A guide for mental health practitioners working with collective trauma victims from Latin America: an experiential approach

Melissa Cordero
Pepperdine University
Graduate School of Education and Psychology

A GUIDE FOR MENTAL HEALTH PRACTITIONERS WORKING WITH
COLLECTIVE TRAUMA VICTIMS FROM LATIN AMERICA:
AN EXPERIENTIAL APPROACH

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by
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July, 2014
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This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

This work is dedicated to Mella DiMartino, who inspired me to live a life dedicated to serving others and be who I am today. I also dedicate this to my family and my amazing husband, who has supported me through it all.
ACKNOWLEDGEMENTS

I would like to thank my dissertation committee, Dr. Harrell, Dr. Castaneda-Sound, and Dr. Aviera for their support over the past three years as I moved from an idea to a completed study. I am especially thankful to have worked with a group of psychologists who are rare gems in the field of psychology and contribute so much through their knowledge and passion for leading the field into one of cultural competence.

I could not have completed this dissertation without the support of my chair, Dr. Shelly Harrell. She provided me with encouragement and insights, and spent countless hours reviewing and helping me strengthen my research.
VITA

EDUCATION
Pepperdine University, Graduate School of Education & Psychology
9/2010-5/2014
Los Angeles, CA
Doctorate in Clinical Psychology

Dissertation: A guide for mental health practitioners working with collective trauma victims from Latin America: An experiential approach

Pepperdine University, Graduate School of Education & Psychology
9/2008-12/2009
Los Angeles, CA
Master of Arts in Clinical Psychology

California State University, Northridge
Northridge, CA
Bachelor of Arts in Psychology

LANGUAGE
Bilingual (English/Spanish)
Proficiency Level-Fluent
Writing and Reading Skills-Advanced

PROFESSIONAL EXPERIENCE
Sharp Mesa Vista (APA Accredited)
8/2013-8/2014
San Diego, CA
Pre-doctoral Intern
  • Setting: Inpatient and Outpatient Psychiatric Medical Hospital
  • Populations: Adult, Older Adult, Children and Adolescents
  • Clinical Duties:
    o Provide intensive group psychotherapy for adults, adolescents, and older adults
    o Teach Cognitive Behavioral Therapy and Mindfulness Meditation lectures
    o Provide family interventions for those caring for a dependent adult or child
    o Provide outpatient and inpatient psychodiagnostic and cognitive assessments to adults, children and adolescents for interdisciplinary evaluation and treatment
    o Provide individual therapy to older adults utilizing a Cognitive Behavioral and Acceptance and Commitment Therapy framework

Harbor UCLA Child and Adolescent Trauma
9/2012-8/2013
Torrance, CA
Therapist/Doctoral Extern
• **Setting:** Outpatient Child Trauma Clinic  
• **Populations:** Children and Adolescents  
• **Clinical Duties:**  
  o Provided evidence-based treatments for traumatized youth and their parents or guardians to reduce various types of trauma symptoms and repercussions  
  o Offered a variety of treatment approaches, including individual trauma-based cognitive-behavioral therapy, collateral therapy for caregivers, and family therapy to address trauma  
  o Provided therapeutic services to a diverse population of children and adolescents who have survived traumatic events, including physical and sexual abuse, community violence, motor vehicle accidents, natural disasters, and trauma-related bereavement  
  o Offered Parent-Child Interaction Therapy (PCIT) to children with emotional and behavioral disorders by providing the parents or caregiver with skills to enhance their relationship with their child

Pepperdine University West Los Angeles Clinic  
9/2010–6/2013 Los Angeles, CA  
**Peer Supervisor**  
• **Setting:** University Community Clinic  
• **Populations:** Doctoral Students  
• **Clinical Duties:**  
  o Mentored first year doctoral students with various client cases to strengthen therapeutic skills  
  o Provided clinical support in the areas of intake writing, case conceptualization, and therapeutic interventions to facilitate development of clinical skills  
  o Collaboratively set goals with first year doctoral students to facilitate clinical growth

**Therapist/Doctoral Extern**  
• **Setting:** University Community Clinic  
• **Populations:** Adults and Adolescents  
• **Clinical Duties:**  
  o Provided individual and couples therapy to a diverse population, including Spanish speaking clients  
  o Offered cognitive-behavioral therapy to provide symptom relief and restore mental health to clients suffering from a variety of disorders, including anxiety, depression, personality disorders, and interpersonal conflicts  
  o Developed treatment plans based on a trans-theoretical framework, including cognitive-behavioral therapy and mindfulness meditation to address various disorders and symptoms  
  o Maintained progress notes for all clients to ensure proper documentation of session content and interventions  
  o Wrote intake reports and administer measures such as the Beck’s Depression
Inventory, Beck’s Anxiety Inventory, and the Multidimensional Scale of Perceived Social Support to assess effectiveness of treatment
- Presented clients in case conference with a proposed diagnosis and treatment plan with the purpose of exposing other students to new cases as well as receiving feedback that may enhance the client’s own therapy

UCLA Semel Institute for Neuroscience and Human Behavior
8/2011-7/2012
Cultural Neuropsychology Initiative
Los Angeles, CA

**Neuropsychology Assessment Extern**

**PROFESSIONAL EXPERIENCE** (Continued)

- **Setting:** Neuropsychological Institute
- **Populations:** Adults and Adolescents
- **Clinical Duties:**
  - Provided outpatient neuropsychological assessments to Spanish speaking adult with a variety of diagnoses, including dementia, epilepsy, brain tumors, learning disabilities, and other conditions that impact neurocognitive functioning
  - Administered neuropsychological assessments to individuals from diverse cultural background to assess for various neuropsychological disorders
  - Provided linguistically and culturally congruent neuropsychological measures with Spanish dominant and bilingual individuals to assure appropriate diagnosis
  - Participated in all aspects of neuropsychological assessment from the initial intake interview to report writing and feedback
  - Presented neuropsychological cases with a proposed diagnosis, treatment plan and cultural considerations pertaining to the Latino population in order to provide other students with information pertinent to culturally congruent assessment
  - Gave power point presentations on neuropsychological topics such as traumatic brain injury and epilepsy to inform other students about research findings

**Peer Supervisor**
- **Setting:** Neuropsychological Institute
- **Populations:** Doctoral Students
- **Clinical Duties:**
  - Trained new practicum students on Spanish assessment administration, scoring, and interpretation in preparation for their externship

Developmental Dynamo, Northridge, CA

**Behavioral Interventionist**
- **Setting:** Elementary School
• **Populations:** Children and Families  
• **Clinical Duties:**
  o Provided classroom support at the UCLA Lab School for children with special needs, including severe emotional disturbances, autistic spectrum disorders, and developmental delays  
  o Conducted sensory and motor skill integration and behavior therapy with children to foster development and self-awareness  
  o Offered assistance in domains specific to the classroom routine and proper social interaction  
  o Incorporated activities such as gardening, yoga, and art to increase socialization and sensory awareness  
  o Processed acting-out behaviors with children to cultivate coping skills and promote verbalization  
  o Collaborated with special education teachers to increase consistency between daytime classroom and the after-school programs, providing a comprehensive treatment plan for children

Step by Step, Santa Monica, CA  
7/2008-1/2009

**Behavioral Interventionist**

• **Setting:** Early Child Development Clinic  
• **Populations:** Children and Families  
• **Clinical Duties:**
  o Provided on-site and off-site interventions for children with developmental delays  
  o Offered structured programs assisting in the development of language, play, social, and fine/gross motor skills by way of floortime techniques  
  o Administered assessments batteries based on the H.E.L.P assessment instrument to assess for developmental delays  
  o Wrote comprehensive reports for each client to inform client and regional center of child’s presenting problem, proposed interventions, and progress  
  o Processed acting-out behaviors with children to cultivate coping skills and promote verbalization  
  o Implemented sensory integration activities such as finger painting and clay molding to help regulation of sensory input  
  o Attended I.E.P and parent meetings to discuss and develop modified learning plans and appropriate testing environments
Behavioral Consultants and Associates
Woodland Hills, CA
**Lead Behavioral Interventionist**
- **Setting:** In Home Services
- **Populations:** Children and Families
- **Clinical Duties:**
  - Provided in home therapy based on Discrete Trial Training and Applied Behavioral Analysis to children diagnosed with Autism, Aspergers, and Intellectual Developmental Disorder
  - Offered individually structured programs focusing on the development of skills in language, play, social, motor, academics, and self help by way of positive reinforcement and behavior modification techniques
  - Administered and wrote assessments and follow up reports for each client to inform client and regional center of child’s presenting problem, proposed interventions, and progress
  - Held monthly clinic meetings with family members to discuss progress

**RESEARCH EXPERIENCE**
UCLA, Los Angeles, CA
**Research Assistant**
- Conducted research in social psychology by gathering data on people’s opinions and feelings towards proposition eight
- Researched journal articles pertaining to the physiological effects of racism and discrimination
- Analyzed survey results using statistical scores, charts, and graphs to provide a consensus of the influences of stereotype profiles and racism

**VOLUNTEER EXPERIENCE**
Volunteers for Peace, Tierra Bomba, Colombia
7/2010-8/2010
**International Volunteer**
- Worked with families in the community to organize activities such as educational art projects and soccer tournaments
- Advocated for the village to receive funding for basic infrastructure, such as running water

Northridge Academy High School, Northridge, CA
2/2008-5/2008
**Intergroup Relations and Conflict Resolution Teacher**
- Educated ninth graders on multicultural issues to provide skills in reducing discrimination
- Offered interventions in prejudice reduction and conflict resolution to ensure a culturally safe school environment
Dharamsala, India
10/2005-11/2005

International Volunteer
  • Volunteered at a daycare center for children with disabilities
  • Provided emotional support and care for children to aid in their development and overall well-being

SKILLS/TRAININGS
  • Cognitive-Behavioral Therapy (CBT)
  • Trauma-Focused Cognitive-Behavioral Therapy (TFCBT)
  • Parent-Child Interaction Therapy (PCIT)
  • Psychological First Aid
  • Mindfulness Meditation
  • Spanish & English Neuropsychological Assessment Batteries
  • Bilingual Neuropsychological Assessment Batteries
  • Floortime-Child led behavioral therapy
  • Applied Behavioral Analysis
  • Discrete Trial Training
  • Certified Yoga and Meditation Teacher

SCHOLARSHIPS/AWARDS
  • Contribution to Diversity Award, Pepperdine University
  • Colleagues Grant, Pepperdine University
  • Cum Laude, California State University, Northridge

PRESENTATIONS/PUBLICATIONS
A resource guide for mental health practitioners working with Latino victims of collective trauma was developed based on a review of the literature. The development of the resource was also informed by two structured interviews with experts in the field of collective trauma within the Latino population. Review of the literature and structured interviews were used to develop culturally sensitive treatment approaches for victims of collective trauma from Latin America. The resource guide offers clinicians culturally adapted interventions, including PTSD measures, a table to identify culture bound syndromes, PTSD psychoeducation handouts (provided in Spanish and English), relaxation skills (e.g. breathing techniques, progressive muscle relaxation, the use of music, meditation), interoceptive exposure protocols, and tools to help clients live a life of meaning as well as restore their roles in the community and within their family. An additional two experts in the field evaluated the resource guide for validity, content, and applicability to the Latino population. Feedback from the evaluators will be used for future versions of the resource guide. Results indicated that the resource guide may be advantageous for Latino victims of collective trauma and may therefore serve as an adjunct to current treatment protocols. The resource guide may assist mental health practitioners in modifying their approach to treatment as well as offer culturally appropriate interventions in order to enhance cultural sensitivity, thus leading to a stronger therapeutic alliance.
Chapter I: Introduction and Review of the Literature

Introduction

Collective trauma refers to an experience of extreme stress that is shared by a group of people within a common geographic area or who have a shared social or cultural identity (Paez, Basabe, Ubillos, & Gonzalez-Castro, 2007). When compared to individual trauma, collective trauma may have a stronger adverse impact on social support, social sharing, social participation, and behaviors reinforcing social cohesion (Paez et al., 2007). An important type of collective trauma is exposure to violence emerging from political upheaval, revolution, and/or rebellion that frequently involves people becoming refugees. Violence has been a reality in many Latin American countries for several decades (Internal Displacement Monitoring Centre, 2010). As a result, many have sought refuge in the United States. Most recently, the devastating rise in violence in Mexico due to the drug war, and the recently granted political asylum status for Mexican immigrants, suggest that culturally appropriate trauma interventions are essential in the field of psychology. Latinos are the fastest growing minority group in the United States, increasing by 43% between the years 2000-2010 (United States Census Bureau, 2010). In 2010, President Obama announced that up to 5,500 Latinos could be granted political asylum on a yearly basis (Immigration Policy Center, 2010). There is a continuing need for more research and intervention development that addresses issues of trauma common to those fleeing from violence. While there is a growing body of work on cultural competence in trauma treatment, there is relatively less attention to the needs of people affected by collective trauma. Although the field of trauma psychology is rapidly growing, various challenges continue to exist with regard to culture. For example, how do clinicians culturally translate the evidence-based practices provided by trauma studies basing their findings on Euro-American participants?
Challenges include understanding the specific needs of each culture in order to develop trauma-informed, culturally responsive, and client-friendly approaches (Mattar, Droxdek, & Figley, 2010). Brown (2008) stated that although two people may have experienced the same traumatic event, it is never generic, nor the same for those two people. Each experience is unique to the individual as it is impacted by their culture, group membership, and personal experiences and identities that are unique to the individual (Brown, 2008).

Further interventions should be developed to assess the distinct nature of collective trauma that affects the Latino population. Very few empirical studies have focused on collective trauma within a Latino population. In addition, violence has contributed to the displacement of Latinos, making collective trauma a multi-faceted problem within the Latino population. The topic of collective trauma does not only encompass shared trauma that a community experiences but also the repercussions of the displaced individuals, people in exile, and the marginalization and acculturation issues one faces after such a tragedy. Issues of multiple losses, familial separation, survivor guilt, anger, and other dynamics are important to consider in the context of adjusting to a new culture.

Purpose

A guide focused on culturally appropriate treatment interventions for victims of collective trauma from Latin America will be developed to offer mental health practitioners support when working with this specific population. The resource is designed to provide guidance in the treatment of victims of violence that have left their home to seek safety and refuge. This guide is intended to serve as a basic foundation for mental health practitioners working with Latino victims of collective trauma. The goals of this guide include: 1) to provide mental health practitioners with a basic understanding of a perspective of sociopolitical issues
and violence in Mexico, El Salvador, and Colombia, 2) to provide an accessible resource that discusses important cultural factors to consider when working with Latinos, 3) to offer a cohesive program that is suited for the assessments and treatment of collective trauma in Latinos and displaced individuals in their own country or in the United States, and 4) to assist mental health practitioners in reaching out to the Latino community. The following review of the literature will provide a description of the current context of collective trauma in several Latin American countries. The status of empirical and conceptual scholarship on culturally-informed interventions with Latinos will also be presented as a foundation for the development of a guide for mental health practitioners.

**Example of Sociopolitical Issues and Violence in Latin America: Diversity Among the Latino Population**

This section provides examples of collective trauma relevant to Latino populations. The following examples of collective trauma reflect some of the historical events that have taken place in some countries. This section is intended to highlight the idea that the Latino population is diverse within itself and in no way replaces the need to explore the client’s history from their perspective. It is important to understand the effect that one’s race may have on how they perceive themselves and how others may treat them. Although, many people group Latinos together, being mestizo (Indigenous and Spanish descent) versus white (Spanish descent) or black (African descent) will strongly impact their experiences, as those who are of European descent and of lighter skin may not be as impacted by racism. It is also important to highlight the vast diversity in socio-economic status (SES), which strongly impacts an individual’s experience and political beliefs. In addition, their experiences will influence their political beliefs. For example, in Colombia, those who have been kidnapped may have developed more right wing
political views given their experience from the leftist guerilla group. Again, it can never be assumed that a specific treatment is appropriate but rather it should be uniquely developed based on the client’s experiences and beliefs. Although the following information is based on literature and reputable sources, clients may view the events differently given the various biases that occur when discussing political issues and collective trauma events.

**Mexico.** Latinos comprise 16% (50.5 million) of the United States population with a growth rate of 43% in the past decade (Census Briefs, 2010). Hispanics of Mexican origin make up 63% of the Latino population in the United States (Census Briefs, 2010). Due to the rising violence in Mexico, the United States has recently offered political asylum for the critical needs of Mexicans in exile. The drug war in Mexico has claimed more than 40,000 lives after Felipe Calderon’s launch of the anti-crime offensive in December 2006 (NACLA Report on the Americas, 2011). After Mexico’s success in fracturing three out of the five most powerful cartels, the remaining two, the Sinaloa Cartel and the Gulf Cartel, have taken control and dominated the country making violence, torture, kidnappings, and threats a daily reality for Mexican civilians (Kellner & Pipitone, 2010). Between 2006-2010, there were 25,233 requests from Mexican citizens seeking political asylum from the United States and only 3.3% were granted (Ronzio and Associates, 2011). In addition, this data is only reflective of those who have sought exile through government agencies and does not reflect asylees that may be among the 6.5 million undocumented Mexican immigrants in the United States (Pew Hispanic Center, 2010). Given the reality of the struggles Mexican citizens are faced with, immigrating to the United States, whether documented or undocumented, is frequently a means of survival. Therefore, mental health practitioners need to acquire the knowledge and skills needed to properly treat this population who has experienced collective trauma due to violence.
El Salvador. Salvadorians are the fourth largest Hispanic group living in the United States (Pew Hispanic Center, 2010). El Salvador has one of the highest murder rates in the Americas due to gang violence that has dominated the country (Fogelbach, 2011). As a result, among the 1,648,968 immigrants from El Salvador, the United States has been a place of refuge for those affected by violence (Pew Hispanic Center, 2010). The Salvadorian civil war killed 75,000 people and at least 1,000,000 became refugees (Fogelbach, 2011). As a form of protection from the violent racism many experienced in the 1980’s, Salvadorian gangs began to form in the streets of Los Angeles known as “La Dieciocho” or “18th Street Gang” (Fogelbach, 2011). When peace accords were signed in the early 1990’s declaring the end of a civil war in El Salvador, gang members were deported back after their prison sentence (Fogelbach, 2011). This was the beginning of a transnational gang which has been estimated to have a membership of 30,000-50,000 in the United States (Federal Bureau of Investigation as cited in Fogelbach, 2011). Officials estimate 10,500 gang members in El Salvador, 14,000 in Guatemala, 36,000 in Honduras, and 5,000 in Mexico (Fogelbach, 2011). Another Salvadorian gang, Mara Salvatrucha, is considered the most dangerous in the world. This gang was also formed on the streets of Los Angeles during the 1980’s as a form of protection. They are now found everywhere in the world and have approximately 150,000 members (Fogelbach, 2011). These gangs have been known to terrorize Salvadorian cities and suburbs (Fogelbach, 2011). In June, 2010, gang members boarded a bus, locked the doors, and burned victims alive (Fogelbach, 2011). The violence is predicted to escalate due to the drug war in Mexico as cartels have begun to migrate to Central America and align themselves with even more powerful entities such as the Mara Salvatrucha. This has left Salvadorians fearing their lives and many more are seeking refuge in the United States.
Colombia. Hispanics of Colombian origin have also sought refuge due to the civilian war which has spanned over the past forty years. An estimated five million people in Colombia have been displaced due to the political violence (Internal Displacement Monitoring Centre, 2010). An approximated 280,000 individuals have been forcefully displaced in 2010 alone (The UN Refugee Agency, 2011). Colombia has experienced a devastating reality due to the political violence between guerillas, former right-wing paramilitary groups and the Colombian military. Right-wing paramilitary groups were formed as a reaction to the guerillas as they felt the Colombian military was not taking proper action. They claimed to be allied with Colombian Armed Forces as they fought the war against the guerrillas, yet they also waged war against union members, peasant organizers, human rights workers, and religious activists who were all thought to be in line with guerilla ideals. In the past few years under president Alvaro Uribe, most of the paramilitary groups have concluded, yet there is still a dire struggle to restore Colombia as it is reported to have one of the highest level of deaths due to homicides and political violence in the Americas (Briceño-León, Villaveces, & Concha-Eastman, 2008). The United States’ strong relationship with Colombia has allowed for 908,734 Colombians to immigrate, making Colombia the 7th largest representation of Hispanics in the U.S. (Pew Hispanic Center, 2010). Understanding the history in which this population comes from can help therapists consider the complexity of trauma this specific population has experienced.

Cultural and Contextual Aspects of Collective Trauma

It is important to recognize that the effects of trauma may not be expressed similarly across cultures. A culture-bound syndrome is an idiom of distress limited primarily to a specific culture that includes a combination of somatic and psychiatric symptoms (DSM-IV; American Psychiatric Association [APA], 2000). Nervios is a culture-bound syndrome within the Latino
population which is consistently described as a reaction to a stressful or tragic event such as a death, threat, or family conflict (Baer et al., 2003). The culture-bound syndrome, *nervios*, includes the following symptoms as described by the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV-TR; American Psychiatric Association [APA], 2000): emotional distress, somatic disturbances, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, trembling, dizziness, and tingling sensations. Culture-bound syndromes, as presented in the DSM, do not clearly state how many of the symptoms must be present or the possible precipitating stressors or duration of symptoms.

Puerto Ricans differentiate between using the term *nervios* as a category and as an experience (Guarnacia, Lewis-Fernandez, & Marano, 2003). For example, Puerto Ricans describe the term *ser nervioso* (being a nervous person) as a result of childhood experiences that involved continuous trauma (Baer et al., 2003). It is said that in this case, the syndrome is longstanding and affects the individual throughout the lifespan (Baer et al., 2003). The symptoms experienced as a “nervous person” include unusual amounts of crying, headaches, stomach aches, and heightened anger and violence, predominantly in men (Baer et al., 2003). *Padecer de los nervios* (suffering from nerves) is described as a mental illness that resembles the symptoms of depression and usually begins in adulthood as a result of life problems and marital discord (Baer et al., 2003).

In Guatemala, *nervios* is conceptualized as an illness and described to be a result of anger, grief, birth control pills, anxiety, the birth of a child, or *susto* (fright sickness) (Low, 1989 as cited in Baer et al., 2003). Symptoms include headaches, facial pain, despair, anger, and trembling (Low, 1989 as cited in Baer et al., 2003). Low (1989 as cited in Baer et al., 2003) also states that *susto* is a term used by more indigenous Latino cultures to describe *nervios* and that
the term *nervios* is used by more urban Latino groups. In Guatemala and Mexico, *nervios* is described as a mental illness that is experienced more by women than men and is attributed to their inferior social status (Finkler, 1991 as cited in Baer et al., 2003).

Research states that in the Mexican American population, the term *nervios* is used to describe a reaction to everyday problems that cause distress (Jenkins, 1998 as cited in Baer et al., 2003). These problems may include difficulties with money, work and school (Baer et al., 2003). The symptoms of *nervios*, in this context, are said to include hopelessness, irritability, nervousness, depression, and interfere with social and occupational functioning (Baer et al., 2003).

Due to the various conceptualizations of *nervios* among the Latino population, it is important to understand the individual’s identity through their own explanation of the illness and exploring the cultural factors contributing to their psychosocial environment and levels of functioning (Grames, 2006). Another approach includes incorporating the concept of cultural curiosity which is described as the clinician’s openness to the client’s cultural background and who they identify as (Fontes & Thomas, 1996 as cited in Grames, 2006).

*Ataque de nervios* (nervous attacks) are described as a reaction to a stressful family event such as the death of a family member in which the individual becomes hysterical and loses control (Guarnacia et al., 2003). This is said to be more common in women (Baer et al., 2003). *Nervios, Ataque de nervios*, as well as other cultural expressions of distress, must be considered in order to adequately treat Latinos affected by collective trauma.

The literature points to possible differences in the manifestation of trauma among Latinos when compared to Euro-Americans. The importance of social roles and social connection, as well as the experience of marginalization for Latino refugees have been suggested to be an
important focus in treatment (Jobson & O’Kearney, 2008). Research suggests that trauma survivors with PTSD from individualistic cultures report more goals, self-defining memories, and self-cognitions when compared to trauma survivors without PTSD in their same culture (Jobson & O’Kearney, 2008). In contrast, trauma victims from collectivistic cultures, suffering from PTSD, do not show a difference in trauma-centered goals, self-defining memories, and self-cognitions when compared to non-PTSD trauma survivors from their same culture (Jobson & O’Kearney, 2008). This suggests that trauma survivors from individualistic cultures tend to label themselves differently after the trauma and see the trauma as a component of who they are as a person (Jobson & O’Kearney, 2008). In collectivistic cultures, the individual doesn’t see themselves as different but instead see their role in society as different (Jobson & O’Kearney, 2008). This may include seeing themselves as a dependent refugee, or someone who can no longer provide for their family (Jobson & O’Kearney, 2008). These findings may contribute to the development of culturally appropriate treatment models as interdependent cultures may not find it appropriate or helpful to talk about issues affecting the private self (Jobson & O’Kearney, 2008). This supports the idea that treatment for collectivistic cultures should include a component of social support (Jobson & O’Kearney, 2008). Treatment interventions may include family therapy and an adjustment to cognitive behavioral therapy that would teach them to modify the perceptions about the intentions and reactions of others as well as a focus on reciprocity and social exchange (Jobson & O’Kearney, 2008).

The Emberá people of Colombia provide an example of a community that has been impacted by collective trauma. The Embera are comprised of about 3,000 people living in Chocó (a region in Northern Colombia), an area dominated by the war due to their resources in mineral and wood (Perez-Sales, 2010). This is a severely impoverished population that has a
neonatal and infantile mortality rate that is five times the national average and an infantile malnourishment rate that is ten times worse than the national average (Perez-Sales, 2010). This group has been studied specifically because of the uprising in child suicide attempts, which reached a total of thirty in just one year (Perez-Sales, 2010). Their cultural practices and beliefs differ greatly when compared to the predominant Catholic population of Colombia, and therefore modification to typical treatment modalities are indicated for this population. Since the beginning of the conflict, the religious healers (Jaibanas) have lost their role in their community and have been overwhelmed by the chaos that has stricken their village (Perez-Sales, 2010). The community’s religious beliefs see this suicide crisis as a result of maligned spirits of the deceased victims’ bodies entering their children’s bodies and making them “crazy and hang themselves” (Perez-Sales, 2010). With respect to modifications that address the culture and context of the Embera people, Perez-Sales (2010) suggests the implementation of workshops to address the impact of the conflict by assessing emotional aspects with a focus on how to work with fear. In addition, to help restore the rupture in their religious community, support for the Jaibanas was suggested to help them reintegrate into different parts of the village. The traumatic experiences of the war significantly disrupted the roles of community members, which had helped them maintain balance and well-being. Therefore, it was suggested that encouraging individuals to carry out their social roles, such as the Jaibanas, may facilitate community healing through the use of their religious ceremonies and rituals. Perez-Sales (2010) also suggested implementing educational and play activities that bring the children together, help them heal their trauma, and deal with their strong emotions in a productive manner (Perez-Sales, 2010). This example highlights the importance of not generalizing the experiences of the Latino population and can serve as a foundation when considering culturally appropriate treatments for
more indigenous cultures.

**Displacement.** Displacement refers to a situation in which individuals have lost their home, family members, and community due to a tragedy such as violence or a natural disaster. These individuals have difficulty knowing if their family members are still alive and are forced to leave their home due to safety concerns. This is a common reality to hundreds of thousands of victims of collective trauma. The literature highlights the complexities in the collective trauma experience. When comparing the effects of a collective trauma to interpersonal trauma, the effects of collective trauma are exacerbated by displacement and relocation (Richards et al., 2011). As displaced individuals arrive in unfamiliar areas for shelter, many become marginalized due to regionalism, as this is common in many Latin American countries. Whether victims are forced to find refuge in their own country or the United States, they suffer discrimination as well as struggle to adjust to a foreign place.

**Language.** Research evaluating the use of a shared native language suggests it may enhance the development of an empathic connection (Gamsie, 2009). Although a therapist may speak Spanish fluently, if it is not the language in which the formal therapy training was received, it may therefore be experienced as a hindrance in therapy (Gamsie, 2009). This issue should be considered in order to formulate a treatment that is most suited for the client, given that strictly translating previously learned information is not sufficient when considering cultural factors such as education, social economic status, and religion. To ensure cultural congruence, modifications to treatment should be made to reflect the client’s needs.

When working with bilingual Latinos, “language switching” has been suggested to be therapeutic, as it enhances trust and increases the client-therapist bond (Santiago-Rivera, Altarriba, Poll, & Gonzalez-Miller, 2009). A study assessing the use of language within the
therapeutic setting also found that the use of “dichos,” (i.e. Spanish idiomatic expressions) enhances therapeutic engagement as well as increases self-understanding and awareness (Santiago-Rivera et al., 2009). Research has also shown that when clients speak in their native language, their words have much stronger emotional impact (Santiago-Rivera et al., 2009). Just as clients who wish to express their emotions easier may choose to do so in their native language, clients may also choose to distance themselves from their emotions by using their non-native language (Santiago-Rivera et al., 2009). This may have implications for trauma treatments, such as narrative exposures. By having clients first practice their narrative exposure in their non-native language, therapists may assess the readiness of the client for exposure in their native language, as the exposure would have a much stronger impact emotionally.

Marginalization/Acculturation. Political violence tends to take place in rural areas where indigenous populations, as well as farmers and individuals with lower socio-economic status, reside. These groups are more vulnerable to violence exposure in that they often do not have the means or resources to escape the violence. Marginalization defines groups of people who live on the “margins” of society with limited access to resources. Marginalization often happens as a result of discrimination but also through the lack of knowledge and education that would provide them the information needed to access those resources when in a foreign country. They often do not speak the language which keeps them segregated and contributes to low acculturation. Level of acculturation is frequently operationalized by English proficiency, immigration status, and length of time in the U.S. (Berdhal & Torres-Stone, 2009). The challenges of the acculturation process adds an additional component to the treatment of trauma and restoration of mental health for Latino refugees, which includes language barriers and access to resources.
**Access to Healthcare.** Intervention approaches should not only consider the devastation of experiencing a collective trauma, but also the repercussions of being in a foreign country without the knowledge of how to access healthcare resources. Research indicates that foreign born Latinos are less likely to access mental health services when compared to Hispanic Americans (Berdhal & Torres-Stone, 2009). This is indicative of the role that language barriers can play in impeding access to healthcare. Research also has found that 40% of depressed minorities, compared to 12% of Caucasians, reported financial barriers being a cause of lack of mental healthcare (Ojeda & McGuire, 2006). These factors contribute to lack of mental healthcare which causes many trauma symptoms to go untreated. Due to various barriers, many do not get culturally sensitive treatment even when help is sought (Ojeda & McGuire, 2006). These obstacles are commonly due to financial barriers, health system barriers, and cultural stigmas (Ojeda & McGuire, 2006). It is essential that mental health practitioners see this multifaceted problem in its entirety in order to restore mental health within this population.

In addition to poor access, Latinos report stigma as being an important factor in lower use of healthcare (Berdhal & Torres-Stone, 2009). Education about psychological intervention is imperative when reaching out to the Latino community. Many Latinos see psychologists as professionals who only work with the severely mentally ill such as those with psychosis. Misperceptions about psychotherapists may also place limitations on the perceived need and desire to access mental health services.

**Culturally Appropriate Assessment Trauma**

An example of a trauma assessment tool appropriate for Latinos is the Post Traumatic Stress Disorder (PTSD) Checklist (Pineda, Guerrero, Pinilla, & Estupiñán, 2002). The twenty-four item checklist was developed specifically for Latino victims of political violence. It was
developed in San Joaquin, Colombia, a rural area in Colombia that endured a political war (Pineda et al., 2002). This assessment tool was designed based on each criteria section, A-F, in the PTSD diagnostic criteria of the DSM-IV-TR (Pineda et al., 2002). It was elaborated from this point to include specific questions about war and symptoms one endures after a politically violent trauma in a way that is culturally appropriate and understood (Pineda et al., 2002). One question in the questionnaire “Últimamente he vivido al menos una situación relacionada con muertes o amenazas contra mi vida o la de otras personas relacionadas conmigo,” which translates to “I have recently experienced at least one situation relating to death or threats to my life or someone near me” (Pineda et al., 2002). In addition to this culturally appropriate modification, a scale of 1-4 was added to assess the severity of the symptoms. This measure has been demonstrated to be an efficacious tool when assessing the unique manifestation of collective trauma in Latinos (Pineda et al., 2002).

Assessing for Culture-Bound Syndromes. There are unfortunately several unresolved challenges associated with assessing for nervios due to the variability in symptomatology from culture to culture as well as the lack of guiding literature available to practitioners. Additionally, the presence of nervios may overlap symptoms experienced in other psychological disorders such as major depressive disorder (MDE), generalized anxiety disorder (GAD), and PTSD. This can lead to a misdiagnosis and a misconception of the individual’s cultural context. Hinton, Lewis-Fernandez and Pollack (2009) developed a nervios scale to assess the presence of this disorder among various Latino ethnic groups. The scale consists of three items, rated on a four point Likert scale ranging from “not at all” (0) to “extremely” (4) (Hinton, Hofmann, Rivera, & Otto, 2011). One question assesses the degree of distress caused by nervios in the last month and another measures the number of ataques de nervios experienced in the last month (Hinton et al.,
The Emotion Regulation Scale is another scale developed to assess the ability to distance from negative affects, which is a primary component involved in emotional regulation (Hinton, Hofmann, Pollack, & Otto, 2009). The inability to regulate emotion is a strong contributor to the experience of nervios, therefore this scale assesses important factors involved in the disorder. A quantitative analysis and assessment of the disorders nervios and ataque de nervios was conducted in Puerto Rico to further understand methods of evaluating the symptoms (San Miguel, Guarnaccia, Shrou, Lewis-Fernandez, Canino, & Ramirez, 2006). The study’s results indicated a two dimensional experience of the diagnosis, an internalization and an externalization (San Miguel et al., 2006). The internalization refers to the somatization of the distress and the externalization represents episodes of violent outbreaks, being more prevalent in men, and crying spells, being more prevalent in women (San Miguel et al., 2006). This is crucial in understanding how to assess for nervios in both genders and in evaluating that the measure is valid.

**Current Treatment Approaches for Trauma**

**Exposure Therapy.** Evidenced-based treatments are defined as approaches to therapy that are supported by research findings providing support for their effectiveness (Pucci, 2005). Exposure therapy has long been an evidence-based treatment for PTSD although outcome data is inconsistent. It has been found that many English speaking populations find trauma memory exposure difficult to tolerate (Cahill, Foa, Hembree, Marshall, & Nacash, 2006 as cited in Hinton et al., 2011; Markowitz, 2010 as cited in Hinton et al., 2011). When considering this treatment with the Latino population, specifically refugees, it has been suggested that there must be modifications to address the severity of distress experienced given the multifaceted effects of collective trauma (Hinton et al., 2011). In addition, when looking at the Latino population
regardless of refugee status, the literature points to the importance of addressing somatization (Hinton et al., 2011). Given this research, it is suggested that exposure therapy be modified so that relaxation techniques are integrated into the exposure. Further adaptations to traditional exposure protocol are addressed below under “Culturally Specific Treatment Techniques.”

**Experiential Techniques as a Treatment for Trauma**

**Mindfulness Meditation and Acceptance.** Mindfulness based approaches are increasingly being used in the treatment of trauma. Mindfulness has become a widely used treatment among various cultures as it blends well with many spiritual beliefs. A core philosophical component is based on accepting suffering as an inevitable part of human existence. The importance of accepting our suffering is seen as a way to change the relationship we have with our own distress (Lama & Cutler, 1998). Mindfulness has also been defined as a form of participation-observation that focuses on awareness of mental and emotional states, physical sensations, perceptions, thoughts, and imagery (Hoffman, Grossman, & Hinton, 2011). Mindfulness is based on the belief that in this life all humans suffer, and that through the acceptance of this reality, one can eliminate the distress of trying to make suffering not exist (Lama & Cutler, 1998). Another core belief of Mindfulness is that our tendency towards attachments is an important contribution to human suffering. These attachments do not only refer to materialism but also to attachment to one’s ideas such as that life should be different than what it is even if events are out of human control (Lama & Cutler, 1998). Mindfulness practice encourages “letting go” of these attachments so that the beliefs which cause people to suffer are no longer experienced (Lama & Cutler, 1998). The use of mindfulness practices have been rapidly growing within hospitals and veteran affair healthcare centers. The use of mindfulness as a form of treatment for trauma has received increased attention in the area of research (Catani et
Meditation has been shown to be effective in decreasing PTSD symptoms in victims of collective trauma, such as political violence survivors (Catani et al., 2009).

**Breathing Techniques.** Studies have shown breathing techniques to be an effective treatment for anxiety disorders, including those related to trauma (Descilo et al., 2010; Hinton et al., 2011). A study comparing the efficacy of a yoga breathing intervention alone and combined with exposure therapy in collective trauma survivors showed there were no significant differences between the two treatments (Descilo et al., 2010). This suggests that breathing techniques may be an efficacious treatment and that exposure therapy, although empirically supported, may be substituted if needed. This study helps support the concept of using holistic treatments for PTSD and demonstrates strong findings in the treatment of community members who have suffered a collective trauma (Descilo et al., 2010).

**Somatic Experiencing.** Somatic Experiencing is a mind-body approach to treating trauma (Levine, 2010) that addresses the biological foundations of trauma as well as the defensive ways the body attempts to protect itself from threat or fear (Levine, 2010). This approach focuses on treating dysregulation in the nervous system that has been caused by the trauma (Leitch, Vanslyke, & Allen, 2009). The focal point of Somatic Experiencing is based on the idea that a human’s response to threat is primarily instinctual and biological and that the cognitive and psychological responses are secondary (Leitch et al., 2009). This technique is practiced by having the client focus on the sensations in their body and describe them in detail, allowing for the body to naturally process the changes (Levine, 2010). For example, if the client feels their legs trembling, they may describe it as a sensation to move their legs. The therapist would then ask them to do so in order to respond to what the body is asking them to do. The client is then asked to focus on either a part of their body that feels relaxed or on a scene that is
especially tranquil for them. The therapist guides them back and forth between the two with the intent that the somatic symptoms will slowly decrease in severity. Due to the somatic manifestation of trauma symptoms in Latinos, somatic experiencing may be a particularly appropriate adjunctive treatment for trauma in this population (Skapinakis & Araya, 2011).

**Sensorimotor Therapy/Focusing Technique.** Sensorimotor therapy is a “bottom up” processing technique used to treat trauma. This is in contrast to most traditional therapy approaches which are “top-down,” beginning at thought process then moving to either exposure or cognitive restructuring, with the assumption that the change at the cognitive level will shift to the physical level. Sensorimotor therapy directly addresses trauma in the body, which is assumed to facilitate change at the cognitive level (Ogden, Pain, & Fisher, 2006). Research suggests that both approaches may be equally important (Ogden et al., 2006). Sensorimotor therapy was developed to work with the specific somatic symptoms in the body that reflect the unresolved trauma. According to Ogden et al. (2006), the experience of somatic symptoms is the gateway into the treatment of the unresolved trauma.

**Culturally Specific Treatment Techniques**

A study by Richards et al. (2011), surveyed 69 Latinos of Colombian origin to assess intervention needs. The participants responded to the inquiry by stating they would benefit from the following (arranged from most endorsed to least): a support group to discuss their experiences, a cognitive behavioral approach to help relieve the distress of their symptoms, recreational activities to help re-focus their attention, community building to help them feel less discriminated and a sense of belonging, material support and job training, drug treatment, psychoeducation, role recovery and interventions to help in rebuilding one’s life, and an outreach program to reach those who don’t seek treatment due to stigma (Richards et al., 2011). These
results suggest that cognitive behavioral interventions and group modalities may be received positively by Latino victims of trauma seeking help through psychological services.

**Culturally Adapted Cognitive Behavioral Therapy.** Current treatment modalities for trauma are frequently applied to Latino clients using interventions developed on Euro-Americans. The few studies that have evaluated treatments specific to Latino refugees indicate that modifications need to be made to common trauma interventions such as exposure therapy (Hinton et al., 2011).

There is some research support for culturally adapted CBT (CA CBT) as an efficacious treatment for Latinos suffering from PTSD that were resistant to traditional exposure therapy (Hinton et al., 2011). Within the conceptualization of the disorder, culture-bound syndromes such as nervios and ataque de nervios were factored into treatment assessment and development. The study done using this approach by Hinton et al. (2011) was based on a group of Latina women who had experienced a trauma prior to the development of PTSD and had been unresponsive to traditional exposure therapy (Hinton et al., 2011). This treatment was developed with the intention of being easily understood by individuals with minimal formal education and congruent with the needs of disadvantaged populations (Hinton et al., 2011). Additionally, it was designed to incorporate modalities that are less focused in Euro-American psychological concepts and more consistent with Latino’s cultural beliefs and values such as religion and the importance of social roles (Hinton et al., 2011). The intervention specifically addresses the client’s understanding of arousal-related mental and somatic symptoms, as well as the physiology of these symptoms and the idioms of distress in PTSD and the culture-bound syndromes nervios and ataque de nervios (Hinton et al., 2011). The intervention includes a trauma-processing protocol involving a series of steps that address emotional regulation through
the following modalities of treatment: acceptance; loving-kindness meditation; and a multi-sensorial, mindfulness meditation (Hinton et al., 2011). The interventions also include applied muscle relaxation, stretching, and breathing retraining to specifically address somatic symptoms (Hinton et al., 2011).

Psychoeducation is a key component in CA-CBT treatment. In addition to helping the client understand the etiology of PTSD, nervios, and ataque de nervios the client is informed of the process of treatment and the investment of time and energy needed in the course of therapy as healing takes time. This is introduced through analogies that are related to their everyday life experience. For example, the process of making a dish, such as a Latin American stew, is broken down into all of the steps from growing or buying the ingredients all the way to its final preparation (Hinton et al., 2011). This helps individuals who are not familiar with the process of therapy to understand the time as well as the multiple steps required in healing.

Culturally modified loving-kindness meditation has shown to be an effective treatment for the Latino population (Hinton et al., 2011). The meditation includes Catholic-type imagery such as light and heat radiating from the heart to represent the sacred heart of Jesus or Sagrado Corazón de Jesus (Hinton et al., 2011). In addition to introducing emotional regulation techniques, methods that are regularly practiced among the Latino culture are encouraged such as doing the rosary, lighting a candle, and opening the bible at random to read a passage (Hinton et al., 2011). This is done to help aid in the process of healing and restoring mental health as it is congruent with the spiritual beliefs of Catholic Latinos. Furthermore, decentering techniques and stretching are paired with culturally congruent imagery (Hinton et al., 2011). This allows for the client to have a variety of culturally appropriate treatments that can be easily integrated into their everyday lifestyle as many are already being practiced without the knowledge of how it
may enhance the healing of their distress.

Acceptance and mindfulness have been shown to develop psychological flexibility by creating adaptive default processing networks (Hinton, Pich, Hoffman, & Otto, 2013). The ability to develop flexibility of thought through acceptance allows a client to change the relationship to their thoughts. For example, if a client has continued thoughts of the traumatic event, they are encouraged to accept that the thought is there while continuing to live a life of value. This has been shown to help the client disengage, distance, and decenter from a current mind-set that may be keeping them from living a life of value. Studies have shown this to be a culturally appropriate way to address rumination as well as shame and guilt, as they are then able to live in accordance with their values, thus helping them make reparations and move forward in their life (Hinton et al., 2013).

Cognitive reframing is another intervention used to help modify thoughts that are causing distress (Beck, 2011). This has been used in a cultural context when treating PTSD, nervios, and ataque de nervios by addressing the thoughts that exacerbate fear responses such as dizziness (Hinton et al., 2011). Research states that the fear of experiencing somatic symptoms further reinforces nervios because the thoughts create a “snowball” effect. Cognitive reframing is used to modify the association to the symptom. For example, if the individual is feeling dizzy, rather than associating this symptom with the fear of falling or the fear of losing control, the client is asked to relate it to an experience where feeling dizzy may have been positive by using the “limbic child” analogy (Hinton et al., 2011). The “limbic child” analogy will have the client recall a time as a child when rolling down a hill for the sake of feeling dizzy was pleasant or when being spun blindfolded during piñata games was actually a positive experience (Hinton et al., 2011). This aims to rid the fear associated with dizziness and therefore reframes their
negative thinking. This intervention is also done prior to the individual feeling the distress in order for the mind to create a new association and be prepared when another episode occurs.

Another way to address cognitions is to modify them by clarifying misinterpretations (cognitive distortions) of somatic and psychological sensations and to normalize the experience in which they may be catastrophizing (Hinton et al., 2011). Many times individuals become fearful of these sensations as they relate it to a dangerous disorder and ataque de nervios. By teaching them not to fear the physiological reaction and how to tolerate it, as it is only temporary, the client begins to feel less fearful and more in control. This is a mindfulness approach which allows the client to allow the distress to pass without an intense reaction that causes the symptoms to exacerbate.

As mentioned earlier, applied muscle relaxation is incorporated to address the somatic symptoms. After relaxation, the clients are asked to visualize a palm tree swaying from side to side in the wind at a sunny and sandy beach (Hinton et al., 2011). This visualization aims to reinforce the idea of flexibility and enacts analogous movements of a straight spine, while tightening the abdominals and rotating the neck and evoking statements of adaptive and flexible thinking (Hinton, 2008 as cited in Hinton et al., 2011). This culturally appropriate imagery may be modified as needed for each individual client to reflect appropriate content experienced in their everyday lives. Muscle relaxation techniques are used to decrease somatic complaints due to the heightened experience of somatization in the Latino population and in the disorders of PTSD, nervios, and ataque de nervios. Affirmations and analogies are also implemented to address maladaptive thinking patterns.

**Religiously Based Models.** Incorporation of the client’s religious background enhances the development of culturally congruent services and contributes to the satisfaction and
therapeutic growth among religious populations (Whitley, 2012). Whitley (2012) states the client’s beliefs, values, attitudes, and conventions are infused with religion, and therefore ignoring such factors would constitute cultural insensitivity. To develop religious competence, a therapist should create an environment in which the client feels safe to discuss their religious practices as the use of religion in a therapeutic setting can promote resilience, recovery, and healing (Whitley, 2012). Hinton et al. (2011) has incorporated the use of religion within a CBT practice for Latinos. The modifications to CBT incorporate the use of religiously based imagery as well as the integration of spiritual practices such as prayer (Hinton et al., 2011). The use of such treatments not only can enhance the process of therapy but can help to create a strong therapeutic alliance characterized by a humble and respectful approach to understanding the client.

**Therapeutic Relationship**

The therapeutic relationship is the most essential component of treatment. Without a strong therapeutic relationship, trust is never established and difficult emotions and events can never be spoken about (Gallardo, 2013). In a Latino population where psychology is often stigmatized, it is particularly important to establish a strong therapeutic bond to facilitate change. The following values and tenets, common in many Latino cultures, are suggested by the literature to help build therapeutic alliance.

**Integration of Values, Traditions, and Cultural Beliefs.** The integration of values is essential in order to facilitate a strong therapeutic alliance. The following is a list of common values and tenets of the Latino culture. Again, these are guidelines and may not reflect all values held by an individual.
**Familismo:** Refers to the value of maintaining close connections to the family (Gonzalez-Prendes, Hindo, & Pardo, 2011). In order to incorporate this into therapy, the therapist may include the use of family members as a means to support the therapeutic process. This may be done by having family members participate in homework assignments by teaching some of the techniques practiced. This may increase a sense of self-efficacy and contribute to the cohesiveness of the family.

**Personalismo:** Refers to the value of building and developing interpersonal relationships to include warm and friendly relationships (Santiago-Rivera et al., 2002 as cited in Chadwick Center, 2012). This is important to the therapeutic relationship in that trust is especially important in adherence to therapy.

**Respeto:** Refers to the hierarchal relationship between individuals. Within a family context this represents the respect to elders (Santiago-Rivera et al., 2002 as cited in Chadwick Center, 2012). In a therapy setting this may affect the interpersonal relationship as the therapist may be seen as someone who deserves respect, therefore possibly impeding the collaborative approach to therapy. In order to address this issue, the therapist should openly discuss the need for a partnership and create a safe environment for honest feedback.

**Simpatía:** This refers to the importance of being polite and pleasant despite disagreements (Chadwick Center, 2012). In order to encourage honest feedback, the therapist should first develop a strong, trusting relationship to allow the client to feel safe in disagreeing with the therapist. The benefits of communicating disagreement should be discussed to encourage the client to openly discuss issues with the therapist.

**Summary**

Given the commonly reported somatization of psychological distress within the Latino
community, further research on techniques, such as Somatic Experiencing, would contribute to the interventions available for Latinos who have endured a trauma. In addition, further research on cognitive behavioral therapy (CBT) approaches for Latinos from lower socio-economic status is essential to better understand how to adjust these techniques to the Latino population. Although Hinton et al. (2011) and others have examined culturally adapted CBT, more studies confirming the use of these techniques would better inform the potential applicability of this approach with Latinos who have experienced collective trauma.
Chapter II: Methodology

The goal of this research project was to develop a Resource Guide for psychologists and other mental health practitioners working with Latino victims of collective trauma. Collective trauma refers to an experience of extreme stress that is shared by a group of people within a common geographic area or who have a shared social or cultural identity (Paez et al., 2007). The content of this resource includes the current status of research on collective trauma with an emphasis on identifying and evaluating intervention approaches that can integrate attention to cultural and sociopolitical dynamics of collective trauma among Latino in the United States. This Resource Guide is intended to be used as an adjunct to existing treatment protocols in order to guide therapists to more effectively work from a culturally sensitive lens. The focus of this chapter is to describe the methodology that was utilized in the development and evaluation of the Resource Guide.

Procedures for Developing the Resource Guide

Review of the Literature and Existing Resources. An extensive review of the literature was utilized in the identification of culturally appropriate interventions for Latino victims of collective trauma. This literature includes empirical research on trauma treatments as well as scholarly books discussing the implication and practice of interventions among the Latino population. The sources of data utilized were identified from academic databases including Psych INFO, Academic Search Elite, Psych ARTICLES, Books in Print, and internet resources connected to national and international organizations. These organizations included Consultaría Para los Derechos Humanos y el Desplazamiento (Consultation for Human Rights of Displaced Individuals), Internal Displacement Monitoring Centre, and the Pew Hispanic Center.
Integration of Data and Development of Program. Information obtained from a comprehensive literature review was used as the foundation for the development of the guide. Structured interviews with two experts in the field of trauma treatment within the Latino population was used to confirm and supplement the content of the Resource Guide. These two mental health professionals had specific experience and expertise working with Latinos and were consulted to inform and further support the development of the Resource Guide. Culturally-appropriate treatments identified by empirical research were also examined. The experts in interventions with Latinos were identified to participate in a telephone interview during the development of the Resource Guide (Appendix B). Inclusion criteria included: having a at least masters or doctoral degree in either social work or psychology, having received formal training in trauma interventions, having received specific training or supervision in trauma interventions for Latinos, and having worked with victims of collective trauma for at least 7 years, 5 of those being with Latinos (Appendix C). One of the participants was recruited through an organization that focuses on serving refugees and Latino victims of collective trauma. Nine organizations were contacted first via email and second through telephone if contact was not reached. They were asked to provide a list of mental health practitioners that would be appropriate for the study (Appendix G). Only one of the nine organizations provided referrals, and the two individuals who were referred by this agency were contacted. The researcher chose participants from the list of two individuals provided by the organization. The researcher contacted individuals via email in the order received by the organization and were asked to verify eligibility (Appendix C). Since only one participant agreed to participate in this study through this method, other professionals in the field were recruited by directly emailing clinical psychologists and asking for referrals of therapists who are experts in the field of Latino victims of trauma. The second
participant that was included in the first phase of the study was recruited through this method. There were two phases of the study, the initial recruitment of two individuals to help inform the development of the Guide and the final recruitment of two individuals to evaluate the Resource Guide. The eligibility of the participants was verified by conducting a short assessment of their expertise and experience (Appendix C). Confirmed participants were scheduled an appointment for a phone interview. After participants had agreed to participate, all communication was recorded with their consent. Participants were sent the Written Statement (Appendix D) via email prior to the interview. They were given the option to request and sign a consent form if they chose. The Written Statement described the purpose of the study, confidentiality of personal information, such as the individual’s name, which was only attained if the participant requested to obtain and sign a consent form. No participants chose to receive or sign the informed consent form. Additionally, participants were provided with information regarding potential risks and benefits of participation as well as phone numbers of support/counseling services in the case of an adverse or unexpected event (Appendix D). After obtaining verbal consent to record, the participants were then interviewed (approximately 20 minutes) and asked to answer a set of questions (Appendix F) which pertained to their experiences working with Latino clients who have experienced collective trauma, issues they have faced when working with this specific population, and their perception of what strategies are most effective.

Upon completion of the interview, the recorded information was filed and will be stored by the researcher for five years. Privacy and confidentiality of the participants’ names were maintained. The identity of the organization and the participants were not disclosed in the reporting of study results. This information was solely obtained for consenting purposes, if the participant requested to sign and return the form, yet no participants requested to sign.
Each participant was assigned a code to identify whether the participant participated in the
development of the guide or the evaluation. For example, if the participant took part in the
development of the program they were assigned a code beginning with “P1” to indicate that they
participated in the first phase of the study.

The information gathered through these interviews contributed to the development of the
resource by guiding the researcher in further exploring suggested interventions. Interventions
suggested by the participants that were supported by research were incorporated into the
Resource Guide. Some of the interventions proposed by the participants included
psychoeducation to destigmatize treatment, and the importance of informing clients of the mind-
body connection of symptoms. In addition, the integration of religion and cultural practices (e.g.
curanderos) were included in the guide and highlighted as a key component to aligning with the
client. Handouts and/or worksheets were also identified, modified, and developed by the
researcher for inclusion in the guide. This guide has been divided into four sections pertaining to
specific issues in order to facilitate appropriate treatment of Latino clients.

Section I is called “Understanding Collective Trauma” and provides practitioners with a
description and examples of collective trauma relevant to Latino populations. Section II titled,
“Cultural Considerations” includes information gathered from the comprehensive literature
review concerning important factors to consider when working with Latino clients generally.
Issues such as acculturation and cultural beliefs, values, and traditions that are relevant to
assessment and treatment were included. Section III, “Culturally-Appropriate Assessments of
Trauma”, introduces culturally adapted measures that provide clinicians with assessment tools
appropriate for Latinos that take into account their level of education and possible culture-bound
syndromes. Section IV is the most comprehensive section of the guide, it is titled “Culturally-
Adapted Interventions.” Interventions were selected for inclusion based on existing support in the research literature. This section is organized by type of intervention and presented in a sequential order from most basic to more advanced interventions that should be implemented later on in treatment.

**Evaluation of the Program**

The final stage in the development of this Resource Guide consisted of an evaluation by two expert clinicians working with Latinos who have experienced collective trauma. The evaluators were asked to identify strengths and weaknesses of the Resource Guide and its applicability to a Latino population.

**Evaluator Participation**

For the purpose of this Resource Guide, the panel of evaluators included two individuals directly working with Latinos that have endured a collective trauma. Evaluator inclusion criteria included: (a) a master’s or doctorate degree in psychology or related field, (b) formal training in trauma treatments, (c) at least 7 years of providing direct services to victims of trauma, and (d) at least 5 years serving predominantly Latino clients presenting with collective trauma (Appendix C).

**Recruitment Strategies and Procedures**

For the second phase of the study, professionals in the field were recruited by directly emailing clinical psychologists, and asking for referrals of therapists who are experts in the field of Latino victims of trauma. The two participants in the second phase of the study were recruited through this method. The researcher chose evaluators to verify eligibility (Appendix C) by contacting individual referrals in the order received and contacted them via email followed by telephone, if no contact was reached. Evaluators were requested to participate in the study
(Appendix I) until two individuals confirmed their participation. Confirmed participants were emailed an evaluation packet (Appendix J-N). This packet contained: (a) an Evaluator Packet Cover Letter (b) a Written Statement Regarding Research (the evaluator was given the option to sign an informed consent at his/her request, but the consent form was not included in the packet [Appendix L]), (c) the Resource Evaluation Form, and (d) the Resource Guide.

The Written Statement Regarding Research described the purpose of the study, confidentiality of personal information, such as the individual’s name, and potential risks and benefits of participation, phone numbers of support/counseling services were provided in the informed consent in the case of an adverse or unexpected event, a summary of the project that described participation as completely voluntary and their right to withdraw at anytime without penalty (Appendix K).

The Resource Evaluation Form, developed by the researcher, consisted of demographic questions (e.g. work setting and position held), as well as six questions rated on a likert scale (1-5), and six open ended questions. Participants were asked to rate the usefulness of the guide for mental health practitioners and victims of collective trauma, as well as the usefulness of the trauma interventions. Open ended questions regarding the content, accuracy, practicality (e.g. usefulness for the targeted population), strengths and weaknesses of the guide were included (Appendix M).

Evaluators were asked to read all of the enclosed materials upon receipt of the packet. Participants were asked to complete the Resource Evaluation Form, and upon completion of the Resource Evaluation Form, return all materials to the researcher electronically as an attachment. Privacy and confidentiality of the evaluators’ names were maintained. There was no identifiable information obtained from the evaluators, given that all participants refused the option to sign the
consent form. All participants in the study were provided with a twenty-dollar Starbucks card as a thank you for their participation.

**Analysis of Evaluation**

Responses were analyzed by identifying categories of suggestions and limitations and examining the frequency and content of evaluator comments in these categories. Strengths and weaknesses reported by the evaluators are summarized in the results section of the dissertation. These results were used to identify next steps in the development and modification of the guide.
Chapter III: Results

This chapter will provide an overview of the results of the steps taken to develop and evaluate the Resource Guide. First, a brief overview of the process of collecting data to inform the content of the guide through a review of current literature and structured interviews from two experts in the field will be presented. Next, the detailed structure and content of the Resource Guide (see Appendix N) will be discussed. Finally, feedback on the Resource Guide from the two evaluators will be reviewed and examined.

Brief Overview of the Development of the Resource Guide

The initial phase of the study involved an extensive review of literature pertaining to trauma symptom presentation in a Latino culture, considerations with regard to the effects of collective trauma in a Latino population, current treatment approaches to collective trauma, and appropriate adaptations to collective trauma interventions with a Latino population. After reviewing current literature, structured interviews with experts in the field were conducted (see Appendix F: Expert Interview Questions).

Literature Review

Psychoeducation is a key component in trauma treatment. In addition to helping the client understand the etiology of PTSD and cultural-bound syndromes, such as nervios, and ataque de nervios, the client should be informed of the process of treatment and the investment needed in the course of therapy. Once psychoeducation has been presented to the client, any of the following treatments may be effective, as they have shown clinically significant changes in Latino participants.

The literature highlights the importance of modifying currently used trauma treatments, such as Exposure therapy, for the Latino population (Hinton et al., 2011). The literature suggests
that somaticizing an illness is common to the Latino population due to the acceptance of physical pain as oppose to psychiatric illness. Therefore, somatization is a common and more accepting way of experiencing distress (Hinton et al., 2011). The research suggests that because somatization is so common within the Latino community, there are high drop-out rates for those in exposure therapy. This is said to be due to the stronger physical distress that is experienced, thus making traditional exposure treatments intolerable. Given this research, it is suggested that Exposure therapy be modified so that relaxation techniques are integrated into the exposure. In addition to this adaptation, research suggests that relaxation techniques should be modified to include relevant cultural practices as well as religious content, if appropriate.

Incorporation of the client’s religious or spiritual backgrounds enhances the development of culturally responsive treatments and helps clients access and grow personal strengths and resources among religious populations (Whitley, 2012). Whitley (2012) stated that the client’s beliefs, values, attitudes, and conventions are infused with religion, and therefore ignoring such factors would constitute cultural insensitivity. Hinton et al.’s (2011) research on incorporating religion into a CBT protocol has shown to be advantageous for Latinos/as who identify as religious or spiritual. Religious based CBT incorporates the use of religious imagery as well as the integration of spiritual practices such as prayer (Hinton et al., 2011). The use of such treatments not only enhance the process of therapy, but may help create a strong therapeutic alliance.

Research has shown that acceptance and mindfulness can create psychological flexibility by developing adaptive default processing networks (Hinton et al., 2013). The ability to develop flexibility of thought through acceptance allows a client to change the relationship to their thoughts. Research has shown that acceptance and mindfulness techniques decrease somatic
complaints, which is a common symptom among ethnic minority and refugee populations (Hinton et al., 2013). Mindfulness helps clients shift their attention from focusing on the somatic symptoms from a hyperaroused state to a mind frame of acceptance and calmness. An attitude of acceptance has been shown to decrease pain by developing an observational approach of nonjudgment (Hinton et al., 2013).

**Structured Interview**

Two experts in the field were recruited to help inform the development of the Resource Guide from October-November 2013. One of the referral sources was through an organization that focuses on serving refugees and Latino victims of collective trauma, yet the clinician had no current affiliation with the agency (see Appendix G: Agency Contact Scripts-Email Script). The other participant was referred by a clinician known to the researcher, who is familiar with experts in the field of trauma with Latinos. An agency authorization form was not filled out, given that neither participant was associated with a particular agency. The purpose of the structured clinical interview was to gather information for the development of the guide. Both participants met the following eligibility criteria (see Appendix C: Eligibility Form). Table 1 presents the demographics and training experience of the participants. The first participant (referred as Participant #1) was a 36-year-old Latina female, from Guatemala, with a doctoral degree in psychology, who had worked with Latino victims of collective trauma for 12 years. The second participant (referred as Participant #2) was a 45-year-old Latina female, from Colombia, with a doctoral degree in psychology, who had worked with Latino victims of collective trauma for more than 20 years. Evaluators were emailed a written statement regarding the research form (see Appendix D: Written Statement). They were also offered the option to sign an informed consent. None of the participants requested an informed consent (Appendix E). They were then
asked to verbally consent to an audio recording of the structured interview, which was completed in approximately 20 minutes (see Appendix F: Expert Interview Questions).

Table 1
Phase 1 Participants’ Demographics

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Age</th>
<th>Title</th>
<th>Training</th>
<th>Types of Trauma Experience</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant #1</td>
<td>Female</td>
<td>Latina (Guatemalan Descent)</td>
<td>36</td>
<td>Clinical Psychologist</td>
<td>Justice Resource Institute’s certificate in trauma stress studies, and EMDR</td>
<td>Consultation focused on the treatment of psychological trauma. Focus on women and ethnic minorities. Teaching focuses on trauma and working with women across cultures, and international mental health work.</td>
<td>12</td>
</tr>
<tr>
<td>Participant #2</td>
<td>Female</td>
<td>Latina (Colombian Descent)</td>
<td>45</td>
<td>Counseling Psychologist</td>
<td>Theory, research, and techniques</td>
<td>Political persecution, torture, displacement, sexual abuse, domestic violence, child abuse, car accidents, and job related accidents</td>
<td>20+</td>
</tr>
</tbody>
</table>

Integration of Data, Structured Interviews, and Resource Guide Content

The review of the literature and empirical support for culturally adapted interventions for Latino victims of collective trauma, and information from the clinical interviews were gathered to inform the content of the Resource Guide, *A guide for mental health practitioners working with collective trauma victims from Latin America: An experiential approach*. Specifically, the discussion points and activities developed and offered in the Resource Guide were based on
empirical studies and on the structured interviews conducted with two experts in the field.

Content from the interviews that had literature to support its validity were included in the development of the Resource Guide. Table 2 presents the responses from the participants that was provided during the structured interview.

Table 2
Overview of Phase 1 Participants’ Responses

<table>
<thead>
<tr>
<th>Question</th>
<th>Participant #1 Response</th>
<th>Participant #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What issues do you see most when working with Latino victims of collective trauma?</td>
<td>“Isolation, sleep, somatic pain for a number of health concerns, body pain, and headaches.”</td>
<td>“A social context of migration, pre-migration and post migration, political issues from home country, racism with a caveat for immigrants who have European decent. They don’t face the same challenges than those who are mestizos. When you have clients who are of color, lower SES, and political issues then racism is at the fore front.”</td>
</tr>
<tr>
<td>What interventions have you used to address these issues?</td>
<td>“I have training in trauma theory and eco models of treating trauma and models in physiological arousal and use a combination of these approaches and integrate psychodynamic relational training. It is important to be personable and engaged and connected. Address how they are thinking about this and make some connection with the person, therapeutic alliance is the main focus. First bridge the gap about their role after seeing a medical doctor.”</td>
<td>“For survivors of torture, a holistic approach: legal help in addition to psychotherapy. Coordinate services with legal advocacy due to discrimination. Socioeducation and physiological aspects. Exposure to events-imaginal, narrative, mind body techniques are also very useful. Socioeducation and the link between the personal work and social work.”</td>
</tr>
<tr>
<td>What are some specific effects of collective trauma that you have noticed to be culturally</td>
<td>“The spiritual frame that they bring in that helps them make meaning about”</td>
<td>“I don’t think there is a Latino culture, the government (continued)”</td>
</tr>
<tr>
<td><strong>specific to the Latino population or specific to an ethnicity within the Latino culture?</strong></td>
<td>what has happened to them and their community. I hear a lot of feeling like there is a reason because of God. Flashback experiences are common. In this population they come with the question of psychosis and If I ask about flashbacks, like in the DSM, they won’t say anything but rather talk about shadows or “unusual” things like bits of conversations, which are auditory hallucinations. More often then not, it is not psychosis rather they are memories of the trauma. The words that they hear are due to the trauma, like a day dreaming state. Physical symptoms are constant. I haven’t seen one person yet who doesn’t have 2-3 different ones, such as GI, headaches, numbing, conversion-dizziness, dissociation.”</td>
<td>has put that on us. A common theme between clients here is pre-migration experiences and stories, a lack of healthcare access and coverage.”</td>
</tr>
</tbody>
</table>

| **What is your experience and opinion about the use of somatic or experiential methods with Latino trauma survivors?** | “As long as there are alternative healers and encourage bringing that in.” | “Those can work well if used properly—where I have issues with that if you just work from a perspective that there is a universal way to work with people you are contributing to a society that oppresses them. It’s just how they (continued)” |
Overview and Description of the Resource Guide

The following is a detailed description of each treatment focus as well as the interventions selected. Information from the literature and the structured clinical interviews were integrated to develop each treatment focus area and intervention strategies. In addition, a discussion of how interventions were selected for inclusion in the Resource Guide is also included. Table 3 presents an overview of the content of the Resource Guide.

**Treatment Focus #1: Psychoeducation.** This treatment focus area is intended to provide clients with psychoeducation relevant to trauma symptoms and to inform them of the link between perceived medical symptoms and psychological symptoms. The content was determined based on literature suggesting that psychoeducation gives clients a framework for their experience and helps normalize their current distress (Phoenix, 2007). When clients do not understand their symptoms, they may be catastrophized. Understanding why they are experiencing these reactions to the trauma and learning that there are treatments for them, can give clients hope and help them feel more in control. The ability to understand the reasons for stress responses can help minimize self-criticism as they are able to see that these are not personal failings but expected symptoms after experiencing a trauma (Phoenix, 2007). It is crucial that clients are provided with information to help destigmatize psychological symptoms as well as the therapeutic process. In addition, Participant #1 suggested the importance of addressing how clients are thinking about their symptoms in order to make a connection with the person. Participant #1 stated that clinicians must “first bridge the gap” between the client’s
perceived role when initially seeing a medical doctor and now a mental health practitioner. Furthermore, Participant #1 stated that the most common trauma symptoms seen in Latino populations include somatic concerns, such as “pain for a number of health concerns, body pain, and headaches.” Given that this view is also supported by the literature, psychoeducation on this specific topic was included into the guide (Hinton et al., 2011). The specific intervention strategies chosen include psychoeducation addressing common misconceptions of trauma symptoms, as well as psychoeducation regarding somatic symptoms (Phoenix, 2007).

Modifications for the specific population of Latino/a collective trauma survivors includes a user-friendly Spanish version of the psychoeducation handout, a brief discussion on the importance of “bridging the gap” between medical and psychological care to destigmatize treatment, and a description of the phases of treatment to decrease early drop out and prepare the patient for treatment (Phoenix, 2007).

**Treatment Focus #2: Relaxation and Emotion Regulation Skills.** This treatment focus area is intended to provide clinicians with culturally relevant interventions that address common symptoms specific to the Latino population. The content was determined based on literature suggesting that treatments for traumatized refugees should not include traditional exposure techniques, such as prolonged exposure (Hinton et al., 2011). The newer literature states that clients do not need to experience high levels of discomfort associated with the trauma in order to resolve the trauma (Hinton et al., 2011). Instead, the research suggests that the client needs to believe and feel confident that the traumatic memories can be tolerated (Hinton et al., 2011). In addition, Participant #1 and #2 indicated that important interventions should include “mind body techniques.” The specific intervention strategies chosen include breathing techniques, progressive muscle relaxation, Loving-Kindness Meditation with religiously base imagery, and
listening to music (Descilo et al., 2010; Hinton et al., 2011; Hinton et al., 2013). Modifications for the specific population of Latino/a collective trauma survivors include the inclusion of religiously based imagery, a list of culturally appropriate practices, and a user-friendly Spanish version of the Music Log handout. Furthermore, Participant #1 suggested the importance of bringing in alternative healers into treatment, which was also supported by the literature (Hinton et al., 2011). Given this consistent finding, the use of *curanderos* was included in the suggestions for culturally appropriate practices.

**Treatment Focus #3: Recognizing Cognition Distortions.** This treatment focus area is intended to increase awareness of unhealthy and unbalanced thinking by helping clients identify common cognitive distortions. The content was determined based on literature suggesting that cognitive distortions should be addressed by having clients reframe and reassociate their distress (Hinton et al., 2011). Although this was not specifically suggested by the participants interviewed, a brief section was included to prepare the content for the next treatment focus, which focuses on positive reframing. The specific intervention strategies chosen include a list of common cognitive distortion to help guide the therapist and the client in recognizing maladaptive thinking patterns (Burns, 1980). Modifications for the specific population of Latino/a collective trauma survivors were included in the following section in a discussion about culturally relevant positive reframes of cognitive distortions.

**Treatment Focus #4: Interoceptive Trauma Exposure Protocol and Positive Reframing.** This treatment focus area is intended to provide clinicians with a culturally appropriate approach to exposure therapy. The content was determined based on literature suggesting trauma treatments, such as Exposure therapy, should be modified for the Latino population (Hinton et al., 2011). Given the high treatment drop out rates during traditional
exposure therapy within the Latino population, it is suggested that exposure therapy be modified so that relaxation techniques are integrated into the exposure (Hinton et al., 2011). In addition, Participant #2 indicated that imaginal exposure to events may be useful if done appropriately. The specific intervention strategies chosen include Applied Stretching with Visualization and an exposure protocol. The exposure protocol has clients expose themselves to the feared somatic symptoms and reframe the cognitive distortions related to them (Hinton et al., 2011).

Modifications for the specific population of Latino/a collective trauma survivors includes the use of culturally relevant examples of cognitive reframes. Additionally, an exposure protocol for somatic symptoms was included. Furthermore, an introduction discussing the need to integrate relaxation techniques within narrative exposures was provided.

**Treatment Focus #5: Living a life of Meaning.** This treatment focus area is intended to help clients identify their values and rate the importance of each value. The content was determined based on literature suggesting that values can serve to guide a client to live a life of meaning (Hayes, 2004). This is imperative after going through a collective trauma, given that clients have most likely had to deal with a loss of some form. This can be the loss of a loved one, home, lifestyle, role, or loss of functioning. Although neither participant directly suggested to focus on values, studies have shown that living a life in accordance with one’s values can help clients make reparations and move forward with their life (Hinton et al., 2013). The specific intervention strategies chosen include a values chart to help clients identify their values by rating the importance of each value listed (Hayes, 2004). Modifications for the specific population of Latino/a collective trauma survivors includes the inclusion of possible values relevant to immigrants and Latino/as (e.g. citizenship, religion) as well as a Spanish translation of the chart.
**Treatment Focus #6: Shame/Guilt.** This treatment focus area is intended to help clients manage their perceived guilt, and guide them toward acceptance. The content was determined based on literature suggesting when there is excess guilt that is not dealt with, it can develop into shame (i.e. a sense that there is something wrong with the person rather than a behavior or action that occurred) (Fidaleo et al., 2010). In addition, Participant #1 indicated the importance of using the spiritual frame that clients bring in, which helps them make meaning about what has happened to them and their community. The specific intervention strategies chosen include a discussion of the importance of addressing shame and guilt in the context of their cultural and spiritual beliefs. For example, when there are cultural or religious practices that relieve guilt, this should be practiced (e.g. In Catholicism, going to confession or praying a penance is appropriate). Additionally, writing three positive and three negative memories of the loss, an unsent anger letter, a goodbye letter, a letter asking for forgiveness, performing a ritual or ceremony, and making reparations (e.g. advocate for justice, volunteer, find forgiveness through having a purpose), and a responsibility pie (Fidaleo et al., 2010). Modifications for the specific population of Latino/a collective trauma survivors includes culturally relevant examples, such as the use of confession if appropriate, and the suggestions of practicing culturally relevant traditions (e.g. use of fire as a way to symbolically make an offering).

**Treatment Focus #7: Role Recovery and Community Building.** This treatment focus area is intended to encourage clients to find ways to become part of their new community and find purpose in their lives. In addition, it also serves as a guide for mental health practitioners to reach out to the Latino population and provide adequate psychological care in the community as well as link clients to other resources (e.g. legal, occupational). The content was determined based on a study that specifically interviewed victims of collective trauma and assessed the needs
of those displaced by violence. In this study, it was suggested that role recovery and community building are strong components in healing from trauma (Richards et al., 2011). In addition, Participant #2 highlighted the importance of reaching out to clients in the community and providing them with holistic care (e.g. providing clients with links to resources in the community, such as legal services). The specific interventions include suggestions for linking clients to volunteering opportunities, offering support groups for displaced individuals/families in the community, providing resources for occupational support, offering psychoeducational groups in the community, and providing clients with links to legal resources (Richards et al., 2011). All of the aforementioned interventions in this section were included based on the needs identified by Latino victims of collective trauma. Therefore, no cultural modifications were made given that this section was included to address the needs advocated by the victims themselves.

Table 3

An Overview of the Resource Guide

<table>
<thead>
<tr>
<th>Treatment Focus Areas</th>
<th>Interventions</th>
</tr>
</thead>
</table>
| Psychoeducation        | -Psychoeducation relevant to trauma symptoms  
                          -Providing a link between perceived medical symptoms to psychological symptoms. |
| Relaxation/Emotion Regulation Skills | -Deep Breathing, Progressive Muscle Relaxation, Listening to music, and Loving Kindness Meditation (guided by cultural beliefs)  
                                        -Cultural Practices: Lighting a candle, praying the rosary, religious coping (prayer, meditation) |
| Recognizing Cognition Distortions | -Cognitive distortions, specifically catastrophic thinking about somatic symptoms |
| Interoceptive Trauma Exposure Protocol and Positive Reframing | -Exposure to traumatic event followed by emotion regulation skill  
                                                             -Exposure to somatic sensation and positive reassociation to somatic sensation (reframing cognitive distortions) |
| Living a life of Meaning | -Identifying Values |
| Shame/Guilt            | -Finding forgiveness through action  
                          -Responsibility Pie |
| Role Recovery          | -Based on values |
Overview of Evaluators’ Feedback

Three evaluators for the Resource Guide were recruited in March 2014 through recommendations by a clinician known to the researcher (see Appendix I: Evaluator Request Script). The purpose of the evaluation was to assess the guide in terms of design, content, and applicability to the specified population. All three evaluators met the eligibility criteria (see Appendix C: Eligibility Form), which included the following: (a) a master’s or doctorate degree in psychology or related field, (b) formal training in trauma treatments, (c) at least 7 years of providing direct services to victims of trauma, and (d) at least 5 years serving predominantly Latino clients presenting with collective trauma. One of the evaluators (referred to as Evaluator #1) included a 35-year-old Latina female, from El Salvador, with a doctoral degree in psychology, who has worked with Latino victims of collective trauma for more 7 years. The second evaluator (referred to as Evaluator #2) included a 34-year-old Caucasian female, with a doctoral degree in psychology, who has worked with Latino victims of collective trauma for 7 years. Only two out of the three participants returned the evaluation form. The following table presents the participants’ demographic information.

<table>
<thead>
<tr>
<th>Evaluator</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Age</th>
<th>Title</th>
<th>Training</th>
<th>Types of Trauma Experience</th>
<th>Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluator #1</td>
<td>Female</td>
<td>Latina (Salvadorian Descent)</td>
<td>35</td>
<td>Clinical Psychologist</td>
<td>TFCBT, CPT, FOCUS</td>
<td>Immigration, physical and sexual abuse, medical trauma, accidents, traumatic</td>
<td>7</td>
</tr>
</tbody>
</table>

(continued)
Summary of the Results

Overall, on a scale from one to five, one being “Not at All” and five being “Very,” the average of the evaluators’ responses to all items on the Resource Evaluation Form regarding the quality of the Resource Guide was 4.3. The average of the first evaluator’s responses was 3.83, while the second evaluator’s rating average for all items was 4.83 (see Figure 1). Figure 2 presents the ratings for each of the evaluators on six Likert-scale items. In general, the two evaluators were in agreement in their assessment of the Resource Guide, on item four (“How useful do you find this guide for addressing symptoms of trauma directly with Latino clients who...
have experienced collective trauma?”) both evaluators rated equally at a 4, somewhat useful. Items number one (“How useful did you find this guide for mental health practitioners?”), two (“How useful do you find this guide for working with Latino victims of collective trauma?”), 12a (“This program is beneficial for mental health practitioners working with Latino victims of collective trauma”), and 12b (“I would recommend this guide to mental health practitioners working with Latino victims of collective trauma”) were rated 1 point higher by the second evaluator, and item number five (“How useful do you find the treatments described in this guide?”) was rated 2 points higher by the second evaluator. Figure 3 provides the average of evaluators’ responses to each item. The average of the evaluators’ responses to item one, “How useful did you find this guide for mental health practitioners,” was 4.5. For item two, “How useful do you find this guide for working with Latino victims of collective trauma,” the average of the evaluators’ responses was also 4.5. On item four, “How useful do you find this guide for addressing symptoms of trauma directly with Latino clients who have experienced collective trauma,” the evaluators averaged 4 in their responses. Similarly, on item five, “How useful do you find this guide for addressing symptoms of trauma directly with Latino clients who have experienced collective trauma,” the average of the evaluators’ responses was 4. Additionally, for item 12a, “This program is beneficial for mental health practitioners working with Latino victims of collective trauma,” the evaluators averaged 4.5 in their responses. Finally, regarding item 12b, “I would recommend this guide to mental health practitioners working with Latino victims of collective trauma,” the average of the evaluators’ responses was 4.5.
Figure 1. Overall average rating of the Resource Guide

Figure 2. Ratings for each of the evaluators on likert-scale items
Both participants included written feedback regarding the strengths of the Resource Guide, particularly that the guide has “good sequential order and organization of interventions.” However, results indicate that the participants both suggest that some sections would be strengthened if culturally relevant examples were included, such as with the cognitive distortions.

Specific written feedback regarding the strengths of the Resource Guide were included. Evaluator #1 identified particular strengths, such as the inclusion of special considerations for working with the Latino population and a “nice outline of culturally specific syndromes and symptom presentation.” Evaluator #2 identified additional strengths, including the psychoeducational handout, which includes somatic symptomotology, and the interventions, such as The Loving Kindness Meditation and the Applied Stretching with Visualization. In addition, Evaluator #2 identified the following to be strengths: “Interventions provided in Spanish and English,” “Adaptability for various Latino cultures and religions,” “Multiple quality trauma interventions offered,”
and that there was a “Good overview of the course and progression of trauma treatment.”

Weaknesses of the Resource Guide were noted by both evaluators. Evaluator #1 stated there was a need to include interventions on “how to manage trauma reminders [and] triggers.” In addition, Evaluator #1 wrote, “The guide should give the user access to more treatment modalities (including EBP’s), as well as include some information on the efficacy of the treatment models presented. The Trauma exposure section (Treatment Focus #4: Interoceptive Trauma Exposure Protocol & Positive Reframing) has limited options and is somewhat vague.” Furthermore, when asked if there are parts of the guide in which should be omitted, changed, or revised, Evaluator #1 stated the following: “Revise the PTSD handout—make it more user friendly; consider making it a one-pager with most salient points included. Not all Latinos will invest time in reading materials given to them; change some of the language to reach a wider audience (e.g. lower levels of education) and be careful not to include language that may sound a bit too ‘jargony.’” It was also suggested that an assessment of acculturation and enculturation be included. The second evaluator also noted weaknesses in the guide to include a lack of culturally-relevant examples, and a need to include cultural modifications to the cognitive distortions and cognitive reframing techniques in the cognitive distortion section.

Tables 5 through 11 present the evaluators’ responses to the open-ended questions included in the Evaluation Questionnaire.

Table 5

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What did you find particularly useful about this guide as it pertains to offering clinicians with culturally adapted treatments</td>
<td>“I like the inclusion of special considerations for working with this population”</td>
<td>“The psycho-education section that focuses on somatic symptoms is very helpful in assisting clients with connecting physical symptomatology (continued)”</td>
</tr>
</tbody>
</table>
for collective trauma? with their history of trauma. I have found this to be a common phenomenon when working with Latino clients.”

“Culturally adapted treatment interventions I found specifically helpful include: The Loving Kindness Meditation and the Applied Stretching with Visualization. These interventions were salient because they provided culturally appropriate examples or interventions that likely have more relevance with Latino populations.”

Table 6
Evaluators’ Responses to Item Six

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What aspects of this guide did you find not particularly relevant for its intended purposes?</td>
<td>“Spanish resource links are not accessible—update them if needed.”</td>
<td>“none”</td>
</tr>
</tbody>
</table>
Table 7
Evaluators’ Responses to Item Seven

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you consider to be the strengths of the guide?</td>
<td>“Good sequential order/organization of interventions.”</td>
<td>“This guide provides invaluable information to assist with treating trauma survivors.”</td>
</tr>
<tr>
<td></td>
<td>“Nice outline of culturally specific syndromes and symptoms presentation.”</td>
<td>• “User-friendly Interventions provided in Spanish and English.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &quot;Adaptability for various Latino cultures and religions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Multiple quality trauma interventions offered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Good overview of the course and progression of trauma treatment.”</td>
</tr>
</tbody>
</table>

Table 8
Evaluators’ Response to Item Eight

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you consider to be the weaknesses of the guide?</td>
<td>“The guide should give the user access to more treatment modalities (including EBP’s) as well as include some information on the efficacy of the treatment models presented.”</td>
<td>“There is a need for culturally-relevant examples in all sections.”</td>
</tr>
<tr>
<td></td>
<td>“The Trauma exposure section (Treatment Focus #4: Interoceptive Trauma Exposure Protocol &amp;”</td>
<td>“The cognitive distortions section does a nice job of identifying the cognitive distortions, though a treatment provider less familiar with CBT might be less familiar about the connections between thoughts, feelings, and behaviors and how this is relevant to trauma treatment. Additionally,”</td>
</tr>
</tbody>
</table>
Positive Reframing) has limited options and is somewhat vague.”

(continued)

the section does not offer providers tools for reframing distorted thoughts.”

Table 9
Evaluators’ Responses to Item Nine

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What could have been added to the guide to make it more useful for Latino victims of collective trauma?</td>
<td>“Include information on how to manage trauma reminders/triggers—an important aspect of trauma informed work.”</td>
<td>“Though there were several cultural adaptations offered in the treatment interventions, there were some sections that could be strengthened if you used culturally relevant examples or adaptations. For example, the cognitive distortions section could provide culturally relevant examples and/or common cognitive distortions likely to arise for survivors of collective trauma.”</td>
</tr>
</tbody>
</table>

Table 10
Evaluators’ Responses to Item Ten

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
</table>
| Are there any parts of the guide that you would omit, change, or revise? | “Revise the PTSD handout—make it more user friendly; consider making it a one-pager with most salient points included-- Not all Latinos will invest time in reading materials given to them; change some of the language to reach a wider audience (e.g. lower levels of education) and be careful | • “Consider adding a brief introduction on cognitive-behavioral therapy and how it relates to the course of trauma treatment.  
  • Include cognitive reframing techniques in the cognitive distortion section. In the psycho-education section you discuss the “fight-flight” (continued) |
not to include language that may sound a bit too “jargony”

- response as it related to PTSD. More current trauma research integrates “freeze” into this model. Consider integration of the “freeze” component. Additionally, I find that people often have difficulty comprehending the “fight-flight-freeze” model. The inclusion of examples may be helpful to increase relevance and application of the material for trauma survivors.”

Table 11
Evaluators’ Responses to Item Eleven

<table>
<thead>
<tr>
<th>Question</th>
<th>Evaluator #1 Response</th>
<th>Evaluator #2 Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional comments and suggestions:</td>
<td>“Have you considered suggesting a thorough assessment of acculturation, AND enculturation, as well as acculturative stress? (some research suggests that, for children/adolescents, enculturation—having strong connections to one’s own ethnic group/beliefs/values, etc—serves as a protective factor, regardless of level of acculturation). This may differ for adults, but could provide more insight as to interventions that may be more culturally appropriate and effective for some, but not other. “Cognitive Distortions table simply lists what they are, as described by western cultural standards.”</td>
<td>“You highlighted the high drop-out rate for Latino clients in trauma treatment. It may be worth talking about this a little bit more to explore possible explanations for dropout and barriers to treatment as well as solutions for addressing these barriers. If there is a high dropout rate with Latino populations, would providers need to be advised against beginning specific stages of treatment (e.g. prolonged exposure) unless there was some commitment from the client to continue with treatment?” “Given the collectivist nature of the Latino culture, it may be worth exploring how some of these interventions may apply specifically to a group or”</td>
</tr>
</tbody>
</table>
psychology. It would be more helpful to include cultural modifications that can be made to make them more relevant to the population (e.g. of a cognitive reframe: No hay mal que por bien no venga/every cloud has it’s silver lining).”

“Treatment Outline table (p. 22)-- Include a column with “rationale” for using each of the suggested components, for quick access. Presumably, a clinician may need to quickly peruse this table and can help set the frame for using such techniques/interventions.”

community setting, *(continued)*

especially because the interventions are designed for collective trauma survivors. In addition, the interventions could be strengthened if there was some insight into how the family may be incorporated into treatment.”
Chapter IV: Discussion

The current project involved the development of a Resource Guide for mental health practitioners working with Latino victims of collective trauma. Information regarding limitations, areas for improvement, and strengths of the Resource Guide was gathered using an evaluation form completed by two experts in the field, who met all eligibility criteria.

Identified Strengths of the Resource Guide

The two evaluators that reviewed the Resource Guide, as assessed by their responses to the Guide Evaluation Form, reported that strengths of the Guide included having a good sequential order and organization of interventions, and a useful outline of culturally specific syndromes and symptom presentations. The inclusion of Spanish and English interventions were also noted to be a strength, as well the adaptability of interventions for various Latino cultures and religions. The usefulness of integrating culturally adapted interventions has also been supported by the literature (Whitley, 2012; Hinton et al., 2011). In addition, the culturally adapted treatment interventions, specifically The Loving Kindness Meditation and the Applied Stretching with Visualization were noted to be particularly useful. This is further supported by a study developed by Hinton et al. (2011), which addressed treatment resistant PTSD in a Latino population with these specific interventions. Additionally, the psychoeducation section that focuses on somatic symptoms was noted to be very helpful with regard to assisting clients with connecting physical symptomatology with their history of trauma. The need to address the somatic presentation of PTSD was highlighted in several studies by Hinton et al. (2009, 2011).

Identified Weaknesses of the Resource Guide

The evaluators noted that a limitation of the Resource Guide was the lack of culturally-relevant examples in all sections, especially with regard to the cognitive distortions. The
literature also highlights the importance of including culturally driven examples in order for a client to relate their daily life to a foreign concept (Hinton et al., 2011). Additionally, limitations of the Resource Guide that the evaluators noted was that it would be more useful to provide tools for reframing distorted thoughts in the cognitive distortion section. Hinton et al. (2011) addresses this issue in his study and also suggests the need to make new analogies to common cognitive distortions. For example, Hinton et al. (2011) stated that the client’s perception of dizziness may be one of danger, yet if one helps the client reassociate this feeling of dizziness to a previous positive experience (being spun around before hitting a piñata), then a client may learn to tolerate and have a less catastrophic reactions to their symptoms. Other limitations included a need to include “freeze” as part of the psychoeducation handout when discussing the fight or flight response. Finally, it was also noted by the Spanish-speaking evaluator (Evaluator #1) that the language on the Spanish psychoeducation handout should be changed in order to reach a wider audience (e.g. lower levels of education), and that some of the language may have included too much jargon.

**Limitations and Recommendations for Future Steps in Program Development**

Aside from the weaknesses of the Resource Guide noted by the evaluators, there are additional limitations of the Guide that may limit the applicability of interventions. These limitations include the age group in which these interventions may be applied to. The guide is intended to be used with adults and may have limited utility with other family members, such as their children, involved in therapy. In addition, although the handouts are provided in Spanish, several of the interventions, such as the Loving Kindness Meditation were not translated into Spanish, thus limiting the resources that clinicians may provide to their clients after termination. In addition, the lack of resources offering culturally adapted exposure treatments limit the
information available to develop these adaptations in the Resource Guide. This highlights the need for more studies that investigate cultural modifications to evidenced-based treatments, such as exposure therapy.

Furthermore, given the brief nature of the guide and the intention for it to be applied to existing treatment formats (i.e. group, individual, family) and protocols, clinicians may need to be more experienced in other interventions and only use this as an adjunct or as a supplemental guide to inform current treatment. Moreover, homework assignments, such as some of the worksheets may be challenging to complete for those of lower education. Although they are written to be understood by a wide audience, often times the idea of “completing homework” may be a less familiar practice for Latino/a clients (Hinton et al., 2011).

Another limitation of the Resource Guide includes the limited amount of appropriate assessment measures. Although beneficial assessment tools were discussed, only one trauma measure was included. In addition, this measure was provided solely in Spanish, given that it was developed in Colombia. This limits its applicability to English-speaking second or third generation Latinos.

Evaluation results suggest that the following modifications to the next version of the Resource Guide would strengthen its usefulness:

1. Include an assessment of acculturation, enculturation, and acculturative stress, given that having strong connections to one’s own ethnic group, beliefs and values, serves as a protective factor, regardless of level of acculturation. This could provide more insight as to interventions that may be more culturally appropriate and effective for some, but not others.
2. With respect to the cognitive distortions section, it would be useful to include specific cognitive reframing techniques. It would also be more helpful to include cultural modifications to cognitive distortions that are more relevant to the population (e.g., a cognitive reframe: *No hay mal que por bien no venga*/every cloud has it’s silver lining).

3. It may be more helpful to include a rationale for using each of the suggested components in the Treatment Outline table for quick access.

4. Given the collectivist nature of the Latino culture, it may be worth exploring how some of these interventions may apply specifically to a group or community setting, especially because the interventions are designed for collective trauma survivors. In addition, the interventions could be strengthened if there was some suggestions regarding how the family may be incorporated into treatment.

5. It may be worth talking more about the “high drop out rate” for Latinos more and explore possible explanations for dropout and barriers to treatment, as well as solutions that have been proposed for addressing these barriers.

6. Include a brief introduction on cognitive-behavioral therapy and how it relates to the course of trauma treatment.

7. In the psychoeducation section, it may be beneficial to integrate the “freeze” and “faint” component into the “fight” or “flight” model (Shauer & Elbert, 2010). Additionally, given that people often have difficulty comprehending the “fight-flight-freeze” model, the inclusion of examples may be helpful to increase relevance and application of the material for trauma survivors.

8. Links to Spanish resources should be updated.

9. Although the importance of the therapeutic relationship has been highlighted, the next
version of the manual should be more explicit about the significance of therapeutic alliance and have this be a clearer foundation for each of the treatments offered.

Future steps for this Resource Guide include making the revisions suggested by the evaluators in the current study, as well as additional revisions based on the researcher’s reflections and feedback from the dissertation committee. This revised Resource Guide could then serve as the basis for conducting an implementation study in which the content and structure of the Resource Guide could be tested with a small group of clinicians who would integrate the guide into their treatment procedures. The Resource Guide would be further adapted based upon feedback from the clinicians, as well as possibly the individual clients. This study would potentially offer additional identification of strengths, weaknesses, and areas for improvement.

**Conclusion and Implications of this Study**

The Resource Guide was developed as a potential adjunctive or supplemental treatment guide when working with Latino victims of collective trauma. The Resource Guide was developed from existing literature and structured interviews suggesting the need for culturally congruent practices (Hinton et al., 2011). The Resource Guide was evaluated by two experts in the field of working with collective trauma victims from Latin America. These evaluators provided strengths and weaknesses, as well as suggestions for improvement. All responses and comments were thoroughly reviewed and considered in terms of inclusion in future drafts of the Resource Guide. The intention of this Resource Guide is that culturally-informed therapeutic interventions become more frequently utilized when working with Latino victims of collective trauma. It is hoped that future revisions of this Resource Guide can be used to inform practitioners of the unique issues relevant to Latino collective trauma survivors and possible intervention strategies that can be incorporated into treatment.
REFERENCES


Hinton, D., Hofmann, S., Rivera, E., & Otto M. (2011). Culturally adapted CBT (CA-


The UN Refugee Agency. (2011). *Consultaría Para los Derechos Humanos y el Desplazamiento* [Data file]. Retrieved from


APPENDIX A

Literature Table for Latino Victims of Trauma
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Research Questions/Objectives</th>
<th>Sample</th>
<th>Variables/Instruments</th>
<th>Research Approach/Design</th>
<th>Major Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Psychiatric Association (2000)</td>
<td>To provide clinicians with a diagnostic manual to be utilized when diagnosing and treating clients.</td>
<td>N/A</td>
<td>N/A</td>
<td>Book</td>
<td>This manual provides clinicians all of the psychological disorders approved by the American Psychiatric Association. Each Diagnosis is listed with its corresponding symptoms and criteria requirements.</td>
</tr>
<tr>
<td>Baer, R., Weller, S., Garcia, J., Glazer, M., Trotter, R., Pachter, L., and Klein, R. (2003)</td>
<td>To better understand the culture-bound syndrome nervios and susto. To clarify how this disorder may manifest differently across various Latino cultures.</td>
<td>Puerto Ricans: 40 Mexican-American: 40 Mexican: 38 Guatemalan: 40 Female: 149 Male: 9 Age-17-83 Education-1.8-16 yrs.</td>
<td>True/False Questionnaires Open ended interview questions Free listing technique</td>
<td>Qualitative</td>
<td>There was an agreement among all four samples on symptoms of nervios, including nervios being described as a continual stress. There was also overlap when evaluating nervios and susto. Nervios was described as a much broader illness, and susto was related to a single stressful event.</td>
</tr>
<tr>
<td>Beck, J. (2011)</td>
<td>Reviews the fundamentals of cognitive behavioral therapy. Discusses how to conceptualize, treat and structure sessions from a CBT model. Cognitive</td>
<td>N/A</td>
<td>N/A</td>
<td>Book</td>
<td>Specific techniques such as relaxation exercises are beneficial to anxiety disorders. The use of thought logs assist in</td>
</tr>
</tbody>
</table>
behavioral and experiential techniques are reviewed.

| Berdhal, T., and Torres-Stone, R. (2009) | Do Latino subgroups differ in their likelihood to use mental health services? It is hypothesized that Mexicans will have the lowest prevalence of mental health care use and that Puerto Ricans will have the highest prevalence of use. It also hypothesized that self-reliant attitudes about medical care will explain the gap in service use for Mexicans, Puerto Ricans, and Cubans compared to Caucasians. Finally, it is hypothesized that English proficiency and nativity will explain the gap in service use for Mexicans and Cubans and will be less important for Puerto Ricans. | Mexicans: 5,959
Cubans: 340
Puerto Ricans: 623
Caucasian: 23,312
All participants were gathered from the Medical Expenditure Panel Surveys | Logistic regression model-variables are ethnic groups
Medical Self-Reliance Model
Acculturation Model | Quantitative

Any Healthcare Use:
Mexican: 4.5%
Cuban: 5.7%
Puerto Rican: 8.3%
Caucasian: 9.3%

Mental Health Specialist:
Mexican: 1.8%
Cuban: 3%
Puerto Rican: 5%
Caucasian: 4.8%

Non-Mental Health Specialist:
Mexican: 3.2%
Cuban: 3%
Puerto Rican: 5.4%
Caucasian: 6.4%

Mexicans are 53% less likely and Cubans are 44% less likely than whites to use mental health services. When Mexicans speak the English language, the likelihood of seeking mental healthcare is only 34% less than Caucasians as opposed to 53%. |

| Briceño- | This study | N/A | Epidemiological Data | Epidemiology | Results |

<p>| Catani, C., Kohiladev, M., Ruf, M., Schauer, E., Elbert, | This article measures the effectiveness of meditation and relaxation techniques in comparison to a N=31 Ethnicity:Sri Lankan Ages: 8-14 Children all diagnosed with PTSD Male: 17 | UCLA PTSD Index for DSM-IV | Repeated measures ANOVA | Both treatments showed an equal amount of effectiveness. These results indicate marked differences by country in terms of rates of violence. Countries such as Argentina, Chile, Costa Rica, and Uruguay, have low violence mortality rates; Peru, Nicaragua, Ecuador, Dominican Republic, Panama, and Paraguay have moderate rates, and Brazil, Mexico, Colombia, El Salvador, Honduras and Venezuela have high to extremely high mortality rates. Factors related to violence include social inequalities, lack of employment opportunities, urban segregation, a culture of masculinity, local drug markets, and the availability of firearms and widespread use of alcohol. |</p>
<table>
<thead>
<tr>
<th>Author(s) and Source</th>
<th>Description</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>T., &amp; Neuner, F. (2009)</td>
<td>narrative exposure protocol for victims of collective trauma.</td>
<td>Female : 14</td>
<td>suggest that both treatment approached are appropriate for children who have endured a collective trauma such as political violence or a natural disaster.</td>
</tr>
<tr>
<td>Chadwick Center</td>
<td>A hospital website that provides information on Latino tenets.</td>
<td>N/A/ N/A</td>
<td>Hospital Website This website reviews tenets within the Latino culture that include Simpatia, respeto, and personalismo.</td>
</tr>
<tr>
<td>Consultarí a Para los Derechos Humanos y el Desplazamiento</td>
<td>Provides statistics for the occurrence of displacement in Colombia.</td>
<td>N/A N/A</td>
<td>Government Website Cites the percentage of displaced individuals reported in Colombia. The most recent count was reported to be 280,000 in the year 2010.</td>
</tr>
<tr>
<td>Descilo, T., Vedamurtachar, A., Nagaraja, P., Gangadhar, D., Damodaran, B., Adelson, B., Braslow, L., Marcus, S., &amp; Brown, R. (2010)</td>
<td>This article measures the effectiveness of breathing techniques alone compared to breathing techniques and exposure therapy.</td>
<td>N=183 Post-traumatic Checklist-17 (PCL-17) Anova and Mixed effects regression</td>
<td>After the six week period, PTSD decreased by 60% in both treatment groups (Descilo et al., 2010). There was no significant difference between the two treatment groups and the second group did not show a significant decrease of PTSD symptoms after beginning the exposure therapy.</td>
</tr>
</tbody>
</table>
(Descilo et al., 2010). These results show breathing techniques to be an efficacious treatment and that exposure therapy, although empirically supported, may be substituted if needed. This study helps validate the concept of using holistic treatments for PTSD and demonstrates strong findings in the treatment of communities who have suffered a collective trauma.

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fogelbach, J. (2011)</td>
<td>This article provides information regarding the violence in El Salvador.</td>
<td>N/A</td>
</tr>
<tr>
<td>Grames, H. (2006)</td>
<td>This paper discusses culturally appropriate therapy approaches for Latinos suffering from anxiety, depression, and the culture-bound</td>
<td>N/A</td>
</tr>
</tbody>
</table>

This literature review discusses the history of gang violence in El Salvador. It provides statistical facts for the percentage of refugees in the United States as well as the statistical reports of gang membership. Cultural modifications were described. The primary mental healthcare model was
syndrome, *ataque de nervios*. This literature review emphasizes on the importance of having a client-centered approach.

| Guarnacci a, P., Lewis-Fernandez, R., and Marano, M. | This study evaluates a series of open ended questions which were previously taped. It aims to assess the multiple experiences of *nervios* among Puerto Ricans in Puerto Rico and in New York Study. | Female: 523  
Male: 389  
Age: 17-68  
Education:  
<High school:468  
+High school: 444 | Audio recorded responses to open ended questions regarding the definition of various types of *nervios* and the symptoms for each. | Epidemiological Study  
*Nervios*: was described as physical, emotional, and social experiences that may occur simultaneously. It is agreed that this occurs after a stressful event. What is considered as typical behavior of *nervios*, varied among participants. *Ser Nervioso* (being a nervous person) was described as different then having *nervios*. This is stated that it begins in childhood and may be the result of trauma or if the person is affected by everyday stress. It also said that it can run in families and be hereditary. *Padecer de los nervios* (Suffering from nerves) is discussed and adapted to incorporate values of Latinos. This literature review emphasizes on the importance of having a client-centered approach.
This study examined the efficacy of culturally adapted CBT (CACBT) when compared to Applied Muscle Relaxation (AMR). This study was conducted on a group of women diagnosed with PTSD who were treatment resistant to traditional CBT.

**CACBT group:**
- Females: 12
- Age: $M=47.6$ yrs
- Education: $M=7.8$ yrs
- Puerto Rican: 6
- Dominican: 6

**AMR group:**
- Females: 12
- Age: $M=51.4$ yrs
- Education: $M=8$ yrs
- Puerto Rican: 6
- Dominican: 6

Participants receiving CACBT improved significantly more than those receiving AMR. Effect size denote large reductions in PTSD from pre to post-treatment in the CACBT group.

This article examines a model of the generation of *ataque de nervios*. Fear of negative affect and arousal symptoms are associated with the emergence of an *ataque*. The relationship between fear of negative affect and fear of arousal and the severity of the attack is measured.

<table>
<thead>
<tr>
<th>N=40</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female: 89</td>
</tr>
<tr>
<td>Male: 51</td>
</tr>
<tr>
<td>Puerto Rican: 85%</td>
</tr>
<tr>
<td>Dominican: 15%</td>
</tr>
<tr>
<td>All residing in the U.S.: 1-6 months,</td>
</tr>
</tbody>
</table>

Level of fear of negative affect and fear of arousal were related with the severity of the attack. Key attack symptoms, shakiness, chest tightness, palpitations, and a sense of inner heat, were the...
<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>Type</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoffman, S., Grossman, P., &amp; Hinton, D. (2011)</td>
<td>This article provides an overview of the research that has been conducted on the use of meditation as a psychological intervention</td>
<td>Literature Review</td>
<td>This literature review suggests that Loving Kindness and Compassionate Meditation are associated with an increase in positive affect and a decrease in negative affect. Neuroendocrine studies suggest that CM may decrease stress-induced distress and immune response.</td>
</tr>
<tr>
<td>Immigration Policy Center (2010)</td>
<td>This site provides statistical information regarding the percentage of refugees admitted into the US.</td>
<td>Fact Sheet</td>
<td>This site states that 5,500 Latino refugees are admitted a year.</td>
</tr>
<tr>
<td>Interian, A., Diaz-Martinez, A. (2007)</td>
<td>This article discusses important considerations when working with Latinos. It serves as a guide to modify treatment interventions to be culturally congruent.</td>
<td>Literature Review</td>
<td>This article points out important values within the Latino population such as familismo and personalismo. These values lie within the Latino culture and can interfere with treatment if not addressed. This article also highlights ways to translate important phrases used in CBT. The</td>
</tr>
</tbody>
</table>
**Interdependent culture without PTSD:** 25 Male:11 Female:14 Age: $M=33.24$
Length of time in Western Country (Australia): $M=7.22$ yrs.
**Interdependent culture with PTSD:** N=24 Male: 9 Female: 15 Age: $M=34.25$
Length of time in Western Country (Australia): $M=5.49$ yrs.
**Independent culture without PTSD:** N=31 Male:6 Female:25 Age: $M=40.16$
Length of time in Western Country (Australia): $M=34.94$ yrs.
**Independent culture with PTSD:** 26 Male: 6 Female :20 Age: $M=41.15$
Length of time in Western Country (Australia): $M=36.78$ yrs. | -Post-Traumatic Stress Diagnostic Scale (PDS)
- Hopkins Symptom Checklist (HSCL-25)
- Trauma History Questionnaire (THQ)
- Twenty-Statement Test (TST) | 2x2 Ancova | Trauma survivors with PTSD from individualistic cultures reported more self-defining memories and self-cognitions when compared to more collectivistic cultures. Participants from collectivistic cultures indicated more of a need for social support as an adjunct to CBT. |

<p>| Kellner, T., and Pipitone, F. (2010) | This article discusses the events leading to and contributing to | N/A | N/A | Literature Review | This article offers statistical references to |</p>
<table>
<thead>
<tr>
<th>Source</th>
<th>Summary/Details</th>
<th>Methodology</th>
<th>Results/Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lama, D. &amp; Cutler, H. (1998)</td>
<td>The objective of this book is to inform the reader of how a Mindfulness approach to life can help in reducing distress. It offers examples of Tibetan’s trauma and how they have dealt with their losses through this approach.</td>
<td>N/A</td>
<td>Book</td>
</tr>
<tr>
<td>Leitch, M., Vanslyke, J., and Allen, M. (2009).</td>
<td>This study aims to measure the efficacy of Somatic Experiencing (SE) and the Trauma Resiliency Model on victims of Hurricane Katrina and Rita. This was measured after 2 brief sessions of SE.</td>
<td>Participants in experimental group: N=91 Comparison Group: N=51 African American: 33.8% White/Other:66.2% Female: 85.6% Male 14.4% From New Orleans:73.2% Baton rouge: 26.8%</td>
<td>One Way Anova and Chi-Square</td>
</tr>
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</table>

The experimental group showed a significant decrease of PTSD symptoms and an increase of resiliency and coping immediately after treatment when compared to comparison group. At follow up, both groups showed an increase of distress but the experimental group experienced significantly less distress than the
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>N/A</th>
<th>N/A</th>
<th>Type</th>
<th>Notes</th>
</tr>
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<tbody>
<tr>
<td>Levine, P. (2010)</td>
<td>This book discusses the use of Somatic Experiencing as an intervention for trauma. Dr. Levine discusses the method in which this can be practiced and integrates his own experience with Trauma to help the reader understand the development and the prevention of PTSD symptoms.</td>
<td>N/A</td>
<td>N/A</td>
<td>Book</td>
<td>Dr. Levine instructs the reader how to guide a Somatic Experiencing session. He helps the reader understand how trauma is stored within the body and what can be done to process the trauma without fear.</td>
</tr>
<tr>
<td>North American Congress on Latin America (NACLA) Report</td>
<td>This is an article that discusses the crisis in Mexico due to the drug war.</td>
<td>N/A</td>
<td>N/A</td>
<td>Article</td>
<td>This article states that 40,000 lives have been lost since the beginning of this drug war.</td>
</tr>
<tr>
<td>Ojeda, V. and Mcquire, T. (2006)</td>
<td>This study measures the difference in access to healthcare across ethnicities.</td>
<td>N=1498 adults 1139 non-Latino whites (Females: 768, Males: 371), 197 African Americans (Females: 147, Males: 50), 95 Latinos (Females: 64, Males: 31), and 67 from all other race/ethnic groups (Females: 45, Males: 22). The sample size for Asian Americans is too small to report separately and this group is included in the “other” race/ethnicity category.</td>
<td>Healthcare for Communities Survey (HCC)</td>
<td>Bivariate Analysis Logistic Regression Chai Square</td>
<td>This study found that Latinos and African Americans have less access to healthcare. Latinos reported boundaries to be due to financial strain and social barriers such as stigma.</td>
</tr>
<tr>
<td>Author</td>
<td>Title</td>
<td>Abstract</td>
<td>Method</td>
<td>Type</td>
<td>Literature Review</td>
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<tr>
<td>Ogden, P., Pain, C., &amp; Fisher, J. (2006)</td>
<td>This article discusses the use of sensorimotor therapies rather than traditional exposure treatments.</td>
<td>N/A</td>
<td>N/A</td>
<td>Literature Review</td>
<td>This article discusses the vicious cycle of hyperarousal and trauma. It compares the experience of trauma to that of an animal very similarly to Dr. Peter Levine. This article discusses how a client is able to track this trauma in their body while aroused.</td>
</tr>
<tr>
<td>Paez, D., Basabe, N., Ubillos, S., &amp; Gonzalez-Castro, J. (2007)</td>
<td>This study examines how a collective trauma may adversely affect social sharing and the social emotional climate.</td>
<td>N=661 University Students: 63% Direct relatives of University Students: 37%</td>
<td>Questionnaire</td>
<td>Quantitative</td>
<td>This study shows that by participating in social sharing and by being in a positive emotional climate, participants were able to overcome the effects of a collective trauma.</td>
</tr>
<tr>
<td>Perez-Sales, P. (2010)</td>
<td>The author discusses identity in adolescents in Latin America. Broken identities, victim identity, the role of transition, and identity dilemmas are discussed. Colombian adolescents from el chocó are evaluated due to the rise in suicide. (14 in 1 year and 30 attempts)</td>
<td>N/A</td>
<td>N/A</td>
<td>Literature Review</td>
<td>This article discusses appropriate interventions for traumatized youth given the high suicide rate. Treatments are discussed and formulated based on the needs expressed by the Embera people of Colombia. These include a communitarian view, religious</td>
</tr>
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</table>
This article offers the reader factual statistics stating the number of undocumented immigrants. This helps the reader in understanding how many more Latinos there are in the U.S. that may need treatment.


Total Participants: N=202
Participants with PTSD: 76
Age: M=28.3 (with PTSD)
Age: M=24 (without PTSD)
Female: 54 with PTSD
Female: 77 without PTSD
Male: 22 with PTSD
Male: 49 without PTSD
Education: M=9 yrs with PTSD
Education: M=9 yrs without PTSD

24 symptom checklist (Spanish Version) Discriminant Analysis

Checklist had a reliability coefficient of .97. Discriminant analysis found that the scale was 88.6% accurate in its diagnosis of PTSD. The checklist for PTSD had a high reliability, good discriminant capability.

Richards, A., Ospina-Duque, J., Barrera-

This is study aims to assess the needs of Colombians that have been displaced. Surveys

Afro-Colombian (2321%)
Mestizo (44) 77% Other (2) 2%

Open-Ended Questionnaire Focus Group

Qualitative Mixed Method Evaluation Multivariate

PTSD 88.3% exceed cut-off
Anxiety 59.5% exceed cut-off
| Valencia, M., Escobar-Rincón, J., Ardila-Gutiérrez, M., Metzler, T., & Marmar, C., (2011) | and focus groups are utilized to assess the needs by traumatized Colombians. | Married (19) 17.4%  
Single (30) 27.5%  
Domestic Partner (35) 32.1%  
Separated (13) 11.9%  
Widowed (8.3) 9%  
No formal education (14) 12.8%  
Some or all primary school (47) 43.2%  
Some or all secondary school (37) 34%  
Some university training (2) 1.8%  
Displacement time:  
< 1 month (41) 37.7%  
> 1 month but less than 1 year (39) 35.8%  
> 1 year (24) 22%  
Missing data (5) 4.6% | Regression Model | Depression 41.3% exceed cut-off  
Multivariate regression model showed that being female significantly predicts higher levels of PTSD symptoms and that female gender, higher education, and being separated as opposed to married predicted higher levels of depression symptoms.  
Focus group findings suggest that participants are interested in specialized psychological treatments as well as broader psychosocial interventions to treat the consequences of exposure to violence and forced displacement. |
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<tbody>
<tr>
<td>Ronzio and Associates (2011)</td>
<td>This article discusses the recent petitions for political asylum requested by Latinos of Mexican descent.</td>
<td>N/A</td>
<td>N/A</td>
<td>Article</td>
</tr>
</tbody>
</table>
| San Miguel, V., Guarnacci a, P., Shrout, P., | The researcher aims to understand how Puerto Ricans describe the experience of ataque de nervios. | Participants: N=121  
Participants with ataque de nervios: 77  
Ethnicity: Puerto | Questionnaire | Quantitative Factor Analysis | Results showed internalizing and externalizing experiences of |
<table>
<thead>
<tr>
<th>Lewis-Fernandez, R., Canino, G., and Ramirez, R. (2006)</th>
<th>Symptoms described were analyzed using a factor analysis model.</th>
<th>Rican (100%)</th>
<th>ataque de nervios.</th>
</tr>
</thead>
</table>
| Sheroma, P., & Alarcon, R. (2011)                    | This article discusses the prevalence of somatization among chronically mentally ill immigrants. | **Hispanic:** N=90  
Age: M=58  
Female=59  
Male=31  
Time in U.S.=M=28 .05yrs.  
**Russians:** N=90  
Age: M=61  
Female=55  
Male=35  
Time in U.S.=M=10.59 yrs. | SCL90 Somatization Scale  
Acculturation Scale | Descriptive Analysis | Results showed that the longer the participant was in the U.S. the less somatic complaints reported. Lack of social support increased symptoms. There was also a higher prevalence of somatization in the female gender. Level of acculturation was significant contributing factor to somatization. |
| United States Census Bureau. (2010)                  | This article provides the reader with statistical references for Latinos in the United States. | N/A | N/A | Article | This article states that as of 2010, there are 50,747,594 Latinos in the United States. |
APPENDIX B

Interview Participation Request Form
Telephone Script

Hello, is (name of potential interviewee) available?

If no, leave name, number, and end call.
If yes, continue.

Hello, my name is Melissa Cordero, and I am a doctoral student at Pepperdine University Graduate School. I am contacting you to see if you would be willing to answer a few questions regarding the development of a resource guide I am creating for clinicians working with Latino victims of collective trauma. This interview is part of my dissertation research. Do you have a moment for me to describe the nature and purpose of my study?

If no, thank individual for their time and end call.
If yes, continue.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a resource guide that offers clinicians culturally appropriate interventions for Latino victims of collective trauma. At this particular stage in the project, I am looking for health professional in the area of psychological trauma that have experience working with Latino victims of trauma for a minimum of 5 years to participate in a short 15 minute phone interview regarding interventions they feel have been helpful in working with this clientele. If you decide to participate in this study, you will be asked about various interventions that you have found to be efficacious within the Latino population. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. Is this something that you would be interested in doing?

If no, thank individual for their time and end call.
If yes, continue.

Do I have your permission to ask a few background questions, followed by some questions related to your experience with Latino victims of collective trauma? Please note that you may refuse to answer any question at any time during the interview.

If no, thank individual for their time and end the call.
If yes, continue on and refer to the Evaluator Qualification Form (Appendix C).

After reviewing the Qualification Form (Appendix C):
If participant does not meet the requirements: Thank you for your willingness to participate, however you do not meet the criteria to participate in this study.

If participant does meet the requirements: When would you be available to participate in the phone interview?
You will be asked to provide verbal consent over the phone prior to your interview. Would you prefer a copy of the consent form to be sent to you via email or through USPS? May I please have your mailing/email addresses to send you the necessary a copy of the consent form?

Thank you very much for your time. You should receive a copy of your consent form within a week. If you have any questions regarding the study procedures, you can contact myself, Melissa Cordero M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson. Thank you again for volunteering to participate. I appreciate your time and assistance.

End call.

Email Script

Dear (Potential Participant):

Hello, my name is Melissa Cordero, and I am a doctoral student at Pepperdine University Graduate School. I am contacting you to see if you would be willing to answer a few questions regarding the development of a resource guide I am creating for clinicians working with Latino victims of collective trauma. This interview is part of my dissertation research.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a resource guide that offers clinicians culturally appropriate interventions for Latino victims of collective trauma. At this particular stage in the project, I am looking for health professional in the area of psychological trauma that have experience working with Latino victims of trauma for a minimum of 5 years to participate in a short 15-20 minute phone interview regarding interventions they feel have been helpful in working with this clientele.

If you decide to participate in this study, we will schedule a short 15 minute phone interview asking about various interventions that you have found to be efficacious within the Latino population. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. If this is this something that you would be interested in doing, please fill out the attached form (Appendix C) and reply to this email. You may also respond to the questions in the body of the email, if it is more convenient for you.

Thank you very much for taking the time to read this email and consider my request. If you have any questions regarding the study procedures, you can contact myself, Melissa Cordero M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson.

Sincerely,

Melissa Cordero, M.A.
APPENDIX C

Eligibility Form
1. What is the highest degree you have earned?  □ Masters  □ Doctorate

2. What discipline is your degree in?

3. Have you received formal training in trauma interventions?  □ Yes  □ No

4. What has your general trauma training consisted of?

5. Have you received specific training or supervision in trauma interventions for Latinos?  □ Yes  □ No

6. How many years of experience do you have providing direct intervention services to Latino victims of collective trauma?  __________

7. Please briefly describe the trauma issues that were presented with the Latino clients you have worked with:

________________________________________________________________________________________
APPENDIX D

Written Statement
I will be reading you a written statement regarding the research over the phone. This written statement has been sent to you for your records.

By participating in the interview, you authorize Melissa Cordero, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include you in the research project entitled “A Guide for Mental Health Practitioners Working with Collective Trauma Victims from Latin America: An Experiential Approach.” You understand your participation in this study is strictly voluntary.

You have been asked to participate in this study that will include the development of a resource guide for mental health professionals working with Latino victims of collective trauma. You have been asked to volunteer to participate in this study based on your expertise in working with Latino victims of collective trauma. Your participation in this study will consist of approximately 15 minutes of your time, in which you will participate in a telephone interview about your work with treating Latinos who have experienced collective trauma. Your participation in this study will benefit clinicians working with Latino victims of collective trauma and provide Latino clients with culturally appropriate interventions but there is no direct benefit to you. You will be mailed a twenty-dollar Starbucks gift card after the completion of your participation in this study.

All information obtained in this study will be kept confidential. If you choose to sign an informed consent, this would be the only document linking yourself to the research. You can choose to sign an informed consent if you request to do so. If you choose to sign an informed consent form, it will be stored in a file separate from all other study materials, in the faculty supervisor’s private office. All research materials will remain in a locked file cabinet in the faculty’s private office, for five years, at which time the data will be destroyed. Any comments submitted may be published or presented to a professional audience, but no personal identifying information will be released.

Possible risks for participating in the study are minimal but may include mild levels of boredom during the interview. In addition, you have the right to not answer any particular question and may withdraw from the study at any time without penalty. In the case of an adverse or unexpected event due to this study, you can contact a support/counseling service by calling 1-800-therapist.

If you have any questions regarding the study procedures, you can contact myself, Melissa Cordero M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson.

Do you have any questions regarding the study or your participation in the study? Do I have your permission to begin recording the interview?
APPENDIX E

Participant Consent Form
By participating in the interview, you authorize Melissa Cordero, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include you in the research project entitled “A Guide for Mental Health Practitioners Working with Collective Trauma Victims from Latin America: An Experiential Approach.” You understand your participation in this study is strictly voluntary.

You have been asked to participate in this study that will include the development of a resource guide for mental health professionals working with Latino victims of collective trauma. You have been asked to volunteer to participate in this study based on your expertise in working with Latino victims of collective trauma. Your participation in this study will consist of approximately 15 minutes of your time, in which you will participate in a telephone interview about your work with treating Latinos who have experienced collective trauma. Your participation in this study will benefit clinicians working with Latino victims of collective trauma and provide Latino clients with culturally appropriate interventions but there is no direct benefit to you. You will be mailed a twenty-dollar Starbucks gift card after the completion of your participation in this study.

You understand that all information obtained in this study will be kept confidential. You have the option to sign the informed consent sent to you. If you choose to sign and return the form, it will be the only document linking you to the research and it will be stored in a file separate from all other study materials. All research materials will remain in a locked file cabinet in the faculty’s private office, for five years, at which time the data will be destroyed. You understand that any comments submitted may be published or presented to a professional audience but that no personal identifying information will be released.

You understand that possible risks for participating in the study are minimal but may include mild levels of boredom during the interview. In addition, you understand that you have the right to not answer any particular question and may withdraw from the study at any time without penalty. In the case of an adverse or unexpected event due to this study, you can contact a support/counseling service by calling 1-800-therapist.

If you have any questions regarding the study procedures, you can contact myself, Melissa Cordero M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson.

Signature______________________________________   Date________________
APPENDIX F

Expert Interview Questions
DEMOGRAPHICS
(Begin Recording)
What is your age?
What is your gender?
What is your ethnicity?
What is your profession?
Do you have current licensure/credentialing (if applicable):
What is your job title?
What best describes your work setting?
What has been the nature of your work with Latino victims of trauma
What are the ages of population that you have worked with?

1. What is your theoretical orientation?
2. What ethnicities within the Latino population have you worked with?
3. What issues (i.e. trauma symptoms, acculturation, discrimination, marginalization) do you see most when working with Latino victims of collective trauma?
4. What interventions have you used to address these issues?
5. What are some specific effects of collective trauma that you have noticed to be culturally specific to the Latino culture or specific to an ethnicity within the Latino culture?
6. What are some of your treatment approaches to address trauma with Latino clients?
7. What is your experience and opinion about the use of somatic or experiential methods with Latino trauma survivors?
8. Is there anything that you would like to suggest in regards to the development of this treatment guide addressing collective trauma in Latino victims of collective trauma?
9. Thank you very much for participating in my study. This concludes our interview. Do you have any questions?
APPENDIX G

Agency Contact Scripts
Telephone Script

Hello is (Director of Agency) available?
If no, leave name, number, and end call.
If yes, continue.

Hello, my name is Melissa Cordero, and I am a psychology doctoral student at Pepperdine University Graduate School. I am calling to see if your agency would be willing to assist me in my dissertation research by providing me with a list of mental health professionals that you consider to be experts in working with Latino victims of collective trauma. I will be asking 2-3 individuals to provide evaluative feedback on a resource guide I have developed for working with Latinos who have experienced collective trauma. Do you have a moment for me to briefly describe the nature and purpose of my study?

If no, thank individual for their time and end call.
If yes, continue.

I am currently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. This study will include the development of a culturally-responsive - guide for clinicians working with Latino victims of collective trauma. The initial stage of the project consisted an extensive review of the literature of appropriate interventions for Latino victims of trauma. This information was integrated and compiled for inclusion into the development of the resource guide. I am now in the process of recruiting an expert panel of clinicians to contribute to the development of the guide/verify the usefulness, accuracy, and relevance for its intended purposes.

If your agency agrees to assist with the study, I will ask you to provide me with a list of professionals that your agency considers having an expertise in working with Latino victims of collective trauma. Your agency’s participation in this study is completely voluntary. Would you be willing to prepare a list of experts who might be interested in evaluating my resource guide?

If no, thank individual for their time and end call.
If yes, continue.

Thank you for your consent. Your participation is greatly appreciated. In consideration of policies and procedures as outlined by the human subjects review board at Pepperdine University, I will first need your permission in writing authorizing me to reference that I received the recommended experts’ contact information from your agency. May I have your contact information in order to send you an authorizing form? Thank you. If you have any questions regarding the study procedures, you can contact Melissa Cordero M.A

Thank you again for your time. End call.

Email Script

Hello (Director of Agency):

My name is Melissa Cordero and I am a psychology doctoral student at Pepperdine University Graduate School. I am writing to see if your agency would be willing to assist me with my dissertation research by providing me with a list of mental health professionals that you consider to be experts in working with Latino victims of collective trauma. I am currently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. This study will include the development of a culturally adapted treatment guide for clinicians working with Latino victims of collective trauma.
At this particular stage in the project, I am looking for health professionals in the area of psychological trauma that have experience working with Latino victims of trauma for a minimum of 5 years to participate in a short 15 minute phone interview regarding interventions they feel have been helpful in working with this clientele. The initial stage of the project consisted of an extensive review of the literature of appropriate interventions for Latino victims of collective trauma. This information was integrated and compiled for inclusion into the development of the resource guide. I am now in the process of recruiting an expert panel of clinicians to contribute to the development of the guide/verify the usefulness, accuracy, and relevance for its intended purposes.

If your agency agrees to assist with the study, I will ask you to provide me with a list of professionals that your agency considers having an expertise in working with Latino victims of collective trauma.

Your agency’s participation in this study is completely voluntary. If you are willing to participate, please complete and return the attached form authorizing me to reference that I have received the recommended experts’ contact information from your agency. You may then email or call me with a list of professionals, and their contact information, that you would like to recommend to participate in my study.

Thank you very much for taking the time to read this email and consider my request. If you have any questions regarding the study procedures, you can contact Melissa Cordero M.A.

Sincerely,

Melissa Cordero, M.A.
APPENDIX H

Agency Authorization Form
Our agency authorizes Melissa Cordero, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include our agency in the research project entitled “A Guide for Mental Health Practitioners Working with Collective Trauma Victims from Latin America: An Experiential Approach”. We understand that our agency’s participation in this study is strictly voluntary. Our agency has been asked to participate in this study, which will include the development of a culturally adapted treatment guide for psychologists working with Latino victims of trauma. We have been asked to voluntarily participate in this study based on our commitment to working with and providing resources to Latino victims of trauma. Our participation in this study will consist of providing the researcher with a list of professionals that our agency considers having an expertise in working with Latino victims of trauma.

Our agency understands that the professionals we refer will be contacted and asked to participate in the research study, by participating in a 15 minute phone interview regarding interventions they feel have been helpful in working with this clientele. Furthermore, we understand that our agency’s name will be given to the clinician as the referring agency. /Our agency understands that the professionals we refer will be contacted and asked to participate in the research study, by providing evaluative feedback on the resource guide developed for psychologists working with Latino victims of trauma that Ms. Cordero has developed. Furthermore, we understand that our agency’s name will be given to the clinician as the referring agency.

Our agency understands that by providing the researcher with a list of professionals to contact, our agency’s name may be published or presented to a professional audience as an agency that was contacted to participate in this study. We understand that the names of the clinicians provided will remain confidential and unassociated with our agency, with the exception of the researcher informing the referring clinician of the agency providing their name and contact information, when asking for their participation in the study.

We understand that all information obtained in this study will be kept confidential. This authorization form, along with all other research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed.

We understand that if we have any questions regarding the study procedures, we can contact Melissa Cordero, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson

My signature below indicates that I am a representative qualified to sign this authorization form on behalf of the agency. I have read and understand the information in this document and agree to abide by its terms.

Signature________________________________________________Date___________

Agency________________________________________________________

Name (printed) ___________________________________Title________________
APPENDIX I

Evaluator Request Script
Hello, is (name of potential evaluator) available?

If no, leave name, number, and end call.
If yes, continue.

Hello, my name is Melissa Cordero, and I am a doctoral student at Pepperdine University Graduate School. I received your contact information from (name of referring agency), as a professional working with Latino victims of collective trauma for at least 5 years. I am contacting you to see if you would be willing to review and evaluate a resource guide I am developing for clinicians working with Latino victims of collective trauma. This evaluation study is part of my dissertation research. Do you have a moment for me to describe the nature and purpose of my study?

If no, thank individual for their time and end call.
If yes, continue.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a resource guide that offers clinicians culturally appropriate interventions for Latino victims of collective trauma. At this particular stage in the project, I have completed the program and am seeking the input of practitioners like you to evaluate the program content. If you decide to participate in this study, you will be asked to read a 10-15 page outline of the program and answer a few questions related to the effectiveness and usefulness of the guide. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. Is this something that you would be interested in doing?

If no, thank individual for their time and end call.
If yes, continue.

Do I have your permission to ask a few background questions, followed by some questions related to your experience with Latino victims of collective trauma? Please note that you may refuse to answer any question at any time during the interview.

If no, thank individual for their time and end the call.
If yes, continue on and refer to the Evaluator Qualification Form (Appendix C).

After reviewing the Evaluator Qualification Form (Appendix C):
If evaluator does not meet the requirements: Thank you for your willingness to participate, however you do not meet the qualifications to participate in this study.

If evaluator does meet the requirements: Would you prefer the materials to be sent electronically or by USPS? May I please have your mailing/email addresses to send you the necessary materials. In addition to the guide and evaluation forms, you will receive two consent forms, one for you to keep and the other to be returned with the resource guide documents and completed evaluation form.
Thank you very much for your time. You should receive your packet within a week. If you should have any questions or concerns regarding the study, please feel free to contact myself or Dr. Shelly Harrel, Dissertation Chairperson.

Thank you again for volunteering to participate. I appreciate your time and assistance.

End call.

**Evaluator Email Script**

Dear (Potential Evaluator):

Hello, my name is Melissa Cordero, and I am a doctoral student at Pepperdine University Graduate School. I am contacting you to see if you would be willing to review and evaluate a resource guide I am developing for clinicians working with Latino victims of collective trauma. This evaluation study is part of my dissertation research.

I am presently conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop a resource guide that offers clinicians culturally appropriate interventions for Latino victims of collective trauma. At this particular stage in the project, I have completed the program and am seeking the input of practitioners like you to evaluate the program content.

If you decide to participate in this study, you will be asked to read a resource guide and answer a few questions related to the effectiveness and usefulness of the guide. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. If this is this something that you would be interested in doing, please fill out the attached form (Appendix C) and reply to this email. You may also respond to the questions in the body of the email, if it is more convenient for you. If you choose to participate, the only documentation linking you with the research would be if you choose to sign an informed consent, which would be stored separate from all other data. Otherwise, by returning the evaluator packet, you agree to participate in the study with no identifiable information leading you to the research.

Thank you very much for taking the time to read this email and consider my request. I understand that if I have any questions regarding the study procedures, I can contact Melissa Cordero M.A.

Sincerely,

Melissa Cordero, M.A.
APPENDIX J

Evaluator Packet Cover Letter
Dear (Name of Evaluator),

Thank you for volunteering to serve as an evaluator in my dissertation research study entitled “A Guide for Mental Health Practitioners Working with Collective Trauma Victims from Latin America: An Experiential Approach.” Attached are the resource guide, a written statement regarding the research, and a resource guide evaluation form. The evaluation form is provided to facilitate your process in evaluating this guide. It is recommended that the evaluation process be completed at a time that is most convenient to you, taking breaks as needed.

The focus of the evaluation is intended to be on Section IV, Culturally Adapted Interventions. Once you have completed your evaluation of the program, please return the completed guide evaluation form as an attachment via email.

Although your input is greatly appreciated, please remember that you are under no obligation to complete the study. Should you wish to discontinue participation in this study for any reason, please inform the researcher via email.

Thank you very much for your time and contribution to my research project.

Sincerely,

Melissa Cordero, M.A.
APPENDIX K

Written Statement
Melissa Cordero, M.A., is a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., on the research project entitled “A Guide for Mental Health Practitioners Working with Collective Trauma Victims from Latin America: An Experiential Approach.”

Participation in this study will include evaluating a resource guide for mental health professionals working with Latino victims of collective trauma. You have been asked to volunteer to participate in this study based on your expertise in working with Latino victims of collective trauma. Your participation in this study will consist of approximately 45 minutes of your time, in which you will review a resource guide (focus is on Section IV) for mental health practitioners who are working with Latino victims of collective trauma, developed by Melissa Cordero M.A., followed by the completion of an evaluation form related to the usefulness, accuracy, and effectiveness of the guide. Your participation in this study may benefit clinicians working with Latino victims of collective trauma and may help ensure that Latino clients have access to culturally appropriate interventions. You will be mailed a twenty-dollar Starbucks gift card after the completion of your participation in this study.

All information obtained in this study will be kept confidential. If you choose to sign an informed consent, this would be the only document linking yourself to the research. You can choose to sign an informed consent if you request to do so. If you choose to sign an informed consent form, it will be stored in a file separate from all other study materials, in the faculty supervisor’s private office. Otherwise, by sending the completed resource guide evaluator form via email, you agree to participate in the study. All research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed. Any comments submitted may be published or presented to a professional audience, but no personal identifying information will be released.

Possible risks for participating in the study are minimal but may include mild levels of boredom in response to reading the guide and completing the series of rating and open-ended questions on the evaluation form. You may complete the guide at a time that is most convenient, taking breaks as necessary. In addition you have the right to not answer any particular question listed on the evaluation form and may withdraw from the study at any time without penalty. In the case of an adverse or unexpected event due to this study, you can contact a support/counseling service by calling 1-800-therapist.

If you have any questions regarding the study procedures, you can contact Melissa Cordero M.A.
APPENDIX L

Evaluator Consent Form
I authorize Melissa Cordero, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include me in the research project entitled “A Guide for Mental Health Practitioners Working with Collective Trauma Victims from Latin America: An Experiential Approach.” I understand that my participation in this study is strictly voluntary.

I have been asked to participate in this study that will include the development of a resource guide for mental health professionals working with Latino victims of collective trauma. I have been asked to volunteer to participate in this study based on my expertise in working with Latino victims of collective trauma. My participation in this study will consist of approximately 1 ½ hours of my time, in which I will review a resource guide for mental health practitioners who are working with Latino victims of collective trauma, developed by Melissa Cordero M.A., followed by the completion of an evaluation form related to the usefulness, accuracy, and effectiveness of the guide. My participation in this study may benefit clinicians working with Latino victims of collective trauma and may help ensure that Latino clients have access to culturally appropriate interventions. I will be mailed a twenty-dollar Starbucks gift card after the completion of my participation in this study.

I understand that all information obtained in this study will be kept confidential. If I choose to sign an informed consent, this would be the only document linking myself to the research. I can choose to sign an informed consent if I request to do so. If I choose to sign an informed consent form, it will be stored in a file separate from all other study materials, in the faculty supervisor’s private office. Otherwise, I understand that by sending the evaluator packet, I agree to participate in the study. All research materials will remain in a locked file cabinet for five years, at which time the data will be destroyed. I understand that any comments submitted may be published or presented to a professional audience and that no personal identifying information will be released.

I understand that possible risks for participating in the study are minimal but may include mild levels of boredom in response to reading the guide and completing the series of rating and open-ended questions on the evaluation form. In consideration of such factors, I understand that I have the option of writing the answers to questions listed on the evaluation form directly in the margins of the program materials, so as to minimize the time. I have also been advised to complete the guide at a time that is most convenient to me, taking breaks as necessary. In addition, I understand that I have the right to not answer any particular question listed on the evaluation form and may withdraw from the study at any time without penalty. In the case of an adverse or unexpected event due to this study, I can contact a support/counseling service by calling 1-800-therapist.

If I have any questions regarding the study procedures, I can contact Melissa Cordero M.A.

Signature________________________________________    Date_____________
APPENDIX M

Resource Evaluation Form
Focus is on Section IV-Culturally Adapted Interventions

Please note that all information provided on the evaluation form will remain strictly confidential.

DEMOGRAPHICS (Ctrl or Command B to bold selected response)

What is your age?  [ ] 25 – 30  [ ] 31 – 40  [ ] 41 – 50  [ ] 51 – 60  [ ] 61+
What is your gender?  [ ] Male  [ ] Female
What is your ethnicity?  [ ] African-American  [ ] Asian/Pacific Islander  [ ] Caucasian  [ ] Latino(a)  [ ] Native-American  [ ] Multiethnic  [ ] Other
What is your profession?

Do you have current licensure/credentialing (if applicable):

What is your job title?

What best describes your work setting?  [ ] Private Practice  [ ] Hospital  [ ] Community Agency  [ ] Other:

What has been the nature of your work with Latino victims of collective trauma?  [ ] Refugee Population  [ ] Sexual Trauma  [ ] Victims of Natural Disasters  [ ] Other:

What are the ages of population that you have worked with?  [ ] 0-9  [ ] 10-18  [ ] 19-30  [ ] 31-55  [ ] 56+
What Latino nationalities have you worked with?
[ ] South American:  [ ] Central American:
[ ] Mexican:  [ ] Caribbean (Cuban, Dominican, Puerto Rican):
[ ] Hispanic-American (2nd generation or more of living in the U.S.):
[ ] Other:

RESOURCE GUIDE EVALUATION (Insert number next to “Rating”)

1. How useful did you find this guide for mental health practitioners?
   [ ] (1) Not at All  [ ] (2) Not Very  [ ] (3) Neutral  [ ] (4) Somewhat  [ ] (5) Very
2. How useful do you find this guide for working with Latino victims of collective trauma?
   (1) Not at All   (2) Not Very   (3) Neutral   (4) Somewhat   (5) Very

3. What did you find particularly useful about this guide as it pertains to offering clinicians with culturally adapted treatments for collective trauma?

4. How useful do you find this guide for addressing symptoms of trauma directly with Latino clients who have experienced collective trauma?
   (1) Not at All   (2) Not Very   (3) Neutral   (4) Somewhat   (5) Very

5. How useful do you find the treatments described in this guide?
   (1) Not at All   (2) Not Very   (3) Neutral   (4) Somewhat   (5) Very

6. What aspects of this guide did you find not particularly relevant for its intended purposes?

7. What do you consider to be the strengths of the guide?

8. What do you consider to be the weaknesses of the guide?
9. What could have been added to the guide to make it more useful for Latino victims of collective trauma?

10. Are there any parts of the guide that you would omit, change, or revise?

11. Additional comments and suggestions:

In regards to the overall guide, please rate the following statements using the scale below:
   (1) Not at All   (2) Not Very   (3) Neutral   (4) Somewhat   (5) Very

12a. This program is beneficial for mental health practitioners working with Latino victims of collective trauma. Rating:

12b. I would recommend this guide to mental health practitioners working with Latino victims of collective trauma Rating:
APPENDIX N

Resource Guide
A GUIDE FOR MENTAL HEALTH PRACTITIONERS WORKING WITH COLLECTIVE TRAUMA VICTIMS FROM LATIN AMERICA:
AN EXPERIENTIAL APPROACH

Developed By: Melissa Cordero, M.A.
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INTRODUCTION

Latinos are the fastest growing minority group in the United States, increasing by 43% between the years 2000-2010 (United States Census Bureau 2010). In 2010, President Obama announced that up to 5,500 Latinos could be granted political asylum on a yearly basis (Immigration Policy Center, 2010). This resource is intended to be used as a guide to working with Latino victims of trauma. Clinicians may implement various concepts and interventions presented in this guide to assist in the dissemination of a culturally competent treatment.

SECTION I: UNDERSTANDING COLLECTIVE TRAUMA

Collective Trauma

Collective trauma refers to an experience of extreme stress that is shared by a group of people within a common geographic area or who have a shared social or cultural identity (Paez, Basabe, Ubillos, & Gonzalez-Castro, 2007). When compared to individual trauma, collective trauma may have a stronger adverse impact on social support, social sharing, social participation, and behaviors reinforcing social cohesion (Paez, et al, 2007). An important type of collective trauma is exposure to violence emerging from political upheaval, revolution, and/or rebellion that frequently involves people becoming refugees. Violence has been a reality in many Latin American countries for several decades (Internal Displacement Monitoring Centre, 2010).

Example of Sociopolitical Issues and Violence in Latin America

Diversity Among the Latino Population

This section provides examples of collective trauma relevant to Latino populations. The following examples of collective trauma reflect some of the historical events that have taken place in some countries. This section is intended to highlight the idea that the Latino population is diverse within itself and in no way replaces the need to explore the client’s history from their
perspective. It is important to understand the effect that one’s race may have on how they perceive themselves and how others may treat them. Although, many people group Latinos together, being mestizo (Indigenous and Spanish descent) versus white (Spanish descent) or black (African descent) will strongly impact their experiences, as those who are of European descent and of lighter skin may not be as impacted by racism. It is also important to highlight the vast diversity in socio-economic status (SES), which strongly impacts an individual’s experience and political beliefs. In addition, their experiences will influence their political beliefs. For example, in Colombia, those who have been kidnapped may have developed more right wing political views given their experience from leftist guerilla groups. Again, it can never be assumed that a specific treatment is appropriate but rather it should be uniquely developed based on the client’s experiences and beliefs. Although the following information is based on literature and reputable sources, clients may view the events differently given the various biases that occur when discussing political issues and collective trauma events.

**Mexico**

Hispanics of Mexican origin make up 63% of the Latino population in the United States (Census Briefs, 2010). Due to the rising violence in Mexico, the United States has recently offered political asylum for the critical needs of Mexicans in exile. The drug war in Mexico has claimed more than 40,000 lives after Felipe Calderon’s launch of the anti-crime offensive in December 2006 (NACLA Report on the Americas, 2011). After Mexico’s success in fracturing three out of the five most powerful cartels, the remaining two, the Sinaloa Cartel and the Gulf Cartel, have taken control and dominated the country making violence, torture, kidnappings, and threats a daily reality for Mexican civilians (Kellner & Pipitone, 2010). Between 2006-2010, there were 25,233 requests from Mexican citizens seeking political asylum from the United
States and only 3.3% were granted (Ronzio and Associates, 2011). In addition, this data is only reflective of those who have sought exile through government agencies and does not reflect asylees that may be among the 6.5 million undocumented Mexican immigrants in the United States (Pew Hispanic Center, 2011). Given the reality of the struggles Mexican citizens are faced with, immigrating to the United States, whether documented or undocumented, is frequently a means of survival.

**El Salvador**

Salvadorians are the fourth largest Hispanic group living in the United States (Pew Hispanic Center, 2011). El Salvador has one of the highest murder rates in the Americas due to gang violence that has dominated the country (Fogelbach, 2011). As a result, among the 1,648,968 immigrants from El Salvador, the United States has been a place of refuge for those affected by violence (Pew Hispanic Center, 2011). The Salvadorian civil war killed 75,000 people and at least 1,000,000 became refugees (Fogelbach, 2011). As a form of protection from the violent racism many experienced in the 1980’s, Salvadorian gangs began to form in the streets of Los Angeles known as “La Dieciocho” or “18th Street Gang” (Fogelbach, 2011). When peace accords were signed in the early 1990’s declaring the end of a civil war in El Salvador, gang members were deported back after their prison sentence (Fogelbach, 2011). This was the beginning of a transnational gang which has been estimated to have a membership of 30,000-50,000 in the United States (Federal Bureau of Investigation as cited in Fogelbach, 2011). Officials estimate 10,500 gang members in El Salvador, 14,000 in Guatemala, 36,000 in Honduras, and 5,000 in Mexico (Fogelbach, 2011). Another Salvadorian gang, Mara Salvatrucha, is considered the most dangerous in the world. This gang was also formed on the streets of Los Angeles during the 1980’s as a form of protection. They are now found
everywhere in the world and have approximately 150,000 members (Fogelbach, 2011). These gangs have been known to terrorize Salvadorian cities and suburbs (Fogelbach, 2011). In June, 2010, gang members boarded a bus, locked the doors, and burned victims alive (Fogelbach, 2011). The violence is predicted to escalate due to the drug war in Mexico as cartels have begun to migrate to Central America and align themselves with even more powerful entities such as the Mara Salvatrucha. This has left Salvadorians fearing their lives and many more are seeking refuge in the United States.

**Colombia**

Hispanics of Colombian origin have also sought refuge due to the civilian war which has spanned over the past forty years. An estimated five million people in Colombia have been displaced due to the political violence (Internal Displacement Monitoring Centre, 2010). An approximated 280,000 individuals have been forcefully displaced in 2010 alone (Consultaría Para los Derechos Humanos y el Desplazamiento, 2011). Colombia has experienced a devastating reality due to the political violence between guerillas, former right-wing paramilitary groups, and the Colombian military. Right-wing paramilitary groups were formed as a reaction to the guerillas as they felt the Colombian military was not taking proper action. They claimed to be allied with Colombian Armed Forces as they fought the war against the guerrillas, yet they also waged war against union members, peasant organizers, human rights workers, and religious activists who were all thought to be in line with guerilla ideals. In the past few years under president Alvaro Uribe, most of the paramilitary groups have concluded, yet there is still a dire struggle to restore Colombia as it is reported to have one of the highest level of deaths due to homicides and political violence in the Americas (Briceño-León, Villaveces, Concha-Eastman, 2008). The United States’ strong relationship with Colombia has allowed for 908,734
SECTION II: CULTURAL CONSIDERATIONS

Acculturation

Acculturation may be defined as adaptations and changes of one’s cultural patterns that occur when there is regular contact with another culture (Horevitz & Organista, 2012). Although there is no uniform definition of acculturation, it is now understood as a complex and multidimensional process that does not follow a linear movement (Horevitz & Organista, 2012). Research on acculturation has identified a phenomenon termed the “Mexican Health Paradox” (MHP). This paradox suggests that the less acculturated an individual is, the healthier they are. Given that the majority of studies indicate that less acculturated individuals are usually subject to effects of migration, poverty, and racism, leading to decreased health, the MHP has intrigued researchers (Horevitz & Organista, 2012). Research on MHP has suggested that Latino’s traditional values of the centrality of family, religion, (Wills, Yaeger, &Sandy, 2003) as well as lower levels of drinking, smoking, and sexual risk-taking among Latina immigrants, have contributed to stress-buffering effects (Aranda, Castaneda, Lee, & Sobel, 2001). Research also suggests that this protective buffer diminishes as Latinos become a greater part of the U.S. mainstream culture and acculturation level increases among first and second generation immigrants (Horevitz & Organista, 2012). There is contradictory evidence supporting the generalizability of this “Mexican Health Paradox” to all Latino immigrants. Some studies have shown support for an “Immigrant Paradox” for other Latino groups who have immigrated to the United States as adults, yet results indicate that these Latino immigrant groups may only protected against risks relating to substance abuse (Alegria et al., 2008).
Research evaluating the use of a shared native language suggests it may enhance the development of an empathic connection (Gamsie, 2009). Although a therapist may speak Spanish fluently, if it is not the language in which the formal therapy training was received, it may therefore be experienced as a hindrance in therapy (Gamsie, 2009). This issue should be considered in order to formulate a treatment that is most suited for the client, given that strictly translating previously learned information is not sufficient when considering cultural factors such as education, social economic status, and religion. To ensure cultural congruence, modifications to treatment should be made to reflect the client’s needs.

These outcomes are imperative to consider when working with Latino immigrants and their family members. This research highlights the importance of including cultural values and beliefs that help protect this population from the common stressors. This next section will discuss the cultural beliefs, values and traditions that are most important in the Latino culture. This should be the foundation of treatment when developing interventions that address collective trauma.

**Values, Traditions, and Cultural Beliefs**

*Familismo:* Refers to the value of maintaining close connections to the family (Marín & Triandis, 1985, as cited in Chadwick Center). In order to incorporate this into therapy, the therapist may include the use of family members as a means to support the therapeutic process. This may be done by having family members participate in homework assignments by teaching some of the techniques practiced. This may increase a sense of self-efficacy and contribute to the cohesiveness of the family.

*Personalismo:* Refers to the value of building and developing interpersonal relationships to include warm and friendly relationships (Santiago-Rivera et al., 2002 as cited in Chadwick...
Center). This is important to the therapeutic relationship in that trust is especially important in adherence to therapy.

*Respeto:* Refers to the hierarchal relationship between individuals. Within a family context this represents the respect to elders (Santiago-Rivera et al., 2002 as cited in Chadwick Center). In a therapy setting this may affect the interpersonal relationship as the therapist may be seen as someone who deserves respect, therefore possibly impeding the collaborative approach to therapy. In order to address this issue, the therapist should openly discuss the need for a partnership and create a safe environment for honest feedback.

*Simpatía:* This refers to the importance of being polite and pleasant despite disagreements (Chadwick Center). In order to encourage honest feedback, the therapist should first develop a strong, trusting relationship to allow the client to feel safe in disagreeing with the therapist. The benefits of communicating disagreement should be discussed to encourage the client to openly discuss issues with the therapist.

Religion may be incorporated as a strong therapeutic focus if the client perceives this to be a resource for them. Given the research on the Mexican Health Paradox, religion may positively contribute to the individual’s ability to cope with stressors. There are various ways to integrate religion into treatment including the use of religious imagery when introducing evidence-based treatments, such as cognitive behavioral therapy, and as coping techniques. According to Taylor and Francis (2006), third wave therapies such as Acceptance and Commitment Therapy (ACT) and Dialectical Behavioral Therapy (DBT) have incorporated religious beliefs into evidence-based treatments. The common religious belief that “suffering is inevitable” is introduced in ACT (Taylor & Francis, 2006). ACT and DBT both approach this suffering by identifying one’s personal values and facilitating behavior that is congruent with
those values through commitment and willingness (Taylor & Francis, 2006). Further
explanations of merging religion and evidenced based treatments will be introduced in section
IV, Culturally-Adapted Interventions.

SECTION III: CULTURALLY APPROPRIATE ASSESSMENTS OF TRAUMA

PTSD Measures

The 24-Item Symptoms Checklist was developed in San Joaquín, Colombia to measure
PTSD in a rural community that was attacked and partially destroyed by guerilla violence
(Pineda et al., 2002). This assessment tool was designed based on each criteria section, A-F, in
the PTSD diagnosis criteria of the DSM-IV-TR (Pineda et al., 2002). It was elaborated from
this point to include specific questions about war and symptoms one endures after a politically
violent trauma in a way that is culturally appropriate and understood (Pineda et al., 2002).
However, this instrument may be suitable for any Latino population that has been affected by a
collective trauma event, and is not limited to political violence. As an example, one item from
this instrument is “Últimamente he vivido al menos una situación relacionada con muertes o
amenazas contra mi vida o la de otras personas relacionadas conmigo,” which translates to “I
have recently experienced at least one situation relating to death or threats to my life or someone
near me” (Pineda et al., 2002). In addition to this culturally appropriate modification, a scale of
1-4 was added to assess the severity of the symptoms. This measure has been demonstrated to be
an efficacious tool when assessing the unique manifestation of collective trauma in Latinos
(Pineda et al., 2002). Currently, only a Spanish version of this assessment measure has been
developed and tested. It has been included in this resource guide to provide clinicians with an
assessment tool for those working with monolingual Spanish speaking adults.

Other measures that are not included in this guide, but have been translated into Spanish
and appropriate for working with traumatized families, specifically children and adolescents of Latino descent include, UCLA’s PTSD Reaction Index (Rivera, 2008) and the Trauma Symptom Checklist (Maiken-Thorvaldsen, 2008).

24-ITEM SYMPTOM CHECKLIST (Spanish)
(A score of 45 or above suggests a PTSD diagnosis)

Anexo. Lista de síntomas para la valoración psicológica del trastorno de estrés postraumático (TEPT)

A partir de las preguntas que usted contestó, quisiera que marcara ahora cuál es su nivel de acuerdo o de desacuerdo con las siguientes frases. Elija sólo una de las cuatro posibilidades para cada frase, según lo que usted considere. No se trata de establecer valores buenos o malos, sólo de elegir la respuesta que usted crea con mayor relación a lo que usted siente. Por favor señale con una x, según corresponda.
1. Desacuerdo Total, 2. Desacuerdo Parcial, 3. De acuerdo parcialmente, 4. Acuerdo Total

1. Ulitimamente he vivido al menos una situación relacionada con muertes o amenazas contra mi vida o la de otras personas relacionadas conmigo

2. Por esta situación he experimentado mucha angustia o temor excesivo

3. Constantemente tengo pensamientos que me recuerdan la situación desagradable y me provocan mucha angustia

4. Sueño mucho con lo que pasó

5. La mayor parte del tiempo creo estar viviendo lo sucedido

6. Cuando algo me recuerda la situación, me siento muy mal
7. Cuando algo me recuerda un aspecto de la situación, mi cuerpo se altera

8. Siempre evito pensar o hablar de lo que pasó

9. La mayoría de las veces evito cosas y sitios que me recuerden la situación

10. Olvidé muchas cosas de la situación desagradable

11a. A partir de lo que pasó, siento que nada me importa

11b. Después de la situación, tengo muchas dificultades para llevar a cabo las actividades que hacía antes

12. A partir de lo que pasó, las personas que me rodean ya no son importantes para mí

13. Después del suceso desagradable tengo muchas dificultades para querer como lo hacía antes

14. A partir de lo que sucedió, siento que mi futuro es triste y desolador

15. Después del suceso desagradable, me es muy difícil conciliar el sueño

16. Después de la situación que viví, siento que frecuentemente estoy de mal humor
17. Me es muy difícil concentrarme en mis actividades, después de lo sucedido

1 2 3 4

18. Desde que tuve esa situación horrible, siempre observo con sospecha todo lo que ocurre a mi alrededor

1 2 3 4

19. Desde lo que me pasó, cualquier cosa me pone en alerta y me asusta

1 2 3 4

20a. Después de esa situación, la mayor parte del tiempo me siento mal, en todos los sentidos

1 2 3 4

20b. He disminuido casi todas mis actividades sociales después de lo que me pasó

1 2 3 4

20c. Después de lo sucedido, tengo muchas dificultades en mis relaciones con los demás

1 2 3 4

20d. Después de lo que me pasó, he disminuido en gran medida mi ritmo de trabajo

1 2 3 4

Culture-Bound Syndrome Differentials

When working with Latino families, it is imperative to assess for culture-bound syndromes in addition to PTSD and other forms of anxiety. *Ataque de nervios* (translates to attack of the nerves), is one of the most common idioms of distress in the Latino population (Hinton, Lewis-Fernandez, and Pollack, 2009). There are unfortunately several issues when assessing for these syndromes due to the variability in symptomatology from culture to culture as well as the lack of literature available to practitioners. Additionally, the presence of *nervios* may overlap symptoms experienced in other psychological disorders, such as a Panic Disorder and
PTSD. This can lead to a misdiagnosis and a misconception of the individual’s cultural context.

Below is a table to help you differentiate between nervios, ataque de nervios, panic attacks, and PTSD. (Based on DSM-V criteria)

<table>
<thead>
<tr>
<th>Syndrome/Disorder</th>
<th>Symptoms</th>
<th>Check if endorsed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nervios</td>
<td>1. Brought on by a difficult life circumstance</td>
<td>On going symptoms of the following:</td>
</tr>
<tr>
<td></td>
<td>2. Headaches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Stomach disturbances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Sleep difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Irritability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Nervousness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Easy Tearfulness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Inability to concentrate</td>
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<td></td>
<td>9. Trembling</td>
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<td></td>
<td>10. Tingling sensation</td>
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<td></td>
<td>11. Dizziness</td>
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<tr>
<td></td>
<td>12. Inability to function</td>
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</tr>
<tr>
<td></td>
<td><strong>Nervios Total</strong> /12</td>
<td></td>
</tr>
<tr>
<td>Ataque de Nervios</td>
<td>1. Direct result of stressful event relating to the family (i.e. news of the death of a close relative, separation or divorce from a spouse, conflicts with children or spouse, or witnessing an accident involving a family member).</td>
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<tr>
<td></td>
<td>2. Uncontrollable shouting</td>
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<td>3. Attacks of crying</td>
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<tr>
<td></td>
<td>4. Trembling</td>
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<td></td>
<td>5. Heat in the chest rising to the head</td>
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<td></td>
<td>6. Seizure like episodes</td>
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<td></td>
<td>7. Fainting episodes</td>
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<td>8. Suicidal gestures</td>
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<tr>
<td>9.</td>
<td>Absence of fear or apprehension of another event (presence of this fear is a hallmark symptom of panic attacks)</td>
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<tr>
<td>10.</td>
<td>Return rapidly to their usual level of functioning</td>
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</tr>
<tr>
<td><strong>Ataque de Nervios Total</strong></td>
<td>/10</td>
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</table>

**Panic Attack**

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four or more of the following symptoms occur.

- Palpitations, pounding heart, or accelerated heart rate
- Sweating
- Trembling or shaking
- Sensations
- Feeling of choking
- Chest pain
- Nausea or abdominal distress
- Feeling dizzy, unsteady, lightheaded, or faint
- Derealization or depersonalization

- Fear of losing control or going crazy
- Fear of dying
- Paresthesias (numbness or tingling sensations)

Chills or hot flushes

**Total 4 or more?** Yes/ No If yes, continue

**Recurrent and unexpected** Yes/ No If yes, continue

At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, going crazy). Yes/ No

2. Significant maladaptive change in behavior related to the attacks (e.g.,
<table>
<thead>
<tr>
<th><strong>PTSD</strong></th>
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<tbody>
<tr>
<td><strong>Criterion A: stressor</strong></td>
</tr>
<tr>
<td>The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: <em>(1 required)</em></td>
</tr>
<tr>
<td>1. Direct exposure.</td>
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<td>2. Witnessing, in person.</td>
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<tr>
<td>3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.</td>
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<tr>
<td>4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.</td>
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At least one met?  
Yes/No

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<th><strong>Criterion B: Intrusion symptoms:</strong></th>
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<td>The traumatic event is persistently re-experienced in the following way(s): <em>(1 required)</em></td>
</tr>
<tr>
<td>1. Recurrent, involuntary, and intrusive memories. Note:</td>
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<tr>
<td>Criterion B: Intrusion symptoms:</td>
</tr>
<tr>
<td>The traumatic event is persistently re-experienced in the following way(s): <em>(1 required)</em></td>
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<tr>
<td>1. Recurrent, involuntary, and</td>
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</tbody>
</table>
| Criterion C: Avoidance:  
| Persistent effortful avoidance of distressing trauma-related stimuli after the event: (1 required)  
| 1. Trauma-related thoughts or feelings.  
| 2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).  
| At least one met?  
| Yes/No |

| Criterion D: Negative alterations in cognitions and mood.  
| Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required)  
| 1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).  
| 2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").  
| 3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.  
| 4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).  
| 5. Markedly diminished interest in (pre-traumatic) significant activities.  
| 6. Feeling alienated from others (e.g., detachment or estrangement).  
| 7. Constricted affect: persistent inability to experience positive emotions.  
| At least two met?  
| Yes/No |
Criterion D: Negative alterations in cognitions and mood. Negative alterations in cognitions and mood that began or worsened after the traumatic event: (2 required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).
2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.
4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).
5. Markedly diminished interest in (pre-traumatic) significant activities.
6. Feeling alienated from others (e.g., detachment or estrangement).
7. Constricted affect: persistent inability to experience positive emotions.

At least two met? Yes/No

Criterion E: Alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (2 required)

1. Irritable or aggressive behavior.
2. Self-destructive or reckless behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems in concentration.
Using the Table

The table may be used to guide clinician’s evaluation of culture-bound syndromes and compare the symptoms to similar diagnoses in the DSM-V. The checklist for the culture-bound syndromes is to be used by the clinician to gather qualitative information. Given that there are no specific criteria needed to make the diagnosis of either nervios or ataque de nervios, this table may be used to formulate a qualitative interpretation and to inform treatment. Posttraumatic Stress Disorder and Panic Disorder have been outlined to help the clinician determine whether their client meets criteria. All “yes” boxes must be endorsed in order to meet criteria for either PTSD or Panic Disorder.

SECTION IV: CULTURALLY-ADAPTED INTERVENTIONS

Interventions have been selected for inclusion based on existing support in the research literature and structured clinical interviews with experts in the field of collective trauma. This section has been organized by treatment focus and type of intervention and presented in a sequential order. These interventions are designed to be integrated into current treatment and...
may be used in an individual or group setting. Therapists are encouraged to choose those interventions that are most congruent with the client’s cultural beliefs and practices.

## Treatment Outline

<table>
<thead>
<tr>
<th>Treatment Focus</th>
<th>Suggested Interventions</th>
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</table>
| 1. Psychoeducation | -Psychoeducation on trauma symptoms  
-Providing a link between perceived medical symptoms and psychological symptoms. |
| 2. Relaxation and Emotion Regulation Skills | -Deep Breathing, Progressive Muscle Relaxation, Listening to music, and Loving Kindness Meditation (guided by cultural beliefs)  
-Cultural Practices: Lighting a candle, praying the rosary, religious coping (prayer, meditation) |
| 3. Recognizing Cognition Distortions | -Cognitive distortions, specifically catastrophic thinking about somatic symptoms |
| 4. Interoceptive Trauma Exposure Protocol and Positive Reframing | -Exposure to traumatic event followed by emotion regulation skill  
-Exposure to somatic sensation and positive reassociation to somatic sensation (reframing cognitive distortions) |
| 5. Living a life of Meaning | -Identifying Values |
| 6. Shame/Guilt | -Finding forgiveness through action  
-Responsibility Pie |
| 7. Role Recovery and Community Building | -Values-Centered  
-Integration into the community  
-Access to resources |

## Treatment Focus #1: Psychoeducation

Providing psychoeducation to clients gives a framework for their experience and helps normalize their current distress (Phoenix, 2007). When clients do not understand their symptoms, they may be catastrophized. Understanding why they are experiencing these reactions to the trauma and learning that there are treatments for them, can help give the client hope and help them feel more in control. The ability to understand the reasons for stress responses can help minimize self-criticism as they are able to see that these are not personal
failings but expected symptoms after experiencing a trauma (Phoenix, 2007). It is crucial that clients are provided with information to help destigmatize psychological symptoms as well as the therapeutic process. It is common for clients to be referred from a medical doctor having initially presented with somatic symptoms. This suggests that the client should be provided with information to link perceived medical symptoms to psychological symptoms. Psychoeducation should not be only delivered at the beginning of treatment but also throughout the entire course to help the client understand the process of recovery. The following pages include a psychoeducation handout to help clinicians explain PTSD to their clients. The information is written in layman’s terms (In English and in Spanish) so that those with low levels of education, in either language, and minimal English fluency are able to understand the basic concepts.

**Posttraumatic Stress Disorder Psychoeducation Handout**

**What is Post Traumatic Stress Disorder?**

Posttraumatic Stress Disorder (PTSD) is a reaction to a really stressful event. This may include war, rape, abuse, a natural disaster, or an accident. It is a normal reaction by normal people to an abnormal event (Schiraldi, 2009). The traumatic events that lead to PTSD can be so horrific that it would distress almost anyone.

**PTSD Symptoms (DSM-V Criteria)**

- Uncontrollable thoughts about the event
- Traumatic nightmares
- Become distressed when there are reminders of what happened
  - This can be mentally difficult
  - This can also include having a physical reaction (shakiness, heat in the chest, shortness of breath etc.)
- Feel like the event is happening again (flashbacks)
- Effort to avoid talking about what happened
- Effort to avoid any reminders of what happened (ex. Not driving near the area of the accident)
- Can’t remember details about the event
- Excessive blame of self or others
- Feel distant from others
- Persistent emotions, such as fear, horror, anger, guilt or shame
  - Outbursts of anger
- Unable to feel positive emotions
- Difficulty Sleeping

**Somatic Complaints**

Somatic complaints are physical expressions of the trauma. This tends to happen when the trauma has not been verbally expressed and can function as a distraction from the emotional pain (Schiraldi, 2009). Some common somatic symptoms include the following:

- Persistent Pain: headaches, chest pain,
- Body may feel heavy, may tingle, or feel numb
- Lump in throat
- Hypochondriasis: Convinced that these physical symptoms are due to a physical illness even after being told by a doctor otherwise.

**Why does someone get PTSD?**

Evolutionary psychologists believe that PTSD has a logical explanation, by evaluating and avoiding threats we are able to survive dangerous situations (Glassgold, 2006). Flight or
fight behaviors are effective if it is an automatic response when we are in danger. Many PTSD symptoms are common reactions that would help someone escape danger and go into safety. However, these reactions are not useful after the event has passed and danger is no longer present. These behaviors can begin to get in the way of dealing with daily stressors because there can be an overreaction to smaller stressors making it difficult to function adaptively (Glassgold, 2006). Avoidance is one of the most common symptoms of PTSD, therefore sustained participation in treatment may be challenging. The next section discusses some treatments for PTSD.

**How does someone recover from PTSD?**

**Stages of Trauma Recovery** (Phoenix, 2007)

1. Safety and Stabilization
   a) It is most important that the person is safe from the source of the trauma before they begin treatment. If they are still in danger, then it is not safe for them to lower their defenses and become a target once again.
   b) The first interventions offered include techniques that will help to establish (or re-establish) emotional stability. There are various exercises that can be practiced, including breathing techniques, stretching, meditation, and prayer.

2. Remembrance and Mourning
   a) Helping clients to remember parts of the trauma is very important so that the details are no longer feared. This will only be introduced once coping skills and emotional balancing techniques are taught so that there is enough stability to tolerate the details of the trauma.
b) After beginning to remember the details of the event the person can start dealing with the pain related to the traumatic event. This can be done in several ways (i.e. dealing with guilt, writing a forgiveness letter, finding ways to have closure such as performing a ritual etc.).

3. Reconnection

a) This is the final stage of recovery. Once the above phases have been completed it is important to help the client reconnect with aspects of their life that they may have been avoiding due to their symptoms.

Información del Estrés Postraumático

¿Qué es el Trastorno de Estrés Postraumático?

El trastorno de estrés postraumático es una reacción a un evento que fue lleno de horror extremo o trágico. Por ejemplo la guerra, una violación, un desastre natural, un accidente, o abuso. El trastorno de estrés postraumático es una reacción normal a un evento que es anormal (Schiraldi, 2009).

- No poder controlar o parar de pensar del evento
- Pesadillas traumáticas
- Estresarse cuando hay un recuerdo del evento
  - Esto puedo ser difícil mentalmente o físicamente
  - Síntomas físicas incluyen: temblar, calor en el pecho, dificultad al respirar
- Sentirse como si el evento esta pasando otra vez
- No querer hablar del evento
- Tratar de olvidar lo que paso
- No hacer cosas que pueden recordar el evento. (Por ejemplo: no manejar por una calle en el que sucedió el accidente)
- No poder recordar detalles del evento
- Culparse a uno mismo o a otras personas en exceso
- Sentirse distante de otros
- Sentirse miedo, rabia, o culpa
  - Momentos de rabia extrema
- Dificultad de sentir emociones positivas
- Dificultad al dormir

**Síntomas Físicos**

Síntomas físicos son expresiones del trauma. Esto pasa cuando el trauma no es expresado verbalmente. Síntomas físicos sirven como un modo de distraer el dolor que uno siente emocionalmente (Schiraldi, 2009). Síntomas comunes que suceden físicamente, incluyen lo siguiente:

- Dolor: dolor de cabeza, dolor en el pecho
- El cuerpo se siente pesado, entumecido, hormigueo
- Una bola en la garganta
- Convencerse que los síntomas son parte de una enfermedad física en vez de una enfermedad mental

**¿Por Que le Da a Uno Estrés Postraumático?**

Psicólogos evolucionarios creen que el estrés postraumático tiene una explicación lógica. Personas tienen el instinto de evaluar y evitar amenazas o situaciones peligrosas para poder sobrevivir (Glassgold, 2006). Los comportamientos de lucha o huida son reacciones inmediatas
en respuesta a una situación peligrosa. Muchos síntomas del estrés postraumático son reacciones comunes que le pueden ayudar a alguien escaparse de una situación peligrosa. Sin embargo, estas reacciones no ayudan después que un evento paso y el peligro ya no está presente. Estos comportamientos pueden interferir con factores de stress diarios, por que la reacción puede ser demasiada exagerada en comparación con la situación real. (Glassgold, 2006). Evadir es el síntoma más común del estrés postraumático. Por esta razón, comprometerse a un tratamiento es difícil. Lo siguiente es una descripción de tratamientos comunes.

¿Cómo Se Puede Sobrevivir el Estrés Postraumático?

_Fases de Recuperación_ (Phoenix, 2007)

4. Seguridad y Estabilización
   a) Es importante que una persona se sienta segura y que este afuera de peligro antes de empezar el tratamiento. Si uno está en una situación que no es segura, uno puede bajar las defensas y caer víctima otra vez.
   b) El primer tratamiento incluye ejercicios que ayuda a establecer o re-establecer balance emocional. Hay varios ejercicios que uno puede practicar, incluyendo estrategias de respiración, meditación, oraciones, y ejercicios de estiramiento.

5. Recordar y Estar de Luto
   a) Acordarse de los detalles del trauma o el evento es muy importante para que aquellos recuerdos no sean temidos. Uno solamente empieza esto después que a establecido un balance emocional.
   b) Después que uno empieza a recordarse del evento, uno puede empezar a procesar el dolor que causó el evento. Esto se puede hacer de varias maneras.
Algunos ejemplos son: escribir una carta pidiendo perdón, orar, o hacer rituales que tengan valor emocional.

6. Reconexión

   a) Esta es la última fase de la recuperación. Cuando lo anteriormene mencionado ha sido practicado, uno debe de empezar a confrontar partes de la vida que han sido ignoradas o afectadas por consecuencia de los síntomas.

**Treatment Focus #2: Relaxation/Emotion Regulation Skills**

Research on treatments for traumatized refugees highlights the importance of not utilizing traditional exposure techniques, such as prolonged exposure (Hinton et al., 2012). The newer literature states that clients do not need to experience high levels of discomfort associated with the trauma in order to resolve the trauma (Hinton et al., 2012). Instead, the research suggests that the client needs to believe and feel confident that the traumatic memories can be tolerated (Hinton et al., 2012). Therefore, emotional regulation skills should be practiced at the beginning of each session after discussing events that trigger anxiety and throughout a modified exposure protocol (Hinton et al., 2012). Further research supports the need to provide exposure treatment not only for the traumatic memories, but also the somatic complaints associated with them (Hinton et al., 2012).

**Deep Breathing**

   **Diaphragmatic Breathing Script:**

   If you feel comfortable, close your eyes. Place your hands on your stomach so you can feel the rising and falling of your belly as you inhale and exhale. Become aware of your breath as you inhale and exhale through your nose slowly. Each time you inhale, try to feel the belly rise and feel that breath rising up and filling your chest. As you exhale, tune into the breath, slowly
releasing the breath out from your chest back to your belly, feeling your stomach drawing back towards your spine. Take another deep inhale, feeling your belly rise up and chest expanding. Exhale feeling the breath moving back down towards the belly and feel the stomach release down to your spine. Continue inhaling and exhaling as slowly as possible, trying to expand your inhale more and more each inhale and exhale longer each exhale.

**Spanish Resources:**


Guided Diaphragmatic Exercise: [http://www.youtube.com/watch?v=C-4FZ2JXGGk](http://www.youtube.com/watch?v=C-4FZ2JXGGk)

Counted Breathing Script: Beginner: 2,1,4; Intermediate: 4,2,6; Advanced: 6,3,8

If you feel comfortable, close your eyes. Become aware of your breath as you inhale and exhale through your nose slowly. Begin to inhale (for a count of 2,4,or 6), hold the breath (for a count of 1,2, or 3), and exhale (for a count of 4,6, or 8). Inhale (for a count of 2,4,or 6), hold the breath (for a count of 1,2, or 3), and exhale (for a count of 4,6, or 8).

*(Repeat)*

**Spanish Translation:**

Si siente cómodo(a), sierra los ojos. Note su respiración mientras inhala y exhala por la nariz. Empiece a inhalar (por 2,4, o 6 segundos), Mantenga la respiración (por 1,2, o 3 segundos), y exhala (por 4,6, o 8 segundos). Inhale inhalar (por 2,4, o 6 segundos), Mantenga la respiración (por 1,2, o 3 segundos), y exhala (por 4,6, o 8 segundos).

*(Repetir)*

**Progressive Muscle Relaxation**

**Progressive Muscle Relaxation (PMR) Script:**
Begin to focus on your body and body sensations. Take a deep breath, feeling your belly rising up and your lungs filling with air. As you exhale, imagine yourself releasing all of your tension out of your body. Continue to breathe deeply as I guide you through the next exercise.

Begin to tighten the muscles in your forehead by raising your eyebrows (*hold for 5 seconds*). Now release the tension and notice the difference (*pause for 10 seconds*). Now close your eyes and squeeze your eyes by squinting and tight as you can (*Hold for 5 seconds*). Now release and notice any changes from before (*pause for 10 seconds*)... Continue inhaling and exhaling slowly. Now tense your mouth by smiling wide and tensing your jaw (*hold for 5 seconds*). Release and tune in to any changes you notice (*pause for 10 seconds*). Gently bring your head back until you feel tension in the neck (*hold for 5 seconds*). Now bring your head forward and release the tension, feeling your body more and more relaxed (*pause for 10 seconds*).

Begin to clench your fist and hold (*hold for 5 seconds*). Now relax the hands (*pause for 10 seconds*). Flex your biceps and feel the muscles tighten (*hold for 5 seconds*). Release, noticing the body becoming more relaxed (*pause for 10 seconds*). Now begin to flex your triceps by extending your arms out (*hold for 5 seconds*). Relax the arms and notice the changes in your body (*pause for 10 seconds*). Lift your shoulders up to you ears (*hold 5 seconds*). Relax your shoulders and notice the heaviness (*pause for 10 seconds*).

Continue breathing in and out and tense your upper back squeezing your shoulder blades together (*hold for 5 seconds*). Release and take a few moments to notice the changes in your body (*pause for 10 seconds*). Now take a deep inhale in and tense your chest by holding the breath (*hold for 5 seconds*). Exhale releasing all of your breath, begin to breath naturally and notice how relaxed your body feels (*pause for 10 seconds*). Begin to suck the stomach in and
tighten the muscles as you hold your stomach in (hold for 5 seconds). Release the stomach and continue breathing in and out (pause for 10 seconds). Now gently arch your lower back and tense the muscles (hold for 5 seconds). Release and notice how your upper body feels (pause for 10 seconds).

Now begin to tighten your buttocks (hold for 5 seconds). Relax the buttocks and notice the hips beginning to loosen (pause for 10 seconds). Squeeze your thighs towards each other (hold for 5 seconds). Relax the legs and continue breathing in and out as you notice the changes in your body (pause for 10 seconds).

Flex your feet by bringing your toes towards you, noticing the tension in your calves (hold for 5 seconds). Relax the feet (pause for 10 seconds). Now curl your toes under, tensing your feet (hold for 5 seconds). Relax the feet (pause for 10 seconds).

Imagine your breath is moving from the top of the head downward toward your feet, feeling the body relaxing heavy into the chair, let go of all your effort and allow yourself to sink in. Continue breathing in and out and notice how you feel (Bourne, 2011).

**Spanish Resources:**

**PMR Script:**
Listening to music

This is a simple technique to teach to clients. It is important to explore the types of music that actually relaxes them. Many clients do not initially make a conscious connection between music and arousal, so it is important for them to rate their emotional and physiological arousal before and after listening to music to assure that the music is grounding rather than more stimulating. Many religious clients may be inspired to listen to religious chants (alabanzas). The
A therapist can also suggest music, such as music with nature sounds or an instrument such as flute, guitar, piano, or violin. The following handout allows the client to rate their experience.

<table>
<thead>
<tr>
<th>Date/Fecha</th>
<th>Rate level of anxiety 1-10 (10 is the strongest) Nivel de ansiedad 1-10 (10 es lo más fuerte)</th>
<th>Song, Artist, or Genre/ Canción, Artista, o Tipo de Música</th>
<th>Rate level of anxiety 1-10 (10 is the strongest) Nivel de ansiedad 1-10 (10 es lo más fuerte)</th>
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Loving-Kindness Meditation (guided by cultural beliefs)

Research has shown that Loving Kindness Meditation (LKM) can increase positive emotions and decrease negative emotional states by shifting a client’s perception of themselves and others, thus increasing compassion (Hoffman et al., 2011). This approach begins by having the client accept that they have endured a trauma (Hinton et al., 2012). This is followed by having the client develop compassion and an affective state of unconditional kindness for themselves and others (Hoffman, Grossman, & Hinton, 2011). To develop compassion, the client needs to cultivate a deep, genuine sympathy for themselves and others who have experienced suffering with a desire for this suffering to ease (Hopkins, 2001). Loving-Kindness Meditation can be practiced in a sitting or laying down position. The client moves through a series of stages that cultivate empathy and are presented from easiest to more challenging (Hoffman et al., 2011). The following steps are introduced by having the client emanate compassion through culturally appropriate imagery. The following is an example of how LKM can be adapted for Latino clients who value Christianity, but may be replaced with the specific beliefs of your clients. The following example presents the compassion meditation with Christian-centered imagery, involving the client imagining a light radiating from the heart, similar to the sacred heart of Jesus (Hinton et al., 2011).

1) Focus is on self
   a. “Imagine a light radiating from your heart like the light radiating from sacred heart of Jesus. Tune in to a feeling of compassion for yourself.”

2) Focus is on someone close (like a good friend, not someone with sexual desire etc.)
   a. “Imagine a light radiating from your heart to a friend of yours. Visualize this light radiating from you to your friend, similar to the image and compassion of”
the sacred heart of Jesus. Tune in to a feeling of compassion and empathy for your friend. “

3) Focus is on a neutral person (someone that does not illicit positive or negative emotions)
   a. “Imagine a light radiating from your heart to a neutral person. Visualize this light radiating from your heart to this person, similar to the image of the sacred heart of Jesus. Tune in to a feeling of compassion and empathy for this person.”

4) Focus is on a difficult person (someone associated with negative feelings)
   a. “Imagine a light radiating from your heart to a difficult person in your life. Visualize this light radiating from you to this person, similar to the image and compassion of the sacred heart of Jesus. Tune in to a feeling of compassion for this person. “

5) Focus is on 4 previously mentioned people, with attention equally divided
   a. “Imagine all of these people near you. Visualize a light radiating from your heart and connecting to these people equally. Imagine this light connecting you with a feeling of compassion and empathy.”

6) Focus is on the entire universe
   a. “Imagine a strong light radiating from you heart and connecting with all living beings on this universe. Connect to a feeling of compassion and empathy. Radiate love and understanding.

Cultural Practices

Cultural practices are critical to include when working with all clients. Although people within a cultural group may share practices and beliefs, one should never make assumptions about an individual’s particular practices or cultural beliefs are. Below are a few practices that
are common yet should only be used as a guide. The therapist and client should collaboratively come up with a unique list of coping techniques that are meaningful to the client. These practices can be introduced anytime in treatment where they could benefit the client.

- Work in conjunction with family members
- Lighting a candle (Hinton et al., 2011)
- Praying the rosary (Hinton et al., 2011)
- Praying a novena
- Going to confession
- Having an altar
- Offerings to saints
- Holding or wearing a scapular
- Blessing an area with holy water
- Having a priest bless an area
- Work in conjunction with a curandero (folk healer)
- Writing something and burning it as a symbol for letting go or sending a message to a deceased loved one

**Treatment Focus #3: Recognizing Cognitive Distortions**

In order to increase awareness of unhealthy and unbalanced thinking, it may be helpful to introduce the common cognitive distortions. The specific cognitive distortions associated with their trauma can be identified and reframed as instructed in the following section. Cognitive distortions can get in the way of living a life of meaning. This can be addressed through behavioral experiments, which is explained in a later section. The following is a list of common cognitive distortions as suggested by Burns (1980).
<table>
<thead>
<tr>
<th>Cognitive Distortion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All or Nothing Thinking</td>
<td>Looking at situations in absolutes; black and white thinking.</td>
</tr>
<tr>
<td>Overgeneralization</td>
<td>Take one event and generalize it. (i.e “My marriage failed, all my relationships are doomed”).</td>
</tr>
<tr>
<td>Mental Filter</td>
<td>See events through a negative lens and discount the positives.</td>
</tr>
<tr>
<td>Discounting the Positives</td>
<td>Ignore positive accomplishments or events.</td>
</tr>
<tr>
<td>Jumping to Conclusions</td>
<td>Mind reading; assuming the negative; or fortune telling, predicting the worst outcome.</td>
</tr>
<tr>
<td>Magnification or Minimization</td>
<td>Blow negative events out of proportion and minimize good events/ experiences.</td>
</tr>
<tr>
<td>Emotional Reasoning</td>
<td>Reason how you feel (i.e “I don’t feel like doing this, so I’m not going to do it”).</td>
</tr>
<tr>
<td>Should Statements</td>
<td>Judge or criticize yourselves or others with “shoulds” “Shouldn’t” “ought to” etc.</td>
</tr>
<tr>
<td>Labeling</td>
<td>When mistakes are made, you label yourself with a characterological shortcoming (i.e. “I’m a loser” rather than “I made a mistake”).</td>
</tr>
<tr>
<td>Personalization</td>
<td>Blaming yourself or others for something you or they are not entirely responsible for</td>
</tr>
</tbody>
</table>

**Treatment Focus #4: Interoceptive Trauma Exposure Protocol & Positive Reframing**

**Interoceptive Exposure Protocol**

After a daily practice of relaxation skills has been established, exposure to the traumatic event may be introduced in session, which is then followed by emotion regulation skills. These exposures may be a narrative story of the traumatic event or may be exposure to the sensory experience. Somatic sensations are common within this population therefore this may need to be addressed first if the client is attempting to avoid the sensory experience (i.e. trembling, heat in
the chest). The modification of this exposure is that the client has established a daily practice of relaxation techniques and that the client never reaches an extreme level of anxiety (no more than a 7, on a scale from 1-10) and it is immediately followed by an emotional regulation skill. This helps the client gain the confidence that they can tolerate the anxiety or somatic arousal and protects against the possibility of retraumatizing the client (Hinton et al., 2012).

**Applied Stretching with Visualization**

The *Applied Stretching with Visualization* protocol not only works as a form of emotional regulation but also serves as an exposure by creating sensations that may induce dizziness, which can then be used to create positive reassociations (Hinton et al., 2012). This section will further discuss the use of affirmations to help clients reframe their experiences.

It is important to introduce the *Applied Stretching with Visualization* after the client is relatively relaxed. The therapist can target movements that may be catastrophized by the client (i.e. head rolling to induce dizziness).

**Dizziness**

*Option 1:*

“Imagine you are at the beach. Lengthen your spine and imagine it is like a long palm tree trunk. Begin to roll the head in one direction, imagining the palm leaves circling in the wind”.

*Have the client repeat the following affirmation silently or out loud:*

“May I flexibly adjust to each situation just as the leaves of the palm tree adjust to each new breeze” (Hinton et al., 2012).

*Option 2:* (Hinton et al., 2012).
“Imagine you are a child at a birthday party. It is time to play *piñata*, you are blindfolded and being spun around. Tune in to the playfulness of this game and link this dizziness to playing this game”.

*Option 3:* (Hinton et al., 2012).

“Imagine you are on top of a green hill. Begin to do summersaults down the hill and embrace the feeling of being dizzy and out of control”.

(Hinton et al., 2011; Hinton et al., 2012)

**Treatment Focus #5: Living a life of meaning**

**Identifying Values**

“Values are chosen qualities of action that can be insinuated in behavior but not possessed like an object” (Hayes, 2004). Values can serve to guide a client to live a life of meaning. This is imperative after going through a collective trauma, given that clients have most likely had to deal a loss in some form. This can be loss of a loved one, home, lifestyle, role, or loss of functioning. The following forms may help clients identify their values by rating the importance of each value listed. Completing the forms interactively with the client is recommended. (See page 41)
### Values Chart

(More can be added at the bottom)

<table>
<thead>
<tr>
<th>Value/Valores</th>
<th>Not at all/ Nada</th>
<th>Not Very/ Casi Nada</th>
<th>Somewhat/ Un Poco</th>
<th>Very/ Mucho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/ Familia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage/Intimate Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matrimonio/Relaciones Románticas</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Parenting/ Crianza de los Hijos</td>
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</tr>
<tr>
<td>Friendships/ Amistades</td>
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<tr>
<td>Work/ Trabajo</td>
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<tr>
<td>Education/ Educación</td>
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<td></td>
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<tr>
<td>Recreation/ Recreación</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spirituality/ Espiritualidad</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Citizenship/ Ciudadanía</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical self-care/ Autocuidado Fisico</td>
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<td></td>
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</tbody>
</table>


Clients may then be asked to rate how consistently they have lived in alignment with their values over the past week.

<table>
<thead>
<tr>
<th>Value/Valores</th>
<th>Not at all/ Nada</th>
<th>Not Very/ Casi Nada</th>
<th>Somewhat/ Un Poco</th>
<th>Very/ Mucho</th>
<th>Obstacles (Assess for Cognitive Distortions and Avoidance and challenge through opposite action)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/ Familia</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Marriage/Intimate Relationships Matrimonio/Relaciones Románticas</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Parenting/ Crianza de los Hijos</td>
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<tr>
<td>Physical self-care/ Autocuidado Físico</td>
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</tbody>
</table>

Roemer & Orsillo (2010)
Treatment Focus #6: Shame and Guilt

Finding Forgiveness Through Action

It is common for trauma survivors to experience guilt, whether it be survivor’s guilt, or guilt for the repercussions of the event (i.e. unable to provide for family). It is important to manage the perceived guilt to help the client reach acceptance. When there is excess guilt that is not dealt with, it can develop into shame (a sense that there is something wrong with the person rather than a behavior or action that occurred). Shame and guilt should first be addressed in the context of their cultural and spiritual beliefs. For example, when there are cultural or religious practices that relieve guilt, this should be practiced. In Catholicism, going to confession or praying a penance is appropriate. The following are suggestions that may be utilized to address shame and guilt, as well beginning the grief process.

• Writing 3 positive memories and 3 negative memories of the loss (This may help humanize the loss)
• Unsent anger letter to the loss (This may help humanize the loss and process underlying emotions)
• Write a letter asking for forgiveness (either sent, unsent, or symbolically given, such as a message in a bottle or offered to the loss symbolically through the use of fire)
• Write a goodbye letter (can also be given symbolically)
• Ritual/Ceremony to honor the loss
• Make reparations (i.e. advocate for justice, volunteer, find forgiveness through having a purpose)

Responsibility Pie
This activity can be used to help the client visually see that it is impossible for someone to be 100% responsible for a particular outcome. It can help to create a more balance view of the event. This should be done in session with the client in order to guide them into believing they have a reasonable amount of responsibility. It may be counterproductive to have the client do this on their own.

First draw how much the client feels they are responsible for the event (0-100%).

If guilt is excessive, begin to list all factors that may have influenced the event.
5. Client

Assign all factors into the pie with percentages (client is to be placed last)

Reevaluate client’s perceived responsibility (0-100%): __________
Treatment Focus #7: Role Recovery and Community Building

In a study that interviewed the needs of those displaced by violence, role recovery and community building were identified to be strong components in healing from trauma (Richards et al., 2011). This may be done in several of the following ways as suggested by Richards et al. (2011):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volunteering</td>
<td>This can help clients reconnect to a role of being a provider or a caretaker and enforce a sense of belonging in the community.</td>
</tr>
<tr>
<td>Support groups for displaced individuals/families</td>
<td>This will help in creating a sense of community and provide clients with a means to connect with others who have lived a similar experience. This may also increase trust, decrease inhibition, and a sense of relief that they are not alone.</td>
</tr>
<tr>
<td>Occupational support</td>
<td>The goal is to provide support to clients who have to rebuild their life in a completely new environment for which most have not prepared for. This may empower those who have possibly felt shame for needing to utilize resources offered to them.</td>
</tr>
<tr>
<td>Psychoeducational groups in the community</td>
<td>Providing psychoeducational groups in the community can help decrease the stigmatization of mental disorders. Since medical doctors are usually the first point of contact, it may be useful for therapists to get involved with medical doctors to help address these issues.</td>
</tr>
<tr>
<td>Access to Resources</td>
<td>Those who have suffered a collective trauma often are in a new location and have difficulty adjusting given the possibility of language barriers and/or legal concerns. It is important to have a holistic approach to treatment in that the access to these resources are available. Often times, individuals do not know</td>
</tr>
</tbody>
</table>
their rights or that these services are available for them. This may include offering referrals to legal services, especially if they have endured racism or discrimination.

### Final Thoughts

A cultural lens should always be at the forefront of treatment. Although Latinos tend to be grouped together, many factors such as race, SES, migration history, political and religious beliefs, as well as individual experiences make this population diverse in itself. The above resource is to be used as a guide for treatment and modified in any way needed to address the needs of each client. Unique cultural practices should always be encouraged to enhance treatment and establish a strong therapeutic alignment. It is critical to expand on the client’s personal strengths and resources. The literature highlights the issue of high client drop out with regard to exposure type treatments. In order to address this concern, research has supported the use of relaxation skills before and after exposures in order to increase tolerability of interventions.

Limitations of the guide include its use with children and adolescents. Interventions have focused on an adult population and less on appropriate adaptations for other age groups. In addition, the guide is limited with regard to providing clinicians access to specific resources in the community. Connecting clients to resources in the community, including groups and legal counsel, is critical when working with a population affected by collective trauma. It is suggested that clinicians establish a list of referral sources within their community such as volunteer agencies, legal services, and employment agencies. In addition, it is important to offer therapeutic services out in the community, as it may be difficult for clients to be aware of
treatments available. Clinicians may choose to offer outreach services in the community, such as congregations or community centers, in order for clients to have easier access to resources.
REFERENCES


ataque de nervios: The role of fear of negative affect and fear of arousal symptoms. *CNS Neuroscience and Therapeutics, 15*, 264-275.


Utilidad de un cuestionario para rastreo del estrés postraumático en una población Colombiana [Usefulness of a screening questionnaire for posttraumatic stress in a Colombian population]. Revista Neurológica, 34 (10), 911–916.


APPENDIX O

IRB Approval Letter
PEPPERDINE UNIVERSITY
Graduate & Professional Schools Institutional Review Board

July 11, 2013

Melissa Cordero,

IRB# P0413D13
Study Title: A guide for mental health practitioners working with collective trauma victims from Latin America; An experiential approach

Dear Ms. Cordero,

Thank you for submitting your application, A guide for mental health practitioners working with collective trauma victims from Latin America; An experiential approach, for review to Pepperdine University’s Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Shelly Harrell, completed on the proposal. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 6 and 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted Approval. The IRB approval begins today, July 11, 2013, and terminates on July 10, 2014. In addition, your application to waive documentation of informed consent, as indicated in your Application for Waiver or Alteration of Informed Consent Procedures form has been approved.

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond July 10, 2014, a Continuation or Completion of Review Form must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual (see link to “policy material” at http://www.pepperdine.edu/irb/graduate).
Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,


Doug Leigh, Ph.D.  
Chair, Graduate and Professional Schools IRB  
Pepperdine University  

cc:  Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives  
Ms. Alexandra Roosa, Director Research and Sponsored Programs  
Dr. Shelly Harrell, Graduate School of Education and Psychology