3 Tools for Treating Trauma-Related Disorders Among Latinos

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Overview of the Trauma

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

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

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

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

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

Impact of Culture

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

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

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

Over 25 years of research studies has found that Hispanic adults are more likely than their non-Hispanic counterparts to experience severe symptoms of post-traumatic stress disorder (PTSD) (Escobar et al., 1983; Galea et al., 2004; Kulka et al., 1990; Lewis-Fernandez et al., 2008; Norris, Perilla, & Murphy, 2001; Pole et al., 2001; Schell & Marshall, 2008). Eisenman, Gelberg, Liu, and Shapiro (2003) mentioned that a third of the Latino population who have been exposed to traumatic experiences developed symptoms of depression and PTSD. A longitudinal study by Marshall, Schell, and Miles (2010) with over 600 participants replicated several study findings indicating that Hispanics tended to report higher levels of symptoms such as hypervigilance and flashbacks. In contrast, few differences were observed for symptoms characteristic of impaired psychological functioning such as difficulty concentrating or sleep difficulties (other than nightmares). This may suggest that the pattern of symptoms for Hispanics with PTSD may differ not only in prevalence and degree but also in the types of symptoms. A study by Pole, Best, Metzler, and Marmar (2005) comparing Hispanic police officers (n = 189) from their non-Hispanic Caucasian (n = 317) and Black (n = 162) counterparts found that greater peri-traumatic dissociation, greater wishful thinking and self-blame coping, lower social support, and greater perceived racism were important variables in explaining the elevated PTSD symptoms among Hispanics.

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

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

Symptoms/Diagnoses

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

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

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

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

Idioms of Distress

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

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

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

Trauma-Informed Care and Evidence-Based Techniques

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

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

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

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

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

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

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

Index of Bilingual Handouts

Adapted and Translated by Karina Perdomo Below

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

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

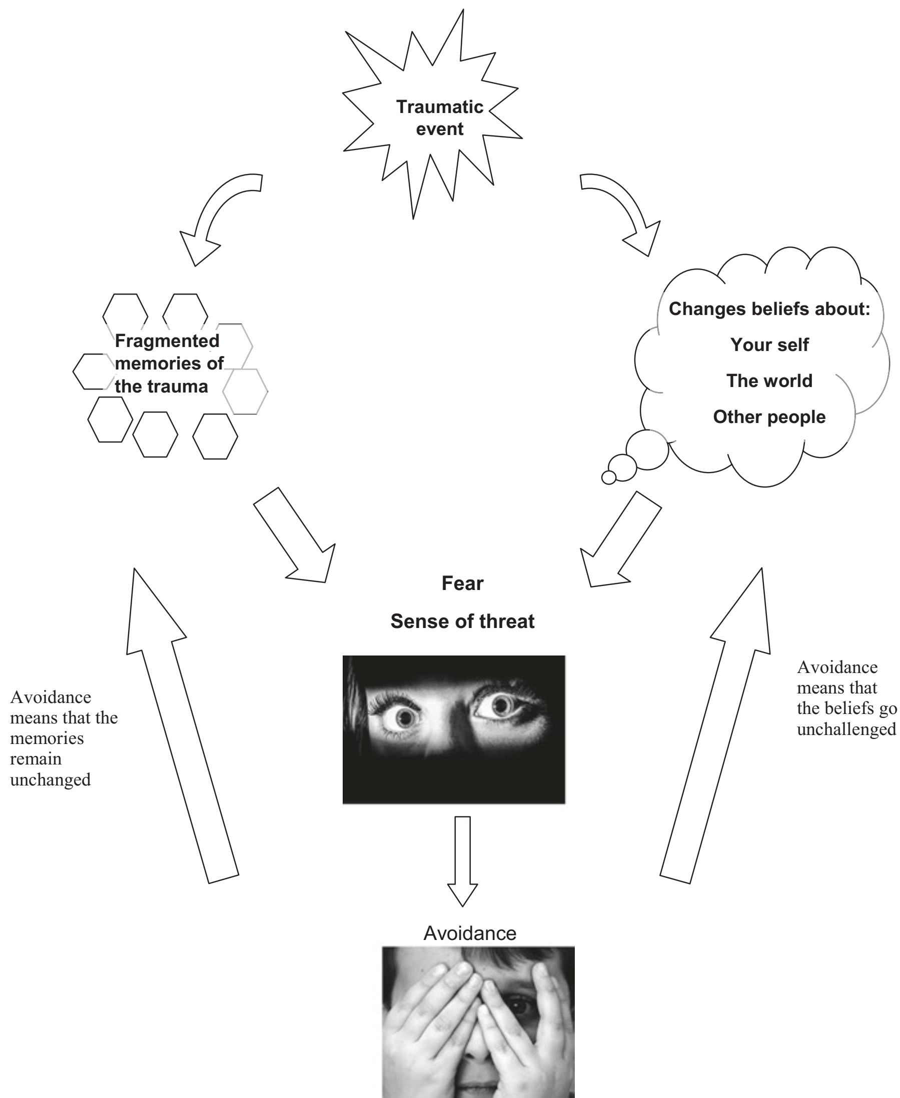
(c) Grounding techniques
- Safe place
- Body awareness
- Moving

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

(e) Triggers
- Trigger grid

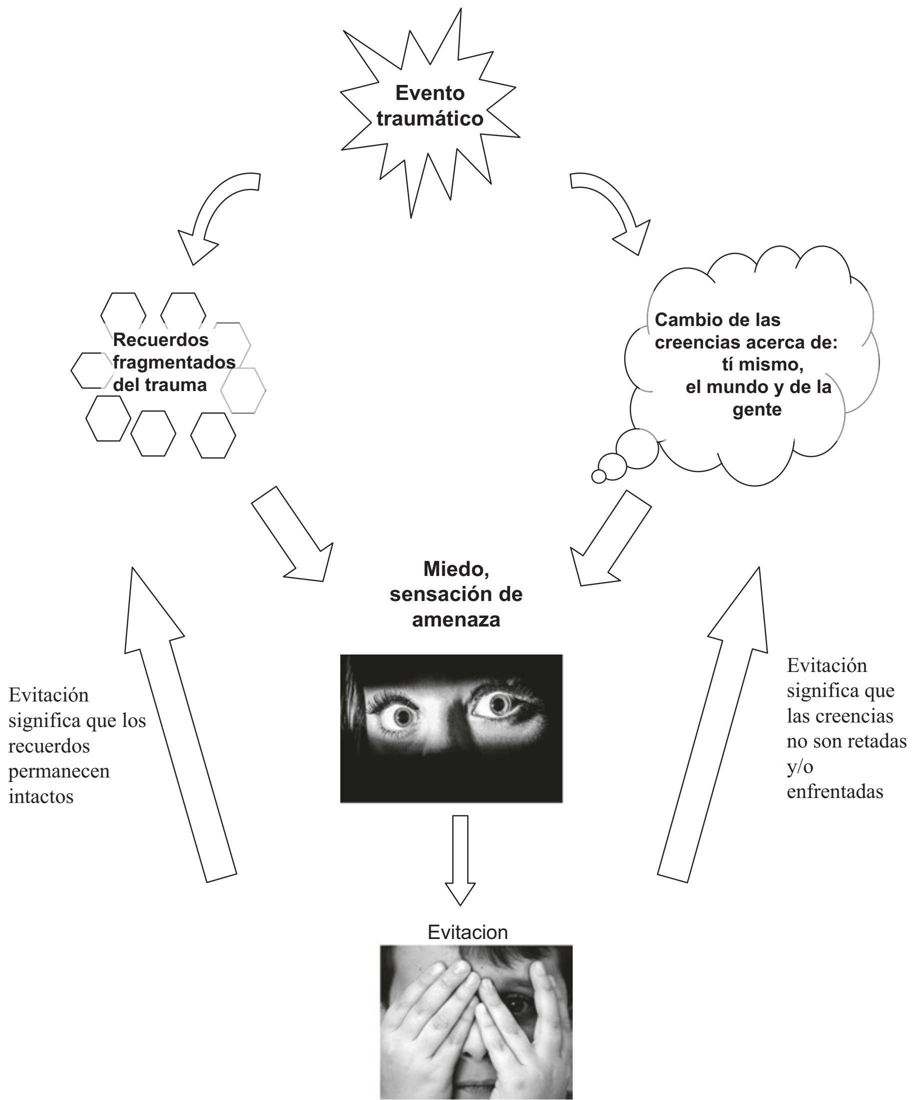
(f) Exposure
- Avoidance & Gradual Exposure: Hydra & Hercules
- Exposure homework

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



Entendiendo el trastorno de estrés postraumático (TEPT)

Entendiendo el trastorno de estrés postraumático (TEPT)



Síntomas de estrés extremo (Extreme Stress Symptoms)

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

The Power of Relaxation

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

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

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

Deep Breathing for Stress Relief

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

El poder de la relajación

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

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

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

La respiración profunda para aliviar el estrés

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

Progressive Muscle Relaxation Sequence

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

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

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

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

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

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

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

Secuencia de Relajación muscular progresiva

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

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

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

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

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

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

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

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

Fecha/Date:

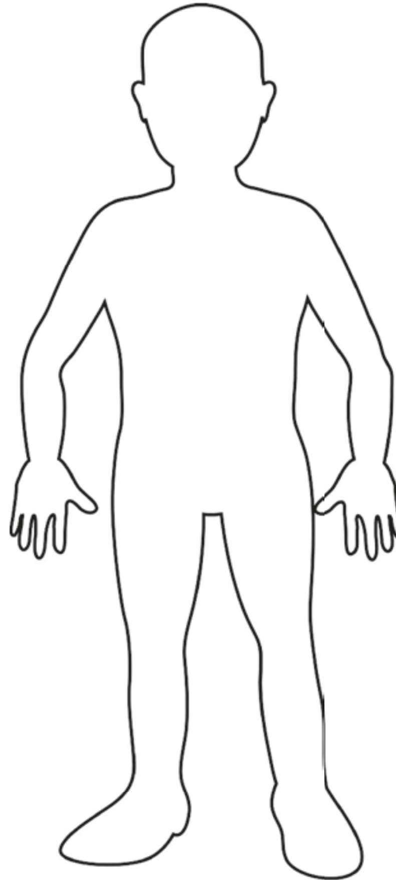
Periodo de la sesión/ Session Time	Sentimiento/Feeling	Intensidad/Intensity
Al inicio de la sesión/ Beginning of session		
En medio de la sesión/ Middle of session		
Al final de la sesión/ End of session		

¿Cómo sentimos las emociones en nuestro cuerpo?

(How do we feel emotions in our body?)

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

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



Grounding Techniques

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

Técnicas de "grounding"

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

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

Finding a Safe Place or Activity

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

Encontrando un lugar o actividad segura

Un lugar seguro es una forma de ancla para reducir el estrés de lidiar con recuerdos traumáticos. Las anclas se pueden utilizar como un "freno" cuando las cosas se complican. Un anclaje adecuado es aquel que da alivio (tanto corporal como emocionalmente) y una sensación de bienestar. Es preferible que un "ancla" provenga de una experiencia de la vida real, de forma tal que los recuerdos positivos en el cuerpo y la mente se puedan acceder. En ocasiones resulta útil trabajar con su consejero para establecer de antemano cuál es este lugar, de forma tal que le resulte fácil visualizarlo o acudir cuando lo necesite. De esta forma pudiera decirse que un lugar o actividad segura es una experiencia actual o recuerdo que produce un sentido de protección. Debe tener asociaciones con sentimientos de tranquilidad y seguridad (en oposición a 'relajante'-que puede resultar inseguro para personas que han sufrido traumas- o 'agradable'- que puede ser sobre-estimulante). Es preferible que el lugar/actividad sea algo real debido a que esto producirá resonancia somática en lugares de la memoria. Los sonidos, olores, etc., que se registran como huellas en la memoria sensorial pueden ser muy accesible. Es útil recordar o acceder a este lugar/actividad en momentos de estrés y ansiedad, o para reducir la sobre exaltación fuera o durante la sesión terapéutica.

Body Awareness

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

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

Moving

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

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

Conociencia de nuestro cuerpo

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

Moverse

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

Dealing with Flashbacks

What are flashbacks?

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

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

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

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

Manejando recuerdos repentinos

¿Qué son los recuerdos repentinos?

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

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

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

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

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

Ideas on How to Cope with Flashbacks

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

Ideas sobre cómo enfrentarse con los recuerdos repentinos

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

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

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

Flashback Halting Protocol

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

Protocolo para detener recuerdos repentinos

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

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

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

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

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

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

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

____

____

____

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

*1.*____

*2.*____

*3.*____

*4.*____

*5.*____

*6.*____

*7.*____

*8.*____

*9.*____

*10.*____

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

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

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

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

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

*1.*____

*2.*____

*3.*____

*4.*____

*5.*____

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

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

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

1.____

____

____

2.____

____

____

3.____

____

____

4.____

____

____

5.____

____

____

6.____

____

____

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

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

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

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

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

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Exposure Homework

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

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

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

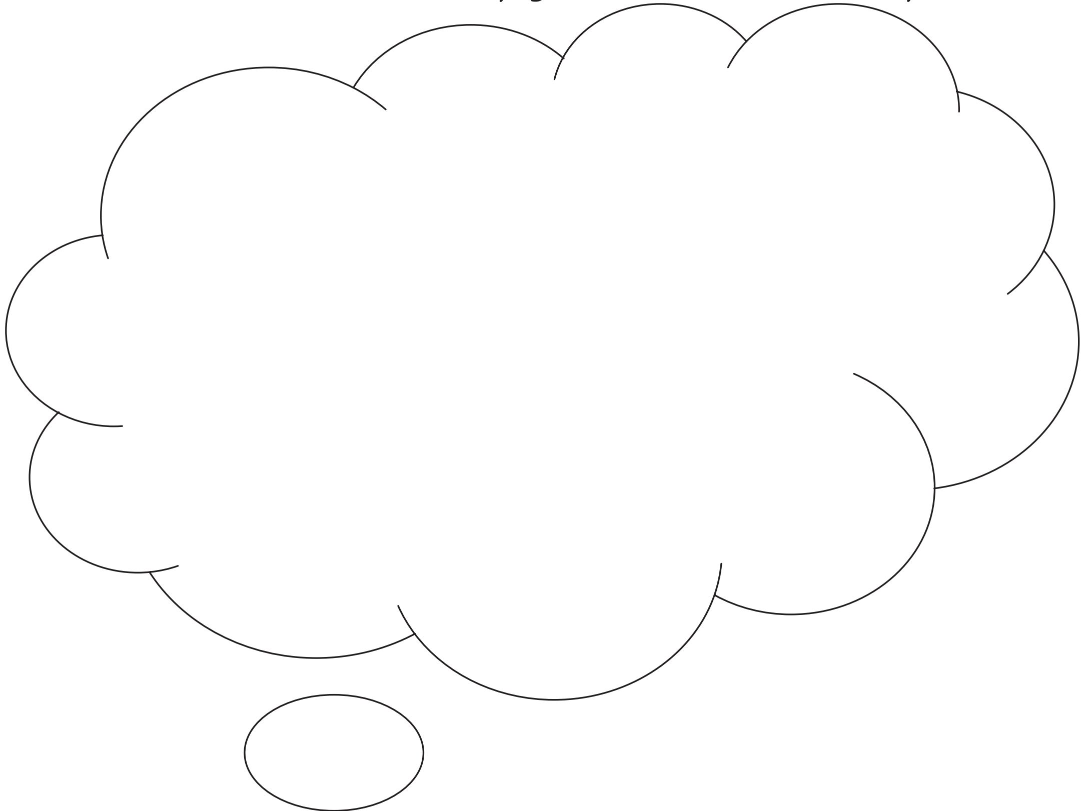
1. *¿Qué es lo peor que podría suceder en esta situación?*
2. *¿Cuál es la probabilidad de que esto pueda suceder?*
3. *Evalúa la evidencia a favor y en contra de la probabilidad de que esto ocurra.*
4. *¿Cuál es el plan de seguridad en caso de que lo "peor" pase?*
5. *Identifica las habilidades (respiración,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

Ratings before and after in vivo exposure:

Rangos antes y después de la exposición "en vivo"

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

Part of remembering what happened is being able to picture it in your mind. You would probably rather block it out of your mind, but that won't make it go away. Picture what happened, in your mind, then draw it on this page. It's hard to do, but try.



Parte de recordar lo que pasó es ser capaz de imaginarlo en su mente. Es probable que prefiera bloquearlo fuera de su mente, pero eso no hará que desaparezca. Imagínese lo que pasó, en su mente, y a continuación, dibuje en esta página. Es difícil de hacer, pero trate.

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