pueden ayudarse mutuamente a lidiar con cualquier barrera que pueda aparecer.
- Paree a los participantes de manera que cada uno tenga un/a "pana".
- Trate de elaborar ejemplos tales como tocar base cada mañana, preguntando cómo le va con su meta o cuál es su meta durante el receso, desarrollando señales para que cada uno/a le recuerde a su "pana" sobre el trabajo de su meta.
- Los miembros del grupo deben ser motivados a ayudarle a su "pana" a recordar durante la semana la meta en la cual está trabajando y ayudarlo a sobrellevar alguna barrera.

<div align="center">

Sesión 3
Destrezas de organización y estudio

</div>

Metas principales:

- Mejorar destrezas de organización académica
- Repasar destrezas de estudio para la escuela y para la realización de las asignaciones en la casa
- Proveer las hojas para facilitar la implementación de destrezas
- Los facilitadores del grupo deben introducir el tema discutiendo la transición hacia un nuevo grado y el incremento en las asignaciones y las demandas de estudio que los maestros le exigirán.

Actividad:

- Los participantes traen sus bultos a la sesión y se hace un concurso para ver quien organiza su bulto mejor.
- Se repasan las destrezas de estudio para la casa y escuela

Enseñar destrezas de estudio para la escuela:

- Tomar notas en clases cuando el/la maestro/a está hablando de nuevas ideas.
- Preguntar a cuando el/la maestro/a cuando no entienda lo que está diciendo.
- Mantener el bulto organizado para que sea fácil encontrar los materiales que necesito.
- Escribir las asignaciones en la libreta de asignaciones.
- Verificar dos veces que escribí las asignaciones correctamente.
- Antes de ir a casa, verificar que tengo todos los libros y libretas que necesito para hacer **las asignaciones.**

<div align="center">

Sesión 4
Conciencia de sentimientos y reconocimiento del sentimiento de enojo

</div>

Metas primarias:
- ■ Identificar los componentes conductuales, cognoscitivos y fisiológicos de varios estados afectivos
- ■ Identificar situaciones desencadenantes de varios estados afectivos
- ■ Reconocer que la expresión de sentimientos puede ser difícil
- ■ Identificar varias señales del enojo
- ■ Identificar los diferentes niveles del enojo
- ■ Identificar desencadenantes para los diferentes niveles del enojo y forma de lidiar con los diferentes niveles del enojo

Expresión de sentimientos:
- ■ Usted tiene la opción de utilizar dibujos faciales de caricaturas (Hojas 5.1 – 5.5), caricaturas emocionales (Hoja 5.6 – 5.7), o fotos de caras reales (carteles de sentimientos, fotos de revistas) para explicar el concepto de estados emocionales.
- ■ La meta de este ejercicio es que los niños/adolescentes aprendan a identificar diferentes claves fisiológicas y físicas de las emociones (incluyendo expresión facial, postura corporal, tono de voz y lenguaje corporal interno) y entender que experimentar cualquier sentimiento es aceptable.
- ■ Enfatice que son las conductas que están asociadas con algunas emociones que necesitan ser cambiadas (ver objetivo 3B).
- ■ Las hojas pueden ser provistas a los niños/adolescentes o usadas como tarjetas de estímulo para discusión.
- ■ Usted tiene la opción de utilizar dibujos faciales de caricaturas), caricaturas emocionales (Figura 5.1), o fotos de caras reales (carteles de sentimientos, fotos de revistas) para explicar el concepto de estados emocionales.
- ■ La meta de este ejercicio es que los niños/adolescentes aprendan a identificar diferentes claves fisiológicas y físicas de las emociones (incluyendo expresión facial, postura corporal, tono de voz y lenguaje corporal interno) y entender que experimentar cualquier sentimiento es aceptable.
- ■ Usted tiene la opción de utilizar dibujos faciales de caricaturas (Hojas 5.1 – 5.5), caricaturas emocionales (Hoja 5.6 – 5.7), o fotos de caras reales (carteles de sentimientos, fotos de revistas) para explicar el concepto de estados emocionales.
- ■ La meta de este ejercicio es que los niños/adolescentes aprendan a identificar diferentes claves fisiológicas y físicas de las emociones (incluyendo expresión facial, postura corporal, tono de voz y lenguaje corporal interno) y entender que experimentar cualquier sentimiento es aceptable.

Figura 5.1
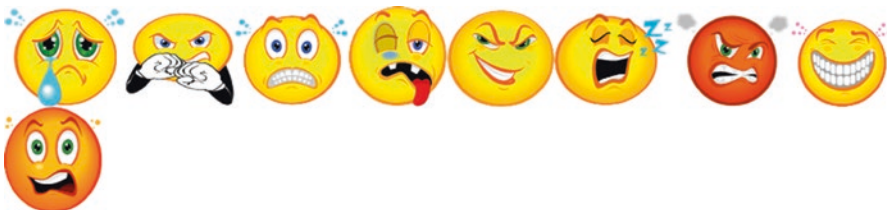
Opciones:
- ■ Opción 1: Los miembros del grupo identifica varios estados emocionales los escriben en papeles y se ponen en una caja para selección.
- ■ Opción 2: Se fotocopia el cartel de sentimientos y se cortan las diferentes caras/estados emocionales y se ponen en una caja para selección.
- ■ Opción 3: Se usan diferentes dibujos de estado emocionales o un conjunto de tarjetas emocionales para que los niños/adolescentes escojan una para actuar.
- ■ Opción 4: Se utiliza un "cubo de sentimientos", el cual muestra diferentes estados emocionales. Cada participante tira el cubo y actúa el sentimiento que salga.

Discutir las dificultades expresando sentimientos y normalizando sentimientos:

- Repase las claves que pueden ser utilizadas para decidir cómo alguien se siente. Discuta la idea que algunos sentimientos pueden ser difíciles de expresar y que no siempre se puede descifrar lo que otras personas pueden estar sintiendo ya que pueden estar encerrando sus verdaderas emociones. Abra la discusión con alguna de las siguientes preguntas y permita que progrese con naturalidad, interviniendo cuando sea necesario:
    - ¿Se puede siempre decir cómo se siente una persona por la forma en qué se ve o lo que hace?
    - ¿Siempre somos capaces de expresar nuestros sentimientos?
    - ¿Hay algunos sentimientos que son más fáciles de expresar que otros?
    - ¿Algunas veces no podemos decir cómo alguien se siente o cómo nos sentimos?

- *Opción*: Use la "Botella de Sentimientos" (Hoja 5.8) y haga que cada miembro del grupo registre varios de los sentimientos que él/ella experimenta
- Utilizando la gráfica de sentimientos de la semana anterior, los facilitadores deben comenzar identificando una situación que haya ocurrido la semana pasada la cual lo ha hecho sentir triste, con miedo o enojado.

Identificación de los diferentes niveles de enojo:

- La meta de este ejercicio es que los miembros del grupo puedan diferenciar diferentes claves físicas o fisiológicas (Ej. Postura corporal, expresión facial, tono de voz, lenguaje corporal, así como, conductas observadas o relacionadas con cada emoción y pensamientos que las acompañan cada estado emocional).
- Palabras que expresan alegría, enojo o tristeza:
    - Hoja con sinónimos de estos sentimientos
- Facilite la discusión de los diferentes niveles de enojo. Primero, discuta los sentimientos de felicidad. Presente una lista de varias palabras que describan diferentes niveles de felicidad (refiérase a la hoja 6.1).
- Repita este ejercicio usando la emoción de tristeza (refiérase a la hoja 6.2). Repita lo mismo para la emoción de enojo (refiérase a la hoja 6.3).
- Facilite la discusión de los diferentes niveles de coraje. Primero, discuta los sentimientos de felicidad. Presente una lista de varias palabras que describan diferentes niveles de felicidad (refiérase a la hoja 6.1).
- Repita este ejercicio usando la emoción de tristeza (refiérase a la hoja 6.2). Repita lo mismo para la emoción de coraje (refiérase a la hoja 6.3).

Discusión:

- ¿Qué ustedes hacen para manejar el coraje cuando están un poco molestos?
- ¿Qué estrategias de manejo utilizan cuando están muy molestos?
- ¿Cómo esas formas de manejo difieren dependiendo de cuán molesto estés?
- ¿Resulta fácil manejar el coraje cuando estás un poco molesto o muy molesto? ¿Por qué?

Asignación:

- Se provee a los participantes con las hojas de termómetro para que recopilen diariamente los sentimientos de coraje (Hoja 6.6).

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Sesión 5
Práctica utilizando auto-afirmaciones para el manejo de coraje

</div>

Metas primarias:
- Reforzar el concepto de la auto-instrucción
- Práctica utilizando auto-instrucción y distracciones como destrezas de manejo

Introduciendo las Auto-Afirmaciones:
- Durante este ejercicio se modela, habla y repasa afirmaciones para decirse a ellos mismos:
  - ¿Qué te dices a ti mismo/a?
  - ¿Estos pensamientos te ayudan a manejar tu coraje?
  - ¿Qué cosas pudiste haber dicho que te hubiesen puesto menos enojado/a?

Juego de auto-control utilizando las marionetas:
"Ahora, nosotros queremos que cada uno/a de ustedes practique afirmaciones de manejo. Queremos que cada uno/a de ustedes utilice la marioneta para que reacciones ante una situación provocadora, esto significa que queremos escucharte decir la afirmación en voz alta. Sabemos que en la vida real ustedes se las dicen en su cabeza, pero por hoy queremos escucharte decir la afirmación en voz alta".

Continuar con la práctica de auto-afirmaciones de manejo:
- Repasar el juego de auto-control de la sesión previa
- Hoja 9.1 (Afirmaciones de Manejo)
- Juego de auto-control de hoy. **"**Hoy vamos a jugar un juego de auto-control, pero esta vez, vamos a dejar que cada uno/a de ustedes sea provocado/a y luego practicaremos el auto-control. La persona siendo provocada se va a parar en el medio del grupo. Para preparar a cada uno de ustedes con afirmaciones de manejo, vamos a tomar unos minutos para repasar la Hoja de Afirmaciones de Manejo".

Frases a repetirse uno mismo

- No vale la pena molestarse
- No haré algo grande de esto
- Haré uso de mi sentido del humor
- No necesito probar nada a nadie
- Yo creceré, no explotaré
- No me meteré en una pelea
- Mantente calmado/a, solo relájate
- Mira lo positivo
- Mis músculos se sienten tensos, es hora de relajarse
- Cálmate, respira profundo

Examen de memoria de frases de manejo/positivas
- *Por favor escribe las mayor cantidad de frases de manejo que puedas recordar*
- Recuerda, frases de manejo/positivas son cosas que te dices a ti mismo (en tu mente) que te ayudan a mantenerte calmado y estar en control de tu comportamiento**.**

Práctica utilizando auto-control:
- Un termómetro largo deberá ser colocado en el piso (o simplemente identifique las áreas de bajo, medio y alto utilizando papel u otra forma de marcador) y se le pedirá a cada miembro del grupo que se pare en el termómetro durante un ejercicio de auto-control. Deberán moverse hacia arriba o abajo del termómetro dependiendo del nivel de coraje mientras son provocados en un ejercicio de auto-control.

Termómetro para registrar el coraje

- MUY ALTO

  _____

- ALTO

  _____

- MEDIO

  _____

- BAJO

  _____

- MUY BAJO

  _____

- **¿Por qué estoy molesto/a?** _____

  _____

- **¿Qué hice al respecto?** _____

  _____

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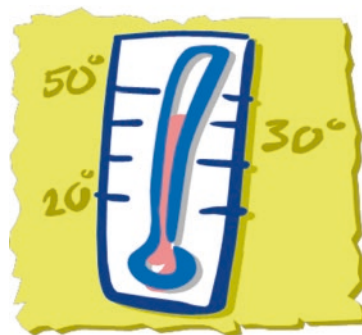
Sesión 6
Relajación y enfrentando barreras para el auto control

</div>

Metas principales:
- ■ **Enseñando el autocontrol a través de la respiración profunda**
- ■ **Identificar y enfrentar barreras utilizando el auto control**

Autocontrol a través de la respiración profunda
Facilitador ofrece estas direcciones:
"Te voy a pedir que te relajes. En unos minutos, voy a decir unas cosas que espero que te ayuden a crear una imagen en tu mente. También te voy a pedir que relajes diferentes partes de tu cuerpo. Aprender a relajarse te ayudará a manejar sentimientos de coraje, tristeza, y miedo. Ponte en una posición cómoda en tu silla, sin tocar a otras personas, y respira profundamente varias veces. Cierra los ojos y relájate. Sacúdete un poco y ponte cómodo. Vuelve a respirar profundamente varias veces. Inhala y exhala. Inhala y exhala. Eso es, te estás sintiendo en paz. Si estuvieras molesto, puedes imaginarte a ti mismo moviéndote de caliente a frío en el termómetro. Te sientes más y más relajado, frío, pacífico. Ahora, con los ojos cerrados, pretende que estás en una nube blanca, alto en el cielo, en un día hermoso.

Estás flotando pacíficamente en una nube mullida y blanca...Moviéndote bien suavemente. Estás tan liviano como una hoja. La nube mullida te aguanta con seguridad, flotando por el cielo. Ahora, mientras cuento del 1 al 3, imagina que estás sumergiéndote cada vez más profundo en la nube, hasta que la nube está a todo tu alrededor. 1...2...3 estás disfrutando la vuelta en la nube. Ahora, siente tus pies y los dedos de tus pies...siente lo relajado que están. Siente tus piernas.

Todos los músculos en tus piernas están livianos y relajados en la nube...siente tus brazos...siente tu cuello...siente tu cabeza...ahora estás totalmente relajado...flotando en la nube mullida...Recuerda que puedes volver a tu nube siempre que sientas que necesites calmarte y relajarte...En cualquier momento que necesites moverte de caliente a frío en el termómetro...Ahora, nos estamos preparando para parar nuestra vuelta en la nube. Pararemos cuando yo cuente hasta tres...1...2...3...Abre los ojos y estírate un poco.

Discusión de la experiencia de relajación:

- ■ ¿Cómo te sentiste durante esta actividad?
- ■ ¿Qué fue lo que más te gustó? ¿Lo menos?
- ■ ¿Cómo podrías utilizar esta actividad?
- ■ ¿Cuáles son los beneficios?

Auto-Relajación

- ■ Hablar con un amigo/a
- ■ Jugar con una mascota
- ■ Hacer deportes

Identificar las barreras que se pueden presentar para utilizar el auto control:

- ■ Discuta con los participantes obstáculos que pueden presentarse y cómo pueden manejarse efectivamente con el uso del hablarse a sí mismos.
- ■ Reitere la idea que a veces es difícil utilizar técnicas de auto-control en situaciones de la vida diaria.

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Sesión 7
Toma de perspectiva

</div>

<u>Metas principales:</u>

- ■ Establecer el concepto de toma de perspectiva
- ■ Identificar las diferentes perspectivas de una situación social.

<u>Toma de perspectiva:</u>

- ■ El propósito principal de esta sesión es ayudar a los miembros del grupo a entender que las situaciones pueden verse desde diferentes puntos de vista. Una meta adicional es el ayudar a los miembros del grupo a entender que estas percepciones influencian nuestros pensamientos y sentimientos que a su vez tiene un impacto en nuestra conducta.

<u>Actividad "Juego":</u>

- ■ Esta actividad refuerza el concepto de que las personas pueden ver una misma cosa de formas diferentes. La hoja de actividad "Juego" es una actividad de ilusión visual, con la palabra "Juego" (u otra palabra) integrada en un trasfondo negro. Haga que cada miembro del grupo mire a esta hoja y escriba en un papel lo que ven sin mirar a lo que su otro/a compañero/a está escribiendo.

<u>Juego de roles:</u>

- ■ Seleccione una lámina estímulo (lámina de una situación social) que tenga un número de personajes y algo de ambigüedad en términos de lo que está sucediendo en la lámina.
- ■ ¿Cuál fue el problema?
- ■ ¿Cuándo comenzaste a ver el problema?
- ■ ¿Quién tenía el problema?
- ■ ¿Qué te decías a ti mismo/a mientras ocurría el problema?
- ■ ¿Cómo te sentiste?
- ■ ¿Qué vas a hacer ahora?
- ■ ¿Qué puedes hacer o decir para resolver el problema?
- ■ ¿Cuál crees será el resultado?
- ■ ¿Cómo tú crees que los demás vieron el problema?
- ■ ¿Qué dirán los demás respecto a cuál es el problema?
- ■ ¿Por qué crees que la persona hizo lo que hizo?

<u>Introducción a los "Blind Spots" (puntos ciegos):</u>

- ■ Se realiza una breve introducción en cómo los sentimientos de las personas pueden interferir con nuestra habilidad para visualizar las intenciones de otros de forma precisa.
- ■ Haga que los niños/adolescentes comiencen a pensar a qué maestro/a quieren entrevistar y qué preguntas les gustaría preguntarles para una entrevista al maestro/a.

<u>Intenciones:</u>

- ■ Tenga una breve discusión sobre las cuatro categorías de las intenciones:

    - ■ **"Ahora que entienden que las personas hacen las cosas por diferentes razones, es hora de etiquetar los tipos de intenciones o razones por las cuales las personas se comportan de la forma en que lo hacen".**

- ■ Verifique si los niños/adolescentes pueden identificar las siguientes intenciones: (1) Fue un accidente, (2) Estaba tratando de ser útil, (3) Estaba tratando de ser malo o enojar a alguien a propósito, y (4) No estoy seguro.

Entrevista para el/la maestro/a:

- Esta actividad está diseñada para ilustrar cómo los sentimientos pueden interferir con nuestra habilidad y precisión al percibir las intenciones, lo cual a su vez puede interferir con nuestra habilidad y precisión al identificar las intenciones de otras personas.
- Los resultados negativos de interacciones previas pueden generar malos sentimientos, los cuales pueden afectar nuestra percepción de otras personas y las intenciones que le adscribimos.
- Estos sentimientos pueden causar que ignoremos algunas claves que estas personas nos estén dando o que ignoremos información importante.
- Ser frustrados por maestros u otras personas nos puede llevar a percibir solo aquellos comportamientos que te hagan sentir enfadado/a y a dejar pasar comportamientos que te llevarían a sentirte de forma más positiva acerca de esa persona. A este proceso le llamamos "Puntos Ciegos".

Entrevista para el/la maestro/a:

- ¿Cómo de diferente era la escuela cuando usted estudiaba?
- ¿Cómo de igual era la escuela cuando usted estudiaba?
- ¿Qué fue lo más que le gustó de escuela elemental/intermedia?
- ¿Qué fue lo menos que le gustó de escuela elemental/intermedia?
- ¿Qué cosas divertidas recuerdas sobre alguno de tus maestros en escuela elemental/intermedia?
- ¿Algunos participantes no entendían algunas veces por qué los maestros tenían reglas?
- ¿Qué usted quiere que pase cuando está dando clase?
- ¿Cuándo un/una estudiante hace ruido e interrumpe la clase, cuál es su meta para toda la clase y con ese estudiante?
- ¿Qué es lo más que le gusta sobre la enseñanza?
- ¿Usted cree que los maestros conocen cuánto los niños/adolescentes aprecian el trabajo tan arduo que realizan?

Sesión 8
Toma de perspectiva y solución de problemas

Metas principales:

- Discutir la entrevista del maestro/a
- Introducción al tema de solución de problemas
- Introducción al Modelo IPOC
- Haga que los niños/adolescentes estén preparados para hablar sobre la entrevista con el grupo. Los facilitadores del grupo deben anotar las respuestas dadas en la entrevista.
- Pregúntele a los niños/adolescentes qué aprendieron en el proceso de entrevistar al maestro/a.

Algunas posibles preguntas de discusión son:

- **"¿Qué aprendieron en el proceso de entrevistar al maestro/a?**
- **¿Encontraste algo sobre el/la maestro/a que no sabías?**
- **¿Cómo te sentiste cuando entrevistaste al maestro/a?**
- **¿Esta actividad te ayudó a entender mejor porqué hay reglas a seguir en el salón de clases?**
- **¿Te sorprendiste por algo que dijo el/la maestro/a durante la entrevista?"**

Identificación del Problema (Introducción al Modelo IPOC):

- **Modelo IPOC. Este es I=identificación, P=problemas, O=opciones y C =consecuencias. El modelo IPOC representa los pasos esquemáticos básicos de solución de problemas. IPOC se delinea de la siguiente forma:**

- **Identificación del problema**
  Opciones
  Consecuencias

Administrar y explicar las siguientes hojas:

HOJA 17.1
SOLUCIÓN DE PROBLEMAS- MODELO IPOCS

IDENTIFICAR EL PROBLEMA (I.P.)
Poner en Perspectiva
- Identificar cual es el problema basado en la perspectiva de cada persona involucrada en la situación.
- Al exponer el problema no se pone sobre nombre, no se le echa la culpa o se hace sentir mal a otro.

Metas individuales
- Identificar la meta en la situación.
- Identificar la meta de la otra persona en la situación.
- Mirar hacia la cooperación y el compromiso.

IDENTIFICAR LAS OPCIONES O ALTERNATIVAS (O)
- Hacer una tormenta de ideas sobre todas las posibles soluciones que tiene el problema. ¿Cuáles son tus opciones?
- No evalúes las soluciones en términos del resultado, solo haz una lista de todas las alternativas posibles.

HOJA 17.2

HOJA DE SOLUCIÓN DE PROBLEMAS

Mi problema es:

_____

_____

_____

Posibles alternativas: Consecuencias de las alternativas:

_____   _____

La solución que escogí es:

_____

_____

Las consecuencias de mi solución eran:

_____

_____

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Sesión 9
Solución de problemas sociales

</div>

Metas principales:

- ■ Completar la introducción a la solución de problemas de la sesión anterior
- ■ Identificación del problema y generando soluciones
- ■ A través de diferentes juegos de roles se aplica el modelo IPOCS a diferentes situaciones.

- ■ Se hace una introducción sobre la relación entre la identificación del problema y el proceso de generar soluciones. Los facilitadores deben comunicarle a los niños/adolescentes que tendrán un juego; la meta del juego es que puedan generar diez soluciones sobre un problema en cinco minutos.
- ■ Los facilitadores pueden utilizar las siguientes categorías para ayudar a los niños/adolescentes a entender que hay unas formas generales de clasificación de soluciones:
    - ▪ Buscar ayuda
    - ▪ Acción Directa No-Agresiva
    - ▪ Acción Directa Agresiva
    - ▪ Evitación
    - ▪ Este tipo de categorización ayuda a los niños/adolescentes a desarrollar ideas más completas de cómo solucionar problemas y aprenderán que hay varios tipos diferentes de soluciones dentro de cada categoría.
- ■ Se introduce el concepto de "consecuencias" (lo que sucede como resultado de hacer algo o es lo que sucede después que se hace algo).
- ■ Se practican varios ejercicios para que los participantes generen diferentes consecuencias motivándolos con preguntas tales como:
    - ▪ ¿Cuál sería la consecuencia para esta solución?
    - ▪ ¿Qué pudiese pasar después de escoger esa solución?
    - ▪ ¿Qué más pudiese pasar?
    - ▪ ¿Qué más pudiese hacer la otra persona?
    - ▪ ¿Qué más pudiese sentir la otra persona?
- ■ El punto o idea principal del ejercicio anterior es dar una introducción a la idea de que a menudo existen varias consecuencias para una solución, y si se quiere tomar buenas decisiones, se debe pensar en todas las posibles consecuencias.
- ■ Utilizando las consecuencias que han sido generadas a la situación problemática anterior, pídale a los niños/ adolescentes, **"¿Cómo pueden decir si una consecuencia es buena o mala? ¿Qué hace una consecuencia buena o mala?"**
- ■ Los facilitadores deben prepara una introducción con la idea de que una consecuencia es buena si ayuda a que la persona logre una meta importante.
- ■ Puede ser útil discutir las metas a corto o largo plazo (Ej. Pelear puede ayudarte a alcanzar una meta a corto plazo de sentirte fuerte/importante/no un tonto pero puede interponerse en el camino de alcanzar una meta a largo plazo como el salir bien en la escuela, completar un buen trabajo y/o mantenerse fuera de problemas).

Sesión 10
Solución de problemas sociales al conflicto con maestros y para hacer amigos y ser amigos de los demás

<u>Metas principales:</u>

- Mejorar la habilidad de toma de perspectiva
- Discutir las perspectivas de los maestros
- Practicar la solución de problemas sociales en el conflicto con maestros
- Ilustrar métodos efectivos vs. inefectivos para unirse a los demás
- Práctica unirse a un grupo y/o hacer nuevos amigos
- Reforzar las cualidades positiva en uno/a mismo/a que son importantes para unirse en actividades de otros/ser amigos
- La idea principal de este ejercicio es enseñarle a los niños/adolescentes a pensar antes de responder.

- Los participantes generan consecuencias para soluciones ofrecidas en varios ejercicios y las clasifican como buena (++), ok (+) o mala (-).
- Recuerde a los participantes la entrevista que hicieron a los maestros e informe que se escogieron las 10 contestaciones más altas a la pregunta:
- **"¿Qué esperan ustedes los maestros de los participantes en el salón de clases?"**
- Divida el grupo en mitad y pregunte a cada grupo que digan las contestaciones más frecuentes que dieron los maestros a esta pregunta.
- Recuerde a los participantes la entrevista que hicieron a los maestros e informe que se escogieron las 10 contestaciones más altas a la pregunta:
- "¿Qué esperan ustedes los maestros de los participantes en el salón de clases?"
- Divida el grupo en mitad y pregunte a cada grupo que digan las contestaciones más frecuentes que dieron los maestros a esta pregunta.
-

<u>Utilizar la técnica de solución de problemas para discutir situaciones con los maestros:</u>

<u>Identificación del problema</u>

- El grupo realiza una "tormenta de ideas" acerca de la diferencia en opiniones que han ocurrido o que pudieran ocurrir entre un estudiante y un/a maestro/a, así como las diferencias en perspectivas entre participantes y maestros.

- Por ejemplo: "**¿Qué esperan los maestros que los participantes hagan en el salón de clases?, Si ellos esperan que hagas el trabajo independientemente, ¿cómo puedes pedirle ayuda al maestro/a cuando la necesites?, ¿Qué esperan los maestros de los participantes en términos de asignaciones? Puedes pensar que las asignaciones son aburridas o te quita tu tiempo libre, pero tus maestros probablemente piensan que las asignaciones son buenas para que retengas lo que aprendiste en clases.**

<u>Participando en actividades y haciendo nuevos amigos</u>

- El propósito de esta discusión es introducir la importancia de la comunicación para unirse a una nueva actividad o para comenzar a ser amigos de personas que no conocemos bien.
- El primer componente de aprender cómo hacer amigos es el ser capaz de reconocer cualidades positivas en uno/a mismo/a y en los demás que uno valoraría en un amigo/a.
- Este ejercicio está diseñado para ayudar a los niños/adolescentes a reconocer las cualidades positivas de ellos que otros valorarían.

Alternativas o maneras para hacer amigos

- Haga un acercamiento positivo (Ej. Sonreír, saludar, decir un halago)
- Encontrar cosas que comparten en común
- Tratar de no estar nervioso/a
- Hacer contacto visual
- Ser amable
- Ser considerado/a con los demás y sus sentimientos
- Escuchar a los demás
- Mostrar interés en las otras personas y sus familias
- Sugerir una actividad que pueda hacerse juntos
- Enfocarse en las buenas cualidades de los demás

Cualidades positivas:

- Confiable
- Honestidad
- Habilidad para escuchar y mostrar interés en los demás
- Ser respetuoso/a
- Ser considerado/a

Conductas positivas:

- Compartir con los demás
- Guardar secretos
- No hablar mal a espaldas de otro/a
- Involucrarse en cosas que a la otra persona le gusta hacer

Maneras inefectivas de unirse a un juego o grupo:

- Parase muy cerca
- Ser invasivo/a
- Tratar de unirse insistiendo
- No mirar a las personas que están jugando
- Hablar muy bajo
- No escuchar lo que la otra persona dice

Sesión 11
Aplicación de solución de problemas sociales a la presión de grupo/pares

Metas principales:

- Reforzar las destrezas de Negociación entre pares
- Ilustrar y discutir que es la presión de grupo/pares y porque funciona
- Generar alternativas para resistir la presión de grupo/pares y agudizar las habilidades de negarse

Estas ideas pueden ser presentadas al grupo de diferentes maneras:

- Este objetivo puede hacerse en un formato grupal permitiendo que el grupo genere diferente razones de por qué los niños/adolescentes caen en la presión de grupo.
- Los facilitadores pueden escribir en unas tarjetas categoría generales de las razones y ponerlas en una caja/sombrero. Un/a participante escogerá una razón y escogerá a otros dos miembros para hacer una parodia o mímica de la razón. El resto del grupo debe adivinar la razón. Se debe repetir para que cada cual tenga la oportunidad de hacer una mímica y adivinar. Los facilitadores pueden involucrarse.
- Los facilitadores pueden tener láminas de grupos de personas (Ej. Revistas, comics, dibujos) que represente cada categoría general y pedir al grupo que discuta la motivación para ceder a la presión de grupo que se presenta en cada lámina.

Las categorías básicas de razones para aceptar la presión de grupo son:

- Aceptación de grupo (ser aceptado/a en un grupo)
- Aprobación (para agradarle a otros)
- Repetición (alguien sigue insistiendo hasta que accedes)
- Ser amenazado física o socialmente (alguien amenaza con hacerte daño o decirle a todo el mundo lo débil o "gallina" que eres)
- Rebajarse (los niños/adolescentes no quieren ser molestados o que se les rebaje)
- Asegurarse o tranquilizarse (los otros dicen que no hay manera de que te cojan haciendo lo que te piden)

Técnicas de negación:

- Decir no gracias ("No Gracias")
- Disco rayado ("Dije que no quiero, dije que no quiero, dije que no
- quiero")
- Dar una excusa ("Bueno, me tengo que ir a casa")
- Abandonar la situación
- Cambiar el tema ("¿Qué crees del juego de baloncesto de anoche?")
- Hacer un chiste
- Actuar en estado de shock o sorpresa ("No puedo creer que me estés
- preguntando eso")
- Cumplidos ("Pienso que estuviste genial en el juego de baloncesto de
- hoy")
- Sugerir una mejor idea ("¿Por qué mejor no hacemos unos tiros al canasto?")
- Devolver el reto ("Vamos, tú de verdad no quieres hacer eso, ¿Por qué te
- quieres hacer eso comoquiera?")
- Encontrar otros niños/adolescentes con los cuales salir
- Tratar de utilizar la mediación de pares

Influencia de la Presión de Grupo/Pares:

- Los facilitadores pueden dibujar 3 líneas, del mismo largo, en diferente orientación o en diferentes lugares de la pizarra. Si los facilitadores van a utilizar este ejercicio uno de los/s participantes debe ser escogido antes de la reunión para tratar de convencer al grupo que la línea "x" es más larga que las demás. Un/a participante que tenga influencia en el grupo debe ser escogido para esta actividad. Se le dará instrucciones de que trate de convencer al resto del grupo de que una de las líneas es más larga que las otras aun cuando no lo es.
- Después de que las líneas hayan sido dibujadas, el/la facilitador/a debe preguntar **"¿Cuál línea es la más larga?"**
- Luego de esta actividad pregunta al grupo: **"¿Cómo decidiste cuál línea es la más larga?, ¿Te ayudo algo a tomar esta decisión?, ¿Decidiste irte con la decisión del grupo o con tu propia idea?, ¿Cómo se siente tener a alguien tratando de convencerte de que tu punto de vista no es el correcto?, ¿Es más difícil resistir la presión de grupo si hay otros niños/adolescentes alrededor?"**
- Haga una discusión general de cómo es difícil mantener un punto de vista cuando existe presión.

Juego de roles:

- El objetivo de este ejercicio es que cada miembro haga un juego de roles de al menos una forma de negarse a la presión de grupos/pares (Ej. Unirse a un grupo para molestar a otro participante, romper alguna regla o hacer algo ilegal).

    - ¿Cómo el grupo trata de presionar a_____? (nombre del participante)
    - ¿Qué ellos hicieron o dijeron?
    - ¿Cómo la otra persona trató de resistir la presión?
    - ¿Qué hizo o dijo la persona?
    - ¿Cómo se siente ser presionado?
    - ¿Cómo se siente ser la persona que ejerce la presión?

<div align="center">

Sesión 12
Reforzar el compromiso público para utilizar técnicas de negación y unirse a grupos positivos, desarrollando calidad positiva y relaciones con los compañeros y cierre

</div>

Metas principales:

- ◼ Reforzar el Compromiso Público para utilizar Técnicas de Negación a través de un poster de Evitar la Presión de Grupo
- ◼ Identificar fortalezas personales y como esas fortalezas ayudan a unirse a grupos y actividades positivas
- ◼ Describir cualidades de buen liderazgo e identificar cualidades específicas para ser desarrolladas por el grupo
- ◼ Reforzar la influencia positiva de los miembros de un grupo sobre otros
- ◼ Reforzar el compromiso público de utilizar técnicas de negación y el ser una influencia positiva para otros niños/adolescentes en la escuela a través de la exhibición del poster
- ◼ Planificar fiesta final
- ◼ Repasar y dar Certificados de Participación

Bombardeo de fortalezas:

- ◼ Provea la Hoja 33.1: Bombardeo de Fortalezas. Se pide a cada participante que escriba sus fortalezas, cualidades positivas o intereses en los círculos.
- ◼ Cada participante debe haber completado su forma "Bull eyes" y la mostrarán al grupo.
- ◼ En este momento el grupo debe "bombardear" al participante con otras cualidades positivas que no haya mencionado. El/la participante que ha sido bombardeado debe escribir las diferentes fortalezas que otras personas sugieren. El propósito de esta sesión es que los niños/adolescentes piensen maneras en las que pueden volverse miembros de un grupo positivo.
- ◼ El propósito de esta sesión es que los niños/adolescentes piensen maneras en las que pueden volverse miembros de un grupo positivo. Ellos deben ser exhortados a traer estrategias para unirse a grupos de personas con los mismos intereses y metas.
- ◼ **"Recuerden que hace unas semanas hablamos de los diferentes grupos de persona y le preguntamos de que grupos ustedes eran miembros".** Espere a que el grupo responda. "**Hoy queremos que piensen sobre algunos grupos que les gustaría unirse o de los que quisieran ser miembros centrales. ¿Qué cosas debes pensar para hacer esto?**"

    - ▪ ¿Son sus intereses iguales a los suyos?
    - ▪ ¿Son sus objetivos a largo plazo los mismos tuyos?
    - ▪ ¿Qué fortalezas tienes que puedes utilizar al tratar de unirte a un grupo?
    - ▪ ¿Cómo puedes volverte un miembro más central de este grupo?
    - ▪ ¿Cómo puedes mostrarle a otros niños/adolescentes las fortalezas que tienes?
    - ▪ ¿Qué tipo de ayuda necesitas para comenzar en este grupo?
    - ▪ ¿Qué tipo de ayuda necesitas para estar involucrado en este grupo?

- ◼ Esta es la sesión final del año. Se habla a el grupo sobre el hecho de que serán contactados en algún momento en los siguientes meses para hacer una evaluación de seguimiento y que pueden ser escogidos para "Intervención de Seguimiento" el próximo año (explique en más detalle).
- ◼ Asegúrese de agradecerles por su participación y señale el interés de que sigan creciendo y desarrollándose.
- ◼ Exhorte a los participantes a guardar sus expedientes para referencia futuro y rételos a que lo miren al menos una vez durante el verano o vacaciones.

Técnicas para el manejo del grupo

- Analizar en un torbellino de ideas todos los posibles problemas y soluciones con el grupo cuando estos surjan.
- Revisar las reglas cuando sea necesario, indicando claramente cuando las reglas tendrán efecto.
- Obtener la atención del grupo antes de hablar.
- Presentar un tono de voz adecuado, señales visuales y verbales y mantener contacto visual.
- Preparar a los niños/adolescentes para transiciones entre actividades.
- Utilizar su atención para manejar la conducta:
    - Ignorar conductas menores de llamar la atención
    - Reforzar participantes que ignoren conductas de llamar la atención de otros
    - Elogiar conductas constructivas específicas
- Administrar consistentemente los "strikes"
    - Los facilitadores deben discutir previamente las diferencias en relación a la tolerancia de conductas
    - Tomar en consideración las diferencias individuales en relación a la línea base de la conducta de cada participante.

Manejo de la conducta individual de los miembros del grupo

- Proximidad física (Ej. Ubicar a los niños/adolescentes más activos entre los facilitadores)
- Contacto físico (Ej. Poner mano en el hombro)
- Enfriamiento de emociones dentro del salón
- Enfriamiento de emociones (tiempo fuera) fuera del salón
- Reunirse individualmente fuera del tiempo de grupo, para procesar los problemas y promover el desarrollo de las relaciones
- Establecer un plan de comportamiento individual

Componentes de Padres/Madres

- Este se compone de 5 sesiones para los padres/madres de los participantes del programa. El mismo está diseñado para el desarrollo de destrezas en el manejo de la conducta agresiva de los participantes y en el brindar apoyo a los mismos en las destrezas adquiridas en el programa.

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Treatment Considerations and Tools for Treating Latino Adolescents with Externalizing Disorders

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Externalizing disorders, such as attention-deficit/ hyperactivity disorder, oppositional defiant disorder, and conduct disorder, are characterized by impulsivity, inattention, and overreactivity and are associated with negative psychosocial outcomes (Nock, Kazdin, Hiripi, & Kessler, 2006). Distinguishing between "normal" teen misbehavior and pathological behavior can be difficult given that most teens (70%) will engage in delinquent behavior at some point (Elliott, Huizinga, & Ageton, 1985; Farrington, 1995). Unfortunately, the empirical literature regarding the prevalence, etiology, and treatment of externalizing disorders among Latino youths remains limited. Lending to this knowledge gap is the fact that the Latinos tend to underutilize mental health services when compared to their non-Latino counterparts (Ojeda & McGuire, 2006). Given these considerations, the aims of this chapter is to provide:

- A brief overview of current research on externalizing disorders and empirically supported treatments
- Cultural considerations for modifying current treatment practices

- Session plans and Spanish language work sheets

Common Externalizing Disorders and Their Prevalence

Attention-deficit/hyperactivity disorder (ADHD), conduct disorder (CD), and to a lesser extent oppositional defiant disorder (ODD) vary across populations and genders. For instance, rates of ADHD have been found to range anywhere between 1.7% and 17.8% (Costello, Mustillo, Keller, & Angold, 2004; Elia, Ambrosini, Rapoport, 1999; Faraone, Sergeant, Gillberg, & Biederman, 2003). Males appear to have elevated rates of ADHD compared to their female counterparts, 11.8% in boys and 5.4% in girls (Froehlich et al., 2007). While less is known regarding the prevalence of ADHD in Latino populations, research suggests that Mexican-American youths have lower rates than Caucasian youths (Merikangas et al., 2010), which may be due to the fact that Latino youths are less likely to be diagnosed by parental report than Caucasians (Stevens, Harman, & Kelleher, 2005).

ADHD and CD are the most commonly co-occurring psychiatric disorders among youths (Merikangas et al., 2010; Costello et al., 2004), and similar to ADHD, conduct disorder (CD) is about 3–4 times higher in boys than girls (Merikangas, Nakamura, & Kessler, 2009). For the general population, estimates of CD range

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from 7.1% of females to 12.3% of males, with a typical onset of 11.2 years (Nock et al., 2006). Latinos have been found to have significantly lower rates of CD compared to Caucasians, 9.09 vs. 9.91%, respectively (Nock et al., 2006). In terms of ODD, some studies report higher rates in boys, while others report equivalent rates between the genders (Loeber, Burke, Lahey, Winters, & Zera, 2000). Bird and colleagues (2001) found that Latinos living in Puerto Rico had substantially lower rates than their mainland Latino and non-Latino counterparts (Puerto Ricans = 3.0%, mainland Latinos = 9.6%, African American = 9.1%, and "others" = 8.0%). In this study, Puerto Rican youths were more likely to report positive relationships with their family, which the authors posit might be a protective factor (Bird et al., 2001). In sum it appears that Latino culture membership may mitigate the risk of developing externalizing disorders.

Mental Health Service Delivery and Latino Youths

Overall, youths with externalizing disorders such as ADHD and CD have the greatest treatment utilization rates (Merikangas et al., 2010). However, a large portion, over 50%, experiencing these disorders will not receive treatment (Merikangas et al., 2010). Latinos have comparable rates of mental health service contact as Caucasians for externalizing disorders, with the exception that Latinos are less likely to receive treatment for severe ADHD (Merikangas et al., 2011). However, Latinos are significantly less likely than Caucasians to receive frequent services (Merikangas et al., 2011), which given the nature of externalizing disorders represents a major impediment. While it is difficult to pinpoint exactly why these differences in service utilization rates exist, stigma, language barriers, and parental beliefs about the nature of externalizing disorders and mental illness may all play a role (Cabassa, Zayas, & Hansen, 2006; Tarshis, Jutte, & Huffman, 2006).

Cultural Factors Relevant to Behavioral Problem Development, Maintenance, and Treatment

Given the considerable variability and expansiveness of Latino culture (Añez, Silva, Paris & Bedregal, 2008), clinicians and researchers alike should be weary of treating this as a homogenous group. It is paramount that clinicians account for intracultural diversity as well (e.g., socioeconomic status, gender, etc.) as these factors have considerable implications for mental health, within and across cultures (López & Guarnaccia, 2000). However, several cultural factors have been empirically linked to behavioral problems and warrant consideration in the treatment process.

Acculturation Acculturation has been conceptualized as the degree to which one adopts behaviors, values, and customs of the majority culture and the degree to which the values, customs, and behaviors of the culture of origin are retained (Berry, 1980). High levels of acculturation have been linked with a number of negative outcomes including serious behavioral problems and substance abuse (Tonin, Burrow-Sanchez, Harrison, & Kircher, 2008). A phenomenon so prevalent it has become known as the immigrant paradox: people who have recently immigrated should experience more health and psychosocial problems, but do not (Alegría et al., 2008). The bidimensional model of acculturation argues that the adoption of the host culture and retention of the culture of origin are independent dimensions; thus, an individual can hold membership to more than one culture simultaneously (Berry, 1980; Cabassa, 2003). Importantly, this model distinguishes between integration (adoption of host culture practices and retention of culture of origin practices), assimilation (adoption of the host culture practices and loss of practices of the culture of origin), marginalization (loss of culture of origin and failure to adopt practices of the host culture), and separation (retention of culture of origin practices and failure to adopt host culture

practices), as subtypes of acculturation (Berry, 1980).

Research suggests that the integrated acculturation, akin to "biculturalism," is associated with positive outcomes such as academic achievement orientations (Gomez & Fassinger, 1994), school adjustment (Coatsworth, Maldonado-Molina, Pantin, & Szapocznik, 2005), high self-worth (Birman, 1998), and increased levels of general well-being (Phinney, 1990) when compared to other acculturation orientations. Assimilation has been linked with increased rates of teen substance abuse (Epstein, Dusenbury, Botvin, & Diaz, 1996; Vega & Gil, 1998), teen delinquency, and conduct problems (Vega, Zimmerman, Warheit, Apospori, & Gil, 1993). Marginalization correlates with internalizing and externalizing disorders (Berry, 2003; Berry & Sam, 1997; Neto, 2002), and separation has been associated with reduced likelihood of participation in delinquent activity (Buriel, Calzada, & Vasquez, 1982). Advocating biculturalism/integration for Latino parents and teens has demonstrated effectiveness in improving family functioning and decreasing teen behavioral problems (Szapocznik et al., 1986, 1989). Specifically, support has been garnered for helping parents and teens to understand each other's cultural orientations, and each other, by reframing intergenerational difficulties as culturally based disagreements (Szapocznik et al., 1989). Given this, clinicians should assess for and consider the acculturation status of the parents, the teen, and other relevant family members, noting any discrepancies, in their case conceptualizations.

Immigration Research has found that the relationship between acculturative stressors, such as language barriers and perceived discrimination, and behavioral problems varies by immigration status (Vega, Khoury, Gil, & Warheit, 1995). Thus, clinicians are advised to consider the families' immigration history (e.g., why they left, what the migration process has been like, what barriers have they faced, etc.) when devising a case conceptualization throughout the treatment process (Bean, Perry, & Bedell, 2001). Immigrant families, and in particular teens, may feel pres-

sured to assimilate to mainstream American culture, which regrettably may lead to the neglect or abandonment of family and cultural traditions that serve as buffers against behavioral health problems (Bean, Perry, & Bedell, 2001; Escobar, 1998). Furthermore, parents may be apprehended to seek or continue to receive mental health services due to concerns about immigration status (Rastogi, Massey-Hastings, & Wieling, 2012). Given this, clinicians should discuss immigration concerns and emphasize confidentiality early on in the treatment process (Sue & Sue, 2003).

Cultural Values and Worldviews Latino cultures stress the importance of cooperation, courteous interactions, respect of authority and boundaries, and the individual's role in the family (Vega, 1990), which can be seen in the cultural construct of *familismo*. Familismo is the practice of placing the importance of family well-being over individual autonomy (Comas-Diaz, 2006). Unsurprisingly, familismo is associated with high levels of parental involvement and thus is frequently cited as a protective factor against the development of externalizing disorders (German, Gonzales, & Dumka, 2009; Romero & Ruiz, 2007; Santisteban, Coatsworth, Briones, Kurtines, & Szapocznik, 2012). However, familismo may diminish through the acculturation process (Sabogal, Marín, Otero-Sabogal, Marín, & Perez-Stable, 1987). Given the robust relationship between familismo and effective parenting, clinicians working with Latino youths exhibiting behavioral problems should place an emphasis on renewing family support, loyalty, and duty of *all* family members (Santisteban et al., 2012).

Family Life Parenting practices such as lax guidelines, rule setting, and monitoring have consistently been linked with the development and maintenance of externalizing disorders (Dishion, Bullock, & Granic, 2002; Gayles, Coatswoth, Pantin, & Szapocznik, 2009). Parenting practices may be disturbed by marital discord and a lack of family cohesion, which are directly and indirectly, via lax and inconsistent parenting, associated with behavioral problems and externalizing

disorders (Lindahl & Malik, 1999; Vega et al., 1995). For Latinos, family cohesion emerges as an even stronger protector against child behavioral problems than their Caucasian counterparts (Lindahl & Malik, 1999), indicating that retaining Latino value such as *familismo* may mitigate the risk of externalizing disorders. Additionally, traditional Latino parenting practices characterized by high levels of involvement, positive parenting, effective discipline, and low levels of discipline avoidance are predictive of lower levels of behavioral problem (Santisteban et al., 2012). One study found that hierarchical parenting styles were associated with an increased risk of problem behaviors for Caucasian and bi-ethnic families, but not Latinos (Lindahl & Malik, 1999), supporting Baer, Prince, and Velez (2004) caution in labeling parenting as "overly involved" prematurely.

Taken together, the research supports the use of culturally augmented interventions targeting Latinos with externalizing disorders through the emphases and restoration of traditional Latino values of the parents, child, and family unit (Santisteban et al., 2012). Therefore, throughout the treatment process, clinicians should consider the acculturation and immigration experiences of the family while working with parents to bridge the cultural chasm and move the family toward biculturalism. Additionally, clinicians are advised to consider whether intergenerational differences are better conceptualized as cultural differences and, if so, aid parents in reframing these conflicts as such.

Treatment of Externalizing Disorders

Behavioral management trainings (BMT) utilizing basic behavioral principles have shown success in the treatment of children and teens with externalizing disorders (Eyberg, O'Brien, & Chase, 2006). BMT is one of the few empirically supported treatments for externalizing disorders (Christophersen & Mortweet, 2001; Kazdin & Weisz, 2003; Kendall, 1998). Typically, BMT interventions last anywhere from 8 to 15 sessions but may be longer when supplemented by additional interventions such as problem-solving therapy, communication training, marital therapy, stress reduction, etc. (Barkley, Edwards, & Robin, 1999; Dadds & McHugh, 1992; Kazdin 2005; Sanders, Markie-Dadds, et al., 2000). Approximately 79% of clinically referred adolescents showed significant decreases in problem behavior at the cessation of treatment (Kazdin & Wassell, 1998), and treatment gains have been found to persist for 1–2 years (Kazdin 2008) with some longitudinal studies finding positive outcomes up to 14 years later (Long, Forehand, Wierson, & Morgan, 1994). Such interventions rest on parents' understanding and enacting core behavioral management principles. Thus, BMT does not directly augment teen behavior but rather modifies teen behavior via educating and altering parents' behavior; therefore, the bulk of the clinician's direct work will be with the parents. The behavioral management principles will serve as the foundation for the remainder intervention, and thus it is crucial to get parents, as well as anyone else who is involved in the parenting of the teen such as grandparents, uncles, aunts, etc., educated and utilize these principles. Additionally, family involvement and an emphasis on familismo may mitigate teen behavioral problems and overall family stress (Santisteban et al., 2012).

Treatment Outcomes in Latino Youth Numerous randomized clinical trials have demonstrated the effectiveness of BMT-based interventions (Kazdin & Weisz, 2003; Kendall, 1998; Serketich & Dumas, 1996). However, fewer studies have been conducted examining BMT-based interventions' impact on Latino youths and families (Barker, Cook, & Borrego, 2010; Forehand & Kotchick, 1996). The available outcome research on BMT-based interventions for Latino and other ethnic groups suggests that the treatment is effective (Gross et al., 2003), and when culturally augmented for Latinos, Latino parents rated the program highly satisfactory (Martinez & Eddy, 2005).

Cultural Adaptations While the empirical literature suggests BMT-based interventions translate cross-culturally, cultural adaptations may increase social validity, decrease dropout, and improve overall effectiveness (Castro, Barrera, & Martinez 2004; Kumpfer & Alvarado, 1995; Zayas, Borrego, & Domenech- Rodriguez, 2009). In their seminal paper, Forehand and Kotchick (1996) highlighted the need for researchers and clinicians to value and understand the relationship between cultural factors and parenting practices, as parent training programs cannot be examined outside of the cultural context. In recent years, there has been an increasing amount of research dedicated to the investigation of culturally adapted parent training programs (Barker et al., 2010). One such study conducted by Martinez and Eddy (2005) investigated the efficacy of a culturally adapted Parent Management Training – Oregon Model for Latino families. The adapted intervention, Nuestras Familias: Andando Entre Culturas (Our Families: Moving Between Cultures), includes basic BMT principles supplemented by treatment modules focused on fostering integrated acculturation, retaining Latino roots, and the role that Latinos play in their families. Compared to the control group, parents in the intervention condition reported an increase in parenting effectiveness and a decrease in child behavioral problems (Martinez & Eddy, 2005). Other culturally adapted BMT-based interventions have opted for surface level modifications, such as bilingual therapists and translated measures (Barker et al., 2010). Unfortunately dismantling studies, parsing which components of the intervention are active ingredients and which are inert or even iatrogenic, are lacking; hence, it remains unclear how substantial cultural modifications should be.

Mindfulness-Oriented Parent Training

Parenting trainings, such as BMT, are based on behavioral principles; hence, the functional dynamics of family are the core of the intervention. Teen behavioral problems are intertwined with parental difficulties in implementing contingencies and setting a stable and productive environment for their children. In the spirit of familismo, it is important for the clinicians and the clients to realize that both the teens' behavior and responses influence the family and the family's behavior and responses influence teens. It is essential to stress that both parties are involved in the problematic behavior and that both parties need to work together to reach mutual goals. Therefore, parents, teens, and other family members are informed that the purposes of the intervention are not to assign blame or punishment but to change current and future behaviors that have caused family and teens' pain.

Before describing BMT, it is important to understand that some parents may express resentment or hostility at the inference that they are in some way responsible for their teen's behavior. They might have little awareness of the reciprocal nature of the teen's behavioral problems and often see causes as black or white, that is, entirely teen's fault or entirely their fault. It is also important to note that behavioral problems can be passed intergenerationally via cultural practices or direct interactions (Hicks, South, DiRago, Iacono, & McGue, 2009). For instance, Latino maternal depression is associated with child externalizing behavior directly and indirectly through negative effects on the family (Corona, Leftowitz, Sigman, & Romo, 2005), indicating that parental stress and mental health issues are valuable treatment targets.

Recently, mindfulness strategies have demonstrated a reduction in parental stress and improvements in child-parent relationships (Van der Oord, Bögels, & Peijnenburg, 2012). Mindfulness is a practice based on meditation and experiential exercises that promote awareness about internal and external events (Monroy-Cifuentes, Torres-Sánchez, & Muñoz-Martínez, in press). Behavioral management training with a mindfulness orientation utilizes strategies to foster present moment awareness in parents' interaction with their children while decreasing behavioral problems through the implementation of the behavioral management techniques (Duncan, Coatsworth, & Greenberg, 2009). García and

Grau (in press) conducted a BMT-based intervention with a mindfulness orientation with parents of Colombian children with externalizing behavioral problems. The results showed a reduction in parental stress and an improvement in child-parent interactions. This preliminary investigation showed positive effects by combining behavioral management techniques and mindfulness in Latinos. These results suggest that the incorporation of mindfulness into the BMT program offers treatment providers an effective way to decrease parental stress, burnout, and distress while increasing present moment awareness; and therefore it is recommended that clinicians utilize this tool.

Core Principles and Techniques

Parent training interventions employing behavioral management principles are well nested within the behavioral analytic framework. In this framework, the central unit of analysis is the operant constituted by antecedents, behavior, and consequences, assuming that behaviors are influenced and maintained by contextual factors (Kazdin, 2008). Behavior, whether problematic or desirable, is primarily maintained by contingencies of reinforcement, which in turn establish the function of the behavior or, in other words, what the behavior "works" for (Cooper, Heron, & Heward, 2014). For instance, when a child has a tantrum in a supermarket because their parents do not buy them candy in the checkout line, the tantrum is likely related to food deprivation and/or a history of reinforcement in which his parents have previously provided candy upon his tantrum. In either case, the consequences will shape the future occurrence of this behavior.

Behavioral modification requires effectively manipulating the core behavioral principles: stimulus control, contingencies of reinforcement, extinction, discrimination, and generalization (see handout 2c; Cooper et al., 2014; Kazdin, 2008). Therapists must be well versed in principles in order to teach parents to precisely implement behavioral techniques with their teens and troubleshoot if things go awry.

Foundations of Behavioral Management

Anticipating and Planning for Problem Behaviors Parents of teen with behavioral problems are often overwhelmed and spend most of their energy punishing the problem behavior after it has occurred rather than predicting it or preventing it. This reactive approach contributes to the challenge of controlling the teen in public settings. Providing parents with the tools to understand, predict, and plan for their teen's problem behaviors allows for much more effective parenting. Explaining behavioral chains or functional analysis is an important component of family training (see handout 2b). Parents will identify those factors that influence behavior and in doing so can alter antecedents and consequences, decreasing the occurrence of teen's problems.

Stimulus Control Changing antecedent stimuli allows parents to set conditions that promote desirable behavior and reduce problematic responses. Altering establishing operations may improve (motivational operations) or demote (abolishing operations) the value of the reinforcers. For instance, a teen deprived of social interactions has an increased probability of doing chores (assuming social interactions are permitted post-chore completion) than a teen that has had multiple social interactions throughout the week. This motivational operation *increases* the value of social reinforcement and in doing so increases the frequency of the target behavior (chore completion).

One type of motivational operation frequently used in BMT-based interventions is the prompt, which can take several forms. Think about a child who does not know how to say "I'm sorry." Some prompts might use to foster that behavior, such as (a) a verbal statement about apologizing (e.g., what you should say when you harm somebody?) (verbal prompt), (b) approaching with him to the person he was rude and waiting until he apologizes (physical prompt), (c) saying "I'm sorry" and asking him saying the same to the other person (model prompt), and (d) signaling the other person and waiting that he approaches and

apologizes (gestural prompt). Parents need to be flexible and broad in their repertoire of prompts as certain types of prompts may be more effective for certain situations and individuals.

Delivery of Reinforcement Reinforcement is the variable that predominantly influences the occurrence of operant behavior. The following features are essential for reinforcement's effectiveness (Barkley et al., 1999; Kazdin, 2008):

1. Immediacy of consequences: the effectiveness of the reinforcement largely depends on a short delay between the occurrence of the behaviors and the delivery of the consequences. Learning improves as the consequences are delivered closer in time to behavior. For instance, if a teen is asked to turn off the TV and go to bed, the parents need to provide the consequences/reinforcement promptly after making the request. If the teen disobeys or complies and the parents wait until the next day to deliver punishment or praise, learning potential is damped, decreasing the likelihood of future compliance and increasing the likelihood of future disobedience.

2. Specificity of consequences: reinforcers or punishers need to be clear as possible in order to allow the teen to properly discriminate consequences of his/her behavior. Meaning, the parents should be descriptive and concrete with their feedback and directly reference the behavior at hand. Punishment particularly should be specific and appropriate, not based on past transgressions or parental frustration or anger but the dimensions of current behavior of the child.

3. Magnitude or amount of the reinforcement: when reinforcement magnitude increases, the strength or probability of behavior occurring rises, though it is important that consequences are proportional to the teen's behavior. For example, a commensurate punishment for a teen that breaks curfew might be a weeklong grounding (proportional punishment). A parent who exceeds punishment amount might acquire aversive properties for the child, dam-

aging child-parent relationship, therefore the capacity of leading behavioral change effectively.

4. Continuous reinforcement: reinforcement must follow the behavior every time it occurs, or at least the vast majority of the time, to be effective. Continuity of reinforcement is of particular importance in the development of new behavior or when contingencies are changed. For instance, when a mother wants to increase the time her child spends reading, she should deliver reinforcement every time the child read.

5. Quality or type of reinforcement: learning history affects the value of reinforcers for individuals, and unsurprisingly, behavioral change is more effective when parents utilize the child's preferred reinforcer. For instance, some teens may find social media or the Internet more reinforcing and hanging out with friends and others vice versa. In this case, parents might negotiate privileges by choosing the reinforcer most valued by the teen.

6. Varied and combined reinforcers: to avoid satiation of the reinforcer, it is recommended to offer a variety of consequences. Such variations also enhance generalization. For example, a father can reinforce his child for doing housework by mixing compliments, allowance, extended curfew, etc. as reinforcers. If the teen is always presented with the same reinforcer, its strength will be reduced.

7. Predictability of consequences: behaviors should always be met with the same kind of consequence (punisher or reinforcer). Often parents, out of ignorance or exasperation, infrequently and indiscriminately provide consequences. Positive consequences should only follow positive behavior. While this may seem apparent, desperate parents may try positive consequences to curb or halt their child's problem behavior. However, these attempts will only reinforce the problem behavior. When a child has a tantrum in the supermarket, parents should ignore him completely, so that the child will learn that the tantrum is related to attention withdrawal and no to attention delivery.

8. Consistency of consequences: guidelines for acceptable and unacceptable behavior and the consequences that follow them should remain consistent across setting, time, and people. Applying swift, specific, and predictable consequences across a variety of situations and settings can be exceedingly difficult. However, only applying consequences in one context, say the home, significantly decreases the chance of generalization. Parents need to clarify that the same consequences will be administered for the same behaviors no matter who applies them or where they are delivered. Creating a document specifying unacceptable behaviors and their consequences agreed upon by all parties involved in the parenting of the teen may help in maintaining consistent consequences.

9. Positive reinforcement before punishment: it is a common misconception that punishment will promote change; on the contrary, punishment only reduces behavior, and it does not provide opportunities for novel responses. Parents, who want their teens to behave differently, are required to reinforce new repertoires that replace the problematic one. Before punishment, parents need to develop an incentive program that rewards appropriate alternative behaviors (e.g., the teen gets an hour of Internet time after completing their chores, etc.). This alternative approach can increase feelings of appreciation and approval in the teen, as solely relying on punishment can induce feelings of resentment.

Shaping Often parents provide multiple instructions about what their children should not do but neglect specifying what the child should do. Behavioral modification becomes more difficult when individuals have failed to learn the appropriate repertoire required by the environment. Imagine a teen that never has asked permission to go out and always leaves the home without saying anything. Rather than discussing why he should not go out without permission, parents are more likely to see a desired change by teaching him when and how to ask for permission. Shaping

is one of the procedures by which parents can modify teen's behavior. This is a graduated process in which individuals learn new repertoires progressively, which requires the achievement of small steps tied to the larger goal. Once the child reaches out one step, parents stop providing reinforcement for it and only reinforce the next step forward. This process continues until the child masters the larger goal.

Using Multiple Exemplars A concern frequently expressed by parents is that target behaviors occur only under specific conditions. Parents may worry that the teen's behavior will not extend beyond or outside of therapy. A consistent practice of the BMT skills across settings, individuals, and conditions is the key for extending and maintaining positive treatment outcomes and supporting generalization. In BMT-based interventions, the spirit of "the more the merrier" is encouraged as when the number of people participate in the implementation of the training increases, so does the probability of lasting behavioral changes in the teen.

Session-by-Session Guide

The treatment consists of 13 sessions, which can be included or added to ongoing treatments. The treatment is unfolding in that each session builds off skills previously learned, and thus it is recommended that clinicians retain the sequencing of the program. This section will provide a step-by-step guide for implementing each session as well as work sheets to be used in session.

Session 1: Orientation to Treatment

- Therapist should provide families with thorough information regarding the psychotherapy process. This should include a discussion of the terms and limits of confidentiality, the role of each family member in the therapeutic process, the role of the therapist, guidelines for attendance and termination, and addressing barriers to attending treatment.

- Provide parents with an overview of the treatment, making sure families have realistic expectations about what the treatment will require as well as what behavioral changes they are likely to see.
  - Explain "the purpose of this treatment is to empower parents through training in skills and techniques proven to improve behavior. While some of these skills and techniques may be familiar to you, I will be asking you to perform them in very specific ways. Some of the skills may be unfamiliar or may even seem counterintuitive. If you find yourself questioning or disagreeing with a skill or technique, please let me know. The parent training program is special in that *you* will be treating your teen. In the beginning, I will play the role of teacher, instructing you on how to implement the skills and techniques. Later in the treatment, I will play the role of coach, helping you implement and troubleshoot when problems arise. These skills and techniques are like any other; the more you practice, the more benefits you receive. You have experienced firsthand how difficult your teen's behavior can be and the pain their actions can cause you, your loved ones, and themselves. The fact that you are here shows how much dedication and love you have for your child. This is an intensive treatment that will require a lot of time and effort. To see benefits, daily practice is required and increasing your practice will increase those benefits. It can be very hard not to get discouraged or feel overwhelmed, but remember behavioral problems are deeply entrenched, and through systematic application of the skills and techniques learned in this treatment, as well as diligent monitoring of your teen's behaviors and your own, these problem behaviors can be trained out and new prosocial behaviors can take their place. The treatment consists of 13 sessions and attendance is curial to see benefits."

Session 2: Considering Culture

- Obtain general information about families' acculturation and/or immigration experiences.
- Discuss the importance of balancing retention of their cultural values and functioning in a new culture, highlighting the benefits of integrated acculturation.
- Emphasize the importance of familismo.
- Help parents to understand their teen's cultural orientation and investigate the impact of reframing problem behaviors as culturally based disagreements.
- Homework: read psycho-education about oppositional defiance disorder and conduct disorder, ADHD, behavioral problems in general, or all.

Session 3: Psycho-education on ODD and ADHD

- Provide the parents with psycho-education regarding their child's diagnosis.
- Check for parental understanding and/or questions regarding their child's diagnosis.
- Instruct parents on the importance of distinguishing between a "behavior" and a "nonbehavior" (see handout 1a).
- Discuss prompting the teen's behavior (see handout 1b).
- Homework: monitor and record teen's behavior and what distinguishes it from a nonbehavior.

Session 4: Mindful Parenting

- Review the psycho-education homework addressing any questions or concerns.
- Provide information about mindfulness and how this practice can help parents in implementing behavioral management training techniques (see handouts 2a and 2B).
- Conduct a brief mindfulness exercise with parents such as mindful breathing or eating.

Inquire about parents' experiences with the exercise. If parents report negative reactions, investigate what about the experience that was unpleasant. It is likely that parents experiencing negative reactions during the exercise were unable to engage in the exercise due to overwhelming distress or judgments, in which case the therapist should spend time discussing how judgments and overwhelming negative emotions can interfere with effective parenting and family harmony. If parents report positive experiences, use this opportunity to reiterate how mindfulness can reduce stress, and allow them to engage more effectively with their child when distressed or overwhelmed.

- Note that some parents may feel guilty about taking time for themselves. In such cases emphasize the importance of self-care to the parents using the metaphor that the family is like a body and the parents are the heart. Before the heart can pump blood to the rest of the body it has to pump blood to itself. A parent who engages in self-care will be better able to parent.
- Introduce a practice of 5 min every session before starting interacting with children.
- Homework: lead a daily mindfulness practice for 15 min a day.

Session 5: Principles of Behavioral Management

- Before diving into new content, it is important to spend time with parents going over their reactions to the last few session.
- Provide education about the four-factor model of adolescent behavioral problems (see handout 3a) tying this into the concept of familismo.
- Educate parents on understanding and predicting their teen's behavior (see handout 3b).
- Introduction to behavioral core principles and foundations of behavioral management (see handout 3c and 3d).
- Homework: use handout 3b to analyze one of the teens' problem behaviors over the next week, consider parenting style, and consider which (if any) principles of behavioral management they used the most, which they used the least, and why.

Session 6: Paying Attention to the Positives

- Review reactions from previous session and homework, and check in on the implantation of the behavioral management principles and the teen's reaction to the implementation of behavioral management principles. Checking in on the teen's reaction is particularly important, as often the teen's problem behaviors will often escalate in response to increased parental control. It is also important to stress to parents that this reaction is normal and should be seen as a success rather than a failure.
- Educate parents on the importance of quality attention to their teen. Address that parents may have animosity toward their teens and normalize this reaction. Explain that while this is understandable, it is key that they are able to engage positively with their child for the treatment to be effective. Some parents may require cognitive restructuring regarding their feelings and attitudes toward their teen.
- Introduce positive attending skills. Explain to parents that most parents of teens with behavioral problems rely on punishment to deal with their teen's behavior (normalizing their experience). However, by adding positive attending skills into the mix, they can see improvements in their teen's behavior. Additionally, this can increase feelings of acceptance, love, and positive feelings in general. The idea is not to remove punishment or negative interactions per say but rather to increase the number of positive interactions with the teen, which will necessitate the parents to increase contact with the teen.
- Discuss strategies for implementing positive attending skills (see handout 4a).
- Homework: practice positive attending skills at least three times, noting any challenges or triumphs.

Session 7: Attuning Attending Skills

- Review reactions from previous session and homework, and check in on the implantation of positive attending and the teen's reaction.

- Provide parents with additional training in positive attending and in ignoring.
  - Providing praise for the absence of common misbehaviors. Review the four-factor model of teen misbehavior (handout 3a), and note that the teen has many predisposing factors that make it likely that they will misbehave (e.g., impulsivity, hyperactivity, defiant, etc.), and thus each time the child is not behaving badly, this is an opportunity for reinforcement. This may seem odd to many parents, so rereviewing the power of reinforcement may be needed. Instruct the parents to pick one or two less severe problem behaviors and praise the teen when they are not engaged in this behavior (see handout 5a).
  - Praising spontaneous compliance. Parents may be so focused on when their teen does not comply, they may neglect the times when their teen does comply. Every time the teen complies they should be praised (see handout 5a). Additionally, parents should set up opportunities that increase the likelihood of the teen obeying (i.e., commands that are appealing and/or easy). Provide the parents with a variety of examples and have them generate commands that they will implement for homework.
- Discuss parents' delivery of commands. Use role-plays to help parents fine-tune their command-giving skills.
- Homework: practice praising compliance, absence of bad behavior praise, and practice giving effective commands.

Session 8: Creating Behavioral Contracts

- Review parent and teen reactions to homework.
- Review content of session 6: positive attending and effective command giving (see handout 1b and 2a) and troubleshoot if problems arise.
- Introduce contingency management. Explain that most teens these days are inundated with gadgets and other material goods and that they often take for granted and see as rights rather than privileges. The goal here is to alter that view so that fun things are seen as privileges only to be accessed through good behavior. Additionally, it is important to stress here that teens with behavioral problems often struggle to persist in goal/task-directed activities without powerful and salient consequences, and thus more tangible and stronger incentives are often required. Parents may show opposition to this idea and view it as bribery or fostering materialism. In which case, provide an expanded discussion of reward deficits in children with behavioral problems (Gatzke-Kopp et al., 2009; Sagvolden, Aase, Zeiner, & Berger, 1998).
- Creating behavioral contracts (see handout 6a). Before creating the behavioral contracts, have parents create a list of chores they typically ask their teen to do that when requested must be done immediately (starting homework, doing dishes, etc.), and then rank the task on teen's difficulty complying. Next, have parents create a "privileges" list and rate these in terms of desirability to the teen. These privileges should be reasonable and specific (e.g., 1 h of Internet time). The first behavioral contract should include a task rate as low in difficulty to comply and a moderate privilege. The parents are to instruct the teen that they can only have access to their privilege (e.g., 1 h of phone time) IF they do their task (e.g., clear the table). Use handout 6a as a template to writing on the behavioral contract to which the teen should receive and sign a copy.
- Setting up a point system. Each required task is assigned a value from 0 to 100 depending on its difficulty. Each privilege is also set up on a 0–100 point system depending on how desirable it is. The teen can then "spend" the points gained from completing a task on a privilege. Privileges may only be accessed if the teen has saved up enough points to "purchase" it. Teens may rebel against this point system; however, it is crucial that parents keep going with the new system, as reverting back reinforces their rebellion. Reassure parents that as they stand their ground, the teen's rebellion will die down.

• Important note: if parents are not ready/
  unwilling to implement the strategies pre-
  sented thus far, treatment should not progress
  further until these difficulties are resolved.
• Homework: discuss the behavioral contract or
  the point system with the teen and implement
  it for the week.

Session 9: Employing Response Cost

• Review reactions from previous session;
  check in on the implantation of the behavioral
  contract or point system and parent and teen
  reactions.
• Review the rationale behind reward-oriented
  point systems and behavioral contracts.
• Introduce the concept of response cost for bad
  behaviors. Up until this point in the treatment,
  the focus has primarily been on reinforce-
  ment. Highlight to parents that while those
  principles are still essential, more tools in our
  arsenal are still needed. Explain to the parents
  that penalties are to be deployed when the teen
  engages in a problem behavior or fails to com-
  ply. However, it is essential that the *punish-
  ment fit the crime*. For example, losing phone
  privileges for a day would not be an appropri-
  ate response to getting suspended from school,
  nor would getting grounded for a month be an
  appropriate response for swearing; one is too
  weak, while the other too strong. Losing
  points or privileges should be employed for
  day-to-day noncompliance, whereas ground-
  ing should be reserved for more severe prob-
  lem behaviors.
  – Behavioral contracts for noncompliance are
    the same as those for rewarding compliance
    with one major difference. Instead of hav-
    ing parents create a list on tasks they want
    their child to do, have them create a list of
    bad behaviors and pair them with a list of
    privileges. Have them write out a contract
    that their teen will read and sign indicating
    that if they engage in behavior X, they will
    lose privilege Y (see handout 6a).
  – Using the point system for punishment. For
    parent using a point system, have them cre-
    ate a list of bad behaviors and assign points

that correspond to the severity of the behav-
ior. Have them explain to their teen that for
each time they engage in problem behavior
X, they will be deducted Y amount of
points from their privilege bank.
• Homework: begin implementing point deduc-
  tions or behavioral contracts for
  noncompliance.

**Session 10: Completing the Contract/Point
System**

• Review reactions from previous session, and
  check in on the implantation of the behavioral
  contract or point system for noncompliance
  and parent and teen reactions. Importantly,
  check in with parents regarding the consis-
  tency of delivering contingency management,
  as it is crucial that all these techniques be
  delivered using the basic principles of
  behavioral management (i.e., immediacy,
  specificity, consistency, predictability, etc.).
• Increase the use of contingency management
  to more serious behavioral problems.
  – Whether families are using behavioral con-
    tracts or a point system, parents should
    pick 3–4 behaviors that the teen MUST
    comply with and create behavioral con-
    tracts or assign points for each of these as
    well as incentive and penalties for noncom-
    pliance (keeping in mind incentives should
    be desirable to the teen and penalties should
    fit the crime).
• Homework: continue with point system or
  implement all behavioral contracts.
  Additionally, ask parents to gather relevant
  school information (e.g., progress reports,
  report cards, detention or behavioral warning
  notes, behavioral contracts developed by the
  teacher, etc.) to bring to the next session.

Session 11: Grounding

• Review reactions from previous session, and
  check in on the implantation of the behavioral
  contract or point system and parent and teen
  reactions.

- Review all the techniques and skills presented to date.
- Introduce grounding for serious problem behaviors. Explain to parents that grounding should be a last resort only used for the most severe acts of misconduct. Provide examples of grounding gone awry and then present parents with handout 7a. After they have read the handout, explain that grounding like all other skills learned thus far should be immediate, specific, consistent, predictable, and reasonable (i.e., the punishment should fit the crime). Additionally, the teen should be kept in the loop, meaning they should be told ahead of time explicitly what behaviors will result in grounding and reminded of this when they start to engage in problem behaviors. While grounded, the teen should not be allowed access to anything that the parents consider privileges, and the parents may incorporate restitution (e.g., making the teen do chores) as a further deterrent. It is important to stress to parents that they need to plan for what offenses warrant grounding ahead of time, as in the moment they may be too overcome with anger and respond with retaliation rather than discipline (this also serves as an opportunity to reiterate the power of mindfulness).
- Additional considerations: some teens may be too old for grounding to make much of an impact (i.e., they can just leave or drive away), and thus keep this in mind for parents of older teens.
- Homework: pick two behaviors that are grounding-worthy offenses. Ask parents to track the use of grounding or time-outs.

Session 12: School Advocacy

- Review reactions from previous session and check in on the homework.
- Discuss teen's academic performance and possible accommodations for improving academic performance.
- Introduce behavioral contracts for homework. If the teen exhibits difficulty with completing homework, discuss with the parents any issues that may be hindering the teen from completing their homework (i.e., are they keeping track of assignments, do they have someone to talk to if there is confusion, are the parents monitoring homework completion, etc.). Additionally, advise parents on creating a behavioral contract for homework completion (see handout 8a).
- Educate parents on the Americans with Disabilities Act, as children with ADHD and other learning disabilities are eligible for special services.
- Wrap up the parent training portion with an overview of topics discussed so far and skills learned. Inquire about parent difficulties and successes, teen reactions, and family reactions.
- Homework: ontinue using skills and techniques, create behavioral contract for homework, and contact school if necessary.

Session 13: Termination

- The goal for the thirteenth session is termination; however, it is important to note that many families may require additional sessions. If this is the case, this session should be used as a review session. Either way, the therapist should review the skills learned over the course of the treatment, the progress made, and setbacks that were encountered and encourage parents to share their experiences with the treatment program.
- If parents are satisfied with treatment success, spend time discussing a relapse prevention plan.
- If teen still requires treatment, it is important to establish if parents were able to implement the behavioral management principles and implement them correctly. If the parents have not been implementing or have been struggling with the behavioral management principles, spending several additional sessions working on these skills may behoove the client. For some individuals, more intensive treatments may be required, in which case we recommend supplementing the treatment presented in this

chapter with interventions to fit the client's needs (i.e., communication training, cognitive behavioral therapy, problem-solving therapy, etc.).

plo, si un adolescente se reí, cualquier persona podría identificar que él sonríe y su sonido al hacerlo. Sin embargo, si un chico ha sido "irrespetuoso" o "desobediente", no todo el mundo

Conductas	vs.	No-Conductas
• Sonreír.		• No decir nada.
• Golpear a un hermano.		• Ser egoísta.
• Correr.		• Irrespetar.
• Disculparse.		• Desobedecer.
• Llorar.		• Tener una mala actitud.
• Lanzar la puerta.		• No colaborar.
• Maldecir.		• Ser indiferente.

Sesión 3
Folleto 1A: Diferencias Entre Conducta y No-Conducta

Las conductas son eventos que suceden, pueden ser *vistos* u *oídos* por una tercera persona, o pueden ser observados únicamente por quien los experimenta, como: sentir o pensar. Las no-conductas no son eventos, por lo tanto no tienen un status de ocurrencia y no pueden ser observados, algunas veces son juicios, evaluaciones o actitudes hacia los otros.

Es importante que en los programas de cambio conductual se identifiquen conductas observables por terceros . Lo que hace a una conducta de ese tipo única e importante es que puede ser reconocida por otros y puede haber un acuerdo acerca de su ocurrencia. Por ejem-

podría reconocer que es lo que él está haciendo, o que se entiende por tales etiquetas. La identificación de conductas observable nos da el mejor chance para establecer el cambio dado que puede ser fácil de establecer en diferentes situaciones.

Sin embargo, algunas de las no-conductas que presenta su hijo adolescente pueden ser las mas estresantes para usted y su familia. Por lo que será útil que durante la próxima semana seleccione un problema que es una no-conducta (e.j., no colaborar, actuar indiferente, etc.) y se de cuenta si puede dividirlo en pequeñas unidades de conducta. Por ejemplo, si el problema en forma de no conducta fue ser "irrespetuoso", ¿cómo podría describir a un tercer observador lo que hace alguien quien es "irrespetuoso"?, ¿Cuáles son los comportamientos que constituyen el ser "irrespetuoso"?

Problemas no-conducta	Conductas que dan indicios de un problema no-conducta
Ser irrespetuoso	¿Cómo se que mi hijo adolescente es irrespetuoso? • ¿Me interrumpe cuando estoy hablando? • ¿Me levanta la voz? • ¿Hace cosas diferentes a las que le pido que haga? • ¿Voltea sus ojos mientras le hablo? • ¿Cuestiona lo que le digo?

Sesión 3
Tarea 1

Problemas no-conducta	Conductas que dan indicios de un problema no-conducta
	¿Cómo se que mi hijo adolescente _____? (mencione al menos tres comportamientos? 1. 2. 3.

En la próxima semana identifique también *dos conductas problema* y *dos comportamientos deseables/objetivo* que quiera que su hijo haga. Regístrelos en el transcurso de las dos semanas siguientes.

	Conductas Problema	Conductas Deseables
Lunes	1. 2.	1. 2.
Martes	1. 2.	1. 2.
Miércoles	1. 2.	1. 2.
Jueves	1. 2.	1. 2.
Viernes	1. 2.	1. 2.
Sábado	1. 2.	1. 2.
Domingo	1. 2.	1. 2.

Sesión 3
Folleto 1B: Consejos para Utilizar *Ayudas* para Promover la Conducta Deseada en su Hijo Adolescente

	Ayuda poco útil	Mejor *ayuda*
1. Sea concreto: Dígale a su hijo *exactamente* lo que usted quiere que él/ella haga.	"Limpia tu cuarto!"	" Puedes por favor recoger la ropa/cosas que están en el suelo de tu cuarto y tender la cama"
2. Manténgase positivo o neural: Sonría, o diga por favor cuando haga una petición	" Para de jugar video juegos y ven a ayudarme con los platos!"	"Carlos, podrías por favor parar de jugar video juegos por un rato y venir a lavar los platos. Realmente te agradecería tu ayuda"
3. Las *ayudas* deben usarse lo más cerca a la conducta que sea posible.	"Quiero que mañana ayudes a tu hermana con la tarea"	"Laura puedes parar de ver el Facebook e ir a ayudar a tu hermana con la tarea, por favor"
4. Evite usar *ayudas* en forma de pregunta	"¿Qué no entiendes acerca de no salir con tus amigos antes de terminar las tareas!?"	"Tomás, termina la tarea antes de irte a ver con tus amigos"

**Las *ayudas* no deben ser usadas más de dos veces. Si su hijo(a) adolescente no cumple con la instrucción no siga insistiendo sobre la conducta deseada (cómo hacer para que su hijo(a) obedezca, será descrito más adelante). Otra opción es examinar si el problema puede ser dividido en pequeñas partes de manera que usted sólo tenga que proveer instrucciones para dichas partes en la cadena que constituye una tarea más grande. Por ejemplo, si la tarea es limpiar la cocina, pídale a su hijo(a) lavar los platos, limpiar el mesón, o barrer el piso. *Cada vez* que cumpla una nueva tarea, provea reforzamiento positivo, con ello será más probable que lo haga el futuro.

Sesión 4
Folleto 2A: Práctica Mindfulness

Estar atento y presente en la interacción con los adolescentes es un reto. Las emociones y juicios, respecto a la interacción con su hijo(a), puede hacer difícil observa y reforzar las conductas deseadas, así como el administrar consecuencias para disminuir los problemas de manera efectiva. La práctica de *mindfulness* ayuda a tener una interacción consciente con su hijo de manera que pueda favorecer la entrega de consecuencias.
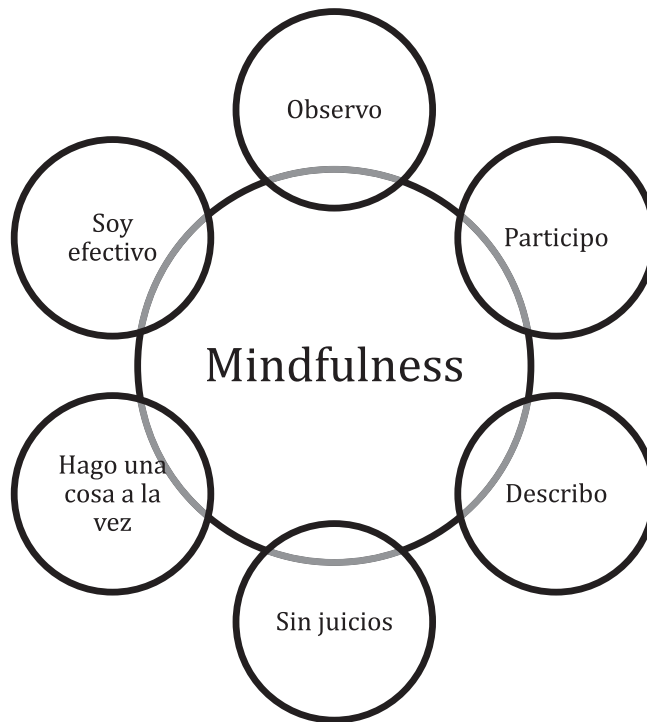
- El mindfulness no requiere una práctica formal o especializada. El objetivo fundamental es integrar la práctica a sus actividades diarias. Piense una actividad cómo lavar los platos, ¿alguna vez ha lavado los platos, *lavándolos?*, ¿ha notado el olor del jabón?, ¿la sensación del agua en sus manos?, entre otros.
- La práctica de mindfulness busca que usted esté más consciente mientras realiza una actividad.
- Piense ahora en los momentos en que usted le da una instrucción a su hijo(a) y él/ella no la sigue. ¿ha estado presente ante la negativa de su hijo, sin juicios, de manera descriptiva y sin dejarse llevar por sus emociones?.
- La práctica de mindfulness busca que usted pueda estar más consciente en la interacción con su hijo(a) para ser más efectivo en ella.

Sesión 4
Folleto 2B: Práctica Mindfulness
Parental (Bögels & Restifo, 2014)

Transformando la mente parental	• Observe la conducta de su hijo, durante 15 minutos. • Durante ese tiempo describa lo que él/ella hace. • Esté atento a no utlizar juicios (e.j. bueno, malo, lindo, torpe) o etiquetas. • Si nota que está emitiendo juicios o se ha distraido, no se enganche juzgando su propia conducta, *vuelva* a conectarse con la actividad hasta terminarla.
Reconectándose con su cuerpo como padre	• Esta práctica requiere imaginar una interacción problemática con su hijo(a) • Mientras imagina esta situación, es importante que note que siente y experimenta en su cuerpo. • Muchas veces luchamos con nuestras reacciones y queremos evitar que nuestros hijos noten la forma en que nos afectan. Olvidamos que sentimos , como cualquier otro ser humano. • Este ejercicio es una invitación para esos sentimientos y emociones. Sin juicios, ni resentimientos, dejelos llegar y dejelos ir. • Recuerde! No se apegue a sus emociones, son sólo eventos que tienen un principio y un final.
Aceptando el estrés parental	• Concentrese en las sensaciones que experimenta generalmente ante las interacciones conflictivas con su hijo(a). • Note las sensaciones en su cuerpo, los cambios en su respiración, el tono de sus musculos, entre otros. • Note sus reacciones ante tal experiencia. ¿Puede parar por un momento su impulso de escapar a éstas?. ¿Puede permitirse vivirlar, y entonces dejarlas ir? • Intente ser un poco más compasivo, con usted y con su hijo. Puede intentar dejar los juicios llegar a su mente y dejarlos ir.

Sesión 5 Folleto 3A: Modelo de los 4-factores del comportamiento

Factores predisponentes de los adolescentes
- Cada individuo tiene características establecidas antes de nacer que influye en la conducta y la forma que interactúa en su ambiente.
- Piense en los bebés, algunos bebés son más fáciles de calmar que otros. Esto se debe a que cada uno tiene su único temperamento.
- El temperamento de su hijo ha influido en su comportamiento desde el día en que nació, y puede ser contribuyendo a sus problemas de conducta

Factores predisponentes de los padres
- Los padres también tienen sus propias y únicas características desde el momento de su nacimiento, influyendo en su comportamiento y en el comportamiento de sus *hijos adolecentes.*
- Algunas veces los padres comparten parte de las características conductuales de sus hijos.

Conducta Problema del Adolescente

Estrés familiar
- El ambiente familiar puede ser impactado por diferentes factores, produciendo diferentes niveles de estrés:
  -Enfermedad de los padres.
  -Problemas financieros.
  -Problemas maritales.
  -Problemas legales.
  -Enfermedad de los hijos
- El estrés puede afectar la manera en que padres e hijos interactúan (e.j. usted puede estar más reactivo ante los comentarios de su hijo, o puede que esté más distraído). El estrés puede hacer que usted sea más estricto o sienta poca empatía.
- Es importante recordar que su hijo(a) también puede estar estresado, afectando su conducta. Problemas en el colegio o con sus amigos, pueden mediar la forma en que se relaciona con usted.

Estilo parental
- El estilo parental hace referencia a la manera en la que los padres se relacionan y responden a sus hijos.
- Aunque es difícil generar cambios en los factores que predisponen los problemas de sus hijos o que producen estrés, es posible cambiar elementos en el estilo parental que mejoren la conducta de su hijo.
- Aunque los cambios en el estilo parental no elimina el efectos de los otros factores involucrados en los problemas de los adolescentes, su modificación disminuye el impacto de estos en la conducta de su hijo y decremento el estrés parental.

Sesión 5
Folleto 3B: Entendiendo y
Prediciendo la Conducta de su Hijo
Adolescente

Antecedente: ¿Qué precede la conducta problemática del adolescente? E.j. hacer cosas diferentes a las que él/ella quiere, discusiones con sus amigos, pedirle que cumpla con una tarea, etc.	Conducta: ¿Cuál es el comportamiento problema del adolescente?	Consecuencia: ¿Cómo reaccionan usted u otros ante el comportamiento del adolescente? E.j. ¿lo ignoran?, ¿hacen lo que él les pide?, ¿lo gritan?

Recuerde que las consecuencias son las que establecen la función de la conducta
   Ejemplo

Antecedente:Ver a su hermana jugando con sus videojuegos.	Conducta: Golpear a su hermana	Consecuencia: Su hermana deja los viedeojuegos y sale de su cuarto

En el ejemplo, cuando el adolescente ve a su hermana jugando con sus videojuegos (estímulo discriminativo), la golpea, consiguiendo que ella deje de utilizarlos. El adolescente aprendió que al golpear a su hermana puede eliminar un evento. Lo anterior incrementa la probabilidad de que vuelva a hacerlo en futuras ocasiones (reforzamiento negativo).

Sesión 5
Folleto 3C: Principios conductuales

Principios Conductuales	Definiciones	Ejemplo
Control Antecedente		
Operaciones de establecimiento	Variable contextual temporal que (a) incrementa o decrementa la efectividad de las consecuencias ; y (b) aumenta o reduce la ocurrencia de una conducta que ha sido castigada o reforzada previamente.	**Estar deprivado de alimento (operación de establecimiento),** puede incrementar la probabilidad de que un niño haga un berrinche en el supermercado, el cual ha sido reforzada en el pasado.
Estímulos Discriminativos	Estímulo en cuya presencia la probabilidad de ocurrencia de la conducta es más alta, dado que ésta ha sido reforzada en el pasado bajo dichas condiciones. Así mismo, en la ausencia dicho estímulo la probabilidad del comportamiento es baja.	Un niño hace berrinche cuando su **madre (estímulo discriminativo)** está en la misma habitación que él, pero no cuando ella está en otro lugar.
Ayudas	Estímulos que sirven como guías que facilitan la respuesta. Estos eventos se encuentran directamente relacionados con la conducta esperada.	Una madre le dice a su hija **"pídele disculpas a tu hermano" (instigador).**
Contingencias de reforzamiento		
Reforzamiento		
Reforzamiento positivo	Estímulo consecuente que sigue una conducta, incrementando su probabilidad de ocurrencia en el futuro.	Una niña le pide disculpas a su hermano, y el niño le dice **"te disculpo" (Reforzamiento positivo**)
Reforzamiento negativo	Estímulo consecuente que tras su terminación o reducción de intensidad incrementa la probabilidad de la conducta.	Un niño se va a su cuarto cuando la madre le pide que lave los platos **(Reforzamiento negativo)**
Castigo		
Castigo positivo	Estímulo consecuente que sigue una conducta reduciendo su frecuencia en el futuro.	Una niña tira al suelo su almuerzo, la madre le pide recoger lo que botó y volver a servir algo para comer **(castigo positivo)**
Castigo negativo	Estímulo consecuente que tras su retiro o reducción de intensidad decrementa la probabilidad de la conducta.	Un niño raya la pared con su crayones, **la madre le quita el acceso a los crayones por dos días (castigo negativo)**
Extinción	Descontinuación del reforzamiento a un comportamiento previamente reforzado, produciendo el decremento y cese de la frecuencia de la conducta.	Un niño le lanza un balón a la cara de su madre, **ella se queda callada y le retira su atención.**
Discriminación	Respuesta diferencial de los individuos ante diferentes condiciones estimulares.	Una niña hace berrinche en presencia de su mamá, pero **NO** lo hace en presencia de su papá.
Generalización	Extensión del efecto del reforzamiento más allá de las condiciones en las que la repuesta fue originalmente aprendido.	Un niño aprendió a decir gracias a su padre cuando le daba lo que él pedía. Ahora cada vez que alguien le entrega lo que él solicita da las gracias, aunque no lo hayan reforzado directamente por ello.

Sesión 5
Folleto 3D: Garantizando la efectividad del reforzamiento y el castigo

Inmediatez	**Especificidad**
Las consecuencias deben proveerse lo más cercano posible a la ocurrencia de la conducta	Las instrucciones y consecuencias con respecto a la conducta objetivo deben describirse de forma específica, y concreta.
Consistencia	**Proporción**
Los acuerdos acerca de la conducta aceptable e inaceptable y las contingencias por dicha conducta necesitan mantenerse consistentes entre diferentes circunstancias y personas.	Tanto las instrucciones como las consecuencias deben ser balanceadas y justas. Especialmente, los castigos requieren ser proporcionales a las conductas problema.
Relevancia	**Predictibilidad**
Las consecuencias tanto de refuerzo, como de castigo, deben ser lo suficientemente significativas para favorecer el cambio.	Las consecuencias necesitan ser provistas cada vez que el comportamiento se presente.

Contingencia
Las consecuencias son administradas únicamente cuando la conducta ocurre y bajo las condiciones que se han especificado.

Sesión 6
Folleto 4A: Atención positiva

Niños y adolecentes, como cualquier ser humano, quieren ser valorados y apreciados. No obstante, dadas las conductas problema que presentan algunos adolescentes, las oportunidades para recibir gratificación por conductas prosociales o deseadas por parte de quienes se encuentran a su alrededor son pocas.

Dar atención a las conductas deseadas es la clave para conseguir mejorar la convivencia con los otros y ayudar a sus hijos a sentirse mejor con lo que hacen. Las siguientes ideas pueden ayudarle a estar más atento (a) a las conductas deseadas y proporcionarle cercanía, cariño, aceptación y apreciación, cuando éstas ocurran.

1. Tiempo uno-a-uno: pasa al menos 10 minutos en la semana con tu hijo(a) y has algo con él/ella que realmente disfrute (e.j., jugar videojuegos, pintar, etc.). Es posible llevar esto a cabo en momentos en los que él/ella estén realizando alguna actividad de disfrute, de esta manera pueden engancharse juntos en la actividad en ese momento. **Importante:** *el tiempo uno a uno es acerca de disfrutar el tiempo juntos, por lo tanto, no de instrucciones, no haga correcciones, o diga que se debe hacer durante ese tiempo. Los comentarios deben ser positivos o neutrales, y aquellas conductas problemáticas de menor intensidad deben ser ignoradas. Si el adolescente se torna agresivo o violento, como padre usted puede interrumpir la conducta y terminar el tiempo uno-a-uno.*
2. Cuando su niño o adolescente no esté realizando comportamientos problema hágale saber cuanto lo aprecia y cómo se siente al verlo comportarse de manera adecuada. Cosas como reconocer que ayuda a su hermanos, que esta realizando sus tareas, o que su cuarto se encuentra ordenado. **Importante:** *sólo muestre apreciación cuando lo sienta de manera sincera, evite situaciones en las que el adolescente pueda sentir que está fingiendo o siendo sarcástico en su comentario.*
3. Cuando su hijo realiza de inmediato lo que usted le pide, muéstrele apreciación y agradecimiento por hacerlo, tan pronto como pueda. Recuerde que la cercanía entre la conducta y las consecuencias mejora las posibilidades de que la conducta se vuelva a presentar.
4. Use reforzadores no verbales: abrácelo, sonríale, o acérquese, hágale saber que está feliz y complacido.
5. No se rinda! Los adolescentes, son adolescentes, posiblemente ellos rechacen sus aproximaciones iniciales respondiendo de manera sarcástica, ignorándolo o siendo indiferente. Puede ser duro recibir tales respuestas inicialmente, pero si mantiene el cambio y la atención positiva, sus conductas cambiarán en el futuro.

Recuerde, entre más practique más pronto verá los resultados!!

Sesión 7
Folleto 5A: Práctica para proveer reforzamiento

Usted puede practicar la entrega de reforzamiento positivo cuando el adolescente no se esté realizando conductas problemáticas.

1. Seleccione uno o dos conductas que no sean tan severas/disruptivas (e.j., ignorar la instrucción de recoger las ropa en su cuarto)
2. Defina la conducta problema (ver folleto1a)
3. Refuerce a su hijo(a) cada vez que no esté enganchado en la conducta problema.

Conductas Problema	¿Cómo define la conducta problema?	Número de veces que el adolescente no se involucró en la conducta problema.	Tipo de reforzador utilizado (apreciación, afecto, etc.)
1.			
2.			

Sesión 8
Folleto 6A: Contrato Conductual (Muestra)

Contrato

Este contrato se establece _____(fecha) entre _____(padres) y _____

(adolecente), en éste se acuerda:

_____

_____

_____

En retorno _____(padres) harán:

_____

_____

_____

Si _____ (adolescente) llega a violar el contrato se administras las siguientes consecuencia(s)

que se han acordado entre las partes son:

_____

_____

_____

Todas las partes han discutido y acordado que este contrato, y todas las partes deberán acordar

cualquier modificación en el mismo.

_____   _____
   (Firma del adolescente)   (Firma de los padres.)

Fecha: _____   Fecha: _____

Sesión 9

Folleto 7A: Contrato Conductual por Incumplimiento de Acuerdos

Este contrato se establece _____(fecha) entre _____(padres) y _____

(adolecente), en éste se acuerda que si _____(adolescente) no realiza:

_____

_____

_____

En retorno _____(padres) harán:

_____

_____

_____

Si _____ (adolescente) llega a violar el contrato se administrarán las siguientes

consecuencia(s) que se han acordado entre las partes:

_____

_____

_____

Todas las partes han discutido y acordado que este contrato, y todas las partes deberán acordar

cualquier modificación en el mismo.

_____   _____
   (Firma del adolescente)   (Firma de los padres.)

Fecha: _____   Fecha: _____

Sesión 11
Folleto 7a: Castigo

** **El castigo se utiliza únicamente con las conductas problema más severas****

- La primera vez que se presenta el castigo (después de la sesión 8), elija 1-3 conductas problema que sean severas en las que su adolescente generalmente se engancha.
- Desarrolle un documento que tanto los padres como el adolescente acuerden que ante la emisión de las conductas X, Y, y Z la consecuencia será estar castigado o encerrado(a) en casa.
- El castigo implica que el adolescente **NO** tendrá acceso a dos privilegios (como se definió en el contrato entre los padres y el adolescente).
- Cuando ejecute el castigo siga los siguientes pasos:
  - El padre debe esta presente en la casa para aplicar el castigo: dado que los padres no pueden estar en casa todo el tiempo, es preferible que no se de el castigo hasta el momento en el que él pueda estar en casa para verificar el seguimiento del mismo.
- La longitud del castigo depende de la seriedad del problema conductual y la habilidad del padre para hacer que el castigo se cumpla. El castigo puede tomar entre 2 y 3 horas, pero no puede exceder dos días.
- Mientras el adolescente se encuentre en restricción dentro de la casa es importante que éste se encuentre realizando alguna tarea relacionada con comportamientos deseados (e.j., organizando el cuarto), con ello puede remediar lo que hizo y que provocó el castigo.
- Castigo de adolescentes mayores: dado que los adolescentes mayores tienen más independencia que los menores, el *castigo* puede ser poco efectivo o inapropiado para esta población. En lugar de ello, los padres pueden aplicar penalidades o negar acceso a privilegios.

Sesión 12
Folleto 8A: Contrato Conductual para el Cumplimiento de Tareas

Este contrato se establece _____(fecha) entre _____(padres) y _____

(adolecente), en éste se acuerda que si _____(adolescente) hace las siguientes tareas:

_____

_____

_____

En retorno _____(padres) harán:

_____

_____

_____

Si _____ (adolescente) llega a violar el contrato se administrarán las siguientes

consecuencias(s) que se han acordado entre las partes:

_____

_____

_____

Todas las partes han discutido y acordado que este contrato, y todas las partes deberán acordar

cualquier modificación en el mismo.

_____   _____

  (Firma del adolescente)   (Firma de los padres.)

Fecha: _____   Fecha: _____

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Tools for Treating Behavior Problems in Young Latino Children

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Origin of Behavior Problems

Disruptive behaviors including aggression, property destruction, hyperactivity, defiance, and self-injury are the most common reasons prompting a young child's referral to mental health services (Kazdin, 2008). These children may receive a diagnosis of oppositional defiant disorder (ODD), characterized by angry and irritable mood, argumentative and defiant behavior, and vindictiveness, or conduct disorder (CD), characterized by a disregard for the rights of others including aggression, destruction of property, deceitfulness or theft, and violations of rules (American Psychiatric Association, 2013). In the United States, 4.6% of children aged 3–17 years received a diagnosis of ODD or CD, with a higher prevalence among boys (6.2%) than girls (3.0%) (US Department of Health and Human Services, Centers for Disease Control and Prevention [CDC], 2013). Among

Latino children, approximately 4% had received a diagnosis of a behavior problem (CDC, 2013). While relatively few preschool-aged children are diagnosed with a psychiatric disorder, researchers have estimated 13–21% of 1–5-year-old children consistently exhibit high levels of disruptive behaviors that pose significant challenges to their caretakers (Carbonneau, Boivin, Brendgen, Nagin, & Tremblay, 2015). Estimates of children living in urban environments who exhibit moderate to clinically significant emotional and behavioral problems may even range as high as 30% (Barbarin, 2007). The typical onset of these disruptive behaviors begins very early in life and, if left untreated, may lead to mental health and social adjustment problems as the child matures into adolescence and even adulthood, including academic impairment, peer rejection, and unemployment (Carbonneau et al., 2015; Odgers et al. 2007).

Many factors influence the development of behavior problems in early childhood, including the parental use of verbal (Berlin et al., 2009) and physical punishment (Gershoff & Grogan-Kaylor 2016), parent marital status and cohabitation (Fomby & Estacion, 2011), maternal mental health (Goodman et al., 2011), child temperament (Rubin, Burgess, Dwyer, & Hastings, 2003), attachment style (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010), parental expectations (Mattek, Harris, & Fox, 2016; Solis-Camara & Fox, 1996), and a myriad

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of stressors endemic to poverty (Santiago & Wadsworth, 2011; Wadsworth et al., 2008). Latino children, especially those in immigrant families, may be exposed to additional risk factors due to acculturation stress, low English language competency, overcrowded housing, and being disproportionately affected by poverty (Leidy et al, 2012). In 2014, Latino children accounted for the highest proportion of children living in poverty (36%), relative to Caucasian (30%), African American (26%), and Asian (3.31%) children (US Census Bureau, 2015). Similarly, researchers have suggested that poverty affects children indirectly through their parents as poverty leads to an increase in parental stress (Wadsworth et al., 2008). Researchers also have demonstrated that Latina mothers of children referred to clinical services for their child's behaviors showed more frequent use of verbal and physical punishment and less nurturing than in non-referred mothers (McCabe & Yeh, 2009; Perez & Fox, 2008).

Latino Cultural Factors

While a similar presentation of early behavior problems appears across cultures (Crijnen, Achenbach, & Verhulst, 1997), cultural values unique to the Latino population may impact the course of such behaviors as well as inform best treatment methods. These Latino values include *familismo*, *machismo*, *marianismo*, *respeto*, *personalismo*, and *simpatía* (Arcia, Reyes-Blanes, & Vazquez-Montilla, 2000; Barker, Cook, & Borrego, 2010; Calzada, Fernandez, & Cortes, 2010; Castillo, Perez, Castillo, & Ghosheh, 2010). Adherence to and identification with these constructs vary greatly between and within families. However, a general understanding of these cultural constructs as well as their influence on family functioning will aid the clinician responsible for delivering culturally sensitive mental health services. Clinicians should be sure to have a conversation with the caregivers regarding their cultural beliefs and values and how they play out in daily family life.

Considered the foundational value of Latino culture, *familismo* is generally defined as the emphasis on family unity and collectivism (Ayón,

Marsiglia, & Bermudez-Parsai, 2010). It encompasses many values such as loyalty and support, as well as the expectation that each family member respects, participates in, and places family responsibilities above individual desires (Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002). It also should be noted that *familismo* extends to non-blood members of the family, such as close family friends (*compadres*) and godparents (*padrinos*). Another expectation of *familismo* is keeping problems private and within the family, which has been shown to decrease mental health service utilization (Villatoro, Morales, & Mays, 2014).

Like *familismo*, *respeto* also encompasses a diverse array of values, including obedience, respect for elders, upholding family honor through appropriate manners and behavior, and adherence to traditional gender roles. It also functions in the hierarchical understanding of social relationships within Latino culture (Antshel, 2002). *Machismo* and *marianismo* are the culturally prescribed roles of men and women, respectively (Castillo et al., 2010; Glass & Owen, 2010). Although *machismo* often connotes male domination, holding power over women, and hypermasculinity, it also may include more family responsibility, a positive work ethic, and respect for women and the family (sometimes viewed as *caballerismo*). *Marianismo* encompasses the qualities and expectations derived from the Virgin Mary that Latina mothers are expected to embrace, such as virtue, chastity, humility, self-sacrifice, and spirituality, with women considered as the primary caregivers and nurturers within the home (Rocha-Sanchez & Diaz-Loving, 2005).

Definitions of *personalismo* and *simpatía* tend to overlap and generally refer to a dislike of competition and confrontation and a desire for warm, trusting relationships and social politeness (Antshel, 2002). These two constructs are especially important to consider in creating the therapeutic relationship, as they tend to include expectations for mutual self-disclosure of personal experiences over less impersonal information and warm interpersonal interactions (Donlan, 2011). Developing a warm, interpersonal relationship between the family and

therapist will aid clinicians working with Latino families to achieve better outcomes and client satisfaction (Parish, Magana, Rose, Timberlake, & Swaine, 2012).

Gold Standard Treatment for Behavior Problems

Research on the effectiveness of treatment programs for behavior problems in young Latino children has recommended they should be family oriented and culturally adapted and delivered by Spanish-speaking facilitators (Bandy & Moore 2011). However, there are relatively few evidence-based programs available for very young children with behavior problems in general and even fewer for children from diverse families living in poverty, including Latino children (Fung & Fox, 2014). *Early Pathways* (EP), a home-based mental health program for young children with behavior problems, was initially developed to serve children 5 years of age and younger, primarily from a diverse population of families living in poverty (Fox & Holtz 2009). EP has since been culturally adapted to serve young Latino children and their families and has undergone rigorous efficacy testing with very positive outcomes and large effect sizes (Fung & Fox, 2014; Fung, Fox, & Harris, 2014).

EP also has been recognized as a highly effective, evidence-based treatment program for addressing behavior problems in young children by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP). EP's theoretical foundation includes a strong developmental perspective and a primary emphasis on the central importance and quality of the parent-child relationship, along with the use of cognitive behavioral strategies for both the caregiver and child. As such, EP initially requires the development of a trusting relationship between the clinician and caregiver(s), and most parent worksheets are designed to facilitate the therapeutic process as well as achieve positive outcomes for the child and family. EP was designed for use by qualified professionals who

when working with Latino families in their homes should have the following: (1) cultural sensitivity and supervised experience working with Latino families; (2) either speak Spanish or have a translator available (which makes therapy a much more arduous process); (3) comfortable in conducting therapy in the child's home; (4) a solid foundation in early childhood development and its myriad of contributing factors; and (5) ability to tailor cognitive behavioral strategies to the unique circumstances of each family.

Treatment Plan

In general, the program requires 8 consecutive weeks of 1 h weekly sessions to complete, depending on how quickly the caregiver can learn and implement the strategies as well as manage the unique referral concerns presented by the child. The subject of each session plan may change in response to the individual needs of the caregiver and child, the goals of treatment, and the potential gaps in parenting knowledge. So, the EP therapist needs to be very flexible, "think on their feet," and be prepared to intervene with any strategy in the program that is warranted. As a general rule, *the child's safety trumps everything else.* Typically, clinicians have found it helpful to introduce a developmentally appropriate discipline strategy (e.g., time-out) much earlier if the child's challenging behavior poses a threat to their safety or the safety of others and if the parent becomes easily frustrated and has a history of using frequent verbal and physical punishment. Consequently, the following treatment schedule should be used only as a general guide.

Session 1: Establishing Rapport and Conducting Assessment
The first session should be used to develop initial rapport with the caregiver and child, as well as gain a clear understanding of the child's challenging behaviors by conducting an extensive intake interview. The intake typically includes an assessment of the child's challenging and positive behaviors (Worksheet 1a), a caregiver

interview, and therapist observation, during which the therapist and caregiver identify one to two challenging behaviors and one positive behavior as the foci of treatment. The therapist should assess the frequency, intensity, and duration of the child's behavior to determine whether it is typical or clinical and if it occurs across home and community settings; determine the degree to which a young child's behavior affects the child's and family's daily functioning; and identify potentially contributing risk factors relevant to a young child's behavior (e.g., mom's age and experience, how many children are in the home, caregiver support system, etc.). This is important to ensure appropriate, effective treatment is given and to prevent therapists from treating nonbehavior problems (i.e., medical problems) with psychological interventions. If there is a possibility of an underlying medical condition (e.g., ear infection), the child should have a thorough physical examination before starting EP. The intake information should be recorded and used to create treatment goals, which are then discussed, agreed upon, and written on the treatment plan (Worksheet 1b). It is important to introduce the EP treatment program and give the caregiver a concrete idea of their expected level of involvement and the daily effort it requires. Any advocacy needs of the family (e.g., housing, food, medical care) should be addressed and resources should be provided.

Session 2: Introduce the EP Treatment Program and Behavior Plan

The therapist and caregiver should begin by reviewing the treatment plan. The majority of the session should be used to establish positive family foundations by teaching, demonstrating, and practicing child-led play (Worksheet 2a). During child-led play, the child is allowed to select what they would like to play with as the caregiver takes a nondirective approach and comments positively on what the child is doing. Therapists should explain the caregiver's role as being "like a sports commentator," positively commenting on what is happening in play without questioning, criticizing, or telling the child what to do next. The therapist should also introduce praise and rewards as

ways to improve the caregiver-child relationship and reinforce prosocial behaviors (Worksheet 2b). If the child does something the caregiver wants, such as cleaning up their toys following play, the caregiver can tell them "good job picking up your toys!" or give a reward (e.g., small prize or a sticker). The therapist should help caregivers identify positive nurturing activities, like child-led play or reading together, that the child and caregiver enjoy and can engage in together. At the end of the session, the therapist and caregiver should complete the behavior plan (Worksheet 2c). The behavior plan specifies what the caregiver should do to implement the treatment plan during the coming week and to track the caregiver's progress with treatment strategies. A new behavior plan is created each week to fit the treatment material covered in that particular week and includes both challenging and positive behaviors with their corresponding treatment strategies. The therapist may include reminders for areas that the caregiver may be struggling with and use the space provided for caregivers to track their implementation of treatment strategies through the week. The therapist may also use the treatment report to track progress (Worksheet 2d). The therapist should continue to address any advocacy needs of the family at each session.

Session 3: Psychoeducation: Cognitive Behavioral Strategies

The therapist should begin each session by reviewing the behavior plan from the previous week and allowing time for child-led play. The focus of session 3 is psychoeducation about developmentally appropriate expectations and cognitive behavioral strategies for understanding behaviors. The clinician may begin this conversation by introducing what a behavior is and help the caregiver identify differences between behavior and the child's personality/temperament (Worksheet 3a). The therapist should explain that children often behave in ways to get their needs met, and so they have learned a behavior because at some point in time it was effective. Behaviors are therefore not about the child being "good" or "bad" but about the child performing an action to get a desired response. An easy way to describe

behaviors is "anything you see or hear your child doing," while a label is a description of a child as an individual. Labeling a child as "bad" can hamper the child's self-concept development. Once this distinction has been made, the therapist can illustrate what contributes to behavior by identifying components of behavior cycles (Worksheet 3b). Behavior cycles are a way of describing how a caregiver and child interact in both positive and negative ways. It includes the child's behavior, the caregiver's thoughts and feelings, the caregiver's reaction to the behavior, and what the child learns from the interaction. The therapist and caregiver should use one of the target behaviors and go through the behavior cycle being sure to incorporate how the caregiver's thoughts and feelings contribute to their child's behavior. The therapist should then practice this strategy in session with the caregiver when applicable, fill out a new behavior plan with the caregiver, and complete the therapist treatment report.

Session 4: Psychoeducation: Promoting Positive Behaviors Through Thoughtful Responses

The therapist should collect the behavior plan from the caregiver and allow time to practice child-led play in session. The therapist should then review and build upon behavior cycles by introducing *PARE y PIENSE* (STOP and THINK) (Worksheet 4a). Following a behavior, caregivers should "*PARE*" ("STOP") before responding to give them time to calm down. Offering anger management suggestions may be appropriate if the caregiver has difficulty calming down. The second step is "*PIENSE*" ("THINK") to allow the caregiver to reflect on their thoughts and feelings (e.g., "My child is just like his father," anger, embarrassed). They should then think about their expectations for the child and examine if they are appropriate before engaging in a thoughtful response to the behavior. The therapist may add this component using "*PREGUNTE*" ("*ASK*") if it is easier for the caregiver to remember this very important step by using an additional "*P*" word. This strategy will help the caregiver begin to understand how they can alter behavior cycles by examining their reactions to their child's behavior.

Their responses should discourage negative behaviors and encourage positive behaviors. For example, if the child has taken a toy away from a playmate, the response might be to have the child practice sharing a toy, instead of just reprimanding the child for the bad behavior. By offering the child what they should do instead, the caregiver has given the child a new, positive behavior to replace the old, negative behavior when the situation occurs in the future. The therapist should also use a prosocial behavior and explain how the caregiver can use *PARE y PIENSE* to reward good behaviors and encourage their future use (see Worksheet 2b for examples of rewards and praise).

Session 5: Improving Communication: Giving Effective Requests

The therapist should collect the behavior plan from the caregiver and allow time to practice child-led play in session. The therapist should then discuss giving effective requests with the caregiver. Very young children only comply with about 50% of parental requests, so giving effective requests that are necessary, clear, and simple is important in achieving optimal compliance. The caregiver can use *PARE y PIENSE* to consider if their request is developmentally appropriate. Similarly, instructions for tasks requiring several actions, such as getting ready for bed, should be broken down into small steps, such as "Time to brush teeth" and then "Now it's time to put on our pajamas." Preparing children for transitions between activities, especially if the child is involved in play or finishing a drawing, can help compliance. Using natural breaks, such as after dinner, can also be helpful for children who usually do not understand time concepts. Along with considering the timing of their requests, caregivers should pay attention to *how* they give the request, being sure to establish eye contact, and use very simple statements. The request should only be repeated once, and then assist the child with completing the task. Offering the child a choice ("either you can put on your pajamas or I can help you") sometimes persuades them to be independent and complete the task on their own. The therapist should stress that following through on the request is important to show the child that the caregiver

means what they say. The therapist can demonstrate following through during session, for example, by gently using a "hand-over-hand" technique if a child refuses to pick up toys where the therapist places his/her hand over the child's and gently helps him/her pick up a toy and put it away. Once the child complies with a request, even after using hand-over-hand technique, the caregiver should praise the child with direct feedback, "Thank you for picking up the toys!" The therapist can give the caregiver the "*escuchando*" ("listening") worksheet to practice giving good requests and rewarding compliance during the session (Worksheet 5a). The therapist and caregiver should also check in on goals and strategies used when filling out the behavior plan (Worksheet 2c) and therapist treatment report (2d).

Session 6: Establishing Home Routines, Supervision, and Planning Ahead

As young children do best when their world is predictable, the therapist should help the caregiver establish a daily home routine, taking into consideration the amount of close supervision a young child requires. To facilitate this discussion, the therapist should ask the caregiver to describe a typical day in the life of their child, from waking until bedtime. Using the "*routina diaria*" (daily routines) worksheets (6a, 6b) may be helpful to establish a daily routine of activities, with the therapist making suggestions to improve the routine, if needed. For example, establishing a standard bedtime is a good start. The therapist can also help the caregiver identify steps they can take to help the child with a disruption in the regular routine or with a transition. This may involve telling the child what they can expect well before the disruption will take place. For example, if the child must go to a doctor's appointment, the caregiver can tell the child the day before and remind him/her in the morning of the day's plans. The caregiver can also prepare to bring toys or other necessary things to help the child with the transition and at the appointment.

Session 7: Discipline Strategies

The therapist can begin the discussion of discipline with the caregiver by stating that the word discipline (both in English and Spanish, *la disciplina*) literally means *to teach*, and it should not be viewed as punishment. Discipline involves setting reasonable limits for children's challenging behaviors to teach them what behaviors are expected and what behaviors are not acceptable. Discipline helps young children gradually develop self-control and does not include teasing, name-calling, belittling, harassing, or physically hurting children. Research shows corporal punishment has an opposite effect than caregivers expect; that is, the more a caregiver uses physical punishment, the more problematic behaviors a child demonstrates (Gershoff & Grogan-Kaylor 2016). However, this is a sensitive topic that often is fully integrated into a caregiver's belief system about child-rearing. The therapist may find it helpful to have the caregiver describe their own experiences with verbal and physical punishment, listing the negative and positive aspects from their perspective. The therapist may introduce the EP discipline strategies as alternatives to punishment that have been proven to reduce challenging behaviors through years of research.

The first discipline strategy is redirection, to distract or redirect the child to more appropriate behavior before the challenging behavior can occur. For example, if a child is told he cannot have a toy, which normally results in a tantrum, redirecting his attention to another activity may prevent the tantrum. Taking precautions, such as "baby proofing" the house by locking cabinets and putting dangerous objects and substances out of reach, may prevent naturally curious children from getting into harm's way. Similarly, if a child is caught drawing on a wall, a caregiver can redirect the drawing to an appropriate piece of paper. The second technique, ignoring (Worksheet 7a), is useful for children who act out for attention. By not giving the child the attention they seek, the caregiver is not reinforcing the acting-out behavior. For example, if a child screams to get her caregiver's attention, the caregiver can ignore this behavior, wait until the child stops screaming, and then calmly redirect the child to a more appropriate way of getting the caregiver's attention. After ensuring the child is safe, a caregiver can also use ignoring during tantrums. The third technique,

natural consequences (Worksheet 7b), teaches children their actions have consequences. The consequence should not be fun or harmful to the child and should logically follow from what the child did. For example, if a child throws a toy, the natural consequence of throwing the toy is not getting to play with it. Similarly, if a child spills milk, the caregiver should have the child help clean it up. The last discipline technique, time-out, should be used after trying redirection, ignoring, and natural consequences, or if they are not practical given the behavior. It is recommended that aggressive behaviors such as hitting, kicking, or biting be given a time-out. The therapist should use the time-out worksheet (7c) with the caregiver and go through the time-out procedure, demonstrated during session when possible. As a general rule, the child should be in time-out 1 min for each year of age (age 2, 2 min time-out), and the time-out location should be neutral (chair in the corner of room), not scary (dark closet).

Session 8: Behavior Maintenance and Treatment Evaluation

The final session should be used to review the strategies, check in on goals, and conduct posttreatment assessment to compare progress with pretreatment assessment scores (Worksheet 1a). This time should also be used to problem-solve issues that arose in implementing the treatment plan. It is recommended that the therapist fill out a behavior plan (Worksheet 2c) with the caregiver as an "ongoing behavior plan" to help maintain treatment gains. The therapist should address any further advocacy needs and make appropriate referrals if necessary. Therapists may also choose to do a "closing activity" to congratulate the family on their progress and reflect on their time spent together. For some parents, additional sessions will be needed to reach the treatment goals.

Treatment Plan Summary

This treatment plan summary has been adapted from *Early Pathways.*

Component	Session plan/goals	Worksheet
Establishing rapport, conducting intake assessment, and creating a treatment plan	Complete an intake evaluation (1a) Introduce EP Develop initial treatment goals Develop initial treatment plan (integrate with intake assessment findings) (1b) Address advocacy needs of child/family	1a, 1b
Review treatment plan, establish positive family foundations, introduce behavior plan	Review treatment plan with caregiver (1a) Describe and implement child-led play (2a) Introduce praise and rewards, and identify ways for parents to effectively praise their children (2b) Introduce nurturing and identify positive nurturing activities Introduce behavior plan (2c) Complete therapist treatment report (2d) Address advocacy needs of child/family	2a, 2b, 2c, 2d
Psychoeducation, cognitive behavioral strategies	Collect behavior plan from parent Practice child-led play Introduce behavior, identify differences between behavior and personality/temperament, and discuss what contributes to behavior (3a) Identify components of behavior cycles (3b) Revise treatment plan (if need be) Complete behavior plan and treatment report (2c, 2d) Address advocacy needs of child/family	3a, 3b, 2c, 2d

Component	Session plan/goals	Worksheet
Psychoeducation, promoting positive behaviors through thoughtful responses	Collect behavior plan from parent Practice child-led play Identify main components of STOP and THINK (PARE y PIENSE) cognitive strategy (4a) Identify positive situations when using PARE y PIENSE is appropriate Identify appropriate developmental expectations Identify appropriate strategies to improve child's listening Identify how to teach families to develop household routines Complete treatment report Address advocacy needs of child/family	4a
Improving communication, giving effective requests	Collect behavior plan from parent Practice child-led play Review and practice child-led play and PARE y PIENSE Identify how to give effective requests using simple, goal-oriented language (5a) Discuss the use of positive reinforcement to promote listening Complete behavior plan and treatment report (2c, 2d) Address advocacy needs of child/family	5a
Establishing home routines, supervision, planning ahead	Collect behavior plan from parent Practice child-led play Complete treatment report Collect behavior plan from parent Practice child-led play Review and practice child-led play and PARE y PIENSE Help caregiver establish a daily home routine, taking into consideration the amount of supervision a child requires Identify steps caregiver can take to help child with a disruption in the regular routine or with a transition Address advocacy needs of child/family	6a, 6b
Discipline strategies	Complete treatment report Collect behavior plan from parent Practice child-led play Review and practice child-led play Review STAR parenting model Identify developmentally appropriate responses (discipline strategies) for a child's challenging behaviors Address advocacy needs of child/family	7a, 7b, 7c
Behavior maintenance and treatment evaluation	Complete treatment report Collect behavior plan from parent Practice child-led play Problem-solve issues that arose in implementing treatment plan Discuss maintenance of treatment gains with caregiver Review and practice child-led play Review STAR parenting model Review discipline strategies and their implementation Review overall treatment progress Address advocacy needs of child/family	

Worksheet 1a

Revisión del Comportamiento del Niño A Temprana Edad

Nombre del Niño/a_____   H/M   Nombre del Padre: _____

Fecha de Nacimiento: _____   Fecha: _____

Instrucciones: A continuación habrá comportamientos comunes en los niños pequeños y Pre-escolares. Piense en el comportamiento que su hijo/a tuvo durante la semana pasada, y marque con que frecuencia ha visto este comportamiento. Circule A Menudo si este comportamiento pasa por lo menos una vez al día, circule Algunas Veces si este comportamiento pasa semanalmente, y circule Casi Nunca si el comportamiento rara vez pasa o nunca pasa.

Su Niño…………….	Con que frecuencia ocurre este comportamiento?			Para uso de la Clínica Solamente	
1. Le Pega a otros	A Menudo	Algunas Veces	Casi Nunca		
2. Come con una cuchara	A Menudo	Algunas Veces	Casi Nunca		
3. Avienta cosas a otros	A Menudo	Algunas Veces	Casi Nunca		
4. Te escucha	A Menudo	Algunas Veces	Casi Nunca		
5. Tiene Berrinches	A Menudo	Algunas Veces	Casi Nunca		
6. Rompe Cosas	A Menudo	Algunas Veces	Casi Nunca		
7. Se Enoja	A Menudo	Algunas Veces	Casi Nunca		
8. Lastima a otros	A Menudo	Algunas Veces	Casi Nunca		
9. Entiende lo que le dices	A Menudo	Algunas Veces	Casi Nunca		
10. Hace lo que le pides	A Menudo	Algunas Veces	Casi Nunca		
11. Juega bien con otros	A Menudo	Algunas Veces	Casi Nunca		
12. Duerme durante la noche	A Menudo	Algunas Veces	Casi Nunca		
13. Le quita juguetes a otros	A Menudo	Algunas Veces	Casi Nunca		
14. Comparte Juguetes	A Menudo	Algunas Veces	Casi Nunca		
15. Le ayuda a otros	A Menudo	Algunas Veces	Casi Nunca		
16. Molesta a otros	A Menudo	Algunas Veces	Casi Nunca		
17. Come bien	A Menudo	Algunas Veces	Casi Nunca		
18. Coopera al vestirse	A Menudo	Algunas Veces	Casi Nunca		
19.Se rehúsa ir a la cama por la noche	A Menudo	Algunas Veces	Casi Nunca		
20. Patea a otros	A Menudo	Algunas Veces	Casi Nunca		

Clinician Note: Sum each column after scoring each item according to the following scale: Often (A Menudo) = 3 ; Sometimes (Algunas Veces) = 2; Almost Never (Casi Nunca)= 1

Raw Score Pro-Social		
Raw Score Challenging		

Clinical significance is reached if child's RAW score meets or exceeds the following cutoff scores:

Age	Male	Female
0-11 months	15	15
1 year old	19	18
2 years old	21	19
3 years old	17	18
4 years old	18	17
5 years old	23	17

Worksheet 1b

Early Pathways Plan de Tratamiento Inicial

Fecha:_____ Nombre del Niño:_____ Nombre del Cuidador:_____

Edad: ____A ____M Edad de Desarrollo: ____A ____M Retrasos de Desarrollo: _____

Puntos Fuertes del niño: _____

Diagnostico: _____ Entrevistador Inicial: _____

Metas

Objetivo del Tratamiento	Estatus Actual	Meta a Corto Plazo (3 semanas)	Meta a Largo Plazo (8 semanas)
Comportamiento Problemático 1:	_____ Veces por semana	_____ Veces por semana	_____ Veces por semana
Comportamiento Problemático 2:	_____ Veces por semana	_____ Veces por semana	_____ Veces por semana
Comportamiento Positivo	0% < 25% 25% 50% 75% >75%	0% < 25% 25% 50% 75% >75%	0% < 25% 25% 50% 75% >75%

Métodos

El programa del tratamiento incluirá los siguientes componentes:

1. Juegos dirigidos por su hijo para fortalecer la relación entre usted y su hijo.
2. Estrategias que le ayudan al padre a pensar positivamente y a como responderle a su hijo calmadamente.
3. Desarrollar las expectativas apropiadas basadas en la etapa actual de desarrollo de su hijo.
4. Estrategias de reforzamiento positivo para reforzar los comportamientos positivos de su hijo.
5. Estrategias para poner limites en los comportamientos retadores y mantener un ambiente seguro.
6. Hable sobre las barreras que existen y que están afectando su participación, su progreso y la terminación del tratamiento.

Horario del Programa

La familia se reunirá en su casa con un consejero familiar una vez a la semana por 3 semanas, en el cual se hará una evaluación de las metas del tratamiento y su progreso se hará para determinar las necesidades y metas del tratamiento.

Evaluación

1. La participación en el tratamiento, su progreso y sus metas se registraran usando planes y reportes de tratamiento semanales.
2. La efectividad del tratamiento se determinara por medio del protocolo de evaluación administrado durante todo el tratamiento.

El padre o tutor tiene la oportunidad de participar en la planeación del tratamiento, leer y entender las metas iniciales del tratamiento.

_____   _____   _____
Padre o Tutor   Fecha   Profesional Certificado en Tratamiento

Worksheet 2a

Instrucciones para los Padres: Juego Dirigido por el Niño

¿Que es esta forma de jugar?

El Juego Dirigido por el Niño es una nueva forma de jugar con sus hijos.

¿Por que es importante?

Esta forma de jugar ayuda a construir una relación más fuerte con su hijo/a. Queremos que su hijo/a lo/a vea como una persona divertida con quien jugar.

¿Cómo se usa esta forma de jugar?

- El niño/a escoge el juguete
- Deje al niño/a que dirija el juego
- El niño/a decide lo que quiere hacer con el juguete (ej. Pone el aro pequeño antes del aro grande)
- El padre usa comentarios positivos cuando describa lo que ésta haciendo el niño/a (ej. pusiste el bloque morado encima del bloque rojo)
- El padre pone limitaciones apropiadas en lo que el niño/a no puede hacer (no deben de correr adentro de la casa, no deben aventar los juguetes)
- <u>No le haga una prueba/examen a su hijo, permítale a su hijo sentirse en control (ej. ¿De qué color es esto?)</u>

Cuando deben de usar esta forma de jugar:

- Escoja aproximadamente la misma hora cada día para jugar con su hijo/a
- Juegue 10-15 minutos con su hijo/a

Worksheet 2b

Instrucciones para los Padres: Tipos de Premios

Premios Físicos
- Abrazos
- Besos
- Unas palmaditas en la espalda
- Un 5 (high 5, choque de mano)

Premios Verbales

1. Palabras no específicas: palabras generales diciéndole a su hijo que están portándose bien.
   - "¡Qué bien!"
   - "¡Buen trabajo!"
   - "Eso es muy bueno. ¡Ojala y yo pudiera hacer eso!"
   - "¡Que divertido!"
   - Usando una palabra: "¡WOW!" "¡Hermoso!" "¡Genial!"

2. Palabras específicas: Usando palabras diciéndole a su hijo exactamente lo que están haciendo bien.
   - "Me gusta cuando…."
   - "Gracias por…."
   - "Hiciste buen trabajo ayudando con…."
   - "Estas haciendo lo que quiero que hagas."
   - "Me gusta jugar esto contigo."
   - "Eres un/a niño/a grande por…."

Premios Tangibles
- Calcomanías (Stickers)
- Premios que se pueden comer: galletas, chocolates, dulces, gomitas
- Premios chicos como- pelotitas de goma, libro, crayón, peluche

Como debe usar premios
- Sea especifico/a
- Dar el premio inmediatamente
- Dar los premios consistentemente
- Enfocarse en la mejoría (use come elogio de paso-a-paso)
- No lo use como un soborn

Worksheet 2c

Plan de Comportamiento

Nombre: _____   Fecha: _____

Objetivo del Tratamiento	Estrategia del Tratamiento
Comportamiento Problemático 1:	
Comportamiento Problemático 2:	
Comportamiento Positivo:	

Recordatorios:

  1. _____

  2. _____

  3. _____

  4. _____

Pudo usted hacer:

	Si	No	# de Veces
Lunes	____	____	_____
Martes	____	____	_____
Miércoles	____	____	_____
Jueves	____	____	_____
Viernes	____	____	_____
Sábado	____	____	_____
Domingo	____	____	_____

	Si	No	# de Veces
Lunes	____	____	_____
Martes	____	____	_____
Miércoles	____	____	_____
Jueves	____	____	_____
Viernes	____	____	_____
Sábado	____	____	_____
Domingo	____	____	_____

Worksheet 2d

Early Pathways Treatment Report (Based <u>only</u> on what you see and hear from parents in session)

Child _____Caregiver _____Date_____Clinician_____Session #:

Behavior Target	Frequency
Problem Behavior 1:	_____ times/week
Problem Behavior 2:	_____ times/week
Positive Behavior:	<25% 25-50% 50-75% >75%

How many times did you do child-led play in the past week? _____

_____

<u>Comments on Play:</u>

Clinician Observation and Parent Report:

Does parent maintain appropriate expectations?	____ Rarely/Never	____ Sometimes	____ Most Times
Does parent stop and think before responding?	____ Rarely/Never	____ Sometimes	____ Most Times
Does parent utilize rewards appropriately?	____ Rarely/Never	____ Sometimes	____ Most Times
Does parent utilize appropriate discipline?	____ Rarely/Never	____ Sometimes	____ Most Times
What is the combined score of Tx variables? ____ Total (Rarely/Never = 1, Sometimes = 2, Most Times = 3)
What is parent's current level of engagement?	____ Minimal	____ Moderate	____ High

Revisión del Comportamiento del Niño a Temprana Edad

Instrucciones: A continuación habrá comportamientos communes en los niños pequeños y Pre-escolares. Piense en el comportamiento que su hijo/a tuvo durante la semana pasada, y marquee con que frecuencia ha visto este comportamiento. Circule Frecuentemente si este comportamiento pasa por lo menos una vez al día, circule A Veces si este comportamiento pasa semanalmente, y circule Casi Nunca si el comportamiento rara vez pasa o nunca pasa.

Su hijo….   Con que frecuencia ocurre este comportamiento?

1. Le pega a otros	Frecuentemente	A Veces	Casi Nunca	
2. Le tira cosas a otros	Frecuentemente	A Veces	Casi Nunca	
3. Tiene berrinches	Frecuentemente	A Veces	Casi Nunca	
4. Rompe cosas	Frecuentemente	A Veces	Casi Nunca	
5. Se enoja	Frecuentemente	A Veces	Casi Nunca	
6. Lastima a otros	Frecuentemente	A Veces	Casi Nunca	
7. Le quita cosas a otros	Frecuentemente	A Veces	Casi Nunca	
8. Molesta a otros	Frecuentemente	A Veces	Casi Nunca	
9. Por la noche se rehusa a ir a la cama	Frecuentemente	A Veces	Casi Nunca	
10. Patea a otros	Frecuentemente	A Veces	Casi Nunca	

Clinician Note: Sum the columns after scoring each item according to the following scale
Often = 3, Sometimes = 2, Almost Never = 1

Raw Score Challenging	
Clinically Significant?	

Age	Male	Female
0-11 months	15	15
1 year old	19	18
2 years old	21	19
3 years old	17	18
4 years old	18	17
5 years old	23	17

How are things going?

Provide data on the family's general status and follow-up on recommendations: events of the week; implementation of treatment strategies; new concerns.

Clinician Comment on progress:

Provide an assessment of treatment progress, level of engagement and barriers to treatment. Indicate plan for focus of treatment and future sessions.

What was addressed during session? (Check all that apply) ___Behavior Cycles   ___Child-led Play   ___Stop and Think
___Listening   ___Expectations   ___Praise/Rewards ___Discipline Strategies   ___Nurturing Activities ___Routines
___Trauma Care ___Advocacy

_____   _____   _____
Clinician Signature   **Date**   **Length of session (minutes)**

Worksheet 3a

Nombre:_____

¿Que es un Comportamiento?

La personalidad de un niño y sus comportamientos son diferentes.
Un niño tiene rasgos personales que heredan o aprenden.
El comportamiento es algo que usted puede ver o escuchar que su hijo hace.

Describa a su hijo/a:
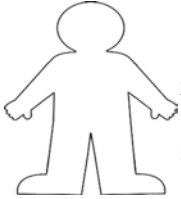
1.) _____

2.) _____

3.) _____

4.) _____

Separando a su hijo/a de su comportamiento

No hay niños malos, solo problemas de conducta.
Esta bien si usted le dice a su niño/a que no le gusta su *comportamiento*
No esta bien si usted le dice a su niño/a que *ellos* son el problema

---

No le diga:

"Eres un niño malo por pegar!"

"Que malcriado eres, nunca me haces caso!"

"Hay! Que niño tan malo eres!"

Dígale

"No me gusta cuando pegas."

"Necesitas obedecerme cuando te diga que tienes que hacer algo."

"No esta bien que le quites los juguetes a tu hermanito."

Worksheet 3b

Nombre:

1) La Conducta Negativa de su Hijo:
  · _____
  · _____

5) Su Hijo Aprende:
  · _____
  · _____

2) Usted Piensa:
  · _____
  · _____

Ciclos de Conducta Negativa

4) Usted Responde:
  · _____
  · _____

3) Usted se Siente:
  · _____
  · _____

---

1) La Conducta Positiva de su Hijo:
  · _____
  · _____

5) Su Hijo Aprende:
  · _____
  · _____

2) Usted Piensa:
  · _____
  · _____

Ciclos de Conducta Positiva

4) Usted Responde:
  · _____
  · _____

3) Usted se Siente:
  · _____
  · _____

Worksheet 4

1) La Conducta Negativa de su Hijo:
- •_____
- •_____

De Como Cambiar el Comportamiento de los Ciclos de

5) Su Hijo Aprende:
- •_____
- •_____

2) Usted Piensa:
- •_____
- •_____

4) Usted Responde:
- •_____
- •_____

PARE Y PIENSE

3) Usted se Siente:
- •_____
- •_____

PARE

Antes de reaccionar:

- ☑ Salgase del Cuarto
- ☑ Respire profundo
- ☑ Cuente hasta 10
- ☑ Tomese un vaso de agua
- ☑ Escuche musica

PIENSE

Antes de reaccionar:

- ☑ Que estoy pensando?
- ☑ Como me siento?
- ☑ Ya estoy calmada?
- ☑ Estoy en un cyclo de conducta?
- ☑ Como puedo combiar este ciclo?

Worksheet 5a

Instrucciones para los papas: Escuchando

¿Qué es un ejercicio de escuchar?

Estos ejercicios van a ayudarle a su hijo que te escuche mejor.

¿Por qué es importante?

Los padres saben lo que es lo mas mejor para sus hijos. Los niños necesitan escucharles a sus papas para ser más responsable cuando estén más grandes. Los padres necesitan tiempo, necesitan practicar y mucha paciencia.

¿Cómo debe de hacer un ejercicio de escuchar?

- Siéntese en la cocina, en la mesa.
- Gane la atención de su hijo/a, use su nombre.
- Antes de preguntarle a su hijo/a que haga algo, necesita verle en sus ojos.
- Dile que haga algo:
    - Levanta le mano
    - Toca la mesa
    - Aplaude
    - Recoge el juguete
    - Dame el juguete
- Si su hijo hace lo que le dijiste, de le un premio verbal. O si quiere una galleta o un dulce.
- Si su hijo no la/lo escucha, ayúdele y use muchos premios verbales.
    - Un ejemplo: agarré la mano de su hijo y levántela…déle un premio como si hubiera echo lo que le pregunto sin ayudo

¿Cuándo debe de hacer un ejercicio de escuchar?

- Escoge un tiempo cuando tenga 5 minutos para enseñarle a su hijo/a.
- Haga un ejercicio de escuchar cada día.

Usted debe de determinar cual premio quiere usar durante estos ejercicios. Unos ejemplos:

Premios:	**Premios Verbales:**
Galletas, Stickers	Que bien! Buen Trabajo!
M&M's, Jugo	Bravo!

Worksheet 6a

ESTRUCTURA A TRAVÉS DE LA RUTINA DIARIA:

¿QUÉ HACE LA ESTRUCTURA?

1) Niños/as **quieren y necesitan estructura** en su vida diaria para un desarrolle sano.
2) Estructura les da a niños/as una sensación de **seguridad**.
3) Estructura les da a niños/as **limites** en su comportamiento, les ayuda a desarrollar **relaciones sanas**, y **les enseñan** sobre el mundo en el que viven.
4) Estructura le provee a niños/as con herramientas para **manejar sus emociones** de una manera sana.
5) Estructura les enseñan a niños/as **responsabilidad**, el cual les ayudara tomar mejores opciones.

¿CÓMO LE PODRE DAR A MI HIJO/A ESTRUCTURA?

1) Provéale a su hijo/a con **actividades** para ocupar su tiempo: Ejemplo. Ir al parque, poner un horario al desayuno, almuerzo, y cena todos los días, cepillar los dientes con su hijo/a por la mañana y noche, etc.
2) Si tiene más de 1 hijo/a, es mejor si todos están en el **mismo horario**.
3) **Es mejor ser lo más consistente posible, para mantener la misma rutina todos los días.**
4) Explique le a su hijo/a lo que viene después en su "rutina diaria," para que se preparen para la transición.

*Ejemplo De Una Rutina:

8:00am → Despertar Cepillar los dientes Vestirse	**9:00am →** Guardería/escuela, ir al parque, ir a caminar, tiempo de jugar, arte & manualidades. 10:00am→Refrigerio 12:00pm→Almuerzo 1:00pm → Siesta	**2:00-2:30pm→**Despertar **2:30pm →** Refrigerio **3:00pm →** Actividades **6:00pm →** Cena **7:00pm →** Comenzar la rutina para acostarse: baño, cepillar

5) **Sea flexible!** Sus rutinas y estructura que tiene para su hijo/a tendrá que cambiar como vaya creciendo y desarrollándose.

   - **Ejemplo:** Un niño/a de 4 años tendrá una hora para acostarse a dormir más temprano que uno/a de 12 años.

Worksheet 6b

¿CÓMO SE MIRARÍA LA RUTINA DIARIA DE MI HIJO/A?

Rutina de la Mañana:
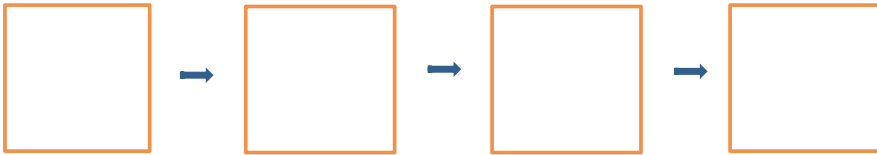
Rutina del Medio-Día (10:00am-3:00pm):
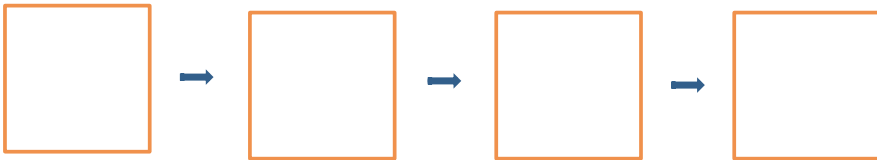
Rutina de la Noche/Para Acostarse:
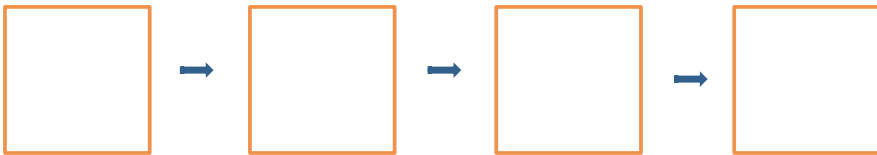
**Unas muestras de Actividades para incluir en la rutina diaria de su hijo/a: ir a la guardería/escuela, ir a caminar, jugar en el parque, el juego dirigido-por-el-niño, ir a la tienda del mandado, tiempo para comer o merendar, artes y manualidades, deportes, nadar, siesta, leer, etc.

Worksheet 7a

Ignorando

Ignorar es un porceso *muy* activo

Ignore cada vez que su hijo:

• _____

• _____

PASOS PARA IGNORAR

1.) Asegurese de que su nino este a salvo. Despues calmadamentee digale, "Te voy hacer case hasta que pares de _____" y vayase deahi.

2.) Usted al Ignorar.
  • **No vea asu hijo**
  • **No toque a su hijo**
  • **No le hable a su hijo**

3.) Siga ignorando. Utilize las estrategias de PARA Y PENSAR como distraccion hacia el comportamiento de su hijo.

4.) Pare de ignorar despues 5 - 10 segundos despues del que el _____termine.

Importante: Tenga en cuenta que el comportamiento de su nino empeorara en cuanto usted empiece a ignorar.

5.) Dirija a su nino hacia una actividad positiva.

Worksheet 7b

Consequencias Naturales

Cuando tu _____ entonces yo_____.

Esta bien quitarles los privilegios/los objetos que no usen de la forma correcta.

Utilize Consecuencia Natural cuando:

- _____
- _____

1. Utilize el PARA Y PENSAR antes de tratar el comportamiento de su hijo.

Acuerdese de Nombrar el Comportamiento.

"No esta bien que le avientes el juguete a tu hermanito"

2. Digale a su hijo que a usted no le gusta su comportamiento.

3. Dele consequencia natural a causa de su comportamiento.

(Ej: guitele el juguete)

Cuando quite un privilegio o un objecto, deselo despues de _____ y uestrele a su nino como usarlo de la forma correcta.

Acuerdese de elogiar a su nino cada vez que se comporte correctamente y use un objecto de la forma correcta!

Worksheet 7c

Castigo

Castigue a su niño cada vez que el/ella:

- _____

- _____

- _____

- _____

Pasos a seguir para el Castigo

1. Calmadamente dígale, "Estas castigado por _____."

2. Lleve a su niño a _____ como lugar de castigo.

3. Empiece a contar el tiempo y déle _____ minutos.

4. Asegúrese de que su hijo este en un lugar seguro PERO
• No vea a su hijo
• No le hable a su hijo
• Y no toque a su hijo

5. Si su hijo/a se sale del área de castigo, sin decirle nada regréselo al área de castigo.

6. Cuando se termine el tiempo.
   a. Si su hijo/a esta calmado/a dígale que ya termino el castigo y diríjalo a una actividad positiva.
   b. Si No se calma, dígale "Te quedaras castigado/a hasta que no te calmes."
      i. Cuéntele _____ minuto mas.
      ii. Revise a su hijo/a cada _____ minuto para ver si ya esta calmado/a.

7. Lo más que puede estar su hijo/a en el área de castigo son _____ minutos.

8. Cuando termine el castigo de su hijo/a envuélvalo en alguna actividad positiva.

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Treatment Considerations and Tools for Treating Latino Children with Anxiety

19

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Anxiety disorders are among the most prevalent disorders for children and adolescents and are associated with significant short- and long-term consequences (Costello, Egger, & Agnold, 2005). Some data suggest that Latinos report higher levels of anxiety symptoms than other groups (Pina & Silverman, 2004). Research comparing non-Latino White and Latino youth who participate in evidence-based treatments for anxiety highlights similar outcomes between groups; however, Latinos continue to underutilize mental health services when compared to non-Latino populations (e.g., Ojeda & McGuire, 2006; Pina, Silverman, Fuentes, Kurtines, & Weems, 2003). While research expands in the realm of anxiety treatment for Latino youth, a gap remains with regard to accessible and applicable materials to use while working with Spanish-speaking populations. This chapter provides practical information for clinicians working with Spanish-speaking Latino children and families. The following information and resources are provided:

- Brief overview of current research on evidence-based practices with Latino populations
- Cultural considerations to help the provider modify current treatment practices
- Session plan and Spanish language worksheets with culturally relevant examples

Prevalence of Anxiety in Latino Youth

Anxiety disorders are the most prevalent mental disorders in children. Epidemiological studies report lifetime prevalence rates ranging from 6% to 10% for children ages 2 to 5 and from 8% to 27% for children ages 9 to 17, making them more common than well-known disorders such as attention-deficit/hyperactivity disorder and major depressive disorder (Costello et al., 2005; Hale, Raaijmakers, Muris, van Hoof, & Meeus, 2008). Data from epidemiological studies suggest that prevalence rates of anxiety disorders in Latino children are similar to that of non-Latino White children (Canino et al., 2004; Pina & Silverman, 2004). While studies have found many similarities in overall diagnostic rates, there are differences in types of anxiety disorders and symptoms across groups. For instance, Ginsburg and

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Silverman (1996) found that Latino children reported more separation anxiety symptoms than non-Latino White children. In this study, Latino parents also reported that their children experienced higher levels of fear with regard to "fear of the unknown" and "fear of danger and death" when compared to parents of non-Latino White children (Ginsburg & Silverman, 1996). In another study, both Mexican Americans and Mexicans reported more physiological and worry symptoms than non-Latino White children (Varela et al., 2004). Latino children also scored higher than non-Latino White children on anxiety sensitivity suggesting that somatic symptoms may be more distressing for this group (Weems, Hayward, Killen, & Taylor, 2002). Overall, these findings suggest that there are important differences in the nature and severity of anxiety between non-Latino White and Latino children, including higher rates of somatic symptoms and levels of worry in Latino youth.

Latino Youth and Mental Health Service Use

Despite the significant prevalence of anxiety disorders and symptoms in Latino youth, Latino children with anxiety are less likely to receive mental health services compared to their non-Latino White counterparts (e.g., Gudiño, Lau, Yeh, McCabe, & Hough 2009; U.S Department of Health and Human Services [USDHHS], 2000). There are many reasons why such service utilization disparities exist, including parental beliefs about the causes of mental health, language barriers, patient-provider communication, and stigma (Cabassa, Zayas, & Hansen, 2006; Tarshis, Jutte, & Huffman, 2006). Additionally, culture may shape how parents conceptualize and discuss anxiety in their children; differences in symptom terminology and presentation may influence perceptions of anxiety and perceived need for services for Latino children (Gaines et al., 1997; Varela & Hensley-Maloney, 2009).

Latino Conceptualizations of Anxiety

Cultural Concepts of Distress Identification and understanding of anxiety in Latino children may be affected by the use of cultural concepts of distress, such as *nervios* and *ataque de nervios.* Cultural concepts of distress include clusters of symptoms, ways of communicating emotional distress, and explanations for origins of symptoms that may be common in specific cultural groups (American Psychiatric Association, 2013). Parents may reference these terms in lieu of using terms synonymous with anxiety. *Nervios*, for instance, has been used to describe a broad range of mental states including anxiety and somatic symptoms (Salgado de Snyder, Diaz-Perez, & Ojeda, 2000). In adults, the term has been used to describe anxiety, as well as a wider range of mental distress, including symptoms associated with schizophrenia and panic attacks (Jenkins 1988; Salman et al., 1997). Among children, data on the term *nervios* are scarce; however, in one study, findings suggested that Latino mothers use the term to refer to disruptive behaviors in children as well as anxiety (Arcia, Castillo, & Fernández, 2004).

Ataque de nervios, another cultural concept of distress, includes symptoms that commonly occur in Latinos, particularly Puerto Rican and Dominican individuals. Symptoms of *ataques* include trembling, crying spells, screaming uncontrollably, and sudden verbal and physical aggression, which are usually precipitated by a significant stressor (Lopez & Guarnaccia, 2000). Similar to *nervios*, *ataque de nervios* has been researched primarily with adults, and little is known about how this concept is used with children. Limited research, primarily with Puerto Rican youth, suggests the term is associated with symptoms of dysthymia and panic in a community sample and symptoms of post-traumatic stress disorder and depression in a clinical sample (Guarnaccia, Martinez, Ramirez, & Canino, 2005). One study also found that the term was associated with asthma, headaches, and a history of epilepsy or seizure,

suggesting that *ataques* are also associated with a wide range of physical symptoms (Lopez et al., 2009).

Questions regarding these concepts of distress should be included when working with Latino youth. It is important to note that many of these complaints overlap with symptoms of depression and anxiety, but they are not necessarily synonymous with these disorders. Instead, these concepts may represent culturally meaningful ways of expressing distress that are not equivalent to Western psychiatric terms and are more normative using an emic perspective.

Somatic Symptom Presentations in Latino Youth Similar to cultural concepts of distress, somatic complaints may be considered a culturally appropriate way of expressing distress among Latinos (Kirmayer & Young, 1998). Somatic anxiety includes physical symptoms such as restlessness, fatigue, and muscle tension, among others (American Psychiatric Association, 2013). Although most studies on somatization in Latinos focus on adults, there is also considerable evidence for somatization in Latino children (e.g., Pina & Silverman, 2004; Varela et al., 2004). For instance, research suggests Mexican and Mexican American children express more physiological anxiety symptoms than European American children (Varela et al., 2004). Children from Mexico reported the most physical symptoms, followed by U.S. Latino children, followed by European American children; these groups differed only in physical symptoms and not in other types of anxiety (Varela et al., 2004). Similarly, another study found that parents of children living in Puerto Rico were more likely to endorse physical health problems in their children than parents of Puerto Rican children living in the United States (Feldman, Ortega, Koinis-Mitchell, Kuo, & Canino, 2010). Latino, non-Cuban parents also reported more somatic symptoms of anxiety than European American and Cuban American parents for their children (Pina & Silverman, 2004). Thus, parent and child reports of child somatic complaints extend across Latino subgroups (with the potential exception of Cuban Americans) and are more pronounced when the families are living in the country or territory of origin.

Some have proposed that Latinos may perceive somatic complaints as less stigmatizing and therefore more readily report such symptoms. Others have explained that Latinos believe that they are more likely to receive care if they disclose physical problems rather than mental health problems (Canino, Rubio-Stipec, Canino, & Escobar, 1992). Information relevant to somatic symptoms may be critical when conducting a psychosocial assessment with Latino youth. In some instances, physiological symptoms (e.g., stomachache, trouble catching one's breath, tiredness) may be a better indicator of anxiety than traditional questions about anxious thoughts and behaviors.

Research on the Treatment of Youth with Anxiety

Cognitive behavioral therapy (CBT) and behavioral therapy (BT) programs are effective interventions for children with anxiety disorders with response rates ranging from 60% to 80% (see review by Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004). Given numerous randomized clinical trials demonstrating positive outcomes in the presence of rigorous design and methodology, cognitive behavioral and behavioral therapies are currently considered empirically supported treatments for children with anxiety disorders (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). In general, CBT and BT interventions span 12 to 20 sessions and are delivered in individual and group formats. The most widely used child anxiety interventions are based on Philip Kendall's 16-session CBT program for children with anxiety disorders (Kendall, 1994). The basic components of this treatment include relaxation exercises, cognitive restructuring, exposure to feared situations, and reinforcement. The Cool Kids Child Anxiety Program is another CBT program designed for youth and includes posi-

tive event scheduling, cognitive restructuring, gradual exposure, response prevention, behavioral experiments, conflict resolution, parent training, problem-solving, assertiveness, and stress management (Rapee & Wignall, 2002). The session plan and worksheets used in this chapter are derived from the Cool Kids program (Lyneham, Wignall, & Rapee, 2008) and were used in a randomized controlled trial for Latino youth with anxiety (Chavira, Bustos, Garcia, Ng, & Camacho, 2015).

Treatment Outcomes in Latino Youth While there have been a number of randomized clinical trials highlighting the effectiveness CBT for anxiety disorders with non-Latino White youth, randomized clinical trials with Latino youth are limited. Based on the available evidence, findings suggest that CBT outcomes for anxiety are similar across Latino and non-Latino White youth (Pina et al., 2003; Pina, Zerr, Villalta, & Gonzales, 2012; Silverman, Pina & Viswesvaran, 2008). These similarities include treatment gains, maintenance of those gains (up to one-year follow-up), diagnostic recovery, and clinically significant improvement (Pina et al., 2003).

Cultural Adaptations Some have proposed that adaptations to interventions are necessary to improve the cultural appropriateness, satisfaction, and response rates associated with evidence-based interventions for ethnic and racial minorities; however, debate about the utility of cultural adaptations continues (Lau, 2006). Few cultural adaptations have been examined for Latino youth with anxiety. Existing adaptations have usually attempted to improve the cultural match or acceptability of an intervention by including providers who are bicultural and bilingual, translating materials into Spanish, and using engagement strategies to address various barriers to treatment (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006; Pina et al., 2012). As an example, Chavira and colleagues (2015) examined a Spanish translation of a CBT program delivered by bilingual and bicultural therapists using a telephone-based, parent-mediated format for rural Latino youth. Modifications

included the use of engagement strategies to address practical barriers such as lack of time, difficulty scheduling, and difficulty with homework completion. In addition, modifications included the revision and translation of parent and child treatment materials into Spanish with culturally informed vignettes and the creation of media adjuncts to facilitate learning and reduce emphasis on written materials (Chavira et al., 2015). Other adaptations include a deeper survey and integration of the values, traditions, norms, and stressors of a cultural group (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). Such adaptations may modify treatment content to include themes that are relevant to minority youth with anxiety (e.g., acculturative stress, immigration, discrimination) or use delivery methods that are ecologically valid. For example, Pina and colleagues (2012) implemented CBT principles using a prescriptive approach that allowed providers to incorporate cultural values and customs, such as sharing culturally relevant anecdotes or sayings (*dichos*). In treatments such as cuento therapy, which originated in Puerto Rico, folktales are used to convey a message or moral to the reader that is related to the target problem (Constantino, Malgady, & Rogler, 1986; Santiago-Rivera, Arrendondo, & Gallardo-Cooper, 2002). At present, most treatment studies provide favorable support for cultural adaptations; however, more research is necessary to understand whether cultural adaptations of evidence-based treatments fare better than evidence-based interventions without adaptations (Huey & Polo, 2008).

Cultural Factors that Influence Conceptualization and Treatment

In considering cultural conceptualizations for treatment of Latinos, clinicians should not assume that knowledge of a client's ethnicity and cultural background is sufficient to provide culturally competent therapy. Rather, a focus on the therapeutic relationship and client individual differences is still necessary. Such a focus underscores the fact that Latinos are a heterogeneous

group, originating from 20 countries in Central and South America, Spain, and the Caribbean (Añez, Silva, Paris & Bedregal, 2008). Cultural differences between and within groups must be considered when conceptualizing and treating Latino youth with anxiety disorders.

Acculturation Acculturation has been defined as a dynamic process of learning and adoption of another group's cultural norms as well as the degree to which a person maintains the cultural norms of his or her heritage culture (Berry, 1980). Some data suggest that Latinos, particularly individuals of Mexican descent, have higher rates of anxiety and mood disorders with increasing levels of acculturation. This phenomenon is often referred to as the immigrant paradox (e.g., Alegría et al., 2008; Grant et al., 2004) and has mostly been examined in adults. Acculturative stress, on the other hand, is the stress that arises from the integration of two sets of cultural norms and values (Umaña-Taylor & Alfaro, 2009). Children may experience acculturative stress in the form of discrimination, language difficulties, peer conflict, and intergenerational familial conflict (Umaña-Taylor & Alfaro, 2009). Acculturative stress has been examined in Latino youth, and findings consistently suggest that such stress is associated with anxiety, depression, suicidal ideation, and substance use (Hovey & King, 1996; Lorenzo-Blanco & Unger, 2015; Suarez-Morales & Lopez, 2009). These findings underscore the importance of asking questions about acculturative stress and the level of acculturation of family members in order to understand factors that may be contributing to and maintaining anxiety in Latino youth.

Immigration Clinicians may also consider inquiring about a family's migration history and the circumstances that prompted immigration to a new country. Immigrant families may face language barriers, discrimination, deportation fears, and social isolation, which may exacerbate anxiety symptoms (Bacallao & Smokowski, 2013; Ryder, Alden & Paulhus, 2000). Additionally, concerns about immigration status may deter individuals from seeking or continuing mental health services out of fear that they would be reported if they spoke to a clinician (Rastogi, Massey-Hastings, & Wieling, 2012). As such, providers should explain confidentiality surrounding these issues and address potential concerns in session (Sue & Sue, 2003).

Cultural Values and Worldviews Collectivism refers to the cultural idea that individual needs should be secondary to the needs of the collective group. As such, collectivism has been associated with self-control, emotional restraint, compliance with social norms, and social inhibition (e.g., Hofstede, 1984; Varela & Hensley-Maloney, 2009). A collectivistic orientation is most frequently reported in individuals from Asian and Latino groups and associated with values such as *personalismo* and *familismo*, which emphasize the importance of social support, interpersonal harmony, and family. Among those with a collectivistic orientation, psychoeducation about therapy and therapeutic strategies may need to emphasize the benefits of treatment for the family as a unit, thereby upholding their values and still providing potentially helpful skills (e.g., Comas-Diaz, 2006; Sue & Sue, 2003).

Spirituality and Religion A potentially important area to explore with families is the role of religion and spirituality in their lives. It may be helpful for clinicians to have the client or client's parent state a problem in his or her own words in order to shed light on the possible influence of religious or spiritual beliefs. Further, religious coping can be a powerful tool in managing distressing emotions and is used in Latino culture more frequently than in non-Latino cultures (Finch & Vega, 2003; Sanchez, Dillon, Ruffin, & De La Rosa, 2012). Understanding the importance of such coping strategies and collaborating with religious and spiritual providers may strengthen the therapeutic relationship for families who adhere to such values.

Parenting Styles Parenting that is characterized by overcontrol or lacking in warmth and acceptance has been consistently associated with clinical anxiety (e.g., Ginsburg & Schlossberg, 2002; Wood, McLeod, Sigman, Hwang, & Chu,

2003); however, this same finding does not consistently hold for Latino youth. There is evidence to suggest that parenting behaviors characterized by control are interpreted as consequences of love or obligation to the family by Latino youth (Halgunseth, Ispa, & Rudy, 2006). For instance, in one study controlling parenting was positively associated with anxiety in non-Latino White children, but negatively associated for Mexican American children (Luis, Varela, & Moore, 2008). Interestingly, a favorable connection between overcontrol and anxiety was found for Mexican children, suggesting that controlling parenting may be serving an adaptive function for Mexican American children living as ethnic minorities in the United States (Luis et al., 2008). Another study found that controlling behavior by mothers was associated with child anxiety in Latinos and non-Latino Whites; however, controlling behavior by fathers was associated more strongly with anxiety symptoms for non-Latino White children than for Latino children (Varela, Sanchez-Sosa, Biggs, & Luis, 2009). Further research is needed to clarify the complex relationships between parenting, ethnicity, gender, and anxiety.

In addition, the acceptability of parenting strategies may differ between Latinos and non-Latino Whites. For instance, Calzada and colleagues (2012) examined the acceptability of evidence-based parenting practices, such as using praise and rewards with Latina mothers. They found that there was acceptance of praise and use of privileges as rewards; however, Latina mothers found material rewards objectionable because children should abide by the value of *respeto* rather than need material rewards to behave (Calzada, Huang, Anicama, Fernandez, & Brotman, 2012). Thus, providers should be sensitive to these cultural differences when developing reward systems and implementing parenting strategies.

Stigma and Attitudes Toward Treatment Stigma, the negative perception of mental illness and psychological services, or the fear of being perceived negatively if associated with mental illness, has been linked to increased resistance to seeking care (Ojeda & McGuire, 2006). Stigma is reported at higher rates in ethnic minority families and is more prevalent in foreign-born than U.S.-born Latino groups (Nadeem et al., 2007). In light of this, it is necessary for clinicians to provide ample psychoeducation about therapy and to address stigma as a potential barrier to treatment. Further, clinicians may need to address other attitudes toward treatment that may lead to premature termination, such as the perception that services will not be helpful, unrealistic expectations of therapy, and parental perceptions that they should be able to handle their child's mental health problems on their own (McCabe, 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). Care should be taken to address these potential attitudes at the beginning and throughout treatment.

Sample Session Plan

The following materials are adapted from the Cool Kids Outreach Program (Lyneham et al., 2008), developed for children ages 6 to 12. The session plan assumes knowledge of the elements of CBT and training in basic therapeutic skills for working with children and their families. The session plan is not intended as an introduction to CBT and does not provide detailed explanations of CBT components. The following sample session plan and fictional case study are intended to help providers use evidence-based practices for the treatment of anxiety with Latino and Spanish-speaking families.

Ten Spanish language worksheets are included with the sample session plan. These worksheets are reprinted with permission from the developers (Lyneham et al., 2008) and include examples based on the case study in this chapter, in order to assist clinicians in understanding how to use these skills.

Session 1: Worksheet 1, Culture and Context (Cultura y Contexto)

- This session may include introductions, including time set aside to review terms and limits of confidentiality with parent, child, and other family members (if applicable). For Latino families, providers may need to spend extra time addressing questions regarding confidenti-

ality, particularly when immigration status is a concern.

- Previous research has found that it can be very useful for providers to explain the therapy process to ethnic minority families (McKay & Bannon, 2004) and to explain why therapy is necessary for their child. It may also be helpful for providers to inquire about stigma. Keep in mind that some clients and their families may have limited familiarity or misconceptions regarding the nature of therapy. Previous studies suggest that families are responsive to explanations of therapy that include a skill-building focus that aims to reduce feelings of anxiety, worry, nervousness, and stress and also fosters strength and resilience (Chavira et al., 2015).
- Set expectations for attendance and establish which family members will be attending sessions regularly. There may be other family members not present (including extended family members) that should be involved in the therapeutic process.
- Identify and address potential barriers of coming to therapy. Barriers may include unconventional work hours, the need for childcare during sessions, and lack of transportation to and from sessions. Providers may work to build rapport by acknowledging the difficulty of attending sessions, while helping family members to problem solve solutions to barriers.
- As part of the conceptualization, it is important to gather information on cultural or environmental factors relevant for the child through an open-ended discussion with the child, as appropriate, and the parents. Cultural considerations may include stressors related to immigration, intergenerational conflict, discrimination, and language barriers.
- The child's parent or another adult family member should fill out Worksheet 1: Culture and Context. Encourage family members to consider cultural and environmental aspects that may be contributing to the child's anxiety at the level of the child, the family, the school, the community, and the society. This worksheet can be considered a work in progress and revisited throughout treatment.

Session 2

- This session consists primarily of psychoeducation for both the child and family.
- Start a conversation with the child about the different types of feelings people can have. Try to encourage the child to use a variety of feeling words and to think about how feelings are expressed (e.g., through facial expressions or body language).It may be useful to query cultural concepts of distress such as *nervios* or *ataques*.
- Talk to the child and family members about defining the concept of anxiety. Emphasize the connection between bodily sensations, thoughts, and behaviors and how these three elements together make up the sensation of anxiety.
- Discuss the bodily symptoms of anxiety, using a cartoon drawing of a body as a guide.
- Have the child identify some of the things that cause him or her anxiety and how this anxiety may be interfering with his or her life.
- Discuss the purpose of anxiety and normalize anxiety by explaining that it is a natural feeling that all people experience.
- Provide psychoeducation on the causes of anxiety including biological factors (inherited, temperament) and learned factors (modeling influences).
- Homework: Have child, with the help of a family member, record daily feelings.

Session 3: Worksheet 2, The Worry Scale (La Escala de Preocupación), and Worksheet 3, Linking Thoughts and Feelings (Conecta Los Pensamientos y Sentimientos)

- This session may include the introduction of a worry scale or thermometer. A worry scale can be any visual that will help the child to conceptualize low and high levels of anxiety.
- Have the child use the worry scale to describe his or her amount of worry in the different situations listed on the Worry Scale worksheet. The worksheet also has anchor points

on the scale; have the child identify situations that are associated with the anchor points.

- This session may also include an introduction of the idea that there is a connection between thoughts and feelings. Point out that different people can have different thoughts and that even the same person can have different thoughts about one situation. Use the Linking Thoughts and Feelings worksheet to have the child identify situations that were anxiety provoking and their corresponding thoughts.
- Explain to parents and other family members the connection between thoughts and feelings.
- Homework: Have the child use the Linking Thoughts and Feelings worksheet to record examples of situations, thoughts, and feelings that caused anxiety throughout the week.

Session 4: Worksheet 4, Calm and Worried Thoughts (Pensamientos Relajantes y Preocupantes), and Worksheet 5, Thoughts, Feelings, and Actions (Pensamientos, Sentimientos, y Acciones)

- Revisit the concept that thoughts are connected to feelings and that one person can have two different thoughts in the same situation. Introduce the idea that a thought can sometimes be negative and cause anxiety but that it can be replaced with a calm thought.
- Using the cartoons on the Calm and Worried Thoughts worksheet, have the child identify a calm thought and a worried thought for each situation.
- Introduce the idea that different thoughts can lead to different actions. Provide examples relevant for the child and family members.
- Have the child complete the Thoughts, Feelings, and Actions worksheet to emphasize how he or she may behave and feel differently if a calm thought replaces a worried thought.
- Homework: The child, with the help of a family member, can fill in the Thoughts, Feelings, and Actions worksheet with situations from the week.

Session 5: Worksheet 6, Practicing Calm Thoughts (Practicando Pensamientos Relajantes)

- This session includes evaluating the validity of thoughts by showing the child how to gather facts about the thoughts.
- Explain to the child that some thoughts seem like they are true, even when they are unlikely.
- Outline each step of practicing calm thoughts, including identifying the worried thought, choosing a worry rating, listing all the evidence for and against that thought, writing down a more realistic calm thought, and choosing a worry rating associated with the calm thought.
- This skill is best learned through examples. It may be beneficial to complete Worksheet 6: Practicing Calm Thoughts with a number of different examples, as well as the child's own example from the previous week.
- Encourage the child to start with small worries and work his or her way up to bigger worries.
- Homework: Have the child, with the help of a family member, practice calm thoughts for two or three scenarios over the course of the week.

Sessions 6–11: Worksheet 7, Step-by-Step Plan (Plan Escalón por Escalón); Worksheet 8, Rewards (Las Recompensas); and Worksheet 9, Fighting Fear with Fear (Lucha Contra el Miedo Enfrentándote a Él)

- These sessions may involve the introduction of fear hierarchies and the use of exposure to help the child confront anxiety-provoking situations. Explain the rationale of exposure to the child and parent or family members. Give an overview of the steps, including generating a list of anxieties, organizing them based on worry rating, and engaging in gradual exposures.
- Help the child to complete a fear hierarchy using the Step-by-Step Plan worksheet. Emphasize that each step should be repeated until the child feels comfortable with that step.
- Help the child to brainstorm rewards using the Rewards worksheet. Explain that big achievements and efforts get big rewards, while small

achievements and efforts get small rewards. Also explain to the child that they can get rewards for doing good things, helping others, or completing exposures.

- Explain to parents and family members that rewards can be privileges and praise, not just material items. Keep in mind Latino cultural differences with respect to the preference of affection and praise over material rewards (Calzada et al., 2012).
- Use the Fighting Fear with Fear worksheet to aid the child in keeping track of exposure activities. Emphasize the use of the Practicing Calm Thoughts worksheet in preparation for each step of the exposure. Remind the child that it takes a lot of practice to overcome fears.
- Practice exposures in session and model appropriate responses when possible.
- Have the child explain the worksheets to family members to allow for the opportunity for the child to seek support from family.
- Homework: Have the child practice exposures and use the Fighting Fear with Fear worksheet to keep track of his or her progress.

Session 12: Worksheet 12, Problem-Solving (Resolviendo Problemas)

- Introduce the Problem-Solving worksheet with an example. Have the child think of another solution, and work out what might be the consequences of that solution.
- Using a blank worksheet, choose a problem that the child recently faced. If the child cannot think of one, imagine a situation that may be difficult for the child or cause anxiety (e.g., you have to give a speech at school for a child with social anxiety).
- Emphasize that it is important to brainstorm all possible solutions before evaluating them and choosing a solution.
- Have the child explain the steps to problem-solving to a parent or other family member.
- Homework: Have the child attempt the solution to the problem or choose a problem to work on using the Problem-Solving worksheet during the week.

Case Study: Social and Separation Anxiety

Cristina is a 9-year-old Latina girl who lives with her mom, dad, 6-year-old brother, and grandmother. Cristina and her brother were born in the United States, but her parents and grandmother were born in Mexico and do not speak English fluently. Cristina speaks only Spanish at home and English in school. Cristina worries frequently that she will say something wrong in class or that other kids will laugh at what she is wearing. Cristina also worries about looking different than other kids and feels embarrassed that her family speaks Spanish more than English. She tells her mom that she does not like to talk to other people other than members of her family and frequently avoids situations where she may have to talk or play with new children. Cristina's parents tried to introduce her to other children that speak Spanish, but she is also fearful of these interactions. Cristina is a fantastic artist who likes to draw and paint, but she does not show her work to anyone except her mother because she is afraid other people will make fun of it.

Cristina also has trouble being away from her parents and grandmother. If her mother or grandmother is late picking her up from school, she worries that something terrible has happened. She will not spend the night at her cousin's house because she is afraid to be away from her parents overnight. In the evenings, she spends time praying with her grandmother. She stated that she often prays for the safety of her family members.

Cristina often tells her parents that she has a stomachache and that she feels dizzy before school. Her family is noticing that, aside from wanting to avoid school, she is starting to appear down, and they are not sure what to do. They are apprehensive about starting treatment since they are unsure of what to expect and whether therapy will be helpful for their family. Cristina's grandmother is the most ambivalent. She believes that Cristina may just outgrow these problems and is therefore reluctant to join in the treatment.

Cultura y Contexto

Completar los aspectos que crees que está contribuyendo a la ansiedad de tu niño.

Sociedad

Situación legal   Discriminación   Los traslados a un nuevo país

Comunidad

Actividades extracurriculares   Temor a violencia   Acoso cibernético

Escuela

Clases bilingües   Influencia de los amigos   Las relaciones con maestras

Familia

Estilo parental

Divorcio   Mi ansiedad (del padre)

Niño/a

Temperamento

Autoestima   Problemas de salud

La Escala de Preocupación

Algunas veces cuando estamos preocupados solamente estamos un poco preocupados pero a veces nos sentimos muy, muy preocupados. Usar una escala es una buena manera de describir que tan fuerte es un sentimiento. Una escala es como un termómetro. Cuando el sentimiento es bajo, el número en el termómetro es bajo. Cuando el sentimiento es fuerte, el número en el termómetro es alto.
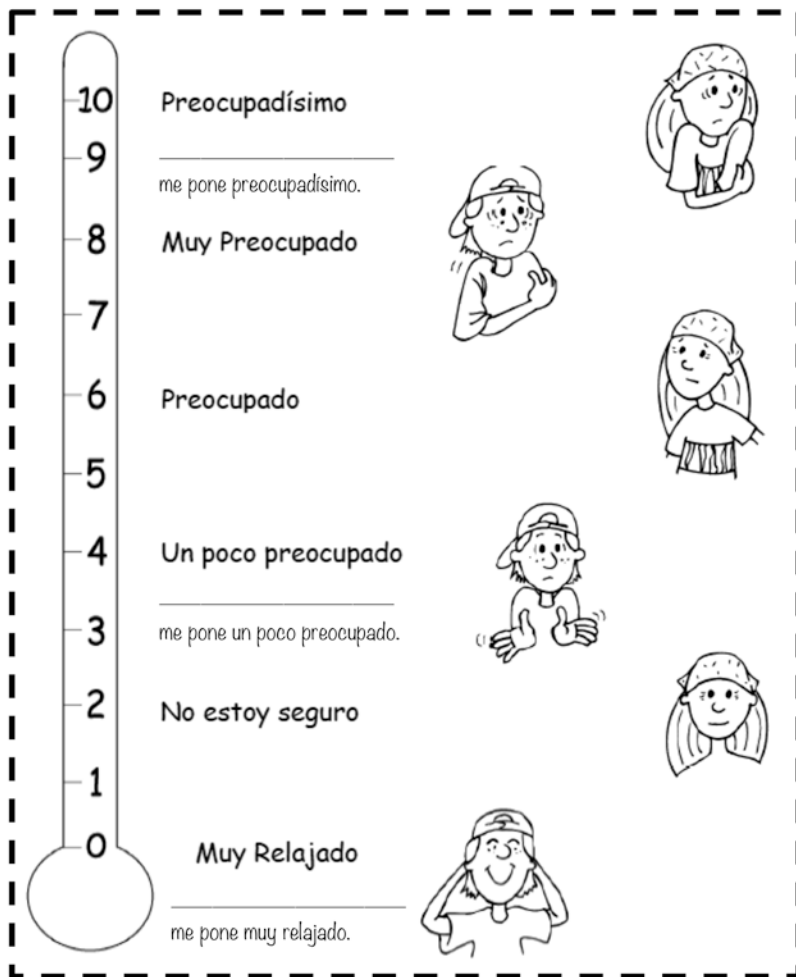
Esta es una escala para el sentimiento de preocupación. La estaremos usando bastante para que nos ayude a decir que tan fuerte es el sentimiento de miedo o ansiedad. Para usar la escala, piensa en la situación y después asígnale un número que demuestre que tan preocupado estás por cada situación.

Por ejemplo, si estás apunto de subirte al escenario para cantar solo en frente de toda la escuela, el nivel de esa preocupación sería 9 en la escala.

- Nivel de preocupación si estás yendo a la nevería.
  __1__

- Nivel de preocupación si tienes que empezar en una escuela nueva mañana:
  __8__

Escribe ejemplos de las situaciones en que estás muy relajado, un poco preocupado, y preocupadísimo.

10	Preocupadísimo
9	*Presentaciones en la escuela* me pone preocupadísimo.
8	Muy Preocupado
7	
6	Preocupado
5	
4	Un poco preocupado
	Ir a la casa de una amiga me pone un poco preocupado.
3	
2	No estoy seguro
1	
0	Muy Relajado
	Pasear por el parque me pone muy relajado.

Adapted from *Helping Your Anxious Child Children's Workbook* (2nd Ed), by H. J. Lyneham, A. Wignall, & R. M. Rapee, 2008, Center for Emotional Health, Macquarie University: Sydney, Australia. Adapted with permission.

Conecta Los Pensamientos y Sentimientos

Lo que tú piensas y cómo te sientes tienen que ver mucho uno con el otro. Vamos a pensar en algunos ejemplos. Piensa en una ocasión en que estabas muy, muy feliz. En las figuras a continuación escribe lo que paso, lo que estabas pensando, y lo que estabas sintiendo. Circula el nivel de preocupación que hubieras sentido para esa situación.

¿Qué fue lo que paso?   **¿Qué estaba pensando?**   **¿Qué estaba sintiendo?**

El primer día del verano

Me voy a diverter comiendo helado y tomando horchata

Contenta

Nivel de (0) 1 2 3 4 5 6 7 8 9 10 Preocupación

Ahora piensa en situaciones que han pasado en los últimos días en las que estabas preocupado. Si se te hace difícil recordar, cierra tus ojos y trata de imaginar que estás de regreso en esa situación. No olvides evaluar lo preocupado que estabas en cada situación.

¿Qué fue lo que paso?   **¿Qué estaba pensando?**   **¿Qué estaba sintiendo?**

Mi madre perdió su trabajo.

No vamos a tener dinero para comer.

Asustada y preocupada

Nivel de 0 1 2 3 4 5 6 7 (8) 9 10 Preocupación

¿Qué fue lo que paso?   **¿Qué estaba pensando?**   **¿Qué estaba sintiendo?**

El primer día de la escuela

Se van a reír de mi porque mi ropa no es nueva, o porque me miro diferente de ellos

Triste

Nivel de 0 1 2 3 4 5 6 (7) 8 9 10 Preocupación

Pensamientos Relajantes y Preocupantes

Unos pensamientos pueden ayudar a una persona a relajarse y otros pensamientos quizás pueden ocasionarles más ansiedad y miedo. Circule el perro que estaría más ansioso en esta situación. Por qué crees que ese perro se sentiría más ansioso?
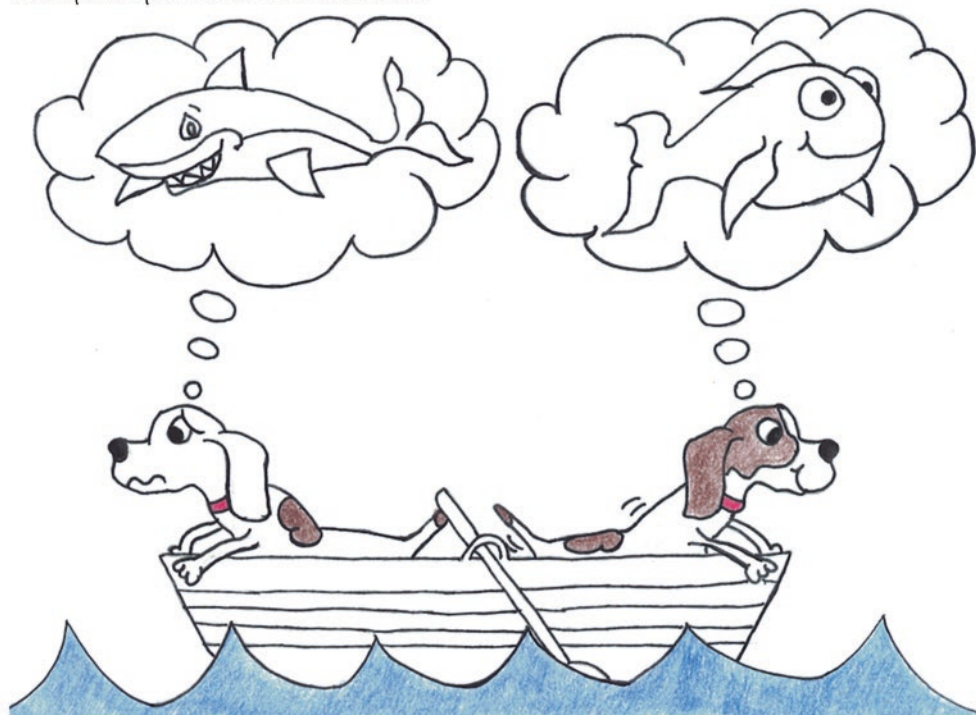
En las caricaturas de abajo, escribe dos pensamientos diferentes que la niña podría tener. Trata de escribir un pensamiento relajante y un pensamiento preocupante.

A ella no le va a gustar lo que llevo puesto.

Ella va a ser agradable y voy a hacer una nueva amiga.

Necesita más tiempo para terminar su trabajo.

¡Ha ocurrido algo terrible!

Te encuentras con una nueva persona.

Tú mamá llega tarde a la casa.

Pensamientos, Sentimientos, y Acciones

Los pensamientos y sentimientos pueden influir tus acciones. En cada uno de los siguientes ejemplos escribe un pensamiento preocupante. Después, escribe que es lo que sentirías y lo que harías. Haz cada uno por segunda vez con un pensamiento de tranquilidad. ¿Te sentirías diferente si tuviera un pensamiento de tranquilidad? ¿Te comportarías diferente?

Situación: No has terminado tu tarea de la escuela.

	Pensamientos	Sentimientos	Acciones
Preocupación	Mi maestra me va a gritar y mi abuela se va a sentir decepcionada.	Asustada y triste	Niego ir a la escuela.
Tranquilidad	Estará bien, mi maestra comprenderá.	Calma	Voy a la escuela voy a explicar la situación a mi maestra.

Situación: Quieres invitar a un amigo nuevo a tu fiesta.

	Pensamientos	Sentimientos	Acciones
Preocupación	Se va a reír de mi porque mi casa no es tan bonita.	Nerviosa	No le llamo y no lo invito.
Tranquilidad	Mi amigo vendrá y nos vamos a divertir.	Emocionada	Llamo a mi amigo y lo invito.

Situación: Tu equipo tiene un partido muy importante mañana.

	Pensamientos	Sentimientos	Acciones
Preocupación	Nunca seremos tan buenos como el otro equipo.	Triste y nerviosa	Niego ir al partido porque tengo un dolor de estómago.
Tranquilidad	Vamos a jugar lo mejor posible.	Relajada	Voy al partido y animo a mis amigos.

Situación: (Tu ejemplo) Voy a dormir en la casa de mi prima.

	Pensamientos	Sentimientos	Acciones
Preocupación	Sus padres van a ser malos y me van hacer llorar.	Nerviosa y asustada	Le digo a mis padres que me duele la cabeza y no voy.
Tranquilidad	Nos vamos a divertir mucho jugando y riendo toda la noche.	Emocionada	Organizo mis cosas para la fiesta.

Practicando Pensamientos Relajantes

A menudo, los pensamientos de preocupación no son realistas. Una manera de decidir si lo que estás pensando es realista es pensar en los hechos. Esto es lo que hace un científico o un juez. Necesitas ver si hay más hechos que confirman el pensamiento preocupante o si hay más hechos que confirman un pensamiento relajante. Hay cuatro pasos para ayudarte a practicar pensamientos relajantes.

1.   Anota tu pensamiento preocupante y utiliza la escala de preocupación para evaluar que tan preocupando estás cuando tienes ese pensamiento.

2.   Contesta las preguntas en las cajas para crear una lista de hechos.

3.   Averigua si hay más hechos que confirman el pensamiento preocupante o que no confirman ese pensamiento. También te puedes preguntar si los hechos para el pensamiento preocupante son más favorables que los hechos que no confirman ese pensamiento.

4.   Anota un pensamiento realista. Pregúntate: "basado en los hechos, ¿qué pienso que de verdad pasará? Utiliza la escala de preocupación para evaluar que tan preocupado te sientes cuando piensas en el pensamiento relajante.

Situación	Tengo que dar una presentación en la escuela.
Pensamiento Preocupante	Voy a hacer un mal trabajo y los niños hablaran de mi a mis espaldas. Mi nivel de preocupación es: ____8____

¿Cuales son los hechos?	He estado practicando mi presentación, así que voy a estar bien.
¿Qué me ha pasado antes en esta situación?	He dado presentaciones antes y solo me fue mal una vez. Algunos niños se rieron de mí.
¿Qué le diría a un amigo si tuviera este pensamiento?	He visto a otros niños que se han avergonzado un par de veces, entonces tu no serás el único.
¿Qué es probable que vaya a suceder de verdad?	Yo probablemente haré un bueno trabajo porque he practicado.

Pensamiento realista: ¿Qué pienso ahora que he considerado los hechos?	Probablemente haré un buen trabajo y aunque tenga algunos errores los demás niños no lo notaran. Mi nivel de preocupación es: ____3____

Plan Escalón por Escalón

Si tienes miedo de algo, lo evitarás. A menudo, los miedos nos impiden hacer las cosas que nos gustaría hacer. Los miedos no se irán tan fácilmente al menos que los enfretemos junto con las situaciones que el miedo nos dice que evitemos. Puedes explicar tus miedos con más detalles para ayudar a vencerlos.

META	Poder pasar la noche en casa de una prima sin preocuparme de estar lejos de mamá.	
Escalón 10	Dormir en la casa de mi prima sin mi mamá.	10
Recompensa 10	Mi mamá me lleva al parque toda la tarde.	
Escalón 9	Dormir en la casa de mi prima sin mi mamá por una hora.	9
Recompensa 9	Invitar a mi prima a dormir en mi casa.	
Escalón 8	Ir a la casa de mi prima sin mi mamá por una tarde.	7
Recompensa 8	Cenar mi comida favorita.	
Escalón 7	Ir a la casa de mi prima sin mi mamá por 3 horas.	6
Recompensa 7	Salir a pasear en bicicleta con mamá.	
Escalón 6	Ir a la casa de mi prima sin mi mamá por una hora.	5
Recompensa 6	Mamá traerá a casa una sorpresa.	
Escalón 5	Ir a la casa de mi prima con mi madre pero sin hablar con mi mamá.	4
Recompensa 5	Acostarme media hora más tarde de lo acostumbrado.	
Escalón 4	Quedarme en casa con mi abuela todo el día mientras mi mamá sale todo el día.	4
Recompensa 4	Escoger una actividad para hacer con mamá.	
Escalón 3	Quedarme en casa con mi abuela mientras mi mamá sale por 3 horas.	3
Recompensa 3	Dibujar por 30 minutos.	
Escalón 2	Quedarme en casa con mi abuela mientras mi mamá sale por 30 minutos.	2
Recompensa 2	Escoger lo que vamos a comer a la hora de la cena.	
Escalón 1	Quedarme en casa con mi abuela mientras mi mamá sale por 15 minutos.	1
Recompensa 1	Jugar 15 minutos extra antes de acostarme.	

Empieza Aquí

Las Recompensas

Las recompensas son un paso importante para controlar la ansiedad. ¿En cuántas recompensas diferentes puedes pensar? Recuerda que las recompensas no solo son dinero y otras cosas materiales. También pueden ser pasar tiempo con personas especiales para nosotros, actividades o salir a pasear. Cada idea puede encajar en más de una categoría.

Mis cosas favoritas	Actividades que son rápidas y fáciles
1. Legos 2. Calcomanías 3. Materiales de arte	1. Ir al parque 2. Jugar 15 minutos extra antes de acostarme 3. Cenar mi comida favorita
Las cosas y actividades gratuitas	Actividades puedo hacer con mi familia o mis amigos
1. Libros de la biblioteca 2. Ir al parque 3. Dibujar o pintar por 30 minutos	1. Invitar a mi prima a cenar 2. Salir a pasear en bicicleta con mamá 3. Mi mamá me lleva al parque toda la tarde.

¿Sabías que te puedes recompensar? Esto suena un poco gracioso al principio pero si es posible. Cuando haces algo bueno o superas un miedo, te puedes decir en tu mente algo como 'hice un buen trabajo' o puedes hacer algo especial que te guste. Durante la próxima semana, te recompensarás por hacer un gran esfuerzo.

¿Qué cosa buena hice?	¿Fue algo pequeño o grande?	¿Cómo me recompensé?
Hoy ya hice toda mi tarea.	Pequeño	Cenar mi comida favorita
Ayudé a mi prima con su tarea.	Pequeño	Invitar a mi prima a cenar
Superé un miedo: quedarme en la casa de mi tía sin mi mamá.	Grande	Pasear por el parque con mi mamá
Compartí los juguetes con mi hermano.	Pequeño	Dibujar por 30 minutos
Superé un miedo: di una presentación en la escuela.	Grande	Materiales nuevos de arte

Lucha Contra el Miedo Enfrentándote a Él

Utiliza las actividades en tu escalera a fin de que enfrentes tus miedos. Practica cada escalón muchas veces. Por ejemplo, si tienes miedo hacer preguntas en la clase, haz preguntas muchas veces hasta que se te haga fácil. Cada vez que practiques, llena una sección que te pregunta sobre tu nivel de preocupación, las habilidades que usaste, lo que aprendiste, y tu recompensa.

Los tipos de habilidades que puedes usar son cosas como: 1) conectar pensamientos y sentimientos, 2) practicar los pensamientos relajantes, 3) resolver problemas, y 4) relajación, etc.

¿Qué escalón voy a practicar y cuando voy a practicarlo?	¿Qué habilidades voy a usar para ayudarme con este escalón?	Nivel de preocupación	¿Qué he aprendido al enfrentarme a este miedo?	¿Recibí mi recompensa?
Quedarme con mi tía mientras mamá sale por la tarde. Voy a practicar viernes y la próxima semana.	Practicar los pensamientos relajantes. Me recuerdo de pensar en lo que es probable suceder de verdad.	Antes: 6 Durante: 7 Después: 3	No le va a pasar nada malo a mamá cuando sale por la tarde.	Sí ✔ No ☐
Quedarme en casa de mi prima este sábado por la noche.	Conectar los pensamientos y sentimientos: Los pensamientos como 'Voy a extrañar a mi madre' me hacen sentir triste.	Antes: 9 Durante: 5 Después: 3	Voy a tener miedo al principio, pero me voy a divertir.	Sí ✔ No ☐
Después de la escuela el martes, iré a 5 tiendas y preguntaré donde se encuentra un producto.	Pensamiento realista: Las personas no pensarán que soy tonta por preguntar donde se encuentran las cosas.	Antes: 7 Durante: 8 Después: 2	Los asistentes de tienda están para ayudar y no piensan que eres tonta por hacer preguntas.	Sí ✔ No ☐

Adapted from *Helping Your Anxious Child Children's Workbook* (2nd Ed), by H. J. Lyneham, A. Wignall, & R. M. Rapee, 2008, Center for Emotional Health, Macquarie University: Sydney, Australia. Adapted with permission.

Resolviendo Problemas

Paso 1: ¿Cuál es el problema?	
Mamá y papá van a salir y yo no quiero que ellos se vayan.	
Paso 2: ¿Qué puedes cambiar?	
Yo puedo cambiar mi reacción, ellos van a salir aunque yo no quiera.	
Paso 3: Piensa en todas las ideas para resolver este problema. Todas las soluciones son bienvenidas. No evalúes las soluciones.	**Paso 4: ¿Qué pasaría si lo hicieras?**
Llevar las llaves del carro y esconderlas.	Me meteré en problemas y ellos se irán en taxi.
Ver una película y ya no pensar en eso.	Me divertiría y ya no pensaría tanto.
Crear un pensamiento relajante.	No estaría pensando en accidentes y podría sentirme mejor.
Voy a decir que no salgan.	Me consolarán y me dejarán de todos modos.
Hacer un berrinche muy grande.	Me harán pasar un tiempo sola y acabaría más alterada.
Voy a decirle a mi abuela cómo me siento.	Ella me consolará y yo podre sentirme mejor.

Paso 5: ¿Cuál es la mejor idea? ¿Cuál es la segunda mejor idea?
Voy a usar las soluciones 2 y 3. Primero voy a crear un pensamiento relajante y después veré la película.

Paso 6: Evalúa cómo funcionó tu idea – ¿Qué harías la próxima vez?
Mis preocupaciones pararon cuando empecé a disfrutar la película y como premio fui a andar en bicicleta con mi papá. Mis soluciones funcionaron bien.

Cultura y Contexto

Completar los aspectos que crees que está contribuyendo a la ansiedad de tu niño.

Sociedad

_____ _____ _____

Comunidad

_____ _____ _____

Escuela

_____ _____ _____

Familia

_____

_____   _____

Niño/a

_____

_____ _ _____

La Escala de Preocupación

Algunas veces cuando estamos preocupados solamente estamos un poco preocupados pero a veces nos sentimos muy, muy preocupados. Usar una escala es una buena manera de describir que tan fuerte es un sentimiento. Una escala es como un termómetro. Cuando el sentimiento es bajo, el número en el termómetro es bajo. Cuando el sentimiento es fuerte, el número en el termómetro es alto.

Esta es una escala para el sentimiento de preocupación. La estaremos usando bastante para que nos ayude a decir que tan fuerte es el sentimiento de miedo o ansiedad. Para usar la escala, piensa en la situación y después asígnale un número que demuestre que tan preocupado estás por cada situación.

Por ejemplo, si estás apunto de subirte al escenario para cantar solo en frente de toda la escuela, el nivel de esa preocupación sería 9 en la escala.

- Nivel de preocupación si estás yendo a la nevería.

  _____

- Nivel de preocupación si tienes que empezar en una escuela nueva mañana:

  _____

Escribe ejemplos de las situaciones en que estás muy relajado, un poco preocupado, y preocupadísimo.

10 Preocupadísimo
9
   _____
   me pone preocupadísimo.
8 Muy Preocupado
7
6 Preocupado
5
4 Un poco preocupado
   _____
3 me pone un poco preocupado.
2 No estoy seguro
1
0 Muy Relajado
   _____
   me pone muy relajado.

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Conecta Los Pensamientos y Sentimientos

Lo que tú piensas y cómo te sientes tienen que ver mucho uno con el otro. Vamos a pensar en algunos ejemplos. Piensa en una ocasión en que estabas muy, muy feliz. En las figuras a continuación escribe lo que paso, lo que estabas pensando, y lo que estabas sintiendo. Circula el nivel de preocupación que hubieras sentido para esa situación.

¿Qué fue lo que paso?   ¿Qué estaba pensando?   ¿Qué estaba sintiendo?

Nivel de   0   1   2   3   4   5   6   7   8   9   10   Preocupación

Ahora piensa en situaciones que han pasado en los últimos días en las que estabas preocupado. Si se te hace difícil recordar, cierra tus ojos y trata de imaginar que estás de regreso en esa situación. No olvides evaluar lo preocupado que estabas en cada situación.

¿Qué fue lo que paso?   ¿Qué estaba pensando?   ¿Qué estaba sintiendo?

Nivel de   0   1   2   3   4   5   6   7   8   9   10   Preocupación

¿Qué fue lo que paso?   ¿Qué estaba pensando?   ¿Qué estaba sintiendo?

Nivel de   0   1   2   3   4   5   6   7   8   9   10   Preocupación

Pensamientos Relajantes y Preocupantes

Unos pensamientos pueden ayudar a una persona a relajarse y otros pensamientos quizás pueden ocasionarles más ansiedad y miedo. Circule el perro que estaría más ansioso en esta situación. Por qué crees que ese perro se sentiría más ansioso?

En las caricaturas de abajo, escribe dos pensamientos diferentes que la niña podría tener. Trata de escribir un pensamiento relajante y un pensamiento preocupante.

Te encuentras con una nueva persona.

Tú mamá llega tarde a la casa.

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Pensamientos, Sentimientos, y Acciones

Los pensamientos y sentimientos pueden influir tus acciones. En cada uno de los siguientes ejemplos escribe un pensamiento de preocupación. Después, escribe que es lo que sentirías y lo que harías. Haz cada uno por segunda vez con un pensamiento de tranquilidad. ¿Te sentirías diferente si tuviera un pensamiento de tranquilidad? ¿Te comportarías diferente?

Situación: No has terminado tu tarea de la escuela.			
	Pensamientos	Sentimientos	Acciones
Preocupación			
Tranquilidad			

Situación: Quieres invitar a un amigo nuevo a tu fiesta.			
	Pensamientos	Sentimientos	Acciones
Preocupación			
Tranquilidad			

Situación: Tu equipo tiene un partido muy importante mañana.			
	Pensamientos	Sentimientos	Acciones
Preocupación			
Tranquilidad			

Situación: (Tu ejemplo)			
	Pensamientos	Sentimientos	Acciones
Preocupación			
Tranquilidad			

Practicando Pensamientos Relajantes

A menudo, los pensamientos de preocupación no son realistas. Una manera de decidir si lo que estás pensando es realista es pensar en los hechos. Esto es lo que hace un científico o un juez. Necesitas ver si hay más hechos que confirman el pensamiento preocupante o si hay más hechos que confirman un pensamiento relajante. Hay cuatro pasos para ayudarte a practicar pensamientos relajantes.

1. Anota tu pensamiento preocupante y utiliza la escala de preocupación para evaluar que tan preocupando estás cuando tienes ese pensamiento.

2. Contesta las preguntas en las cajas para crear una lista de hechos.

3. Averigua si hay más hechos que confirman el pensamiento preocupante o que no confirman ese pensamiento. También te puedes preguntar si los hechos para el pensamiento preocupante son más favorables que los hechos que no confirman ese pensamiento.

4. Anota un pensamiento realista. Pregúntate: "basado en los hechos, ¿qué pienso que de verdad pasará? Utiliza la escala de preocupación para evaluar que tan preocupado te sientes cuando piensas en el pensamiento relajante.

Situación	
Pensamiento Preocupante	Mi nivel de preocupación es: _____

¿Cuales son los hechos?	
¿Qué me ha pasado antes en esta situación?	
¿Qué le diría a un amigo si tuviera este pensamiento?	
¿Qué es probable que vaya a suceder de verdad?	

Pensamiento realista: ¿Qué pienso ahora que he considerado los hechos?	Mi nivel de preocupación es: _____

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Plan Escalón por Escalón

Si tienes miedo de algo, lo evitarás. A menudo, los miedos nos impiden hacer las cosas que nos gustaría hacer. Los miedos no se irán tan fácilmente al menos que los enfretemos junto con las situaciones que el miedo nos dice que evitemos. Puedes explicar tus miedos con más detalles para ayudar a vencerlos.

META		
Escalón 10		
Recompensa 10		
Escalón 9		
Recompensa 9		
Escalón 8		
Recompensa 8		
Escalón 7		
Recompensa 7		
Escalón 6		
Recompensa 6		
Escalón 5		
Recompensa 5		
Escalón 4		
Recompensa 4		
Escalón 3		
Recompensa 3		
Escalón 2		
Recompensa 2		
Escalón 1		
Recompensa 1		

Empieza Aquí

Adapted from *Helping Your Anxious Child Children's Workbook* (2nd Ed), by H. J. Lyneham, A. Wignall, & R. M. Rapee, 2008, Center for Emotional Health, Macquarie University: Sydney, Australia. Adapted with permission.

Las Recompensas

Las recompensas son un paso importante para controlar la ansiedad. ¿En cuántas recompensas diferentes puedes pensar? Recuerda que las recompensas no solo son dinero y otras cosas materiales. También pueden ser pasar tiempo con personas especiales para nosotros, actividades o salir a pasear. Cada idea puede encajar en más de una categoría.

Mis cosas favoritas	Actividades que son rápidas y fáciles
Las cosas y actividades gratuitas	Actividades puedo hacer con mi familia o mis amigos

¿Sabías que te puedes recompensar? Esto suena un poco gracioso al principio pero si es posible. Cuando haces algo bueno o superas un miedo, te puedes decir en tu mente algo como 'hice un buen trabajo' o puedes hacer algo especial que te guste. Durante la próxima semana, te recompensarás por hacer un gran esfuerzo.

¿Qué cosa buena hice?	¿Fue algo pequeño o grande?	¿Cómo me recompensé?

Lucha Contra el Miedo Enfrentándote a Él

Utiliza las actividades en tu escalera a fin de que enfrentes tus miedos. Practica cada escalón muchas veces. Por ejemplo, si tienes miedo hacer preguntas en la clase, haz preguntas muchas veces hasta que se te haga fácil. Cada vez que practiques, llena una sección que te pregunta sobre tu nivel de preocupación, las habilidades que usaste, lo que aprendiste, y tu recompensa.

Los tipos de habilidades que puedes usar son cosas como: 1) conectar pensamientos y sentimientos, 2) practicar los pensamientos relajantes, 3) resolver problemas, y 4) relajación, etc.

¿Qué escalón voy a practicar y cuando voy a practicarlo?	¿Qué habilidades voy a usar para ayudarme con este escalón?	Nivel de preocupación	¿Qué he aprendido al enfrentarme a este miedo?	¿Recibí mi recompensa?
		Antes: _____ Durante: _____ Después: _____		Sí ☐ No ☐
		Antes: _____ Durante: _____ Después: _____		Sí ☐ No ☐
		Antes: _____ Durante: _____ Después: _____		Sí ☐ No ☐

Resolviendo Problemas

Paso 1: ¿Cuál es el problema?	
Paso 2: ¿Qué puedes cambiar?	
Paso 3: Piensa en todas las ideas para resolver este problema. Todas las soluciones son bienvenidas. No evalúes las soluciones.	Paso 4: ¿Qué pasaría si lo hicieras?
Paso 5: ¿Cuál es la mejor idea? ¿Cuál es la segunda mejor idea?	
Paso 6: Evalúa cómo funcionó tu idea – ¿Qué harías la próxima vez?	

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Tools for Working with Spanish-Speaking Latino Couples

Kristin Lindahl and Sara Wigderson

Introduction

Many couples encounter difficulty at some point in their relationship, and if these problems are not ameliorated, a variety of negative consequences can occur for both the couple, and, if there are children, their family. It is estimated that about one-third of couples experience distress or discord at any one point in time (Whisman, Beach, & Snyder, 2008). Marital satisfaction drops considerably over the first 10 years of marriage (Bradbury, Fincham, & Beach, 2000), and chronic relationship distress can sufficiently erode the positive elements of a relationship such that couples ultimately divorce. Divorce is common in the United States, and it is estimated that nearly 50% of marriages end within the first 20 years (Copen, Daniels, Vespa, and Mosher, 2012). Marital distress can have a powerful effect on the partners, and it often leads to sadness, worry or anxiety, and tension. If prolonged, it also can negatively impact one's physical health.

Though the quality of marital communication is certainly not the only factor that is predictive of marital quality and its trajectory over time,

decades of research point to the critical role the ability to resolve disputes holds in predicting marital satisfaction and divorce (e.g., Birditt, Brown, Orbuch, and McIlvane, 2010; Kelly, Fincham, and Beach, 2003). Over time, a breakdown in communication tends to lead to increased arguing and to counterproductive behaviors such as stonewalling, defensiveness, and contempt. Once negative communication patterns are established, they are hard to break, and as distance grows between the partners, the capacity for intimacy declines.

The limited literature to date suggests that, overall, Hispanic couples are at similar risk for marital difficulties as non-Hispanic Whites (Bulanda & Brown, 2007). How distress manifests itself, however, may differ across ethnic groups. Hispanic and Latino couples are diverse in their country of origin, level of acculturation, socioeconomic status, and cultural practices, and with the limited amount of research available thus far, any conclusions to be drawn regarding ethnic differences need to be done with caution. In terms of communication skills, however, it does appear that cultural differences exist with respect to what is normative in the expression and management of conflict, and thus, it seems reasonable to assume that the meaning and impact of conflict likely vary across couples. Several studies also show differences in acculturation to be related to lower marital quality (Negy, Hammons, Reig-Ferrer, & Carper, 2010;

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Negy & Snyder, 2000; Vega, Kolody, & Valle, 1988). Acculturation can be operationalized in different ways, but it commonly refers to the degree to which an individual endorses beliefs, attitudes, and behaviors of their culture of origin, the dominant culture in their new environment, or both (Negy & Snyder, 1997). In general, it will be important for therapists working with distressed Hispanic or Latino couples to ask about their perceived norms for couple behavior and communication and how they see their cultural and ethnic identities as impacting their marital interactions and expectations.

There are a variety of evidence-based treatments that serve distressed couples. Although there is some evidence that marital interventions can be effective among diverse populations (Daire et al., 2012; Owen, Quirk, Bergen, Inch, & France, 2012), most of this research focuses on marital education programs rather than therapy. Cultural diversity factors are rarely directly incorporated into marital programs or interventions (Perez, Brown, Whiting, & Harris, 2013), though this is a goal of current research and it is goal for this chapter.

This chapter attempts to integrate key principles from evidence-based treatments for couples. Below are key references and Web page links to the evidence-based treatments that were consulted in organizing material for this chapter.

Integrative Behavioral Couple Therapy

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples. *Journal of Consulting and Clinical Psychology, 72*(2), 176–191.

Doss, B. D., Cicila, L. N., Georgia, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2016). A randomized controlled trial of the web-based Our Relationship program: Effects on relationship and individual functioning. *Journal of Consulting and Clinical Psychology, 84*(4), 285–296.

Webpage: ibct.psych.ucla.edu

The Prevention and Relationship Education Program (PREP)

Markman, H. J., Renick, M. J., Floyd, F. J., Stanley, S. M., & Clements, M. (1993). Preventing marital distress through communication and conflict management training: A 4- and 5-year follow-up. *Journal of Consulting and Clinical Psychology, 61*(1), 70–77.

Webpage: https://www.prepinc.com/

Module 1: Establishing Rapport and Setting Goals

Recommended Length: One to Two Sessions

Goals of module: Module 1 has several goals. As with any other kind of therapy, a primary goal for the first couple of sessions is to help those seeking intervention feel comfortable with the therapist and the process of therapy. A second goal is to clarify the reasons for seeking therapy and to set goals. A third goal is to motivate the couple and give them hope that therapy can be effective.

Couples' responses to the handouts for Module 1 also will help the therapist better understand the couples' needs. Total scores lower than 13.5 on the Couple Satisfaction Inventory (CS) (Handout 1b) indicate significant couple distress. Lower scores on the CSI likely suggest that therapy will take longer than higher scores. Responses to the CSI also are helpful to the therapist in monitoring couple progress over time. The Dyadic Adjustment Scale (DAS) also provides information on level of couple distress, but in addition, it also provides information about specific sources of distress.

Session #1 Outline

Have the couple complete (1) Intake Form (Handout 1a), (2) Couple Satisfaction Inventory (CSI) (Handout 1b), and (3) Dyadic Adjustment Scale (DAS) (Handout 1c).

Spend some time getting to know the couple and building rapport:

- What do they do? How did they meet? How long have they been together?

Goal setting:

- How did they decide to seek therapy?
- What are their goals and expectations for therapy?
- Discuss responses on the Intake Form (Handout 1a) when relevant.

Help motivate the couple:

- All couples will experience difficulty at one point or another. The key to a healthy relationship is how each couple deals with the problems they encounter.
- The cognitive-behavioral approach to couple therapy is backed by decades of research and literally hundreds of studies. The basic premise is that communication difficulties are one of the main factors that contribute to the distress couple experience, and there are proven ways to help couples improve how they talk to each other and solve problems. This will help reduce conflict as well as build intimacy. It is important for the couple to believe that it is possible to improve and strengthen their relationship.

Session #2 Outline

- Not all couples will need a second session for Module 1, but many will, especially more distressed couples. Session 2 is essentially an extension of Session 1.
- A common use of this session will be to have further discussion about specific goals for therapy and review problematic areas identified on the DAS.

Therapist Guide to the CSI and the DAS

It is recommended that therapists assess the level of marital distress in the couple before starting an intervention. This will inform the therapist about how serious the marital problems are, and measurement tools also are important for monitoring the effectiveness of therapy. Both the Couple Satisfaction Index (CSI: Funk & Rogge, 2007) and the DAS accomplish this goal, though each one is useful in its own way. The CSI items assess global satisfaction with the relationship and are rated on Likert scales ranging from 0 to 6 or 0 to 5, with total scores ranging from 0 to 21. The cutoff score for marital distress is 13.5. The four-item version of the CSI has demonstrated good convergent and construct validity. Given its short length, the four-item version of the CSI is a commonly used measure to assess couple distress and also to monitor couple progress over time.

The DAS also measures couple distress, but it is longer and more detailed and provides a greater amount of information. Although it does contain several subscales, more commonly, only the total score is used in assessing couple distress. A cutoff of 100 has been determined to differentiate distressed from non-distressed couples on the Spanish version of the DAS (Cano-Prous, Marin-Lanas, Moya-Querejeta, Beunza-Nuin, Lahortiga-Ramos, & Garcia-Granero, 2014). In this chapter, the DAS is used primarily as a tool for therapists to better evaluate specific sources of stress or disagreement in couples' relationships.

COUPLES' THERAPY – INITIAL INTAKE FORM

Name _____   Date _____

Name of partner _____

Ethnicity/Country of origin – how to lay out?

Language most comfortable speaking?

Relationship status: (check all that apply)

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Dating
- ☐ Living together
- ☐ Living apart

How long have you and your partner been together?: _____

Have you ever been to counseling or therapy as a result of problems with this relationship prior to today? _____   If so, what was the outcome?

What are the things you like most about your relationship?

What are the things you most want to change?

Do either you or your partner drink alcohol to intoxication or take drugs to intoxication? If yes for either, who, how often, and what drugs or alcohol?

Have either you or your partner struck, physically restrained, used violence against or injured the other person? If yes for either, who, how often, and what happened?

Índex de Satisfacción Para Parejas-4 - Español

1. Por favor indique el grado de felicidad, incluyendo todos los aspectos de su relación.

Extremadamente infeliz	Bastante infeliz	Un poco infeliz	Feliz	Muy feliz	Extremadamente feliz	Perfectamente feliz
0	1	2	3	4	5	6

2. Tengo una relación cálida y estoy a gusto con mi pareja.

Nada cierto	Un poco cierto	Un poco mas cierto	Generalmente cierto	Casi completamente cierto	Completamente cierto
0	1	2	3	4	5

3. ¿Qué tan gratificante es la relación con su pareja?

Nada	Un poco	Un poco mas	Generalmente	Casi completamente	Completamente
0	1	2	3	4	5

4. ¿En general, qué tan satisfecho está con su relación?

Nada	Un poco	Un poco mas	Generalmente	Casi completamente	Completamente
0	1	2	3	4	5

Healthy Families Program
DAS

2559

27377

| N I D A | - | C F S | - | 0 0 0 8 | ASSESSMENT DATE: ____ / ____ / _____ (mm/dd/yyyy) |

NODE: 0 7

PHASE: O Baseline   O Post Randomization

SITE ID: 0 1 - 0 0

SEGMENT: [ ]   **SEQUENCE:** [ ]

PARTICIPANT ID: [   ]

FORM COMPLETED BY: [   ]

RELATION: [ ] - [ ]

FORM COMPLETION LANGUAGE: O English   O Spanish   O Both

[ ] **FORM COMPLETION STATUS**

1=Form completed as required
2=Participant refused
3=Responsible person did not complete

4=Not enough time at the visit
5=Participant did not attend visit
6=Other (specify: _____)

La mayoría de las personas tienen desacuerdos en sus relaciones. Por favor indique debajo aproximadamente el nivel de acuerdo o desacuerdo entre usted y su pareja, ____ (primer nombre), para cada una de las siguientes preguntas en la lista.

		Siempre de Acuerdo 5	Casi Siempre de Acuerdo 4	Ocasional-mente en Desacuerdo 3	Frecuente-mente en Desacuerdo 2	Casi Siempre en Desacuerdo 1	Siempre en Descuerdo 0
1.	Manejando las finanzas de la familia	O	O	O	O	O	O
2.	Asuntos de recreación	O	O	O	O	O	O
3.	Asuntos religiosos	O	O	O	O	O	O
4.	Demostraciones de afecto	O	O	O	O	O	O
5.	Amistades (Amigos)	O	O	O	O	O	O
6.	Relaciones sexuales	O	O	O	O	O	O
7.	Convencionalismo (comportamiento correcto o adecuado)	O	O	O	O	O	O
8.	Filosofía de vida	O	O	O	O	O	O
9.	Maneras de tratar con los padres o los familiares políticos	O	O	O	O	O	O

SITE: [0][1] - [0][0]   PART ID: [ ][ ][ ][ ]   RELATION: [ ][ ] - [ ][ ]   ASSESS DATE: ___/___/_____

		Siempre de Acuerdo 5	Casi Siempre de Acuerdo 4	Ocasional-mente en Desacuerdo 3	Frecuente-mente en Desacuerdo 2	Casi Siempre en Desacuerdo 1	Siempre en Desacuerdo 0
10.	Metas, goles (objectivos) y cosas que se creen son importantes	○	○	○	○	○	○
11.	Cantidad de tiempo que se pasan juntos	○	○	○	○	○	○
12.	Tomando decisiones importantes (mayores)	○	○	○	○	○	○
13.	Labores de la casa	○	○	○	○	○	○
14.	Intereses y actividades del tiempo libre	○	○	○	○	○	○
15.	Decisiones de carrera	○	○	○	○	○	○

		Todo el tiempo 5	La mayoría del tiempo 4	Más frecuente-mente que no 3	Occasional-mente 2	Raramente 1	Nunca 0
16.	¿Cuán frecuentemente han discutido o considrado el divorcio, la separación o terminar su relación?	○	○	○	○	○	○
17.	¿Cuan frequentemente usted o su pareja (cónyuge) salen de su casa despúes de una pelea?	○	○	○	○	○	○

SITE: [0][1] - [0][0]   PART ID: [ ][ ][ ]   RELATION: [ ][ ]-[ ][ ]   ASSESS DATE: ___ / ___ / _____

		Todo el tiempo 5	La mayoría del tiempo 4	Más frecuente-mente que no 3	Occasional-mente 2	Raramente 1	Nunca 0
18.	En general, ¿cuán frecuentemente usted piensa que las cosas entre usted y su pareja están yendo bien?	○	○	○	○	○	○
19.	¿Usted confía en su pareja (cónyuge)?	○	○	○	○	○	○
20.	¿Alguna vez se arrepiente de haberse casado (o haber vivido juntos)?	○	○	○	○	○	○
21.	¿Cuán frecuentemente usted y su pareja pelean (tienen discusiones)?	○	○	○	○	○	○
22.	¿Cuán frecuentemente usted y su pareja (cónyuge) "se llegan hasta la coronilla"?	○	○	○	○	○	○

		Cada día 4	Casi cada día 3	Ocasional-mente 2	Raramente 1	Nunca 0
23.	¿Besa a su pareja (cónyuge)?	○	○	○	○	○

SITE: [0][1] - [0][0]   PART ID: [ ][ ][ ][ ]   RELATION: [ ][ ] - [ ][ ]   ASSESS DATE: ___ / ___ / _____

		Todos 4	La mayoría 3	Algunos 2	Muy pocos 1	Ninguno de ellos 0
24.	¿Usted y su pareja (cónyuge) se dedican a intereses (actividades) externos (de afuera) juntos?	O	O	O	O	O

¿Cuán frecuentemente diría que los siguientes eventos ocurren entre usted y su pareja (cónyuge)?

		Nunca 0	Menos de una vez al mes 1	Una o dos veces al mes 2	Una o dos veces a la semana 3	Una vez al día 4	Más frecuente-mente 5
25.	Tienen un intercambios estimulante de ideas	O	O	O	O	O	O
26.	Ríen juntos	O	O	O	O	O	O
27.	Discuten de algo calmadamente	O	O	O	O	O	O
28.	Trabajan juntos en un proyecto	O	O	O	O	O	O

Hay ciertas cosas por las parejas algunas veces están de acuerdo o a veces en desacuerdo. Indique si alguno de los puntos debajo causó diferencia de opiniones o fueron problemas en su relación duranrte las últimas pocas semanas.

		Yes Sí 1	No No 0
29.	Estar demasiado cansado para sexo	O	O
30.	No demostrar amor	O	O

| SITE: | 0 | 1 | - | 0 | 0 | PART ID: | | | | | | RELATION: | | | - | | | | ASSESS DATE: __ __ / __ __ / __ __ __ __ |

Los puntos en la siguiente línea representan diferentes grados de felicidad en su relación. El punto medio, "feliz", representa el grado de felicidad de la mayoría de las relaciones. Por favor llene el circulo que mejor describa el grado de felicidad, considerando todas las cosas, en su relación.

	Extremada-mente _Infeliz_	Bastante _Infeliz_	Un poquito _Infeliz_	_Feliz_	Muy Feliz	Extremada-mente Feliz	Perfecto
	●	●	●	●	●	●	●
	0	1	2	3	4	5	6
31.	O	O	O	O	O	O	O

¿Cuál de las siguientes afirmaciones describe mejor cómo se siente acerca del futuro de su relación?

32.   O   _Desesperadamente quiero que mi relación tenga éxito, y iría a cualquier medida para ver que así sea_

     O   _Quiero (deseo) mucho que mi relación tenga éxito, y haré todo lo que yo pueda para ver que así sea._

     O   _Quiero (deseo) mucho que mi relación tenga éxito, y haré mi justa parte para ver que así sea._

     O   _Seria bonito que mi relación tuviera éxito, pero no puedo hacer mucho más de lo que estoy haciendo para ayudar a que tenga éxito._

     O   _Seria bonito que (mi relación) tuviera éxito, pero me niego a hacer más de lo que ya estoy haciendo ahora para mantener la relación._

     O   _Mi relación nunca podrá tener éxito y no hay más que yo pueda hacer para mantener la relación._

Comments: _Comentarios:_

Module #2: Teach and Practice Communication Skills

Recommended Length: Two Sessions

Goals of module: In these sessions, you guide the couple on learning listener and speaker skills. These skills are useful when understanding and defining relationship problems. They help to structure conversations in a way that allows for both partners to share their piece of the argument, while also feeling understood by his/her partner. In these sessions, you will also have the couple discuss and rate their top problems. This will help the couple in selecting topics to use for practicing the listener and speaker skills. These skills are initially practiced over two sessions and will continue to be emphasized and practiced throughout therapy.

Session Outline #1

- Provide couple with *Handouts 2a and 2b* and review these with the couple:
  - This worksheet provides information on what the "listener" and "speaker" roles entail. Go through the worksheet and describe both roles to the couple.
  - You don't need to walk through all of the practice examples in session, and instead couples can complete these at home.
- After reviewing the listener and speaker roles, ask the couple to think of a problem in their relationship that they tend to argue about, but not have heated discussions about. The problem also needs to be something that they are both willing to talk about. You want this first conversation to go smoothly, and picking a topic that is too heated/difficult may set the couple up for more disagreements. The couple will be ranking their top problems for homework, and this first discussion is meant to be a conversation that is low-level conflict (i.e., the 1–3 range).
  - Possible topics:
    - Division of chores/housework
    - Finances
    - In-laws

- Your role here is to make sure that the couple is following the "rules" of the listener and speaker roles. For example, if the listener interrupts the speaker, let the listener know that they will have time to share their view when they are in the speaker role.
- *Homework*: Assign the couple *Handout 2c* (top problems) for homework and ask them to first individually rate issues in their relationship and then come together to fill out the six problems (*Handout 2d*) they will discuss in sessions using the listener and speaker roles.

Session Outline #2

- *Homework review:* Go over *Handout 2d* with the couple and discuss how the conversation went when they were picking their top problems.
- Practice the listener and speaker skills through two conversations in session that are more difficult topics than previously practiced. One conversation should start with a "moderate" conflict topic from *Handout 2d* and the second conversation should be a "high" conflict topic.
- If couples are struggling with the listener and speaker roles, therapists can mention that these skills may feel unnatural and that it can take a while for them to become natural. Also, emphasize that this technique is not one that needs to be used multiple times per day, but instead one that should be used for difficult conversations that may escalate into hostility and anger.
- Due to normative cultural differences in emotional expression, not all types of conflict will have the same impact on couples. Understanding how these differences present in therapy will be important to the therapist.

It is important for therapists to understand cultural differences in communication, and it may not be necessary to remedy the conflict that a couple is experiencing, unless it is hostile. Be sure to check in with couples to get a better understanding of what type of conflict is normative in their relationship and whether both individuals are negatively impacted by it.

Communication: Listener Skills

There are techniques you can use to become better listeners and speakers. Using these techniques can lead to understanding each other better. These communication techniques can also slow down your conversations, so that they don't escalate to distressing, heated conversations. You two are a team, and that is still the case during difficult conversations! First, practice listening skills, and then the speaker skills.

<u>Listener Skills</u>: Use reflection techniques

- ❖ **Repeat back** what your partner has just said to you, using your own words (but not your own opinion on the topic)
    - o   This demonstrates that you are trying to understand your partner

- ❖ Use a **respectful tone of voice** in your reflection back to your partner and be aware of your **nonverbal** body language (e.g., making eye contact, keeping an open body posture)

- ❖ Reflect not only the words, but the **emotions** too

- ❖ Don't worry about reflecting the details, and **focus on the main point** instead!

- ❖ Use different types of phrasing, if you are having a hard time making it sound natural:
    - o   **"What I hear you saying is…"**
    - o   **"You're telling me that…"**
    - o   **"It sounds like you're feeling…"**

Example:

Speaker: "I get frustrated when you spend money on big purchases without talking to me about it, since we have been struggling with money lately."

Listener: "You're telling me that it is frustrating when I make big purchases without talking to you about it since we haven't been doing so well financially."

Practice:

> **Speaker:** "I was in a bad mood when I got home from work today because the house was a mess. I am so stressed at work and having so much to do at home is really stressing me out too."
>
> **Listener:**

> **Speaker:** "I get upset when I don't hear from you for a few hours because I think something bad may have happen to you."
>
> **Listener:**

> **Speaker:** "I don't think you're listening to what I'm saying, and then I get mad when you interrupt me. I just want you to hear me out."
>
> **Listener:**

> **Speaker:** "I think we need to keep better track of our money and our spending is getting out of control. We really don't have the money to be going out to restaurants as much as we do."
>
> **Listener:**

Communication: Speaker Skills (Using "I" Statements)

Taking responsibility for your feelings and linking them to specific situations can help you improve your communication. You can achieve this by using **"I" statements**. This technique allows you to communicate your feelings in a **specific situation**, opposed to generalizing your partner's behavior to multiple situations. This also helps to *minimize blaming*. Using statements about how you feel, opposed to "mind-reading" what you partner is thinking, can help to *minimize defensiveness.* It helps to keep your statements **brief**. **Remember to pause** to allow your partner to reflect back what you have said.

"I" Statement format: "I feel _____ when you _____ because _____."

<u>Examples</u>

Blaming statement	"You make me mad because you never come home when you say you will."
"I" Statement	"I feel upset when you come home late because I was looking forward to spending time with you."

Blaming statement	"You're so careless with your money."
"I" Statement	"I feel frustrated when you spend a lot of money because saving money for our future is important to me."

<u>Practice</u>

Scenario	You have spent the past two weekends doing the household chores. Your partner said that he/she would do them this weekend, and you feel frustrated that your partner didn't complete the chores.
"I" Statement	

Scenario	You get home from work and your partner doesn't want to talk to you and turns on the television instead. This leaves you feeling hurt.
"I" Statement	

Scenario	You made dinner plans with your friends and partner, and your partner shows up an hour late without calling first. You feel angry that your partner didn't let you know that he/she would be late.
"I" Statement	

Top Problems

Partner 1: What are the biggest problems in your relationship? Rate the following problems on a scale of 1 (*very low conflict*) to 10 (*very high conflict*).

Conflict Rating
(1 = Very Low Conflict;
10= Very High Conflict)

1. Division of household tasks   _____

2. In-laws   _____

3. Religion   _____

4. Trust or jealousy   _____

5. Alcohol or drugs   _____

6. Career/job decisions   _____

7. Parenting/children   _____

8. Emotional expression   _____

9. Cultural activities   _____

10. Money management   _____

11. Time spent with family   _____

12. Sexual intimacy   _____

13. Making major decisions   _____

14. Time spent together   _____

15. Friends   _____

16. Showing affection   _____

17. Leisure activities   _____

18. Other:_____   _____

Partner 2: What are the biggest problems in your relationship? Rate the following problems on a scale of 1 (*very low conflict*) to 10 (*very high conflict*).

Conflict Rating
(1 = Very Low Conflict;
10= Very High Conflict)

1. Division of household tasks   _____

2. In-laws   _____

3. Religion   _____

4. Trust or jealousy   _____

5. Alcohol or drugs   _____

6. Career/job decisions   _____

7. Parenting/children   _____

8. Emotional expression   _____

9. Cultural activities   _____

10. Money management   _____

11. Time spent with family   _____

12. Sexual intimacy   _____

13. Making major decisions   _____

14. Time spent together   _____

15. Friends   _____

16. Showing affection   _____

17. Leisure activities   _____

18. Other:_____   _____

<u>Top Problems</u>

Both Partners: What are the biggest problems in our relationship? From your list of individual top problems, agree on 6 problems that you would like to discuss in treatment. Pick two that fit into each conflict grouping.

<table>
<tr><td></td><td align="right">**Conflict Rating**
(1 = Very Low Conflict; 10= Very High Conflict)</td></tr>
</table>

Low Conflict

1. _____   _____

2. _____   _____

Moderate Conflict

3. _____   _____

4. _____   _____

High Conflict

5. _____   _____

6. _____   _____

Module #3: Deeper Understanding of Issues

Recommended Length: Two to Three Sessions

Goals of module: In these sessions, you guide the couple as they try to more fully understand one or two of their main issues. These sessions are meant to build intimacy as couples work on understanding, but *not solving their problems*. Through using the listener and speaker roles, couples will continue to deepen their understanding of their partner's perspective. Your role as a therapist is integral in these sessions, as you encourage couples to dig deeper into their issues without trying to solve the problem.

Session 1 Outline

- Describe the process of polarization to the couple and provide them with *Handout 3a*. Have them discuss an example of how this process has occurred in their relationship:Polarization is a natural process in which partners' differences become more extreme over time. For example, one partner may seek to be closer, while the other partner wants more space. By one partner pushing for more closeness, the other partner wants more space and distances further. This process continues after conflict and the couple becomes polarized.
- Next, provide the couple with *Handout 3b:*
    - Describe that in this session, the couple will be taking a deeper look into a moderate- or high-conflict issue from *Handout 2d.* They should have already been able to work through low-conflict issues in previous sessions.
    - Go over the worksheet and the various factors that could potentially relate to couples' problems:
        - These differences are not "defects" but instead are part of how people are naturally different from each other and have had different experiences.
    - Ask the couple to fill out Problem #1 in session and save the second for homework.

- After the couple fills out some factors related to Problem #1, ask which partner would like to share first. Have this partner use the speaker skills:
    - Stay with this partner after he/she shares and ask questions geared at building intimacy (e.g., "What was it like to share with your partner?"). Use the partner's own words as you ask additional questions.
    - Allow the other partner to respond and also share their understanding. A way to continue to build intimacy is to ask this partner: "How did it feel to have your partner open up to you?" or "How did it feel when your partner said X [something that was not blaming]?"
- The goal of these questions is to get beyond the *content* of what the couple shared, and instead tap into the *emotions* they felt during the conversation. If they are not sharing emotions, you can ask questions targeted toward that (e.g., "What did you feel when [partner] said that?").
- *Homework*: Ask the couple to fill out the second problem on *Handout 3b* and have a conversation regarding the factors impacting this problem. Ask them to use listener and speaker skills. These factors and the discussion will be covered in the next session.

Sessions 2+ Outline

- *Homework review:* Go over Problem #2 on *Handout 3b* and ask them how their conversation went. If they did not complete the homework, start the session by having them do this.
- Spend session 2 (and potentially more depending on the couple) on continuing to build intimacy. The goal here is to remove blaming language that the couple uses and instead focus on the factors (from *Handout 3b*) that are related to their problems.
- Couples are ready to move onto Module 4 when you feel like they have gained more acceptance of their partner. This can be demonstrated through tone of voice, using non-blaming language, physical gestures, etc.

Note: Be sure to jump in if the couple starts to use blaming language and a negative tone of

voice or tries to problem solve. Problem-solving occurs in a separate module, and the purpose in these sessions is to better understand that these problems aren't necessarily to blame on someone, but that these differences are natural and have become worse over time.

Polarization: A Downward Spiral

I do this…

My partner reacts this way…

My partner does this…

I react this way…

CONFLICT
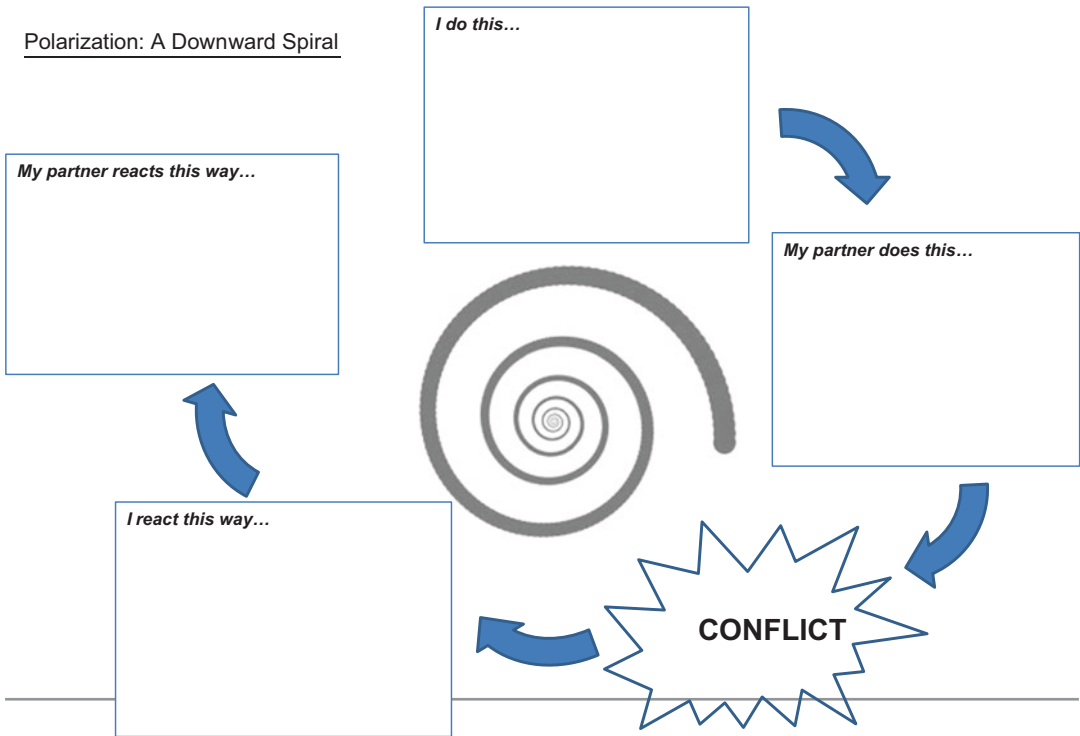
<u>Developing a Deeper Understanding</u>

Couples have *natural differences* that may initially attract partners to each other. However, as time goes on these differences can escalate into bigger problems. Frequently these problems are intensified because of specific factors going on in each individual's life. These factors can include:

- **external stressors** (e.g., work, children, finances)
- **patterns of communication** (e.g., withdrawal, defensiveness)
- **how you display your emotions/feelings** (e.g., verbal affection, physical touch)
- **previous relationships with parents, friends, or significant others** (e.g., mistrust in past relationships)
- **other differences** (e.g., culture, sexual desire)

Talk with your partner about 1 or 2 moderate to high conflict issues (from *Handout 2d*) in your relationship and write down personal factors that influence how you handle this problem.

<u>Partner 1:</u>

Problem #1:

_____

_____

Factors that influence this problem:

1)_____   4) _____

2)_____   5) _____

3)_____   6) _____

Problem #2:

_____

_____

Factors that influence this problem:

1)_____   4) _____

2)_____   5) _____

3)_____   6) _____

<u>Partner 2:</u>

Problem #1:

_____

_____

Factors that influence this problem:

1)_____   4) _____

2)_____   5) _____

3)_____   6) _____

Problem #2:

_____

_____

Factors that influence this problem:

1)_____   4) _____

2)_____   5) _____

3)_____   6) _____

Module #4: Argument Triggers and How to Control Them

Recommended Length: One to Two Sessions

Goal of module: The overarching goal for this module is how to help couples identify cues for arguments and to help them practice argument-control strategies. For most couples, one session is likely to be sufficient before proceeding to problem-solving in Module 5. However, if the time-out sequence does not go well when practiced at home, some couples may benefit from a second session for further review of the steps involved.

Session Outline

- Step 1: Help the partners identify cues that an argument is impending. See also Handout 4a:
  - What are the *behaviors* that they notice occur prior to an argument?
  - What are the *thoughts* that they notice occur prior to an argument?
  - What are the *feelings* that they notice occur prior to an argument?
  - What are the *bodily sensations* that they notice occur prior to an argument?
- Step 2: Partners agree to cool off when one of the triggers occurs – teach the couple how to take a brief time-out (see Handout #4b).
  - After each partner is able to identify for themselves the behaviors, thoughts, feelings, or bodily sensations that are signs of an impending argument, they each can be asked to make a contract that they will take some sort of action to cool off before the discussion escalates further.
  - Examples of actions that members of the couple could agree to take include:
    - Pause the conversation
    - Take time to calm themselves down
    - Take time to think about ways in which they are contributing to the problem
- Step 3: Help the partners identify times that are conducive to discussing and/or solving problems (after children have gone to bed, before children get up in the morning, a weekend morning) and also times that are not conducive (e.g., the moment one partner returns from work, in the middle of preparing dinner, while helping children with homework).
- Step 4: Partners need to identify a time to return to the discussion. The general recommendation is for this to happen within an hour or two, but no more than 24 h later. Optimally, time-outs or brief pauses in an escalating argument help the members of the couple calm down sufficiently so that they can come back and have a productive discussion. Time-outs, however, should not be overused or used to avoid a topic or to block a difficult but productive discussion.
- Step 5: As needed, the members of the couple can sign a contract which would specifically outline the steps they will take during a time-out (see Handout 4c).
- *Homework*: Practice the time-out steps at home.

Triggers for an Argument

BEHAVIORS I engage in prior to an argument:

_____

_____

_____

THOUGHTS I am aware of prior to an argument:

_____

_____

_____

FEELINGS I experience prior to an argument:

_____

_____

_____

BODILY SENSATIONS I am aware of prior to an argument:

_____

_____

_____

How and When to Take a Time-Out

A time-out is a good idea when you and your partner are becoming argumentative, insulting, or aggressive:

- Partners should identify in advance the *warning signs* that a time-out makes sense, and they also should agree upon what kind of *verbal or visual signal* is going to be used to call for a time-out.
- Either partner can call for a time-out.
- The partner that calls for the time-out must agree to a set a time to return to the discussion (preferably, within no more than 24 h).
- Each partner should separately engage in an activity that is relaxing:
  - Examples: going for a walk, reading a book, listening to music
- Complete *Handout 4c* ("Time-Out Agreement") which outlines what each person agrees to do to help themselves calm down. The goal is to prepare oneself to return to the discussion.
- At the designated time, when both partners are calmed down, partners return to the discussion.
- Time-outs should be used only when truly needed and not overused.

Time Out Agreement

By signing this document, we agree to follow the guidelines for how to manage a Time Out.

Partner 1: When a discussion begins to escalate and/or a trigger for an argument is identified, I agree to:

_____

_____

Partner 2: When a discussion begins to escalate and/or a trigger for an argument is identified, I agree to:

_____

_____

Date   _____

Signatures

_____ & _____

Module #5: Problem-Solving Skills
Recommended Length: Two to Three Sessions

Goals of module: In this session, you teach the couple problem-solving skills and describe the steps to take in problem-solving. Not all problems can or need to be solved, and sometimes a partner wants to vent opposed to solving a problem. In sessions, you will work with the couple through a specific problem that they would like to apply the problem-solving steps to.

Session Outline
- *Homework review*: Discuss how the use of the time-out strategy worked at home.
- Describe the rationale behind problem-solving. It is important to inform couples that not all problems need to be solved. These steps for problem-solving are for mutual problems that the couple wants to work through. Problem-solving should not occur in the heat of the moment, and instead it is helpful for couples to set aside a time to have problem-solving discussions (e.g., on Wednesday after the kids go to bed). Problem-solving conversations are structured, and it is helpful for couples to have a notepad where they can write down elements of their discussion.
- Let the couple know that not all problems can be solved. These include problems that are not under voluntary control, such as directly influencing a partner's level of trust or influencing a partner's sexual desire. Other problems that are not a good fit for problem-solving include ones where there are only two possible solutions (e.g., whether or not to have a child).
- There are also problems that don't need to be solved. Sometimes a partner only wants to vent about a specific issue (e.g., problems with a co-worker), and it is important to use listener skills in that moment, opposed to suggesting solutions to your partner.
- Describe the steps of problem-solving and provide couple with *Handout 4*. As you are describing the steps of problem-solving, engage the couple in working through these steps in the session:

1. *Discuss and define the problem*:
   - Have the couple use the listener and speaker roles to discuss the problem.
   - The problem must be mutually agreed upon.
   - The problem should be specific.
   - The problem should *not* be labeled in a blaming way.
   - Try to include a positive in the problem (e.g., I like it when you hold me when we watch movies, but I feel rejected when you aren't as affectionate during other times of the day).
   - Have the couple set an agenda of what specific problem they will discuss, and tell the couple how they should only attempt to resolve a single problem in a problem-solving session.

2. *Brainstorm possible solutions* (using *Handout 4*):
   - Have the couple generate solutions on their own first.
   - These solutions should include a wide variety of ideas – have couples think outside the box.
   - Partners should not criticize each other's solutions.

3. *Agree on a solution*
   - The couple should be able to answer "yes" to the following: "If we were to adopt this solution, would it help to resolve our problem?" If the answer is "yes," have the couple discuss the pros and cons of each feasible solution and list their agreed-upon solutions on *Handout 4*.
   - The final agreed-upon solution that they will try first should be a compromise that is very specific.
   - Once the couple agrees on the solution, they should pick how long they are going to try out that specific solution (see *Handout 4*).
   - The couple should schedule a follow-up for when they will check in on how the agreed-upon solution is working. This should be in approximately 1 week.
   - If the first solution they try out doesn't work, they should try out another

solution from their list and follow up with that solution.

- *Homework*: Ask the couple to implement their solution and be ready to discuss it at the next session.

- Have the couple repeat these steps in additional sessions. Some couples, especially distressed ones, may need to work on problem-solving more than others.

Problem Solving

Step 1: <u>Discuss and Define the Problem:</u> What is the problem you have selected?

_____

_____

_____

Partner 1: List 5-10 possible solutions to this problem.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Partner 2: List 5-10 possible solutions to this problem.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Both Partners: List 5-10 solutions that you have <u>agreed</u> upon. Rank the solutions in order of what you will try first.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

<u>Our Agreement:</u>

We're going to try _____

_____

for _____.
       (time frame)

We will follow up on _____.
              (date)

Module #6: Building Caring and Intimacy Behavior
Recommended Length: Two Sessions

Goals of module: In these sessions, you guide the couple on building intimacy through caring acts. This part of the treatment is meant to engage the couple in behavioral strategies. Relationships are sustained through continued efforts by each partner, and these sessions provide strategies on how to engage in caring behaviors. When partners continue to engage in these behaviors over time, this can help to prevent relationships from becoming negative and hostile.

Session Outline #1
- Ask each partner to share how they think fun and friendship is going in their relationship. Most couples will likely benefit from continuing to use the listener and speaker roles to navigate this discussion.
- Provide couples with *Handout 6a* and ask them to generate a list of ideas *together* for what they can do for fun. Discuss this with the couple and make sure their ideas are specific.
- Next, provide couple with *Handout 6b* and ask the couple to spend a few minutes thinking of two to three ideas of what each partner can do for the *other* partner.
- To ensure that each partner has selected behaviors that are doable and appropriate, give feedback to each partner about the two to three ideas. This occurs while the other partner is still in the room; however, other partner should not be an active part of the discussion and should only listen. Explicitly explain this to the couple. It may be hard for each partner to not chime in regarding whether he/she likes the partner's idea. The goal is to have little to no input from the other partner and let each partner take initiative on his/her own.
  - Make sure the ideas are specific.
    - *Example*: If one partner writes "be romantic," it is the therapist's job to transform that into an operational, concrete behavior that can be easily executed (i.e., go on a walk with [partner] and hold her hand).

- If the other partner is unable to stay silent during this time, it may be a sign that the couple is not ready to complete this assignment yet, and that more understanding/acceptance work needs to be completed.
- Describe to the couple that this can be an "experiment," during which they try to implement one caring behavior each day.
- *Homework*: Have the couple fill out the rest of *Handout 6b* and also implement one or more of the behaviors daily. It can be the same behavior each day or a different one each day; it is up to the couple. Also, instruct the couple to not share their lists with each other or tell each other which items they have chosen from the list. One of the reasons they don't share with each other is so that these tasks can become more natural, instead of something artificial that is prescribed by the therapist. Instruct the couple to be ready to report back next session on how the "experiment" went. Finally, have the couple complete one activity over the week from *Handout 6a* and have them specifically tell you which activity they intend to complete. They can change their mind and complete a different activity, but it is important for them to commit to completing at least one activity together.

Session Outline #2
- *Homework review:* Go over *Handout 6b* with the couple. Start with the partner that went second in the first session.
- You can generally tell right off the bat whether this assignment was a success or not. For those who it was successful, ask more about which tasks were attempted, successful, noticed by the recipient, etc. There may also be some tasks that take up too much time or are too difficult and need to be taken off the list.
- In this session, the recipient has the opportunity to ask for additional items to be added to the list. This does not mean that the giver needs to oblige and perform these tasks.
- If the assignment did not work, problem solve around why the task did not work out. Was it related to each partner not completing daily tasks, or was the list not tailored to what the

recipient wanted? Discuss this with the couple if there were any problems with the task. Also, be mindful of using listener and speaker roles in this session, as needed.

- Describe to the couple that they should continue to choose one item from their Fun and Friendship list weekly and implement tasks from their Behavior Change sheet daily.

Fun & Friendship

Generate a list of ideas that you can do as a couple to increase fun and friendship in your relationship. Take into consideration the cost of the activity, both in terms of money and time.

Low Cost:

1) _____

2) _____

3) _____

4) _____

5) _____

Moderate Cost:

6) _____

7) _____

8) _____

9) _____

10) _____

High Cost:

11) _____

12) _____

13) _____

14) _____

15) _____

<u>Behavior Change</u>

What would *your partner* like to see you do less or more of? Generate ideas that are specific and targeted toward what you can do for your partner.

<u>Partner 1:</u>

1) _____

2) _____

3) _____

- -

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10)_____

What would *your partner* like to see you do less or more of? Generate ideas that are specific and are targeted at what you can do for your partner.

<u>Partner 2:</u>

    1) _____

    2) _____

    3) _____

— · — · — · — · — · — · — · — · — · — · — · — · — · — · —

    4) _____

    5) _____

    6) _____

    7) _____

    8) _____

    9) _____

    10) _____

Module # 7: Ending Therapy and Planning for the Future

Goal of module: Ideally, couples' therapy ends when the goals that have been mutually agreed upon are achieved or the problems that brought the couple to therapy have been resolved. Below are some general guidelines for therapists as couples' therapy comes to a close.

- Remind the couple of the approaching ending of the sessions that remain. This should be done at least two to three sessions prior to the final one.
- It is helpful to review the progress that the couple has made during the therapy ses-

sions. It is not uncommon for couples to forget the advances that they have made or to fail to give themselves credit for their accomplishments.

- Check in with the couple about what they have learned and what they intend to do with what they have learned after they leave therapy. What did they find helpful about the therapy sessions?
- Review the tools and skills that the couple has acquired through couples' therapy. This will help solidify the gains the couple has made and also give them a sense of confidence and self-sufficiency going forward as they leave therapy and will have to handle problems on their own.

Treatment plan

Module	Session plan/goals	Worksheet
1 - Identify goals for therapy: rapport building; review of intake information; identify weaknesses in communication skills	Session 1: review reasons for why coming to therapy now; history of relationship; goals the couple hope to accomplish Sessions 2–3: the couple is observed trying to talk about a significant problem in their relationship; therapist notes strengths and weaknesses and provides this feedback to the couple	Intake Form (1a); Couple Satisfaction Inventory (1b); Dyadic Adjustment Scale (1c)
2 - Introduction to speaker-Listener skills: teach and practice communication skills	Sessions 1–2: teach appropriate speaker and listener skills (e.g., "I" statements; supportive listening); practice speaker-listener exercises Sessions 3–4: practice speaker-listener skills: The couple tries to discuss low-conflict issue to practice communication skills	Listener skills (2a); speaker skills (2b); top problems (2c and 2d)
3 – Deeper understanding of issues	Help couples more fully understand the context and contributing factors to top problems	Polarization handout (3a); developing a deeper understanding (3b)
4 - Argument triggers: identify triggers for arguments and practice communication and problem-solving skills	Help the partners identify cues that an argument is impending; identify times and conditions that are conducive to problem-solving; review how to take a time-out	Triggers (4a); time-out (4b); contract for time-out (4c)
5 - Problem-solving skills: teach and practice problem-solving skills	Sessions 1–2: teach and practice problem-solving steps and apply to a low-conflict couple problem Sessions 3–4: the couple tries to discuss conflict topic of moderate intensity, using the speaker-listener task, brainstorming, and plan selection	Problem-solving (5)

Treatment plan		
6 - Caring and intimacy-building behavior	Session 1: have the couple discuss what they can do for fun; generate Behavior Change lists for what each partner can change for the other partner Session 2: review how behavior change went; revise Behavior Change lists	Fun and Friendship (6a); Behavior Change (6b)
7 - Planning for the future and ending therapy	Help the couple in maintaining their gains after therapy	

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Tools for Working with Latino Sex Offenders

Ricardo Martinez, Jesselly De La Cruz,
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Introduction

There exists much cultural, socioeconomic, and historical diversity between and within the 21 countries where Spanish is the primary language spoken. In spite of these acknowledged differences, this chapter will present some of the unifying dynamics clinicians can expect to find when treating Latino sex offenders (LSO) in the USA. In addition, readers will be provided with methods for assessing the role of these dynamics on sexually abusive behavior, mitigating their negative impact, and increasing any potentially protective influence.

Note: This chapter will focus on adult male sexual offenders, as they comprise the majority of sexual offenders who will present for treatment. While there is a growing body of evidence that females commit sexual offenses, they appear to do so at much lower rates than their male counterparts and as a result will not be exhaustively covered in this chapter. Additionally, some

key terms and concepts will be presented in Spanish, as a means of allowing clinicians to "red flag" culture-bound areas ripe for further exploration and integration into treatment.

It has been well documented that cultural sensitivity increases the effectiveness of mental health services with ethnic minorities (Griner & Smith, 2006). However, a thorough review of the extant literature yielded only four book chapters explicitly addressing the treatment of sexual offenders of Latino descent (Carrasco & Garza-Louis, 1997; Cullen & Trevin, 1999: Ford & Prunier, 2005; Loredo, 1999). This dearth of writings in this area persists in spite of studies indicating that Latinos comprise 18% of the US population and 22% of those incarcerated for sexual assault/rape (Carson, 2014; US Census Bureau, 2015).

Sex Offenders

Perhaps no other clinical population incites a more visceral reaction from clinicians and the public alike than sexual offenders. The issue of sexual assault prevention has become a defining dynamic in the fields of law enforcement, education, mental health, and parenting. Studies have consistently found that approximately 20% of women and between 1% and 2% of men in the USA have been raped during their lifetime (Black et al., 2011). In 2012 alone, there were 86,456

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arrests for rape and other sexual offenses, not including prostitution (Langton, Berzofsky, Krebs, & Smiley-McDonald, 2012). Although a study by Langton et al. (2012) found that as many as 60% of sexual offenses go unreported and the majority of sexual offenders are never prosecuted, there are nearly 843,260 registered sexual offenders in the USA (NCMEC, 2016). Given the pervasive negative sequelae of life and psychological outcomes for survivors of sexual abuse, the public's interest in preventing sexual assault and recidivism by known offenders is understandable.

The term, sex offender, refers to a diverse group of individuals often linked by only one aspect of their behavior (e.g., victim choice or specific sexual abusive act) rather than by psychological, social, or developmental dynamics. To date, biological, psychological, and sociocultural theories have all been offered as explanations for sexual offending behavior. However, more recent efforts have begun to formulate multifactorial theories of sexual offending with sexually deviant arousal, psychopathy, attachment disorders, cognitive impairment/deficits, misogyny, abuse histories, situational opportunism, poor social skills, and sociocultural factors, to name a few, playing varying roles in the offense dynamics of any individual offender (CSOM, 2016). Clinicians treating sexual offenders must develop and modify interventions guided by a thorough assessment of an offender's specific strengths and vulnerabilities across the aforementioned areas. Given the complexity of sex offender behavior and treatment, services to this population should be provided by specially trained clinicians (ATSA, 2014).

Latino Sex Offenders It is largely believed that sexual abuse is found across racial, ethnic, cultural, and socioeconomic subgroups in roughly equal rates and that any observed differences are largely due to differences in disclosure and reporting rates, rather than incidence rates. There is, however, some evidence that Latino men are slightly overrepresented among those imprisoned for rape or sexual assault, although these differences may be due to socioeconomic disadvan-

tages, such as inadequate legal representation (Carson, 2015). At this time, it is not possible to determine, with a high degree of psychological certainty, the specific impact of cultural factors on a group of sex offenders. However, language and several Latino-specific social and cultural dynamics may affect LSO presentation and ultimately the engagement in and effectiveness of treatment. This section will describe three Latino culture-bound dynamics (i.e., machismo/ Marianismo, collectivism/familismo, and immigration/acculturation stress), their potential impact on treatment with LSO, and methods for addressing these dynamics within best practice treatment models.

Latino Archetypes

In English, the Spanish terms "macho" or "machismo" refer to "an attitude, quality, or way of behaving that agrees with traditional ideas about men being very strong and aggressive" (Merriam-Webster, 2016). These terms are often used with a negative connotation of a man (typified by Latino men) having an "exaggerated" sense of maleness, strength, or power. Western myths about what it is to be male, to Latinos, are largely constrained by this unidimensional view.

However, Latino male identity is actually bidimensional (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008). Specifically, Arciniega et al. (2008) found evidence of two independent potential paths for male identity, where one fits the traditional aggressive and antisocial "machista" path, while the other (i.e., "un caballero") encapsulates the identity of a "gentleman." For Latino men, the bidimensional concept of maleness can be effectively used as a justifier of sexual aggression or as a protective factor against sexually abusive behavior.

Machismo The identity of a man beholden to a traditional "machista" self-concept (i.e., male chauvinist) assumes male superiority, is self-aggrandizing, is dominant and exploitive over others, and is misogynistic. A "machista" uses his physical aggression and violence to get his

needs met, exploit others (especially women), and avoid responsibility. His self-esteem is based on his ability to take advantage of others, have a high number of sexual partners, and, in some subcultures, have many children, although not actively caring for them. "Machistas" may also pride themselves in their ability to convince, bully, or trick others into supporting them. Men living under this paradigm may get visibly drunk and have little respect for laws or authority. Rather than protect women and children, a "machista" views them as potential targets due to his belief that the weak deserve to be exploited or taught to be tougher. A LSO, who is a "machista," candidly blames the sexual abuse victim's dress, passivity, gullibility, or secret wish to be dominated for his sexually aggressive behavior. More often than not, he is feared rather than respected. Since apologizing and remorse are seen as a sign of weakness, the "machista" takes little responsibility for infidelity, domestic/interpersonal violence, or sexual abuse. It is a noteworthy risk factor that individuals adhering more closely to traditional "machista" ideology are more likely to struggle with negative cognitions and emotions such as anxiety and cynical (i.e., interpersonal) hostility (Nuñez et al., 2015).

Caballerismo The concept of being "un caballero" (i.e., a good or real man, a gentleman) requires that men use their assumed superior physical strength, emotional fortitude, tolerance, and bravery to be the providers and protectors of women and children (Arciniega et al., 2008). A man who considers himself a "caballero" works hard, sacrifices, protects his family's honor, is loyal, and helps those in need. Violence is used in a reactive manner in response to a perceived attack against him, his family, or vulnerable others. While he is expected to perform sexually, his sexual ego is based on sexual performance (i.e., his ability to please his partner) rather than the quantity of or exploitation of partners. Within this cultural paradigm, a "real man" pays his debts, takes responsibility, is on time for work, does not use foul language around women and children, "can handle his alcohol," and obeys the law. He can also be counted on to rush to the aid

of those in need or those being hurt or abused by others. A "caballero" is essentially a pillar of his community and is thus afforded respect. Thus, clinicians who understand these two concepts of maleness can use them to juxtapose LSO's specific decisions, as leading him on one path or the other (see Activity 1).

Marianismo The word "Marianismo" refers to patriarchal social conceptualization of a woman's identity and worth being tied to her chastity, piety, and subservience to others (Gil & Vázquez, 1996; Stevens, 1973). Within this paradigm, a woman's function is to serve others, especially men. A woman is to dress modestly, remain a virgin until marriage, not use alcohol/drugs, not have friends, and not be career minded or assertive. This view of what it means to be a "good woman" inherently creates dichotomous paths for women as well, where women are categorized as being "de la casa" (i.e., of the home) or "de la calle" (i.e., of the street) with only the former being a desirable mate and deserving respect. Within this context, non-gender role conforming women who are anything from assertive and goal oriented to sexually liberated or who are out at night unescorted, drinking at a bar, dating, dressing in a non-conservative manner, etc. can provoke judgment by others, including women, and sexual harassment and abuse by men (machistas in particular).

It is likely that men who are more beholden to traditional "machista" attitudes are more likely to hold and act upon such a dichotomous view of women. Similarly, some LSO who adhere to this black and white concept of women may view a woman with the western values of independence, sexual liberty, or general freedom as not deserving of respect and safety and instead deserving or secretly wanting to be sexually exploited. In clinical practice, we have frequently witnessed sex offenders who rationalize their assaults or minimize the impact of the same by explicitly citing the "type of woman" the victim was, alluding to this dichotomy.

In contrast, a "caballero" may still hold judgment on such women but would not see her perceived status as an excuse to sexually harass,

abuse, or mistreat her. Although, far from a feminist, the "caballero" views the woman of the street (i.e., la mujer de la calle) as a "tragic soul" or a victim of the streets and as a result would still view himself as a protector rather than an opportunist. Clinicians can challenge the cognitive distortions that facilitate sexual abuse by highlighting the resilience, strength, and worth of all women, regardless of the cultural class within which they fall, and by noting how "real men" are accountable for their behavior regardless of the supposed "class" of individual with which they are in contact.

Turning Machistas into Caballeros Using the Good Lives Model (GLM, Ward, 2003) as a model of sex offender treatment, clients holding "machista" attitudes are challenged with the dissonance between their stated long-term, and otherwise normative, wants and needs (i.e., respect, power, sexual pleasure, connection, etc.) and their negative and largely ineffective (i.e., "machista") methods for obtaining the same (i.e., sexually abusive behavior). Through Socratic questioning and other cognitive behavioral therapy methods, clients are led to understand that sexual abuse only yields short-lived proxies for the otherwise normal needs and goals and in the long term, in fact, lead to the opposite of each.

For example, the primary need of control or power can be reframed from the "machista" goal of having "control and power" over others to having "self-control" and "influence" over others. The LSO is taught how this paradigm shift leads one from being feared to being respected, loved, and valued with about as much effort and much better life consequences.

Mistrust of Systems, Legal Status, and Immigration Trauma

The process of immigrating to a new country is stressful and often traumatic, regardless of an individual's legal status in the host country or the reasons for leaving their homeland. Fear and mistrust of healthcare and legal systems may result from language barriers, financial difficulties, per-

ceived or actual racism, experience with corruption in their country of origin, and being overwhelmed by the bureaucracy of most American systems. By the time a LSO reaches a clinician, they have, often blindly, navigated numerous legal and social service entities which may have been hostile, threatening, and insensitive. While likely daunting for most sex offenders, the LSO navigating the adjudication and post-adjudication system may have experienced the added stress of language barriers or documentation secrets. Even navigating the front desk at a clinician's office or health center may create extra (i.e., nonsex offender-related) anxiety that can easily be overpathologized as hostility or avoidance during initial encounters with evaluating or treating clinicians.

It is estimated that as many as half of the 11.3 million undocumented immigrants in the USA are of Mexican descent, with a significant percentage of the rest being from other Central and South American countries and the Caribbean (Pew Research Center, 2014). Thus, the actual percent of undocumented individuals who are of Latino ancestry is likely over 60%. Once apprehended, a sex offender who is undocumented faces the added risk and stress of possible deportation for himself and his family. During the evaluation and treatment process, an undocumented LSO may present with anxiety, evasiveness, and manipulation, especially around questions regarding his home life, employment, or family, that is born more of the fear of deportation, than of psychopathology, sexual deviance, psychopathy, or lack of responsibility. The already difficult process of establishing trust and combating shame, implicit in sex offender work, can be made more difficult by the added layer of mistrust of agencies and fear of being outed as being undocumented.

Clinicians can mitigate the negative impact of this added level of fear and resistance by making explicit their policy of not reporting clients to Immigration and Customs Enforcement (ICE). Additionally, clinicians can have the literature available in clear view or offer referrals to immigration attorneys or social service organizations. Finally, clinicians can convey empathy for and

offer assistance with the everyday struggles of undocumented clients (e.g., transportation issues due to inability to obtain driver's license, financial difficulties, employment issues, or lack of access to healthcare or psychiatric care).

Premorbid and Immigration Trauma A comprehensive sex offender-specific evaluation includes an assessment of an offender's exposure to violence, abuse, or other traumas, since studies have found that a disproportionate number of offenders have a history of trauma (Levenson, Willis, & Prescott, 2016). In addition to screening for childhood sexual or physical abuse and neglect, clinicians working with non-native born LSO should inquire about the individual's life in their country of origin, since many Latinos immigrate to escape civil or drug wars, gang-infested neighborhoods, extreme poverty, and a host of other environmental/social maladies. Regardless of their pre-immigration lives, for individuals immigrating illegally through the southern border, the passage to the USA from South and Central America was likely physically arduous, dangerous, and often exploitive (Perreira & Ornelas, 2013).

Many immigrant Latino families must separate, often for years, in order to send money home and to establish a foothold in the states for the later arrival of more vulnerable family members. As a result, children left behind may be witnesses or victims of violence, sexual abuse, or even exploitation while separated from their parents. Children and adolescents left behind are often reunited with parents who left them as infants and may now have new children or even spouses. Given how common these separation experiences are, adult LSO themselves may not be aware of the negative impact these disruptions have had on attachment, sexually abusive behavior, and later mental health (Marshall, 2010). In clinical practice we have treated many LSO for whom the time between their parent's departure and their own arrival in the states was wrought with character shaping abandonment, sexual trauma, and physical abuse and even being prostituted.

Clinicians should also inquire about how the individual navigated the process of acculturation and assimilation and their experiences with racism, bullying, and isolation upon first arriving to the USA. Even for nearly assimilated or fully bicultural Latinos, their level of continued isolation, depression, and resentment (i.e., pervasive anger) as a result of the immigration experience should also be assessed and targeted for clinical intervention. One LSO we treated was not only sexually abused by an uncle under whose care he was left but, upon arrival to the USA, went to a school where he was bullied and often beaten, due to his accent and poverty. The ensuing isolation and pervasive anger for what he viewed as abandonment, an unwanted move to the USA, and for having to care for younger siblings he barely knew contributed greatly to his excessive use of pornography and ultimate physical and sexual aggression against younger children in his care.

Collectivism: "Familismo"

Compared to the western cultural value of individualism and a focus on "self-actualization," in Latino cultures, an individual's identity is more likely to be rooted in their family of origin and their self-worth in the successes and failures of their family. To many Latinos, immediate family may include grandparents, aunts and uncles, cousins, and even friends of the family. Many recent immigrants may be forced to rent a room in their apartment to a stranger, who is ultimately treated as extended family. It is noteworthy that this generalization will apply on a continuum based on actual country of origin, socioeconomic status, individual family dynamics, and, perhaps most of all, the individual's level of acculturation and assimilation into western culture.

When working with LSO, assessment and treatment efforts must take into account not only the potential physical presence of extended family, including strangers and quite possibly non-related children, but also the positive or negative influence of the offender's extended family. For many Latinos, clergy is consulted about major family decisions and problems, and the offense itself may be interpreted as a lapse in faith.

Clinicians working with LSO need to be sensitive to the potential impact a collectivist psychological orientation may have on traditional clinical targets such as accepting responsibility for the offense, the role of family secrets, a resistance to separating the family (including victim from perpetrator), fear that the offender's contact with the courts may lead to legal/immigration consequences for other family members, and the financial strain caused by the offense becoming a burden for the entire family system. Accordingly, viewing the LSO as part of a system may require including key family members in treatment sessions, especially if the offender is young.

Once assessed, understood, and validated, culturally astute clinicians can use each of these dynamics to facilitate treatment. Specifically, thoughts, emotions, and behavior that support offending can be framed as hurting the collective, while increasing motivation for treatment, adopting to a healthier lifestyle, and assuming responsibility can be seen as ways to repair damage they have done to their family. Failure to view a LSO within the context of what he defines as "his family" can lead to unsafe placement issues, increased resistance to clinical recommendations, over-pathologizing of the client, wasting resources better spent on actually higher-risk offenders, and, ultimately, increased risk of reoffense.

Treating Latino Sex Offenders

Nearly three decades of research has shown that while most identified sexual offenders will not go on to sexually reoffend, somewhere between 16% and 50% will go on to commit additional sexual or non-sexual offenses, respectively (Harris & Hanson, 2004; Langan, Schmitt, & Durose, 2003). Nevertheless, the public's understandable fear of sex reoffense has led to the enactment of strict and often costly adjudication, sentencing, and monitoring laws (Velázquez, 2008). Currently, individuals adjudicated for a sexual offense may face imprisonment, civil commitment, lifetime registration and supervision, housing and employment restrictions, mandatory treatment, and a host of other legal and

social consequences. However, in spite of the many sanctions levied against them, the vast majority of sex offenders will ultimately return to the community and require ongoing monitoring, assessment, and psychological treatment.

Most sexual offenders are mandated to treatment, and failure to engage in mental health treatment places them at an elevated risk of reoffense and a host of severe legal sanctions. This poses an added obstacle for those treating LSO since, for reasons likely discussed elsewhere in this book and in the literature at large, Latinos continue to under-utilize mental health services in the USA. Thus, in addition to helping to ensure community safety, those who evaluate and treat LSO also have the social justice burden of making sure their work does not actively or passively contribute to the disenfranchisement of an already marginalized population. For a review of relevant issues in the "assessment" of reoffense risk with Latino offenders, refer to Cirlugea, Benuto, and Leany (2013).

Establishing a therapeutic relationship based on trust and empathy has been found to be one of the most important factors to the effectiveness of psychotherapy. However, sexual offenders mandated to treatment often have little intrinsic motivation to change their behaviors, other than avoiding the negative legal consequences that follow failing out of treatment. Additional barriers to therapeutic engagement with sex offenders may include the therapist's countertransference, the offender's lack of insight or remorse, deviant sexual arousal, denial of responsibility, cognitive deficits, and shame, and the presence of other social problems that may seem more pressing for the offender.

With LSO, how clinician/client mismatches in language and culture are handled can also have a significant impact on the process of establishing a rapport, trust, and, ultimately, therapeutic alliance. As with most psychological interventions, establishing rapport with and fostering change in sexual offenders requires a clinician to be able to show genuine empathy, gain trust, communicate complex concepts, and ultimately see the world the way the offender does. Only by way of these clinical tasks can a clinician begin to foster the changes in beliefs, attitudes, values, and lifestyle thought to produce behavioral change.

Clinicians working across language barriers, or lacking knowledge of an offender's culture, can handle these barriers in a manner that actually increases trust and fosters collaborative therapeutic relationships. For example, a clinician working cross-culturally can show genuine interest in helping the offender communicate what they mean, by having the client first say what they mean in Spanish and working backward toward English. Clinicians can use humor and model vulnerability while attempting to repeat a word in Spanish or help deconstruct a concept as a collaborative process. By taking the position of a curious anthropologist, non-Latino clinicians can inquire about cultural and family of origin beliefs, customs, or behaviors that would otherwise remain private for fear of feeling judged or poorly understood.

Sex Offender-Specific Treatment Evidence has shown that sex offender treatment decreases the rates of sexual and nonsexual reoffense for sexual offenders (Hanson et al., 2002). Currently most sex offender treatment programs utilize a variation of cognitive behavioral therapy (CBT) with a relapse prevention (RP) component. These approaches assume that sexually abusive behavior is the result of distorted beliefs, thoughts, emotions, and behaviors (i.e., risk factors) which are supportive or reinforcing of sexually abusive behavior. For example, it is not uncommon for sexual offenders early in treatment to assert that an unconscious or provocatively dressed woman or even a playful child is being flirtatious and secretly desires sexual contact. Additionally, many offenders condition themselves toward sexually abusive behavior by repeatedly masturbating to rape or child pornography or visit and fantasize in places where children are playing in public. For others, issues of power and control lead them to use sexual abuse to exert themselves over children or otherwise vulnerable adults.

Using psychoeducation, interpersonal skills training, management of deviant interests, emotion regulation techniques, empathy work, and various behavioral reconditioning activities, CBT-based treatment efforts seek to challenge and replace these beliefs and behaviors with more appropriate and safer alternatives. RP efforts help the offender avoid and manage high-risk situations (e.g., substance use, parks, family events) in order to avoid entering into their offense cycle. Several meta-analytic studies have shown that sex offender-specific treatment (i.e., cognitive behavioral with relapse prevention) significantly lowers the incidence of sexual and general reoffense among male sexual offenders (Hanson et al., 2002; Lösel & Schmucker, 2005. Two CBT-based models which have received significant empirical support are the risk-need-responsivity (RNR) model and more recently the Good Lives Model (GLM; Ward, 2003).

Risk-Need-Responsivity (RNR) Model The RNR model assumes that treatment intensity level is determined by the level of "risk" of reoffense of the individual. This model begins with an assessment of the offender's dynamic risk factors, which may include substance abuse, empathy, deviant arousal, problems with expression of anger, insight, remorse, cognitive distortions or beliefs supportive of sexual abuse, emotional/behavioral proclivities, etc.

Traditional RNR management models focus on assuring community safety by identifying, challenging, and managing these risk factors for sex offending behavior. Clinicians first illuminate an offender's offense cycle and then attempt to remove elements across cognitive (e.g., distorted thoughts), emotional (e.g., repressed anger), and behavioral (e.g., alcohol use, baby sitting, etc.) domains that are thought to contribute to the individual's offense cycle. This model assumes that an offender's motivation to change will be rooted in their fear of negative sanctions for themselves and in their, often questionable, desire to desist in hurting others.

However, RNR-based models are hampered by the offender being asked to give up many of their needs, values, wants, and, for some, parts of them they consider to be their culture. For example, the age of legal adulthood, and likewise sexual or marital consent, in many Latin American countries can be much lower than 18 years of age. For some, the belief that women "act" coy to seem pure and virginal (i.e., consistent with Marianismo) but secretly

have a wish to be "conquistada" (i.e., seduced or conquered) may serve as a dating template. Some LSO, who identify with "machista" attitudes and values, may believe that they do not have control over their sexual feelings or behavior once aroused or that male value is based on sexual domination of others. Similarly, the physical/geographic restrictions placed on adjudicated sex offenders, by courts and clinicians alike, may actually serve to worsen the lives of LSO who are already struggling with isolation because of financial and language limitations or simply lack of appropriate social outlets, ultimately placing them at higher risk of reoffense. Thus, traditional risk models are, in effect, imposing the general population's value system and priorities onto the offender and expecting the offender to capitulate in order to avoid punishment and for the good of the community. This obstacle can be especially difficult to overcome with LSO since they not only hold criminogenic beliefs and values that support offending but also non-criminogenic culturally determined values.

Good Lives Model (GLM; Ward & Gannon 2006; Ward & Stewart 2003) Currently, the gold standard of treatment with individuals who have sexually abused employs the components of the traditional RNR along with the underlying philosophy of the Good Lives Model (GLM; Ward & Gannon 2006; Ward & Stewart 2003). GLM assumes that sex offenders use sexually abusive behaviors to attain otherwise normative goals, such as intimacy, pleasure, power/control, etc. While these goals can be considered otherwise normal human needs, the offender's methods for attaining those goals (i.e., sexual offending) are hurtful to others. Assessment not only assesses their risk of reoffense but also assesses the offender's needs and wants, the availability of those needs in their environment, their capacity to attain those goals in legitimate ways, and what interventions are likely to allow the offender to attain those goals without hurting others (see Ward for a comprehensive detail about the GLM). Incidentally, the GLM is likely to be less prone to ethnocentric bias or clinician blind spots, as it is more client centered and positivistic than the often manualized traditional CBT and risk management models.

The GLM's focus on identifying the offender's underlying needs and goals and then helping them attain the same in healthy ways that do not lead to negative consequences largely bypasses the need for victim empathy, the external motivation of punishment, or the resistance universally attributed to this population. With respect to LSO whose cultures (e.g., low age of consent) or subcultures (e.g., "machista" or street) maybe supportive or tolerant of offending, treatment providers no longer have to indoctrinate offenders to the values of the larger society, a process typically universally resisted and difficult by its very nature. Instead, the offender's intrinsic needs are valued, supported, and facilitated via more appropriate means and now absent the risk of harm to themselves and others.

Clinical Supervision and Consultation

Sexual offenders, arguably more than any other population, require clinicians to overcome moral disgust, vicarious trauma, and client resistance in order to form a therapeutic relationship. Additionally, clinicians working cross-culturally with LSO may have their own negative biases in the form of overt/covert racism, low expectations, beliefs in culture-specific myths (e.g., Latino promiscuity, Latino tolerance for sexual aggression), or cultural overidentification (e.g., tolerating cognitive distortions supportive of sexual aggression as actual culturally accepted values).

As such, programs who serve a significant number of LSO should actively seek out and commit funding to hiring or developing bilingual/bicultural clinicians to work with this specialized population. Clinicians who are unfamiliar with Latino culture in general or specific Latino subcultures are encouraged to seek out formal supervision, readings, and training in the dynamics and methods for providing cross-cultural mental health. The Association for the Treatment of Sexual Abusers (ATSA) can also be contacted for a list of providers who speak Spanish for consultation or direct services. Informal supervision can be sought from the many statewide Latino/Hispanic mental health

associations or divisions that have been formed over the past decade. Finally, the ease with which clinicians can foster collegial relationships across great geographic distance via the Internet and online forums makes working in isolation and beyond the area of expertise unnecessary, possibly unethical, and inexcusable.

Case Formulation and Treatment Planning

GLM requires that treatment planning should not be standardized or assume "one-size-fits-all approach" (Ward, Mann, & Gannon, 2006; Ward, Yates, & Long, 2006). Specifically, the GLM emphasizes identifying and thoroughly understanding an offender's individual needs and goals, their current (and in some cases problematic) methods for achieving those goals, the barriers to achieving these needs/goals, and the devising of more healthy and effective methods for achieving otherwise normative needs and goals. In brief, GLM treatment planning follows five phases of case formulation and 11 components of treatment plans. Note: For a comprehensive clinician guide to the GLM model, see Yates, Prescott, and Ward (2010).

Clinician's working with LSO should go to great lengths to assure that the offender's culture, language, and immigration-related needs, goals, risk factors, and strengths are integrated into the case formulation and addressed in the treatment planning phase.

Simplified Sample Case Formulation and Treatment Plan

Alex is a 24-year-old, Guatemalan born male, who had been in the USA legally for 18 months before the assault. For several weeks before his arrest, he was increasingly fantasizing, leering, and attempting to flirt with the 15-year-old daughter of the couple from whom he was renting a room. One night he came home drunk and attempted to sneak into her room to try to have sex with her. He pled guilty to a downgraded charge of sexual assault and was paroled after 2 years of prison. Alex has limited English

proficiency, is physically slight, works doing low-paying odd jobs, and appears younger than his stated age. His main social interactions consisted of drinking with older co-workers from the restaurant and, up until the assault, participating in family gatherings at the home where he was residing. He had also purchased a computer to study English and connect with family out west and back home in Guatemala, but most of its use had gone to pornography. His last relationship was to his high school sweetheart in Guatemala prior to moving to the USA.

Alex loves sports. However, he is shy and has not yet made the effort to find a group of peers with which to watch or play soccer. He would also like to have a better job, his own apartment and car, and someday have his own family. Since his release, he has been living in a halfway house, is drug and alcohol screened, and, other than work, is afraid of going out for fear that someone who knows what he did will retaliate. Alex's needs and goals (i.e., "primary goods") are to obtaining a good life, intimacy, sexual pleasure, friendship, connectedness, and excellence at play and work. He is depressed and has all but given up on several of these and was using alcohol, pornography, and ultimately the abuse as proxies for the things in life he really wants. He misses his family and wishes he had never left Guatemala but cannot visit because he is unsure of his residency status after the conviction.

Alex's Good Lives Treatment Plan (Based on Yates et al., 2010):

- *Duration/intensity*: Alex will be seen for individual sessions weekly and, when enough Spanish-speaking clients are referred, group (in Spanish) one time per week. Average time in treatment is 2 years but is highly dependent on the level of commitment, cognitive/intellectual difficulties, and comorbid disorders.
- *Dynamic risk factors*: The primary dynamic risk factors for reoffense of Alex include the cognitive distortions about men/women, age of consent, and relationships. Specifically, he believes his victim was mature and receptive to his flirting, he is insecure because of his

physical stature, he does not believe he hurt his victim, and he believes women in the states only date men with lots of money. He also needs a better job to make more money, so he can have his own apartment, feel more confident, dress his age, and date.

- *Responsivity factors*: Alex meets the criteria for depression. He feels hopeless, isolates, and binges with alcohol in between drug screens. He will need a psychiatric evaluation for possible psychopharmacological intervention. He will also need CBT-based interventions aimed at challenging the negative cognitions he has about himself, increasing his motivation to create a life worth living, and reinforcing his positive qualities (hard worker, sense of humor, avid reader).
- *Specific treatment needs*: In order to address his risk factors, Alex's treatment will focus on the following areas:
  - Depression and substance abuse
  - Poor/immature interpersonal skills
  - Difficulty regulating emotions (e.g., anger, sadness, stress, sexual)
  - Financial and education deficits
  - Social isolation, especially from family of origin
- *Good lives planning*:
  - A psychiatric evaluation
  - Psychoeducation about dating, sex, and relationships
  - Addressing avoidance and helplessness
    - Using mindfulness, emotion regulation, distress tolerance
  - Interpersonal skills training
- Assistance in finding funding and helping with application for English/vocational training.
- Explore finding a church with a large Central American congregation and an active adult social group.
- Refer to an immigration attorney and encourage to reconnect online and by visiting family out west.

Objective Measures of Progress

Alex will be actively encouraged to attend sessions and appointments and to set realistic and agreed upon time frames for adherence to plan, e.g., appointments, applications, meetings, calls, etc. Alex will be reinforced for his efforts in planning and execution as well as honesty and openness about psychogenic and external obstacles. Alex will identify an informal soccer league in his town or county and work on becoming a member of their team. Once enrolled in a vocational training program, he will be encouraged to attend social and study groups. All aspects of the plan are subject to change based on discussions with his clinician, developing new interests or goals, or in view of obstacles to the plan.

Additional Topics to Incorporate into an Evaluation

- Where were you (your parents) born? How old were you when you arrived? Why did you (your parents) leave their birth country? What was your (their) life like before they left? Did you come with your parents or were you left behind? With whom were you left? How was life with that person? When did your parents send for you? How often did you have (phone, mail, in person) contact with your parents during that time?
- How did you get to the USA? Was it an easy trip? If they came here illegally through the southern border, ask: Did you feel safe/unsafe? Did you witness or experience violence while traveling to the states? Did anybody get hurt or arrested?
- Did you witness (or were a survivor of) domestic, sexual, street, gang, drug, and war-related violence in your country of origin or during the passage to the USA? If yes, screen for post-traumatic stress disorder.
- With whom did you live when you arrived here? How difficult was the adjustment process? What made it difficult? How long did the depression last? Were you well received by neighbors, peers, and teachers upon arriving? How did your family help you with the adjustment process?
- How are relationships (including dating and sex) different in your country of origin? What is the age of sexual consent in your country of

origin? How is courtship handled in your country of origin?

- What if any is the role of religion in your family? Do you attend mass or other church functions? How do you view your assault or treatment based on your religious beliefs?
- With whom do you live? Are there extended or non-blood relatives or friends who stay with you/your family?

origen? ¿Cómo se maneja el cortejo en su país de origen?

- ¿Cuál es el papel de la religión en su familia? ¿Asiste a misa u otras funciones de la iglesia? ¿Cómo ve su asalto o tratamiento psicológico basado en sus creencias religiosas?
- ¿Con quién vives? ¿Hay familia extendida o parientes no sanguíneos o amigos que se quedan con usted / su familia?

Temas Adicionales Para el Proceso de Evaluación

- ¿Dónde naciste? ¿Dónde nacieron sus padres? ¿Qué edad tenías cuando llegaste? ¿Por qué salió usted de su país de nacimiento? y sus padres? ¿Cómo era tu vida antes de salir? ¿Cómo era la vida de sus padres? ¿Viniste con sus padres o te quedaste atrás? ¿Cómo era la vida con esa persona que te cuido, mientras que sus padres enviaron por usted? ¿Con qué frecuencia usted tenia (teléfono, correo, en persona) el contacto con sus padres durante ese tiempo?
- ¿Cómo llegaste a los EE.UU.? ¿Fue un viaje fácil? ¿Si vinieron aquí ilegalmente por la frontera al sur, pida; Usted se sintió seguro / inseguro? ¿Usted es testigo o fue víctima de la violencia al viajar a los estados? ¿Alguien fue herido o detenido?
- ¿Fue usted testigo (o era un sobreviviente de) violencia doméstica, sexual, de cuadrilla, o de la violencia relacionada con la guerra en su país de origen? ¿Si es así, evalúa para el Trastorno por estrés postraumático?
- ¿Con quién viviste cuando llegaste aquí? ¿Qué tan difícil fue el proceso de ajuste? ¿Qué fue lo que lo hizo difícil? ¿Cuánto tiempo duró la depresión? ¿Fue bien recibido por los vecinos, compañeros y profesores al llegar? ¿Hay sido víctima del racismo? ¿Cómo su familia le ayudo con el proceso de ajuste?
- ¿Cómo son las relaciones (incluyendo citas y sexo) diferente en su país de origen? ¿Cuál es la edad de consentimiento sexual en su país de

Activity Sheet 1 Good Life Male Qualities Clarification

Caballero	Machista
Physically/emotionally strong *(Emocionalmente Y físicamente fuerte)*	Violent, bully, aggressive *(Violento, matón, aggressivo)*
Protector, defender *(Protector, defendedor)*	Dominator *(Dominante)*
Loyal, purposeful, determined *(Leal, con propósito, determinado)*	Ruthless, relentless *(Despiadada, implacable)*
Honorable, secure, proud *(Honorable, seguro, orgulloso)*	Chauvinist *(Chauvinista, misógino)*
Emotionally connected, mature *(Emocionalmente conectado, maduro)*	Callous, unempathic, emotionally numb *(Insensible, falta de empatía, emocionalmente paralizado)*
Provider, self-sacrificing *(Buen proveedor, sacrificado)*	Parasitic, exploiter, selfish *(Parasito, abusador, vividor, egoista)*
Sexually potent, ego from partner's pleasure *(Potente sexual, ego del placer de su compañero)*	Promiscuous, player, selfish lover *(Promiscua, jugador, amante egoísta)*
Hard worker *(Trabajador)*	Poor work ethic *(Peresoso, echado)*
Educated, knowledgeable, wise *(Educado, informado, sabio)*	Incurious, ignorant *(Indiferente, ignorante)*
Humble *(Humilde)*	Narcissist, insecure *(Narcisista, inseguro)*
Respected and loved *(Respetado y querido)*	Feared and avoided *(Temido y evitado)*

Activity 2 A Good Life Decision Flowchart Activity

Purpose: To develop and promote a healthier psychological decision-making process for men who have been socialized into a "machista" value system of maleness. Men who have sexually abused others may struggle with inconsistencies between what they say they want/need (e.g., good life, power, relationships, sex, freedom, etc.) and the outcomes their methods actually yield (i.e., incarceration, isolation, shame, fear/disgust by others).

Method

1. Clients are first introduced to the concept that their male identity (as a caballero or a machista, see Activity Sheet 1) is a dynamic process with divergent paths based on future decisions, rather than on static labels based on the past. Clients are taught that they have control over their identities and their life outcomes, based on decisions they make from this point forward. This concept can be taught by analyzing past decisions.

2. After processing the two distinct definitions of maleness (see Activity Sheet 1), life decisions (e.g., dating, sex, relationships, fantasies, work, recreation, public/private behavior, etc.) are evaluated ahead of time using the decision tree (Activity Sheet 2), and men are empowered to make decisions consistent with their long-term healthy needs and goals ("primary goods"). The alternative "machista" identity and subsequent outcomes are made explicit.

Proposed Outcome

Clients are taught the fluid nature and origin of male identity, as well as some methods for decision-making that increase the likelihood that they can attain their wants and needs in a healthy and sustainable way as good men. Clients are encouraged use this decision making process throughout all life areas as a means of making sure every day decisions are consistent with their long term goals and needs and the most effective method for securing the same.

Activity Sheet 2 Good Life Decision Flowchart

Good Life Decision Flowchart
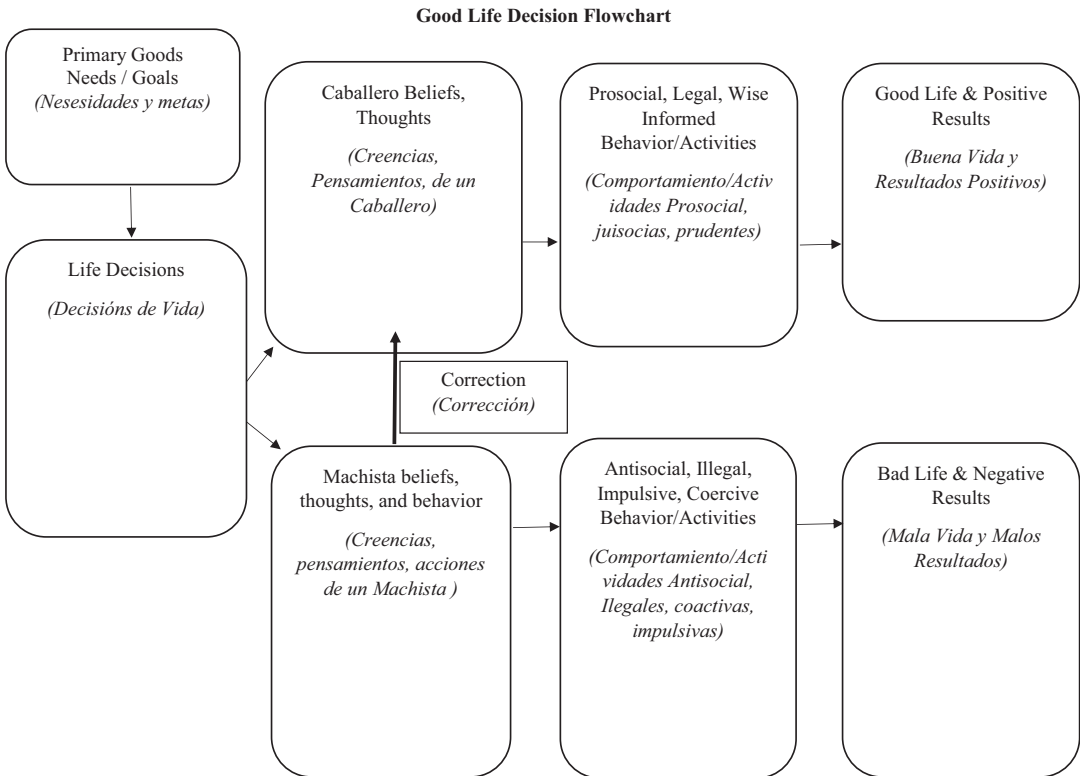
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Tools for Restoring Legal Competency with Latinos

Jena Casas and Brian D. Leany

Introduction

Criminal Competency

In the United States (US), a person who is not competent to stand trial cannot be tried for a crime, thereby delaying or even derailing traditional due process (United States Department of Justice, N.D.-a). Criminal competency is a jurisprudential construct that allows criminal proceedings to be postponed if the defendant is unable to participate in their case's defense due to reasons of mental disease or intellectual disability (Roesch, Zapf, Golding, & Skeem, 1999; Weiner & Otto, 2014). The case law for competency established by D*usky v. United States* has been recognized by all US states as the standard. Though there is some minor variation among states, this standard generally requires "a reason-

able rational understanding of the proceedings and a sufficient present ability to consult with one's attorney" (Dusky v. United States, 1960; Roesch, Zapf, Golding, & Skeem, 1999). Though the standard is well established (and is reliably assessed across evaluators; Grisso, 2006), *Dusky* unfortunately does not specify how to successfully restore a defendant (Zapf & Roesch, 2011). If a defendant's competency is called into question, forensic psychological assessments are used to evaluate competence (Roesch et al., 1999), but we lack a consensus for the process of restoration. Further, when considering cultural differences in language and respective justice systems, in this case specific to Hispanic clients, the issue of restoration becomes more complex.

Criminal Responsibility and Insanity

It is important to remain cognizant of the distinction between competency and criminal responsibility or insanity. While competency refers to the present ability of the defendant to participate in their case and understand the nature and consequences of the charges against them, criminal responsibility and insanity refers to the defendant's mental status in the past (i.e., at the time of the crime, the defendant had/did not have the capacity to appreciate the nature and quality or the wrongfulness of his acts) (United States Department of Justice, N.D.-a, N.D.-b). Criminal

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responsibility may be reduced if there is evidence linking mental illness to certain offense-related behavior (i.e., violence or aggression; Friel et al., 2008).

Although US states vary in their statutory definitions (with only some states following the M'Naghten exception), generally, a person is considered insane if they lack the capacity to appreciate the wrongfulness of their conduct at the time of the crime (Friel et al., 2008).

Civil Capacity

In addition to the distinction between competency and criminal responsibility, it is also important to differentiate criminal competency from civil capacity. Because forensic psychology applies scientific, technical, or specialized knowledge to legal, contractual, or administrative matters (Kaufmann, 2016; APA, 2013), capacity can be evaluated in contexts outside of criminal cases: testamentary capacity, contractual capacity, business judgments, and job capacity, for instance (Kaufmann, 2016). Forensic psychological experts can and have attested to capacities in civil cases, such as the ability to preform job functions (Michael v City of Troy Police Dep't and City Troy, 2014), to decisions made under durable power of attorney documents (*Protective Proceedings of Vernon H.* (2014)) (Kaufmann, 2016), or to psychological and cognitive impairment for determination of disability benefits (*Henarie v. The Prudential Insurance Company*, 2013). In fact, in recent years, forensic assessment instruments (FAIs) have been developed to answer specific questions in civil cases (Sousa, Simoes, Firmina, & Peisah, 2013, 2014). However, in spite of their similarities, because these capacities have monetary consequences rather than physical impositions on an individual's liberties, it is important to understand that the content covered in this chapter would not be beneficial in restoring civil capacity. Rather, the tools provided here are specific to the restoration of competency when an individual has been found incompetent in a criminal proceeding.

Prevalence Rates of Evaluations of Competency

While the number of requests for evaluations of criminal responsibility remain relatively stable (approximately 1% raise a mental health defense, while only about 25% are successful in affirming the defense; Grisso, 2006; Kimonis, 2015; Zapf, Zottoli, & Pirelli, 2009), competency evaluations are on the rise. It is estimated 60,000 evaluations are being conducted in the United States annually (Morris & DeYoung, 2012; Pirelli, Gottdiener, & Zapf, 2011; Zapf, Roesch, & Pirelli, 2014). An estimated 20% of all defendants in the US criminal justice system are found incompetent, though these rates vary by jurisdiction (Beltrani, Zapf, & Brown, 2015).

Rates of Commitment and Time to Restoration

The time to restore competency varies (Fogel et al., 2013): in one study, 75% of defendants were restored to competency within 6 months and 85% were restored to competency within 1 year (Morris & Parker, 2008); in another study, the average time to restore competency was just less than 1 year, although time ranged from 1 to 24 months within the study sample (Wolber, 2008). Unfortunately, defendants diagnosed with organic or intellectual/learning deficit disorders are often found to have a low probability of being restored if able to be restored at all (Warren et al., 2006; Mossman, 2007).This is particularly important with regard to this chapter as the process presented is predicated on the individual possessing the cognitive capacity to benefit from treatment to restoration to competency.

Statistics Specific to Hispanics

A key idea to note is that like other psychological constructs, competency to stand trial is a cultural idea that reflects dominant culture-specific values (Mossman et al., 2007), with the added complexity of a statutory definition. As such, the relevance of

these standards to minorities has been called into question. Professionals conducting competency evaluations of Spanish-speaking individuals are likely to encounter significant challenges such as ethical issues related to cultural competency, appropriate test selection, as well as the related interpretation (Acevedo-Polakovich et al., 2007). Additionally, research assessing defense attorney perceptions suggests Spanish-speaking defendants are more often viewed as less incompetent and are referred to competency evaluations less often than their White counterparts (Varela et al., 2011), suggesting Spanish-speaking defendants may be overlooked. Perhaps it is for this reason that the influence of cultural factors on legal outcomes has received attention in recent years (Kalmbach & Lyons, 2006), and the demand for bilingual and bicultural information in all areas of psychology to inform practice is growing (Burton, Vilar-Lopez, Puente, 2012).

For instance, the field of neuropsychology acknowledges the need for quality assessments created specifically in Spanish and relevant to Hispanic culture (Burton, Vilar-Lopez, & Puentes, 2012). There is evidence to suggest that translated neuropsychological tests from English to Spanish are problematic (Judd et al., 2009). For instance, symptom validity tests (SVTs), often standard in clinical neuropsychological testing during litigation where capability or culpability of an offender is questioned, have been the focus of research on appropriate use with Hispanics from Spain, but are not easily generalizable to US Hispanic populations (Burton, Vilar-Lopez, & Puentes, 2012). Though there was no literature identified for the actual frequency of competency requests specific to Hispanics, we do know that within the larger pan-ethnic group, several distinct ethnicities exist (i.e., Mexican, Cuban, Puerto Rican, Colombian, and so forth; Kalmbach & Lyons, 2006), making determinations of culturally appropriate behaviors and legal outcomes difficult.

Populations and Countries

In July 2015, the Hispanic population reached 56.6 million people (American Fact-Finder, 2015), with 63.4% identifying as Mexican, 9.5% as Puerto Rican, 3.8% as Salvadoran, 3.7% as Cuban, 3.3% as Dominican, and 2.4% as Guatemalan, with small percentages of other Central American, South American, or other Hispanic or Latino origins (U.S. Census Bureau, 2015).

Hispanic Incarcerated Population

In 2015, the rate of Hispanic adults imprisoned was 820 per 100,000 people aged 18 years of age in the United States, with 59% of Hispanic people in federal jurisdiction serving time for a violent offense (Carson & Anderson, 2016). Furthermore, in 2010, nearly 300,000 removal proceedings in US immigration courts occurred (Korngold, Ochoa, Inlender, NcNiel, & Binder, 2015). Because of the *Franco* litigation, legal representation is now ordered for immigrant detainees in California, Arizona, and Washington who are incompetent (See Korngold et al., 2015 for a detailed review of this process). These numbers suggest that forensic psychological professionals likely will encounter and evaluate Hispanic defendants engaged in both civil and criminal legal proceedings (Morewitz & Goldstein, 2013).

Restoration to Competency

The concept of treatability is paramount to the field of forensic psychology (Rogers & Webster, 1989). The ability of a person to be "treated" or restored to competency effects court decisions in many ways: probability of parole or probation, facility type, sentence duration, and more (Nicholson & McNulty, 1992). The court ruled in *Jackson v Indiana* (1972) that once a person is found incompetent, they cannot be held indefinitely and are limited to commitment for a "reasonable period" of time and that their commitment must be justified by progress toward restoration (Mueller & Wylie, 2007). Therefore, the Jackson standard requires an accurate prediction of treatment outcome for incompetent defendants (i.e., can the defendant's competency be restored?

If so, can their competency be restored in a reasonable amount of time?) (Nicholson & McNulty, 1992).

Most research on restoring competency focuses on individual characteristics related to an initial incompetency diagnosis, the prediction of restorability, or on the success of specific treatment approaches (Mueller & Wylie, 2007; Zapf & Roesch, 2011). Because incompetency is based on the individual having a mental disorder or cognitive impairment as well as a deficit in competency-related abilities (Zapf & Roesch, 2011), it naturally follows that research will focus on factors that could effect restorability and on appropriate treatment options.

Serious Mental Illness

Unfortunately, the ability of clinicians to predict competency restoration is generally poor (Hubbard, Zapf & Ronan, 2003; Zapf & Roesch, 2011), but certain characteristics are often associated with a lower probability of restoration: older age, mental retardation, and the presence of psychotic disorders (Cooper & Zapf, 2003; Zapf & Roesch, 2011). The literature most reliably shows incompetency to be related to psychotic disorders (Cooper & Zapf, 2003; Zapf & Roesch, 2011; Crocker, Favreau, & Caulet, 2002). For instance, people with psychotic disorders are more likely to be found incompetent and are less likely to be restored for competency than people without a psychotic disorder (Mueller & Wylie, 2007). Ethnicity, race, and culture influence many aspects of mental illness and in forensic psychological evaluations for court (Carter & Forsyth, 2007).

Medication

Treatment programs often target the mental disorder/cognitive impairment and the competency-related deficits, with improvements in the mental disorder/cognitive impairment causing improvements in the competency deficits (Zapf & Roesch, 2011). Treatment success is found to be highly variable and depends on the type of treatment and the type of defendant being evaluated (Zapf & Roesch, 2011). Because incompetency and psychotic disorders are strongly associated, it follows that pharmacological interventions (i.e., antipsychotics) are the preferred treatment for competency to target the underlying mental health issue (Mueller & Wylie, 2007; Zapf & Roesch, 2011). Although predominately used, antipsychotic medication is not a perfect solution. Mueller and Wylie (2007) suggest the paucity of research and recent court cases addressing constitutional concerns of voluntariness exemplify this point (see *Harper v. Washington* (1990); *Riggins v. Nevada* (1992); and *Sell v. United States* (2003)).

Alternatives to Medication

Most importantly, *Sell v. United States* (2003) allowed medication to be involuntarily administered only if "there are no alternative, less intrusive treatments that could achieve substantially the same effect", calling into question the availability, reliability, and validity or alternative treatments to restore competency. Elwork (1992) and Mueller and Wylie (2007) argue little progress has been made in assessing these "alternative" interventions to restore competency. To date, the alternatives with some research to support their use are hospitalization (Nicholson & McNulty, 1992).

Most notably, several researchers (Bertman et al., 2003; Mueller & Wylie, 2007; Siegel & Elwork, 1990) attempted to assess how effective alternative interventions are in restoring competency. Siegel and Elwork (1990) found legal educational competency training programs that taught legal concepts using a cognitive, problem-solving approach and psycholegal educational components to be effective with defendants with various mental disorders. Bertman et al. (2003) found psycholegal education programs to be effective when taught in both group and individual formatting. Although the study groups that incorporated individual sessions showed statistically significant improvement

from pretest to posttest, the study design made determining the reasons for the results unclear (Mueller & Wylie, 2007). Finally, Mueller and Wylie (2007) evaluated competency restoration through informational board games: the Fitness Game (Cuneo & Owen, 1990) and the Healthy Behaviors Game. Ultimately, the results did not support the Fitness Game as an effective method to restore competency. Interestingly, patients tended to improve on competency-related abilities over time regardless of treatment intervention. Thus, once treatment for psychiatric symptoms has been provided and the symptoms have begun to abate, the focus of the clinician should be to identify and differentiate persistent psychiatric symptoms from deficits in legal process knowledge as a result of culture as well as potential cognitive deficits.

Developmental Disability/Cognitive Impairment

Assessing IQ

Culture can and does affect IQ testing; the current edition (as with past editions) of the DSM directs practitioners to be sure that intellectual testing procedures are attentive to a person's ethnic, cultural, or linguistic background, which includes considering the client's background and native language, choosing an appropriate testing instrument, and interpreting the results (Leany, Benuto, & Thaler, 2013; Usman, 2011). Because language differences and culturally based behaviors can be distorting, practitioners need to understand the culture, degree of acculturation, and language competency of the client (Usman, 2011). Unfortunately, cultural bias in IQ testing remains a serious issue, where the reliability and validity of use with nonnative English speakers, uneducated people, or people from non-Western or third world countries are called into question (Usman, 2011). Given that the practical tools provided here rely on an educational component, any concerns regarding intellect should be addressed via formal cognitive testing. For a thorough review of cognitive testing with

Hispanic individuals, see Leany, Benuto, and Thaler (2013).

Issues Specific to Language and Norms

There are forensic psychological issues in relation to language. First, a language barrier may present itself early on in the legal process, between the defendant and their defense. This language barrier may impact the client's ability to participate in their defense in many ways: decision-making, developing facts, accepting advice, interacting with witnesses, and so forth (Pothress, Bonnie, Hoge, Monahan, & Oberlander, 1994). Legal concepts, such as due process, may be unfamiliar to defendants of varying cultural backgrounds (Richardson, 2002). A defendant may not understand that in the United States, they are innocent until proven guilty. The defendant may be from a country where the judicial system is poorly developed, and money is integral in deciding who is arrested or detained (Richardson, 2002). The attorney-client relationship depends on effective communication, which is severely impacted by the presence of language differences (Ahmad, 2007).

Secondly, the language barrier may impact the client's opportunity to be recognized as incompetent to stand trial. Varela, Boccaccini, Gonzalez, Gharagozloo, and Johnson (2011) found whether or not the defendant spoke English to be an important factor in attorney's perception of a defendant's mental illness and in the likelihood of referring a defendant for an evaluation of competency to stand trial (CST). For instance, Spanish-speaking defendants were perceived as less mentally ill than English-speaking defendants and consequently were less likely to be referred for a CST evaluation (Varelo et al., 2011). If Hispanic clients are under-referred for CST evaluations as suggested, the rights of the client to assist their counsel and participate in their case are impacted significantly (Varelo et al., 2011). Furthermore, when the client is evaluated and referred for competency restoration, research shows that clients with limited

English fluency take longer to be restored to competency and are often in forensic facilities longer (Richardson, 2002).

Third, when referred for CST evaluations, Hispanic clients may not speak the same language as the professional conducting the forensic psychological assessment. In fact, according to the 2011–2015 American Community Survey, 13% of people in the United States speak Spanish in the home, with 5.5% of people reporting being able to speak English less than "very well," exemplifying the likelihood an evaluation will occur with a client who speaks a dissimilar language to the professional.

Unfortunately, the appropriateness of conducting an evaluation with the use of an interpreter is debated. Ponton (2001) argues that evaluations where the professional and the client do not share the same language do not meet APA standards of practice. Furthermore, issues with using an interpreter are well documented. LaCalle (1987) found that interpreters can make establishing rapport difficult and that a mistaken translation can lead to an incorrect diagnosis, can fail to reveal important symptoms, or can result in a deprivation of the client's rights. Furthermore, the varying available methods and modes of interpretation (i.e., simultaneous or consecutive, constructionist, mechanical, advocate, or cultural broker) may influence the information obtained during the interview (Canales, 2012).

Lastly, many psychological assessment measures are only available in English (i.e., forensic psychological assessments, intelligence tests; Canales, 2012) or have limited research demonstrating reliability or validity for use with non-English-speaking people (Fernandez, Boccaccini & Noland, 2007). Fernandez et al. (2007) reviewed personality and psychopathology tests that had been translated into Spanish for use with Spanish speakers in the United States and found research was only available on 16 out of the 30 tests, suggesting these tests are not psychometrically equivalent to the English versions. However, given the standard established by Dusky, the relevant statutes in most states, and the high degree of concordance among evaluators of competency (Grisso, 2006), it is likely acceptable to use a translated version of an existing assessment measure to assess reasonable proficiency for legal process constructs.

Legal Process

Given that serious mental illness is the primary barrier to competency, and we have established that efficacy of treatment for those illnesses exists, what remains is the issue of legal process knowledge for individuals who are likely naïve to US law. Legal procedures, jargon, hierarchies, and rights are not generally public knowledge (Barrett & George, 2005). Thus, for Hispanic individuals who find themselves accused in the US justice system, their expectations are likely founded in that of their country of origin and not necessarily compatible with the US system of justice.

When we consider the legal process, it is important to note that there are two dominant legal system traditions in the world: English Common Law and Civil Law (Avalos, 2013). The legal system in the United States is different than in many Latin American countries, because it follows a different tradition. Though, this paper will specifically focus on differences of Latin American countries that have a population representation in the United States (i.e., 63.4% identifying as Mexican, 9.5% as Puerto Rican, 3.8% as Salvadoran, 3.7% as Cuban, 3.3% as Dominican, and 2.4% as Guatemalan; U.S. Census Bureau, 2015).

The United States follows English Common Law. This tradition originated from England and spread through British influence and functions as an adversarial process, with two parties providing arguments in a contested case with a moderating judge ("The Common Law," N.D.). English Common Law is generally uncodified, meaning the case rulings are based on precedent (Dainow, 1966; "The Common Law," N.D.). The precedents are then later applied in the decision of each new case brought to court ("The Common Law," N.D.), which leaves judges and juries with much discretionary power to shape the law (Dainow, 1967; "The Common Law," N.D.).

In contrast, many Latin American countries, such as Mexico, Puerto Rico, El Salvador, and Guatemala, follow the Civil Law tradition (Avelos, 2013). This tradition developed in continental Europe and spread to European-controlled colonies, such as Spain and Portugal (Dainow, 1967; "The Common Law," N.D.). This tradition is codified, meaning there are strict legal codes that detail which matters can be tried in court, the applicable procedure, and the appropriate punishment for each offense ("The Common Law," N.D.). Additionally, the sources of law follow "constitution, legislation, regulation, and custom," meaning the constitution can override all legislation, legislation can override all regulation, and regulation can override all custom (Avalos, 2013).

Finally, while English Common Law and Civil Law are the most predominant traditions, there are pluralistic or other less popular legal system traditions in place. For instance, the Dominican Republic is based on the Napoleonic code and Cuba is influenced by Spanish and American law with elements of Communist legal theory ("The World Factbook," 2015).

Napoleonic/Spanish Colonial Civil Code

The Napoleonic code, a French civil code, was the main influence in civil codes developed in continental Europe and Latin American countries and is still enacted in countries such as the Dominican Republic and Bolivia (Brittanica, 2015). Napoleonic code was premised in the idea of rational, common sense law that is free from past prejudices, and its fundamental principles are freedom of person, freedom of contract, and inviolability of private property (Brittanica, 2015).

Spanish colonial civil code was a precursor to constitutional code in that it informed and guided the making of the Spanish Constitution itself (Mirow, 2013). These legal codes were implemented in all the different parts of the Spanish Empire which guided the relationship between the monarchy and the American territories, until it was replaced by the Cortes with the Spanish Constitution (Mirow, 2013).

Comparisons to US English Common Law

Conducting legal research on foreign constitutional rights is difficult for many reasons: the unavailability of online resources, a lack of translated materials, and so forth. Of the research available, it was found that Spanish, Mexican, and Dominican Republican constitutions honor due process to some degree (De La Garza, 2013). Within this document, defendants are granted many rights that parallel US English Common Law constitutional rights: the presumption of innocence, the right to remain silent, the right to a speedy trial, the right to a lawyer, and the inability to be tried for the same crime twice, but the right to postpone trial if found incompetent does not appear to be a consideration or a right within these countries (Dominican Republic, 2015; Mexico, rev. 2015). Additionally, under article 275 of El Salvador's Code of Penal Procedure there is a Miranda warning clause similar to the United States, but no other indications of due process exist (ConstitutionProject.org, N.D.). Furthermore, any information regarding due process clauses at all in the constitutions of Puerto Rico, Cuba, and Guatemala were absent (ConstitutionProject.org, N.D.). This is not to say that case law discussing mental health and criminal responsibility is not occurring, but that in the Civil Law tradition, the constitution is the primary source of law, with other sources being considered next.

Specific Examples of Legal Process Training

The term *Forensic Psychology* used in English-speaking countries is often termed legal psychology in Spanish-speaking countries (Morales Quintero & Garcia Lopez, 2010). Legal psychology is a discipline by which issues related to human behavior in the legal field can be addressed (Beltran & Vargas, 1993). In Latin America, the beginnings of legal psychology are more recent, with the last decade demonstrating an increase of psychologists in the legal field

(Morales Quintero & Garcia Lopez, 2010). Despite this increase in attention, there is a lack of postgraduate courses, little research, and few publications available on the subject in Latin American countries, with few countries (Colombia, Mexico, and Chile) recently starting to offer master's degree programs in this discipline (Morales Quintero & Garcia Lopez, 2010).

Some countries have more developed criminal justice systems and specific psycholegal professionals in place. For instance, Spain, like many other European state legislations, indicates that the mentally ill cannot be prosecuted to the same degree as people without mental illness (Mohíno, Puhol, & Idiaquez, 2011). Spain's current penal code allows for a personality disorder to be included as a factor that permits a modification of criminal responsibility, with antisocial personality disorder and borderline personality disorder representing the majority of diagnoses that result in fully diminished or partially diminished responsibility (Mohíno et al., 2011). The assessment of criminal responsibility is conducted by a forensic professional who evaluated both cognitive capacity as well as volitional capacity (Mohíno et al., 2011).

In Chile, with the recent reform of their criminal justice system to a more adversarial system, forensic psychologists are found to play an integral role in court work (i.e., clinical interviewing, intelligence testing, personality assessments, collecting collateral information, and so forth) (Navarro & Gudjonsson, 2008). Problematically, Navarro and Gudjonsson (2008) found Chilean forensic psychologists to receive little to no training in forensic assessments, report writing, or court appearance procedures (i.e., between 0 and 4.3 years of experience in forensic training). Additionally, there is a lack of reliable forensic measures available for use with Chilean forensic psychologists (Navarro & Gudjonsson, 2008).

Studies examining the influence of demographic information and competency outcomes are mixed: Pinals, Packer, Fisher, and Roy-Bujnowski (2004) found Black and Hispanic males to be more likely than White males to be referred for an inpatient evaluation regardless of diagnosis or severity of criminal charge;

Li, Jenkins, & Sundsmo, (2007) found that Latino defendants were less likely to be diagnosed with any Axis I disorder and were more likely to receive no diagnosis on Axis I than White defendants. Warren et al. (2006) found incompetent defendants to be older and of minority status, but Cox and Zapf (2004) found no association between race and competency findings.

Intervention

Given a sufficiently established foundation for the dilemma of criminal competency for Hispanic individuals in the US justice system, it is important to provide a means of treating deficits in legal process knowledge. In addition to providing medication treatment and related supports, it is important to directly treat a lack of legal process knowledge for individuals who may be naïve to the US justice system. Though there are many methods of treatment for restoration to competency, this intervention specifically addresses deficits in legal process knowledge. A primary benefit of the class is that it can be administered by clinical and nonclinical staff alike. Further, the information can be given to the individuals as an independent study aid that they can review outside of the class.

A psychoeducation process can be utilized that is plainly a direct teaching of legal process knowledge. A four-session course is presented here (specific materials are included in the appendices) along with a test that is used as a pre- and post-intervention assessment. The first course focuses on orienting the individual to what competency is and how they likely came to be involved in a treatment to restoration processes as well as how they can return to the judicial process in order to resolve their outstanding legal issue. In this week, the Dusky standard is described in laymen's terms, and the individual is given a rough expectation for the process as well as general timeframes for when they can expect to return. The subsequent weeks focus on material that addresses the prongs of the Dusky standard.

For example, in the second class, the individual is taught the purpose of a trial as well as the

various roles of trial participants (e.g., the attorneys, the judge, jury, and witnesses); a prelude to aiding and assisting the attorney is presented at the conclusion of this second class, which affirms the individual's autonomy but also identifies the benefit of being honest with their attorney. It is in this second class that they begin to learn the information, specific to the US justice system that allows them to have the factual understanding for the nature and the purpose of the court proceedings.

In week three, the emphasis shifts to the nature and the purpose of the charges against them. The types of criminal charges and various pleas are discussed. It is at this point that the client's specific charges as well as potential consequences are discussed (though this is only done individually and not in a group setting; for group settings broader examples are used that would cover everyone in the class).

In week four, the individual is provided information about plea bargains as an alternative to the trial, including a discussion of conditional/supervised release sentencing. Intermixed throughout the processes is a discussion about individual rights under the law (such as their right against self-incrimination as well as their right to be provided legal counsel or request a change in legal counsel from the judge). Though not psychometrically assessed, the posttest (included in the appendices) is used at the conclusion of the sequence of classes as an indicator of whether or not they have acquired information that would allow them to proceed to a formal evaluation of competency. However, that evaluation is conducted by independent evaluators (as set forth in a jurisdiction's respective statute(s)).

Though the method is imperfect, it is one component of a broad psycholegal issue (that of being incompetent due to serious mental illness or intellectual deficit), and one must remain cognizant of the legal standard set forth by Dusky (primarily that the individual more likely than not possesses a just reasonable ability for the prongs) as well as the demonstrated agreement among raters who evaluate competency (Grisso, 2006). It is important to note that the information presented is broad, intended to provide a sufficient base of knowledge about the US legal system, so that they could sufficiently understand and function within their adjudicative process, and not a comprehensive course of study. It is best used as an orientation and foundation building process, which is supplemented by individual contact. Individual intervention would be specific to identifying persisting psychiatric symptoms that may be interfering with competency-related abilities (e.g., delusions that would preclude them from rationally understanding or aiding), helping the individual relate their specific information to the broader legal process they were taught (e.g., discussing their specific charges or assessing their appraisal of the strength of evidence against them), as well as probing for potential cognitive deficits that may be interfering with their competency-related abilities.

Remaining Challenges in the Field

Though it is hoped that the aforementioned intervention will aid others in restoring Hispanic, Spanish-speaking individuals to competency, it is acknowledged that there remain global challenges for Hispanic clients in the forensic setting. First, although there are few English to Spanish translated psychological instruments available, most of these instruments have little to no empirical support for their use with Spanish-speaking clients (Montes & Guyton, 2014). Thus, practitioners are often relegated to evaluating their Spanish-speaking clients with in-house translated instruments or instruments translated on the fly, by a bilingual practitioner.

A second issue is a scarcity of norms for Hispanic clients. The *Ethical Principles of Psychologists and Code of Conduct* (EPPCC) of the APA has standards that promote the use of assessment instruments with established validity and reliability for members of the client's population and that assessment techniques are consistent with their language (APA, 2002; Canales, 2012). Problematically, there is a lack of good norms for Hispanic populations, making following these standards difficult (Fernandez et al., 2007). Most available forensic assessment measures

were developed for and standardized with primarily English-speaking, White European Americans (Dana, 2000; Montes & Guyton, 2014). Psychological assessment measures need to be developed that are linguistically and culturally appropriate (e.g., personality, neuropsychological, and intelligence measures) and that have been standardized through research with diverse populations (Montes & Guyton, 2014).

Finally, the two aforementioned issues are at the core of assessing intellect and developmental impairment in Hispanic clients. An awareness of what is available and cultural competency, specific to the broader population as well as the individual being assessed, is integral in identifying clients with intellectual or developmental impairments (Usman, 2011). As is human nature, client's reactions may involve concealing disability, feigning disability, or demonstrating a high degree of variability in their seeking and access to medical and therapeutic care founded in cultural norms (Usman, 2011). Thus, the tools presented here are not presented as a determinate solution, but rather with a hope that others will aid in continued development of processes to aid these specific populations.

Appendix A: Psychoeducation Handouts for Restoration to Competency

GUÍA PARA EL ESTUDIO DEL PROCESO LEGAL
CLASE #1

¿Qué es capacidad mental?

La ley dice que antes que alguien pueda tener un juicio, él/ella tiene que ser capaz de:

- Declarar sus cargos y comprender cómo funciona el sistema legal. Esto significa que usted
  tiene que entender la razón de su arresto, lo que ocurre en el tribunal y lo que podrá
  suceder con usted.
- Ayudar a su abogado. Esto significa que usted puede decidir cómo defender los cargos,
  tomar decisiones, explicar su versión de lo que ocurrió a su abogado, comprender sus
  opciones, y seguir las reglas del tribunal.

¿Cómo llegué aquí?

Usted fue arrestado por algún delito y fue llevado a la cárcel. Debido a la manera que usted estuvo pensando, sintiendo, y/o comportándose, su abogado o el juez no pensaron que usted pudo comprender cómo funciona el sistema legal, no supo de qué se le acusaba de haber hecho, y de cómo ayudar a su abogado.

El juez ordenó que se le ayude para tener la capacidad mental para tener un juicio.

¿Qué va a ocurrir?

Cuando usted llega a [institution name] a usted se le asigna a un grupo/equipo de tratamiento que incluye a un psiquiatra, psicólogo, trabajador social, enfermero/a, terapeuta de recreo, y un patrocinador.

El equipo ha recibido entrenamiento especial para proveer cuidado y apoyo a individuos quienes han sido arrestados pero que se les halla mentalmente incapaz de tener un juicio.

¿Cuándo regresaré al tribunal?

- Nadie viene o se va de [Institution Name] sin una orden jurídica de un juez.
- El juez piensa que si usted recibe tratamiento, que pudiera incluir enseñanza, consejería, y medicación, usted recobrará su capacidad mental y llegará a entender lo suficiente de su caso para poder regresar al tribunal y cuidar de sus asuntos legales.
- Usted tiene que ser evaluado y mandarse al juez los informes.
- El juez entonces fijará una audiencia para capacidad mental.
- Hay muchos factores que afectarán su regreso al tribunal. Estos incluyen su participación en tratamiento, cuan ocupado está el juez, y cuan ocupado esté [Institution Name] (no hay una respuesta sencilla para cuándo).

¿Cómo logro regresar al tribunal?

- La mejor manera de regresar al tribunal es al trabajar con su equipo de tratamiento para demostrarle que usted sabe sus cargos, comprende el proceso legal, y que usted puede ayudar a su abogado.
- Solo el juez puede decidir si usted tiene la capacidad mental para tener un juicio. El informe de [Institution Name] no podrá forzar al juez a decidirse de un modo u otro.
- Usted no tiene que ser 'perfecto' para regresar al tribunal; el juez considera muchos aspectos informativos de [Institution Name], incluyendo esta clase, su trabajo con el equipo de tratamiento, y su conducta.
- Con tal que haya más información que demuestre su capacidad mental en vez de información que demuestre incapacidad mental, el juez probablemente lo hallará listo para tener un juicio.

GUÍA PARA EL ESTUDIO DEL PROCESO LEGAL
CLASE #2

<u>¿Qué papel tienen todos?</u>

¿Qué trabajo tiene el juez, jurado, testigo, el abogado defensor, y procurador (fiscal)?

<u>El Juez:</u> El juez está allí para asegurar que el juicio sea justo. El juez no está de su parte ni en su contra. Él tiene el poder para hacer que las personas se comporten bien en el tribunal. Él decide que pruebas son aceptables. Él le dice al jurado lo que deberían considerar: él no puede decidir por ellos, solo lo que tienen que hacer. Si no hay jurado, el juez decidirá si usted es culpable o inocente. El juez también decide lo que será su sentencia si se le condena.

<u>El Jurado:</u> El jurado se compone de personas de la comunidad y después de escuchar todas las pruebas decide si usted es culpable o inocente.

<u>Un Testigo:</u> Un testigo dice lo que él/ella sabe sobre el caso. Un testigo tiene que estar dispuesto a jurar a los hechos. Los testigos pueden testificar para usted o en su contra.

<u>El Abogado Defensor (Defensor Público):</u> El abogado defensor es su abogado. Él o ella está de su parte y está allí para ayudarlo.

<u>El Abogado Procurador (Abogado Fiscal):</u> El procurador es el abogado que trata de condenarlo y mandarlo a la cárcel o prisión.

<u>El Acusado:</u> Usted es el acusado. Su responsabilidad es de cooperar con su abogado y tomar buenas decisiones para su caso.

¿Tiene que hacer usted todo lo que su abogado le dice?

No, pero tal vez debería hacerlo. Recuerde que su abogad tiene mucha experiencia él/ella seguramente sabe lo mejor y lo que le ayudará en el tribunal.

GUÍA PARA EL ESTUDIO DEL PROCESO LEGAL
CLASE #3

¿Qué tipo de cargos hay?

- Delito Menor: Los tipos de cargos que son menos serios. Si se le
  encuentra

  culpable usted pudiera pasar hasta seis meses en la cárcel.

- Delito Menor Grave: Si se le encuentra culpable usted pudiera pasar hasta un año
  en la cárcel.

- Delito Mayor: El tipo de cargo más serio. Si se le encuentra culpable usted
  pudiera enfrentarse a un año o más en la cárcel o prisión.

¿Qué debería hacer?

La razón que hay abogados es para ayudarlo a decidir qué hacer. Ellos saben la ley y que hacer en el tribunal.

Su abogado trabajará con usted para resolver cómo mejor defenderlo de sus cargos.

A principios de su caso el juez le preguntará su postura que tomará en su juicio. Esto quiere decir que él desea saber si usted disputará (peleará) los cargos. Hay cuatro opciones:

Culpable:	Esto significa que usted admite que hizo el delito y que usted no disputará los cargos. También significa que no habrá un juicio.
No Culpable:	Esto significa que usted va a decir que usted no hizo el delito y que usted no piensa que las pruebas sean lo suficiente sólidas para convencer un juez o jurado que usted lo hizo.
No Disputo los cargos:	Esto significa que usted no va a admitir que usted hizo el delito pero que usted también no va a pelear los cargos. No habrá un juicio.
No Culpable debido a Incapacidad Mental:	Esto significa que usted no es culpable por razón de que en el momento del delito usted no sabía que lo que estaba haciendo era incorrecto debido a enfermedad mental.
Culpable pero con Incapacidad Mental:	Esto significa que eres culpable pero se toma en cuenta las circunstancias respecto a su incapacidad mental.

GUÍA PARA EL ESTUDIO DEL PROCESO LEGAL
CLASE #4

¿Qué es una sentencia acordada por negociación?

Cuando se entra en una sentencia acordada en un caso criminal, el acusado admite hasta cierto grado culpabilidad y el procurador acepta una sentencia menor. En ocasiones la declaración ocurre porque el acusado quiere evitar una sentencia larga de prisión y el procurador desea evitar perder el caso. Con una sentencia acordada por negociación, ambas partes obtienen algo deseado.

El juez tiene que aprobar toda sentencia acordada por negociación.

Usted renuncia algunos derechos cuando usted entra en una sentencia acordada que incluye:

- El derecho de apelar
- El derecho a un juicio
- El derecho a declararse inocente

¿Qué es el libertad vigilada o condicional?

Libertad condicional es una sentencia recibida en vez de cárcel o tiempo en la prisión. A usted se le condena pero puede vivir en la comunidad bajo algunas restricciones. Usted también tiene que presentarse a un agente de libertad condicional y si usted viola la libertad condicional, usted puede ir a cárcel o prisión.

Algunos de los requisitos para libertad condicional pudieran incluir:

- Presentarse a la oficina de libertad condicional
- No tomar alcohol o drogas
- Parar las multas
- Obedecer todas las leyes
- Mantenerse activo en el tratamiento de salud mental
- Buscar un empleo
- Asistir a la escuela

Appendix B: Test

Proceso Legal (Circle One: Pretest/Posttest)

Nombre: _____ Fecha: _____

Líder del equipo de tratamiento: _____

Trabajador Social: _____

(Por favor haga un círculo alrededor de la letra que mejor conteste la pregunta)

1. Si usted ha sido condenado por un delito mayor, eso significa que usted:

    a. Pudiera pasar hasta un año en la cárcel

    b. Pudiera pasar más de un año en la cárcel o prisión

    c. No puede pasar más de seis meses en la cárcel

2. El trabajo del procurador (abogado fiscal) es de:

    a. Defenderlo en el tribunal

    b. Sentenciarlo

    c. Probar que usted es culpable

3. El trabajo del juez es de:

    a. Proteger sus derechos, sentenciarlo, y mantener control del tribunal

    b. Presentar los hechos de su caso

    c. Siempre estar de parte del abogado fiscal (procurador)

4. El trabajo del abogado defensor (defensor público o su abogado contratado) es de:

    a. Sentenciarlo

    b. Defenderlo en el tribunal

    c. Probar que usted es culpable

5. Cuál es el tipo de caso más serio:

    a. Delito menor grave

    b. Delito mayor

    c. Delito menor

6. Para que se le considere mentalmente capaz, usted debería poder:

    a. Ayudar a su abogado

    b. Declarar sus cargos (acusaciones) y saber las posibles consecuencias de los

        cargos.

    c. todo lo mencionado arriba

7. Cuando usted se declara <u>culpable</u> usted está diciendo:

    a. Yo admito haber hecho el delito

    b. Yo no hice el delito

    c. Yo no hablaré del asunto

8. Cuando usted se declara <u>no culpable</u> usted está diciendo:

    a. Yo admito haber hecho el delito

    b. Yo no hice el delito

    c. Yo no disputaré (pelearé) los cargos así que proceda y deme la sentencia

9. Cuando usted se declara <u>no disputo los cargos</u> usted está diciendo:

    a. Yo admito haber hecho el delito

    b. Yo no hice el delito

    c. Yo no disputaré (pelearé) los cargos así que proceda y deme la sentencia

10. ¿Cuál de las siguientes es **CIERTO** tocante a una sentencia acordada por negociación?

    a. El abogado fiscal y su abogado llegan a un acuerdo

    b. Si usted está de acuerdo con la sentencia acordada por negociación, su cargo

        original podrá ser reducido a un cargo que conlleve menos castigo

    c. Usted se declarará culpable o no disputará el cargo

    d. Todo lo mencionado arriba

(Por favor haga un círculo alrededor de la respuesta correcta)

11. Cierto o Falso   Usted es el acusado de su caso

12. Cierto o Falso   Su caso legal está en espera durante el tiempo que usted esté en Lake's Crossing Center

13. Cierto o Falso   Usted puede hablar cuando quiera en el tribunal

14. Cierto o Falso   Solo un juez puede mandarlo a Lake's Crossing Center

15. Cierto o Falso   Los testigos en su caso pueden estar de su parte o en contra de usted

16. Cierto o Falso   Usted tiene que hacer una declaración (o declararse) para su caso

17. Cierto o Falso   Usted fue enviado a Lake's Crossing Center por razón que había

duda tocante a su capacidad mental para tener un juicio

18. Cierto o Falso   Usted siempre tiene que tener un juicio por un jurado

19. Por favor enumere sus cargos:

_____

_____

_____

20. Por favor mencione si sus cargos son delito menores, delito menores graves, o delito

mayores:

_____

_____

_____

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