ABSTRACT

Title of Thesis: THE PREVALENCE AND ROLE OF AVOIDANCE COPING METHODS FOR LATINOS IN THE UNITED STATES.

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Current research concerning Latinos in the United States has indicated that they are at a higher risk for mental illness (e.g., PTSD) than other racial/ethnic groups. The purpose of this study was to understand the possible function a culturally normative coping style plays in the occurrence of depression for Latinos when compared to other racial/ethnic groups. The prevalence of avoidance coping methods and the relationship of depression and avoidance coping was examined for a sample (N=429) of Latino (*n*=129) White (*n*=150) and Black (*n*=150) clients. Results indicated that the frequency with which Latinos engaged in avoidance coping was no different than other groups. However, Black participants were significantly more likely to use avoidance coping that White participants. Furthermore, the use of defensive avoidance coping was linked to high depression; however there was no race/ethnicity by avoidance coping interaction. The empirical and clinical implications of these findings are discussed.

THE PREVALENCE AND ROLE OF AVOIDANCE COPING METHODS FOR LATINOS IN THE UNITED STATES

by

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Chapter I Introduction

Statement of the Problem

Within the last two decades the Latino population in the United States has dramatically increased, a growth that is rapidly changing the demographics of the United States (Alegria et al., 2007). This is due in part to the high birth rate of Latinos in the United States, as well as an influx of immigrants from Central and South America (Asner-Self & Marotta, 2005; Cavazos-Rehg, Zayas, & Spitznagel, 2007). The term *Latino* is typically includes "Spanish-speaking immigrants from Latin America" (Falicov, 1998, p. 34) and the native born United States citizens of Latin American or Spanish decent. Latinos have recently become the largest ethnic minority in the United States, at over 15% of the population in 2007 (Gonzales, 2008; Pole, Gone, & Madhur, 2008).

Due to this significant growth, it is not uncommon for mental health clinicians to see Latino clients requesting their services. The dramatic flood of new immigrants to the United States has forced the helping professionals to "generate new services, new sensitivities, and new interventions for large groups of people who are recognizably needy, but unrecognizably foreign" (Foster, 2001, p.153). Unfortunately, there is comparatively little research to inform and guide clinicians in becoming competent and culturally sensitive when working with this diverse community. In response to this lack of information, many in the field have begun to explore in greater depth the unique characteristics of this new clientele.

The preliminary research regarding Latinos has focused on the general psychological state of Latinos in the United States as compared to that of other groups (e.g., Caucasian, Black). Some of this research shows that for Latinos, the levels of anxiety, depression, and symptoms of trauma are usually higher than those of the general U.S. population (Adams & Boscarino, 2005;

Asner-Self & Marotta, 2005; Pole et al., 2008). For Latino immigrants, it appears that both mental and physical health generally deteriorate as their time in the United States increases (Alegria et al., 2007; Cavazos-Rehg et al., 2007; Hiott, Grzywacz, Arcury, & Quandt, 2006). One particularly significant finding is that Latinos frequently exhibit higher symptoms of Post-Traumatic Stress Disorder (PTSD) than any other racial/ethnic group (Pole et al., 2008). This finding is consistent in a broad array of studies involving police officers, veterans, victims of Hurricane Andrew, and those who experienced the trauma of 9-11 (Pantin, Schwartz, Prado, Feaster, & Szapocznik, 2003; Perilla, Norris, & Lavizzo, 2002; Pole, Best, Metzler, & Marmar, 2005; Pole et al., 2008). Yet, some find no evidence to support this trend (Adams & Boscarino, 2005; Penk et al., 1989). Thus, the existing research findings are unclear, sometimes indicating that the differences among racial/ethnic groups in PTSD levels are clinically significant and sometimes indicating that there are no differences among the groups (Perilla et al., 2002).

The reasons that Latinos would exhibit poorer mental health than other racial/ethnic groups are not clear. Pole, et al. (2005) explore many factors, such as trauma exposure, peritraumatic dissociation (i.e., dissociation during the trauma), social context, and coping styles, in an attempt to answer the question of why Latinos may be at greater risk for PTSD. Pole, et al. (2005) suggest that understanding the difference in posttraumatic stress symptoms might require an examination of possible cultural differences in post trauma coping. When compared to factors that might contribute to high PTSD scores in Latinos (e.g., high trauma exposure, social context, etc.), it seems the post-trauma coping style is a factor that can be controlled by the individual and perhaps influenced by therapy, thus a factor of interest for clinicians. Even so, these authors agree that there is limited research regarding ethnicity and coping style in relation to PTSD (Pole et al., 2005). In other words, little is known about how Latinos respond to and deal with the

traumatic experiences that they may face or how these coping methods affect their mental health (Pole et al., 2008).

Coping strategies can vary by culture and potentially influence how trauma is experienced, reported, dealt with, and recovered from. Coping is defined as the methods by which one manages internal or external demands or stressors that seem to exceed the resources of the individual (Ibanez, Buck, Khatchikian, & Norris, 2004). Falicov (1998) explains that coping strategies could be very different for Latinos as a group, compared to the dominant culture. For example, Latinos commonly tend to see their problems as a result of fate or the will of God (*fatalismo*). Yet even with this perspective, Latinos still hold that varying degrees of self-control are possible. *Controlarse* is a "dynamic theme of Latinos, a central cognitive and behavioral mechanism for mastering one's moods and emotions, particularly anger, anxiety, and depression" (Falicov, 1998, p. 150). Specifically, these coping strategies include: *aguantarse* (withstanding stress), *no pensar* (avoiding thoughts), *resignarse* (resignation to one's fate), and *sobreponerse* (overcoming adversity). If these coping strategies are in fact common among Latinos, some might easily be labeled as cognitive avoidance strategies.

According to the American Psychiatric Association (*DSM-IV-TR*, 2000), the cognitive avoidance coping strategy is one of the criteria for the diagnosis of PTSD. *The Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV-TR*, 2000) lists, as one criteria for a PTSD diagnosis (under criterion C), "efforts to avoid thoughts" (p. 468). Having been exposed to a traumatic event (criterion A) that is persistently reexperienced (criterion B), and having persistent symptoms of increased arousal that were not present before the trauma (criterion D), which causes significant distress (criterion F) and lasts more than 1 month (criterion E) are the remaining criteria for a PTSD diagnosis. The Trauma Symptom Inventory (TSI; Briere, 1995)

operationally defines these criteria with items on its defensive avoidance subscale. The defensive avoidance subscale of the TSI measures this one element of the criteria for diagnosing PTSD in terms of items assessing cognitive and behavioral avoidance strategies, such as "trying to forget a bad time in your life," "pushing painful memories out of your mind," and "trying to block out certain memories" (TSI; Briere, 1995).

However, as Falicov (1998) suggests, trying to control one's thoughts and push forward to overcome problems may be considered culturally appropriate coping strategies among Latinos. If such a strategy is prevalent among Latinos, the defensive avoidance score of the TSI would reflect this. Thus, a high defensive avoidance score for a Latino could be an indication of an acceptable coping behavior instead of pathology, reflecting a cultural bias. It is also possible that this aspect of the Latino culture could be significantly influencing the mental health (e.g., PTSD, depression, etc.) of Latinos in the United States who are faced with trauma and other stressors. Thus, it remains unclear whether high PTSD scores for Latinos are simply a result of a cultural bias, (e.g., mislabeling culturally normative coping mechanisms as pathological) or evidence that Latinos are experiencing more severe symptoms of mental illness compared to other racial/ethnic groups because of cultural differences of acceptable ways to deal with traumatic and stressful events.

After considering the gaps in the current body of research, it appeared that there were several questions regarding the mental health of Latinos that remained unanswered. First, is the avoidance coping style more prevalent for Latinos than for other groups? Second, is the association between avoidance coping strategies and mental health different for Latinos than other ethnic/racial groups? After reviewing the current research, it was unclear how the use of avoidance coping methods serves Latinos and influences their general mental health compared to

other racial/ethnic groups. Although the answers to these questions were not certain, there was clearly a need for comparative research investigating the influence of cultural coping strategies and the mental health of Latinos. Therefore, this study explicitly focused on exploring the prevalence of avoidance coping for Latinos as well as their function in the mental health of Latinos.

Chapter II Review of the Literature

Latinos in the United States

The Latino Identity

Latino is a term used to define an ethnic group with a common Latin heritage (e.g., originating from a Latin American country). While this term is typically used to indicate Spanish speaking individuals from Latin America, technically "Latino" also includes non-Spanish speaking Latin Americans (i.e., Brazilians). Although Latino is often used interchangeably with *Hispanic* to identify the same ethnicity, their meanings are slightly different. Hispanic refers specifically to Spanish descent and the use of Spanish language. The term Hispanic was adopted by the U.S. government, not by the ethnic group themselves, in the 1970s as the official term for uses of polling (Guzman, 2001). In addition, Hispanic is often disliked by Latin Americans, due to its implicit reference to the dominance of the early Spanish conquerors in many Latin American countries (Casanas, 2005). The term Latino(a) may be more culturally appropriate, because it is derived from the Spanish language, can indicate gender, and is considered to be a self-identifying term (Casanas, 2005). Thus, for these purposes, Latino will be the term utilized to signify immigrants from Latin American (i.e., Spanish speaking countries) and their descendants, as well as native born United States citizens with Latin Heritage (i.e., descendants of Spanish American colonists who resided in the southwestern region that is presently part of the United States).

Latinos are culturally distinct from other ethnic groups in many ways, but within the Latino culture, as with most groups, there is diversity among individual members. The Latino group as a whole is united largely by the Spanish language, the Catholic religion, and many shared cultural values (Pole et al., 2008). Some widespread values and beliefs regarding

traditional gender roles in the Latino family and community are *machismo* (i.e., strength and authority for men), *marianismo* (i.e., submissiveness for females), (Mendelson, Rehkopf, & Kubzansky, 2008), *familismo*, (i.e., dedication to the family), *respecto* (i.e.,importance of respect), and *fatilasimo* (i.e., the belief that God or fate is in control) (Perilla et al., 2002).

Although Latinos are united in some aspects (e.g., language, religion, culture), there is also significant diversity within the Latino ethnic group (e.g., race, origin, language). Because of the diversity of race within the Latino group, the U.S. Census Bureau clarified that the terms Latino and Hispanic signify ethnic origin and not race (Guzman, 2001). Thus, this clarification implies that one can identify as White or Black (race) and Hispanic (ethnic origin). Latinos also vary by country of origin, even though most of the Latinos living in the United States (approximately 70%) are from Mexico (Gonzales, 2008). In the United States, foreign and native born Latinos, live in every state (Gonzales, 2008).

Diversity by language also exists, although Latinos are often grouped as "Spanish-speakers", the accent, word choice, and dialect varies considerably by region and country of origin. This diversity extends in many cases from language to culture. For example, even though they are both technically Latino, Argentines might claim they are quite different from Puerto Ricans (or Latinos from another country), and even biases and prejudices may be held regarding Latinos from a different country. Nonetheless, within the United States, Latinos tend to group together based on common language, identity, and possibly because the in-group differences are not as extreme as the differences from other ethnic/racial groups (e.g., Black, European American, Asian, etc.).

The Growth of the Latino Population

Latinos have been members of the population in the United States for most of its history, yet the most substantial growth has occurred in the last few decades. They are currently the fastest growing population in the United States (Fry, 2008). From the year 2000 to 2007, the Latino population experienced a growth of 29%, while the much larger non-Latino population saw only a growth of 4% (Fry, 2008). This high growth rate was almost four times that of the total population (US Census Bureau, 2004). In some areas in the United States the growth rate has been as high at 400% since the 1990 census (Asner-Self & Marotta, 2005). California leads the country with the greatest number of Latinos (37 million; 30% of the U.S. Latino population are found in California, and 98% of the population in East L.A. are Latino) and New Mexico with the highest density of Latinos (45% of the state's population) (Gonzales, 2008). Within the last decade, Latinos have become the largest minority population in the United States (Pole, et al., 2008), making up just over 15% of the general population in 2007 (Gonzales, 2008). Since the year 2000, Latinos have been responsible for over half (59%) of the overall growth in the U.S. population (Fry, 2008).

The growth of the Latino population, especially from 1970 to 1990, has been in large part a result of immigration. Throughout its history, the United States has experienced immigration from all parts of the world. During the 1940s–1960s the majority of immigrants came from European countries. But with a change in immigration policies, specifically the Immigration and Naturalization Act of 1965, the gates were opened to immigrants from non-European countries. Also, the Bracero Program of 1964 increased the number of undocumented migrant workers from Mexico in the United States. Thus, the 1970s saw a surge of immigrants from non-European countries, specifically Latin America, entered the United States. Since the 1980s, over 40% of the immigrants entering the United States have come from Latin America (Fong & Chan,

2008). Within the last decade, the thousands of immigrants from Latin America who have entered the United States borders, illegally or not, have attempted to build a new life for themselves in a new country.

Despite the fact that until the 1990s the growth of the Latino population in the United States could be attributed mainly to immigration, today the most significant factor contributing to this growth is natural increase (births minus deaths) (Fry, 2008). Currently 59% of the Latinos living in the United States are native born (Pole et al., 2008). High birth rates in the Latino community have produced a young population, (e.g., higher percentage of children in the population). The Latino population is significantly younger than the general population; the median age for Latinos is 25.9 years compared to the median age of 35.3 years for the general population (Guzman, 2001). In addition, 35% of Latinos are under 18, compared to 25% of the U.S. population who are under 18 (Guzman, 2001). Compared to other ethnic groups, Latinos have the highest percentage of preschoolers (under age 5), with more than 10% (or 4.2 million) in this age group (US Census Bureau, 2004). This young population may also be a contributor to the high birth rates. Almost 8.5% (7.3% native, 9.6% immigrants) of Latino women ages 15-44 gave birth in 2006, as opposed to the only 6.1% of White women who gave birth (Gonzales, 2008).

Cultural and religious values regarding the importance of the family may also contribute to the growth of the Latino population. Latino families are on average 33% larger than the typical family in the United States (Guzman, 2001). Some speculate that larger families are a reflection of Latino's value on family. Familismo is considered to be one of the most important cultural values for Latinos (Vasquez, 1998). It may also be true that the Catholic position on

birth control, abortion, and divorce may also influence a Latino's decision to stay in a marriage and to continue to have children.

Whatever the reason, it is projected that the growth of that Latino population will continue to rise. It is estimated that by the year 2010 one out of every five Americans will identify as Latino (Pole et al., 2008). The U.S. Census (2004) projected that between the year 2000 and 2050, as many as 67 million people of Latino origin of any race would be added to the nation's population. Thus, Latino numbers are projected to increase 188%, growing from 35.6 million to 102.6 million, and doubling their portion of the U.S. population from 12.6% to 24.4% (US Census Bureau, 2004). With such substantial growth, now and in the future, people from Latino decent and culture require mental health services that are both culturally sensitive and effective treatment and care. "The sheer numbers of immigrants who increasingly request clinical services propels the search for reliable descriptions of phenomena that can inform and guide clinical practice with those whose cultural worlds may markedly differ from that of the clinician" (Foster, 2001, p. 158).

The Mental Health of Latinos

Despite the dramatic growth of the Latino population, scientific research literature is lacking in the area of mental health for ethnic minorities, and has changed little in the last decade (Willerton, Dankoski, & Martir, 2008). This gap has been recognized by a few researchers who have conducted studies regarding the mental health of minority ethnic groups, such as Latinos, in the United States (Andres-Hyman, Cott, & S. N. Gold, 2004; Pole et al., 2008; Rosenthal & Schreiner, 2000). Yet, information on minority health in general is lacking in mainstream psychology journals, especially in terms of empirically tested and culturally sensitive treatment (Pole et al., 2008).

Latinos and Mental Illness

The body of literature that is reviewed below includes a wide variety of findings regarding the prevalence of mental illness and the status of mental health of Latinos in the United States. "Mental illness" is used as a general term used to indicate the presence of disorders such as depression, anxiety, PTSD, etc. There are many researchers who have investigated the occurrence of mental illness of the Latinos without comparing them to other racial/ethnic groups (Alegria et al., 2007; Hiott et al., 2006; Torres & Rollock, 2007). These studies generally report high symptoms of mental illness for Latinos; however, it is difficult to understand the relevance of such findings without a frame of reference (i.e., what is common in the general population). Some comparative research findings suggest that Latinos show more symptoms of mental illness than other racial/ethnic groups in the United States (Asner-Self & Marotta, 2005; Mendelson et al., 2008). However, other studies report that the mental health outcomes for Latinos are no different from other ethnic minority groups (i.e., non-Whites) (Plant & Sachs-Ericsson, 2004; Rosenthal & Schreiner, 2000). And a few studies show no evidence for significant mental health difference among racial/ethnic groups (Adams & Boscarino, 2005; Aneshensel, Clark, & Frerichs, 1983; Penk et al., 1989). These inconsistencies make it is difficult to form any solid conclusions and point to the need for additional research. A brief summary of these different types of findings will be discussed in greater detail below.

Researching Latinos only. This first group of studies includes research focused on Latinos alone, without comparing them to other racial/ethnic groups. In these studies, the outlook is generally poor for Latinos. For example, it was reported that 19% of Latinos had recently (i.e., within the last 12 months) experienced symptoms from a mental disorder and one in three Latinos has a lifetime history of mental illness (Hiott et al., 2006). However, this dismal finding is based somewhat on non-comparative research studies focused only on Latinos as a group.

Such findings can be useful to establish group norms or when examining within group variables, such as acculturation. For example, Latino immigrants seem to be fairly healthy when they enter the country, but their mental health status soon deteriorates with acculturation and/or time in the country (Alegria et al., 2007; Cavazos-Rehg et al., 2007). Below are further details of non-comparative studies reporting on Latino's mental health.

Alegria, et al. (2007) evaluated the prevalence of anxiety, depression, PTSD, and substance use disorders among Latinos in the United States (n = 2,554). Their sample included both immigrant and native born Latinos of both genders and all levels of language proficiency, generational status, and length of time in the United States. Assessment interviews were conducted in either Spanish or English. The purpose of the study was to measure the contextual, social, and immigration factors that might influence Latino's risk for psychiatric disorders. They found that the lifetime prevalence of psychiatric disorders for Latino males was 28.1% and 30.2% for females. Latino immigrants were less likely than U.S.-born Latinos to fulfill the requirements for a lifetime psychiatric disorder. Psychiatric disorder prevalence was higher for those who migrated before age 13 or after 34. Lifetime prevalence of psychiatric disorder was higher among third generation Latinos than those of first or second generation status. Additionally, they reported a trend for higher English proficiency resulting in poorer mental health. Specifically, Puerto Ricans had the highest prevalence of psychiatric disorders of the four sub-ethnic groups (e.g., Mexicans, Cubans, and others).

Torres and Rollock (2007) looked at factors of acculturation and depression among Latinos, questioning whether factors of acculturation contribute to depression. The participants were volunteer Latinos (n = 96) from the Midwest, the majority of whom indicated having lived in the United States for less than 10 years. The participants were assessed for level of

acculturation and depression, as well as coping styles and perceived social effectiveness. The preliminary analysis showed that the sample generally scored low on the acculturation scale and perceived social effectiveness scale. The participants' depression scores implied that they were experiencing "substantial levels of depressive symptoms," with 40% at or above clinical levels of depression (p. 13).

Hiott, Grzywacz, Arcury, and Quandt (2006) documented poor levels of mental health (i.e., anxiety and depression) for Latino immigrants. Approximately 39% of the participants reported anxiety symptoms that might impair functioning and 40% were found to have significant depressive symptomatology. Despite the fact that the previous studies add to the body of knowledge regarding the mental health of Latinos, when they are compared as a group, their findings are inconclusive. A solid conclusion may be difficult to make from these studies without comparing the findings to other racial/ethnic groups in the United States.

Poorer mental health for Latinos. This second group of researchers conducted comparative analyses to understand the differences between Latinos and other racial/ethnic groups. The following studies showed that Latinos may be exhibiting more severe symptoms of mental illness than the general population. Asner-Self and Marotta (2005) examined mental health—defined by levels of PTSD, depression, and anxiety—among immigrants from Central America (n = 68) who were exposed to war trauma. They found that this sample scored significantly higher on the all three mental health scales compared to published norms of a non-patient U.S. population but were similar to the norm of those seeking outpatient services.

Mendelson, Rehkopf, Kubzansky (2008) did a meta-analysis study to assess the difference of major depressive disorder for Latinos and non-Latino Whites (n = 76,270). Although they found no difference in the reporting of lifetime major depression between the two

groups, their findings indicated that the Latinos reported significantly higher depressive symptoms than the White participants. They also point out that the Latinos who were depressed suffered more due to the inaccessibility of culturally appropriate mental healthcare facilities.

Poorer mental health for minorities. A third group of studies, that compared the mental health of ethnic minorities to the majority group, found a significant difference between minority and majority groups (minority groups exhibiting poorer mental health), but these studies showed no mental health difference between Latinos and the other minority groups. For example, Plant and Sachs-Ericsson (2004) compared the symptoms and prevalence of depression of several minority groups (i.e., Latino, Black, Native American) to White participants (n = 4,700). Their findings showed that the minority group members had a higher prevalence of depression and more severe symptoms than the White participants. However, none of the minority groups' scores on the depression scale were significantly different from the others. Thus, in this study, the symptoms of mental illness were no more severe for Latinos than for Black or Native American participants.

Rosenthal and Schreiner (2000) had a similar result in their study regarding the prevalence of psychological symptoms among undergraduates from an ethnically diverse public college (n = 595). They used several subscales on the Trauma Symptoms Inventory (TSI) to indicate the psychological distress of the each participant. Their findings suggest that the college students reported a wide range of symptoms. Although the White students reported lower scores of psychological distress than the other ethnic groups, none of the ethnic groups (i.e., Asian, Black, Latino, White, and other) reported scores that indicated a statistically significant difference among groups.

Latinos were no different. The final group of studies did not produce evidence to support the theory that the mental health of Latinos differ significantly from other racial/ethnic groups. One such study was by Adams and Boscarino (2005), which focused on the link between race/ethnicity and mental health following a traumatic event. Their sample (n = 2,368) was taken from city residents who had experienced the World Trade Center disaster of September 11, 2001. The study was conducted one year after 9/11 and included White, Black, and Latino participants (i.e., Dominicans, Puerto Ricans, and others). This study did not control for immigration status or level of acculturation of the members of the Latino population. The dependent variables were PTSD, major depression, panic attacks, and general physical and mental well-being. They found no evidence to support the theory that Latinos more consistently suffer poorer mental health than other groups.

An investigation of depression, race, and ethnicity conducted by Aneshensel, et al. (1983) also showed no significant mean group differences on the factor of depression. The study included adults from the Los Angeles region who were White (n=595), Black (n=122), English-speaking Latino (n=88), and Spanish-speaking Latino (n=104). The groups differed on individual symptom scores, but not on the total depression score. The researchers suggested that the implication for such findings was that while depression occurrence may not vary among racial/ethnic groups, the way the symptoms are manifested may vary (Aneshensel et al., 1983).

Penk, et al. (1989) examined the connection of minority status and the PTSD symptoms of Vietnam combat veterans. Their sample consisted of Latino (n=60), Black (n=280) and White (n=430) veterans who had similar combat exposure during the war and who were currently seeking treatment for an addiction. They found that Black veterans scored significantly higher on the PTSD measure. Interestingly, however, there was no significant difference in PTSD severity

or occurrence between White and Latino veterans. Therefore, in this case it appears that Latinos' PTSD scores were not different from the majority group.

Latinos and Posttraumatic Stress Disorder

Within a growing body of comparative research on this topic, some studies seem to indicate that Latinos are at greater risk of mental illness than those of the general population (Asner-Self & Marotta, 2005; Galea et al., 2002; Mendelson et al., 2008; Pantin et al., 2003; Pole et al., 2008), however, this finding as shown above is fairly inconsistent. Nevertheless, it should be noted that the research regarding PTSD has more consistently reported higher PTSD rates for Latinos than for any other racial/ethnic group (Pole et al., 2008). Pole, Gone, and Madhur (2008) reviewed the literature regarding mental illness, specifically Post-traumatic Stress Disorder, among ethno/racial minorities in the United States. Their review included information regarding several ethnic minority groups, including Latinos, as compared to White Americans. In their discussion of Latinos, they report that a few studies indicate that Latinos have higher rates of mood disorders and alcohol use disorders than Whites, but other studies reported lower rates of anxiety, mood, and other mental disorders for Latinos when compared to non-Latinos. However, regarding Post-Traumatic Stress Disorder (PTSD), they found that the research reported that Latinos had higher PTSD rates more consistently than their White counterparts. They found that while the differences of PTSD among other groups were mostly explained by differences in trauma exposure, this was not the case for Latinos.

Patin, et al. (2003) investigated the prevalence of PTSD among Latinos (n = 110) who lived 1,000 miles away from New York City after the 9-11 World Trade Center terrorist attacks. They focused on gaining an understanding about the severity of the trauma symptoms and the influence of previous traumatic experiences. Half of the Latinos in the sample had been in the

United States for more than 10 years. The majority of the Latinos in the sample had experienced some degree of first hand war exposure (69.7%) and natural disaster exposure (83.9%). All of the participants reported experiencing the trauma of 9/11 and the majority reported symptoms of intrusive re-experiencing (96%), avoidance and/or numbing (61%), and hyperarousal (60%), but interestingly only 19% were functionally impaired by these symptoms. When levels of impairment were not considered, 35% of this sample could be diagnosed with PTSD. They also found that previous war or natural disaster experience were significant predictors for 9/11 PTSD symptom severity (Pantin et al., 2003).

Perilla, Norris, and Lavizzo (2002) conducted interviews, in English and Spanish, of hurricane survivors six months after Hurricane Andrew hit southern Florida. The sample (n = 404) included equal numbers of Latino, non-Latino White, and non-Latino Black participants. The participants were assessed for PTSD with the Revised Civilian Mississippi Scale (RCMS), which encompasses three types of symptoms (intrusion, avoidance, and arousal). In addition the researchers assessed the degree of trauma experienced, the participants' culturally-related beliefs (e.g., fatalism, familism), and acculturation level. The results showed that the groups varied in the pervasiveness of PTSD. White participants showed the lowest rate (15%), followed by English-preferring Latinos (19%), then Black participants (23%) and finally Spanish-preferring Latinos showed the highest rate (38%) (Perilla et al., 2002).

In a study conducted following the September 11, 2001, terrorist attacks in Manhattan, Galea et al. (2002) attempted to identify predictors for psychological disorders (e.g., depression, PTSD) following a traumatic event. The sample consisted of (n = 1,008) residents of Manhattan who were present during the time of the attacks. They found that 7.5% reported symptoms of PTSD and 9.7% showed symptoms of depression. The frequency of PTSD and depression varied

by ethnic group; for PTSD the percentages were: Asian (3.2%), White (6.5%), Black (9.3%), Latino (13.8%) and other (19.1%). For depression, the percentages were: Asian (5.8%), White (7.4%), Black (11.9%), "other" (19.1%), and Latino (20.4%) In addition, they found that the Latino ethnicity was significantly associated with both PTSD and depression. Although this association of the Latino ethnicity with PTSD and depression was independent of covariates, the authors suggest that this relation could be mediated by social-cultural influences (Galea et al., 2002).

Ortega and Rosenheck (2000) studied the occurrence of PTSD among Latino Vietnam veterans. They found that Latinos who had served in Vietnam had a higher probability of experiencing PTSD and exhibited significantly more severe symptoms than non-Latinos. However, in spite of having a greater risk for PTSD, they were not at any higher risk for other psychological disorders than any other group. According to their findings, this risk for PTSD was not explained by acculturation levels. Even though Latinos suffered more severe symptoms of PTSD more often, they did not report a reduction in overall functioning compared to the other groups. The authors suggest that this may be due more to a culturally common style of expression than to pathology (Ortega & Rosenheck, 2000).

Pole, Best, Metzler, and Marmar (2005) reanalyzed the data from a previous study (Pole, et al., 2001) to understand why elevated levels of PTSD existed for Latino urban police officers when compared to urban police officers of other ethnicities. They found that Latino officers reported more severe PTSD symptoms than the non-Latino officers on several different measures, even though the level of experienced trauma was similar among the groups. Latino officers also reported more severe avoidance symptoms when compared to White officers, but not when compared to Black officers. Latino officers also reported less social support than White

officers. This raises the question as to whether high avoidance symptoms and low social support contributed to the higher rates of PTSD for Latino officers. Interestingly, regarding general psychiatric health, other than the higher rates of somatic symptoms for Latinos, there were no differences in general psychiatric symptoms.

These studies reporting on ethnic minorities and their mental health often operationalized poor mental health as having high levels of depression and anxiety. When no comparisons were made, the studies that focused solely on Latino's mental health generally report poor outcomes. When Latinos are compared to other ethnic groups, some studies show that Latinos report significantly poorer mental health than other ethnic groups (Mendelson et al., 2008), some studies show no significant differences among any of the ethnic groups (Adams & Boscarino, 2005; Aneshensel et al., 1983; Rosenthal & Schreiner, 2000), and others indicate no difference among minority (non-White) groups (Asner-Self & Marotta, 2005; Plant & Sachs-Ericsson, 2004). Furthermore, much of the research regarding Latinos and the occurrence of PTSD indicates that Latinos consistently have higher rates of PTSD. Such discrepancies in the body of research literature invite further investigation to understand if Latinos in reality experience higher rates of mental illness than other groups as well as to discover the factors that could be contributing to the possible poorer mental health for Latinos.

Contributors to the Mental Health of Latinos

It is not clear why there is a lack of consistency in the findings on Latino mental health, with some reporting a mental health status that is no different from other groups, while others reporting significantly high rates of depression, anxiety, and PTSD for Latinos. This discrepancy could be due simply to measurement error or reporting biases, or it could be that some groups of Latinos actually experience higher rates of mental illness and therefore certain variables that are

common among Latinos are contributing to poorer mental health outcomes. For example, some researchers have pointed to higher rates of stress and trauma in the lives of Latinos, compared to other groups, as a potential contributor to the poor mental health outcomes (Plant & Sachs-Ericsson, 2004). Others have suggested strong ties to cultural values, traditions, and coping methods may have an influence (Pole et al., 2008). However, some have pointed out that these ambiguous findings in the research might be an indication of measurement biases and/or poor execution of research methods (Alegria et al., 2007). Currently, it seems that the research is insufficient to make any definite conclusions. However, these three potential contributors, namely stressors, cultural coping differences, and measurement issues, are explored in greater depth below.

Stressors

The high occurrence of depression among minority groups cannot be explained by race/ethnicity alone, but some researchers theorize that certain stressors or combination of stressors have a deleterious effect on mental health (Plant & Sachs-Ericsson, 2004). Plant and Sachs-Ericsson (2004) found that members of minority groups (e.g., Latino, Black, and American Indian) experience more life challenges and have a greater difficulty meeting their basic needs. The authors linked these stressors to the higher prevalence and more severe symptoms of depression they found among the members of the ethic minority groups. Latinos, as an ethnic group in the United States, are faced with many stressors surrounding immigration, trauma, acculturation, limited social support and resources, fear of deportation, discrimination, and poverty. Below is a brief description of these stressors that are commonly experienced by Latinos in the United States and how they might contribute to poorer mental health.

Immigration. The United States may have enough incentives to draw thousands of Latinos to relocate within its borders, but life in this new country is not without a considerable amount of stress. Currently over 40% of Latinos in the United States emigrated from their countries of origin (Fry, 2008); many of whom entered illegally by very dangerous methods, but with high expectations of establishing a new, prosperous life. "The migration process is unquestionably linked to major adjustment stressors," the impact of which are apparent by the higher prevalence of severe mental disorders such as PTSD, depression, and anxiety in immigrant groups (Foster, 2001, p. 154). Some Latino immigrants cross the border as children, in their old age, or even while pregnant. Many walk across desserts or swim in rivers and oceans to arrive in the country undetected. Some may choose to hire *coyotes,* illegal travel brokers, who sometimes subject the travelers to months of physical and sexual abuse along the way (Foster, 2001). They suffer hunger, exhaustion and many even witness the death of a loved one (Zuniga, 2002). These experiences of "trans-border assaults, rapes, robberies and then the terrifying experience of being hunted down by the Border Patrol, will result in… emotional trauma" (Zuniga, 2002, p.145).

Very few Latino immigrants move to the United States without struggle, sacrifice, and trauma along the way, stressors that have been found to be detrimental to mental health of immigrants (Foster, 2001). Steel et al., (2006) found that factors such as past immigration detention and ongoing temporary protection were linked to PTSD, depression, and mental health-related disability. Another study, focused on the impact of immigration on young children, found that the immigrant children in their study (n=114; 32 non-immigrant, 82 immigrant*)* at the age of 8 had more psychopathological disturbances, cognitive difficulties, and more scholastic problems than non-immigrant children (Moro, 2003). Cervantes, Salgado de Snyder, and Padilla (1989)

examined the mental health of Latino immigrants (n=258) and native born Latinos and Anglo-Americans (n=329). They found that the immigrants had higher levels of distress than native-born Americans. In addition their findings indicated that PTSD was the result of not only the immigration experience, but also to previous trauma (Cervantes, Salgado de Snyder, & Padilla, 1989).

Trauma. After considering the risks of the journey, one might ask what inspired so many to leave their countries of origin, their careers, and in many cases their families, to settle in a foreign country. Often this can be explained by looking to the financial and educational resources and opportunities available in the United States and the lack thereof in their countries of origin. But in many cases it is not due to what the United States has to offer, but what they are leaving behind. Many Latinos flee their countries of origin due to violence, dire poverty, war, political persecution, and other traumatic events.

These prior traumatic experiences could contribute to high PTSD rates and poor mental health for Latinos. In one study, 11% of the Latino sample had experienced some type of political violence, but 76% had experienced some other (unspecified) traumatic events (Fortuna, Porche, & Alegria, 2008). Zuniga (2002) suggests that the trauma of war, torture, and witnessing death, can result in a feeling of powerlessness and truly stress the human psyche. When such trauma is followed by migration and "traumatic or derailing events before, during, or after dislocation continue," the result is often clinical psychological distress (Foster, 2001, p. 155). Some researchers even suggest that Latinos in general are exposed to higher incidences of traumatic stress than other ethnic groups (Kulka et al., 1990; Perilla et al., 2002).

With a history of previous trauma, Latinos may be more susceptible to symptoms of posttraumatic stress. In communities affected by war, disasters, and violence, the most common

psychiatric ailment is PTSD (Ruggiero, Rheingold, & Resnick, 2006). Many Latino immigrant families escaped from countries where war, violence, or natural-disaster related traumas were common (Pantin et al., 2003). One study found that over half (52%) of their sample of Central Americans who fled their country as a result of war or political unrest reported symptoms of PTSD (Cervantes et al., 1989). A study regarding the September 11 terrorist attacks reported that previous trauma was strongly related to both the severity and prevalence of PTSD symptoms. In fact, those who were diagnosed with PTSD reported twice as much war exposure and one-and-a-half times as much natural disaster trauma as those without PTSD symptoms (Pantin et al., 2003). Thus, because the prevalence and severity of PTSD is often higher for people who are from such countries, the stress of previous trauma may have made Latinos more susceptible to PTSD in the future.

Acculturation. Even though many Latinos made great sacrifices and faced potentially dangerous situations to flee their countries of origin, perhaps the true battle for survival began once they were living within the borders of the United States. It seems that traumatic experiences prior to migration are only exacerbated once Latinos enter the United States and begin adjusting to a new culture (Foster, 2001). Latinos appear to have better mental health before they move to the United States than after arrival (Alegria et al., 2007); thus the process of acculturation and/or other factors common to U.S. culture could be very stressful for Latinos (Asner-Self & Marotta, 2005). The stress of maneuvering through a culture that is oftentimes in conflict with their own can be especially difficult for newly immigrant Latinos. Cavazos-Rehg et al., 2007 point out that empirical data establishes the fact that the stresses Latinos face when merging and adapting into a new culture raise their risk for psychological and physical problems. In fact, some suggest that acculturation status, or the degree to which Latinos adhere to the traditions and values of their

ancestors versus those of the United States, may be a moderator for PTSD symptoms in Latinos (Pole et al., 2008).

Torres and Rollock (2007) examined both acculturation and depression among Latinos. The majority of the sample, Latinos (n = 96) from the Midwest, had lived in the United States for less than 10 years. The preliminary analysis showed the sample was poorly acculturated and over 40% of the participants were at or above clinical levels of depression. They also found that acculturation and time in the United States was negatively correlated with depression scores.

Limited social support and resources. Prejudices, cultural conflicts, language barriers, and the loss of social support are contributors to potential psychological distress as well as barriers to obtaining social and clinical services (Foster, 2001). Seeking social support is a positive coping mechanism, especially for Latinos who have more collectivist values. However, by choosing to immigrate to the United States, in many cases they are also choosing to leave behind family and friends. Many years might pass when husbands are separated from their wives and children from their parents (Zuniga, 2002). Thus, some Latinos find themselves with limited social support networks due to immigration, deportation, and poverty, a stressor that could be more detrimental to Latinos, especially compared to the social support to which they are accustomed (Cavazos-Rehg et al., 2007). Research examining Latino police officers, veterans, and survivors of terrorist attacks support the relationship between poor social support and high PTSD symptoms (Pole et al., 2008). In addition, one study reported that Latinos perceived they had less social support than other groups (Pole, et al., 2005). This lack of social support might be especially detrimental for the Latino population than for more individualistically centered ethnic groups (Pole et al., 2008). Due to economic, social, and language issues, it is often difficult for Latino immigrants to find adequate moral support and networks as they had in the past (Zuniga, 2002). Zuniga (2002) warns that if Latino immigrants do not "find and use community and cultural supports, their

emotional, psychological, and situational needs will not be met and they will become more vulnerable and more isolated'' (p. 152).

In addition to loss of social support, there are many barriers Latinos face when attempting to attain other social resources. First of all, Latinos may hold varying cultural beliefs about family, parenting, interaction styles, mental health services, and even mental illness in general. These values may conflict with the norms of American society. For example, because the Latino family is founded upon the values of *machismo* and *familismo* (Vasquez, 1998), it may be strained when confronted with the U.S. culture of individualism and feminism (Willerton et al., 2008). Furthermore, conflict may increase as the younger generation attempts to assimilate new values and roles that jeopardize the family's cultural framework (Zuniga, 2002).

Certain biases or beliefs might also inhibit Latinos from seeking out mental healthcare services (Willerton et al., 2008). When faced with stress or trauma, Latinos tend to seek support from the family or community, to seek divine intervention or religious meaning, and attempt to forget or not think about the negative events (Ibanez et al., 2004). Seeking out mental health services may not be a common practice for Latinos (Hiott et al., 2006; Padilla, Ruiz, & Alvarez, 1975; Willerton et al., 2008). Additionally, Latinos may not have access to services that provide bilingual therapists who are educated in the needs of Latinos (Cavazos-Rehg et al., 2007). Negotiating a system and trying to learn a new culture in a foreign language can be especially anxiety provoking. Stressors such as separation from family influence, language barriers, cultural differences, poor education, and more possibly affect Latino's emotional and physical wellbeing and may limit their accessibility to mental health resources (Cavazos-Rehg et al., 2007; Hiott et al., 2006).

Fear of deportation. Another stress common to Latinos, regardless of the acculturation level, is the fear of deportation. Whether immigrants themselves (40%), or descendants of

immigrants (60%) (Fry, 2008), Latinos are very aware of and sensitive to the issues surrounding immigration (Cavazos-Rehg et al., 2007). Many Latinos are undocumented or illegally living in the United States (i.e., approximately 9.3 million undocumented immigrants live in the United States) (Cavazos-Rehg et al., 2007). Especially as immigration laws have tightened in recent years, Latinos feel a sense of being constantly hunted (Cavazos-Rehg et al., 2007). Regardless of immigration status, many Latinos are aware of the threat that they or one of their family members could be arrested and deported without warning. The stress or fear of deportation is linked to poor health and is a significant predictor of poorer mental health status (Cavazos-Rehg et al., 2007).

Discrimination. Latinos are often met with other difficult social situations, such as racism and discrimination, from White people as well as from other minority groups (Hiott et al., 2006; Pole et al., 2008), which contributes to poorer mental health (Hiott et al., 2006). Perceived discrimination could even account for some of the high PTSD symptoms in Latinos (Pole et al., 2005). Pole et al. (2005) found that one variable which distinguished Latinos from other officers was their lower social desirability scores, greater perceived racism in the workplace, and less social support. However, in another study, the perceived discrimination for Latinos was reported as less than the discrimination experienced by Blacks (Pole et al., 2008). Perhaps the experience of discrimination to such a degree is a new experience for the Latino immigrant, and thus more influential. Proficient and educated Latino professionals find themselves unemployed or working in degrading jobs just to survive. Discrimination is not only experienced by immigrants; even those who are third or fourth generation American citizens may experience discrimination or negative prejudices because of their Latino heritage. These stressors may be significantly linked to the occurrence of mental illness, especially PTSD, for Latinos (Pole et al., 2005).

Poverty. Many researchers point to stressors surrounding poverty as detrimental to minority groups in general, including Latinos (Foster, 2001; Plant & Sachs-Ericsson, 2004; Willerton et al., 2008). The median annual earnings for Latinos is lower ($20,124) than the poverty level for a family of four ($21,200) (Department of Health and Human Services, 2008) and lower than both Whites and Blacks' median annual earnings ($30,186 and $22,941 respectively) (Gonzales, 2008). Ironically, Latinos' lower income is not due to high unemployment or poor work ethic. The male Latino labor force participation is higher (80%) than non-Latinos (74%), but yet they remain the poorest ethnic group (Vasquez, 1998). This is true for immigrants as well as second and third generation Latinos (Zuniga, 2002). Interestingly, however, Latinos are less likely to depend on government subsidies than other groups (Zuniga, 2002).

Even though Latinos may work long hours and perhaps several jobs, they still suffer the effects of poverty. The high poverty rate among Latinos can be attributed to their generally low education levels. For example, only 9% of Latinos completed 4 years of college, compared to 22% of non-Hispanics (Vasquez, 1998). Poor education might limit Latinos' employment opportunities and increase the difficulty of escaping poverty. Consequentially, many Latinos live in substandard conditions due to the combination of poverty, inadequate supports, and minority discrimination (Foster, 2001). Poverty conditions are linked with physically dangerous living conditions and inadequate heath care (Zungia, 2002). Over 32% of Latinos are uninsured (compared to the 19.5% of Blacks and 11.1% of Whites), which limits their access to both physical and mental health resources (Willerton et al., 2008).

Impoverished conditions also contribute to social and family problems. Zuniga (2002) explains that when families are living in poverty, at times parents cannot adequately supervise

their children. Such environmental conditions can expose children to sex and violence, challenging their emotional wellbeing. This also may lead to the assignment of parental responsibilities to an older sibling, which could interfere with the older child's developmental and educational needs.

Cultural Coping Styles

Stress can be damaging to one's mental health and these factors could potentially explain why Latinos have poor mental health. However, Latinos are not the only ethnic minority group who experience the stressors discussed previously. In addition, life stressors only account for less than 15% of the variance in mental health outcomes (Blalock & Joiner, 2000). Therefore, in order to explain why Latinos are frequently found with poorer mental health than other ethnic groups, it is imperative to consider cultural differences, specifically how Latinos cope with such stressors. If all ethnic minority groups experience similar stressors, but the way they cognitively and emotionally deal with them is different, this variable could explain some of the difference in outcomes.

Coping is defined as one's "efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Ibanez et al., 2004, p. 69). The method one chooses to manage stressors can be influenced by the familial and cultural norms. Several coping styles have been identified, but there is disagreement as to how to best classify them (Blalock & Joiner, 2000). The two most commonly identified extremes, problem-solving and avoidance coping, differ by degrees of perceived control and proactive efforts to manage the stressor. For example, a "problem-solver" sees the stressor as something within one's control (i.e., internal locus of control) and actively works to manage the stressor or find a solution. In contrast, the "avoider" sees the stressor as something that is out of one's control

(e.g., external locus of control) and, either consciously or unconsciously, avoids thoughts and situations that heighten the stressor.

Avoidance coping. Cognitive avoidance strategies are efforts to minimize the severity of the stressor or attempting to ignore distressing thoughts completely (Blalock & Joiner, 2000). While cognitive avoidance coping tends to be a more passive style, it is also possible for one to *actively* avoid stressors. This is evident by behavioral means, such as engaging in a behavior to reduce tension or distract oneself from the stressor. Avoidance coping is one of the criteria (criterion C) for PTSD diagnosis (DSM-IV; American Psychiatric Association, 2004). This is because avoidance coping behaviors "interfere with cognitive processing of trauma-related memories; provide inadequate opportunity for habituation of trauma-related emotional distress, and ultimately facilitate maintenance of PTSD symptoms" (Pole et al., 2005).

Generally, the avoidance coping style has been found to be the most detrimental to mental health (Holahan, Moos, Holahan, Brennan, & Schutte, 2005). Chronic thought suppression and avoidance of emotions can lead to more intense feelings of despair and hopelessness and has been linked to an increased risk of suicide, especially in older adults (Cukrowicz, Ekblad, Cheavens, Rosenthal, & Lunch, 2008). In a study done on male patients from a residential drug treatment program, avoidance coping was associated with poorer alcohol use outcomes. The study found that when the men had low self-efficacy, or low confidence to carry out a behavior or goal, and engaged in avoidance coping, the alcohol use outcomes were poor. Thus, as the levels of self-efficacy decreased, the negative effects of avoidance coping increased (Levin, Ilgen, & Moos, 2007). In another study, the predictors of PTSD for men and women (n = 70) with cancer undergoing a bone marrow transplant were examined. The findings

indicated that lower social support and higher avoidance coping predicted more severe PTSD symptoms following the transplant (Jacobsen et al., 2002).

Ingledew, Hardy, and Cooper (1997) studied how coping styles (e.g., problem-focused, emotion focused, and avoidance) affect overall psychological well-being. They found that problem-focused and emotion-focused coping were beneficial to mental health, but avoidance coping had delayed detrimental effects. They also noted that coping methods were chosen based on resources available. For example, if one had emotional support, he or she would engage in emotion-focused coping; a person with physical resources (e.g., money) would chose problem-focused coping; and for those without resources or social support, avoidance coping was the method most commonly utilized (Ingledew, Hardy, & Cooper, 1997).

It is clear from previous research that coping methods and emotional distress are linked by avoidance coping, which is generally associated with depression (Holahan et al., 2005). Holahan et al. (2005) suggest that avoidance coping may actually produce more negative stressors. In their study, they found that avoidance coping strategies was associated with more chronic and acute life stressors four years later after the initial trauma or stressor. These were indirectly or directly linked to greater depressive symptoms.

Blalock and Joiner (2000) not only found evidence of the reality of cognitive and behavioral coping methods, but also found that they predict the symptoms of depression and anxiety, especially in women. The authors concluded that gender and coping styles moderate the relationship between life stressors and depression. The difference between genders is suspected to be influenced by cultural mechanisms (i.e., the socialization of men versus women), and thus the authors encourage further study pertaining to the cultural aspects of coping.

Coping styles for Latinos. The culturally common and accepted means to cope for Latinos seems to differ from that of other groups, especially Non-Latino Whites. Falicov (1998), a Latina immigrant from Argentina and a leader in the field of multicultural family therapy, explains how coping strategies could be very different for Latinos as a group when compared to the dominant culture. Latinos commonly attribute their problems to the will of God or fate (*fatalismo*). Many Latinos believe their lives are not in their control, but troubles or prosperity will come *si Dios quiere* (God willing). This passive approach surrenders one's control to external forces. Even so, Latinos believe that some degree of self-control is possible. In fact, the idea of controlling one's self *(controlarse)* is a fundamental strategy for mastering one's *caracter* (i.e., personality, moods, and emotions). Falicov (1998) points to several common coping strategies. First, *aguantarse* means to endure trials and press on but does not necessarily imply actively working to solve or escape problems. Second, *no pensar* refers to cognitive efforts to avoid thoughts about the stressor, or what might be called "just not thinking about it." Third, *resignarse*, or resigning to fate, connotes either a passive surrender or an acknowledgement that the current situation cannot be changed. Finally, *sobreponerse* is to press forward and overcome. Perhaps the underlying assumption behind these coping methods is that one can endure his or her life stressors by pressing forward and making a concerted effort to "not think about the problem", instead of working to eliminate it. These coping strategies described by Falicov (1998) may also be defined as cognitive avoidance strategies. If they are in fact common among Latinos, these coping styles could contribute to the mental health outcomes of the Latino population.

Constantine, Alleyne, Caldwell, McRae, and Suzuki (2005) did a comparative study of the coping styles of Latinos, Asians, and Black New York City residences following the

September 11, 2001 terrorist attacks on the World Trade Center. The sample (n = 24) included a diverse sample of ethnicity, race, immigration status, age, and gender. The methods were qualitative, using data from in person interviews focused on coping mechanisms. Seven coping styles emerged from the data, (a) sought information, (b) expressed emotions, (c) sought or gave support, (d) engaged in religious activities, (e) avoidance, (f) forbearance, and (g) indigenous healing techniques. Many Latinos, along with other members of minority groups, used avoidant coping methods such as "keeping busy," "keep from thinking about the terrorist attacks," and "attempts to resume normal activities." The authors suggest that in this case, such strategies may have been helpful, at least in the short term. However, the "minimization or denial of psychological concerns could mask more serious mental health concerns," which might delay appropriate interventions.

Ibanez, Buck, Khatchikian, and Norris (2004) used qualitative methods to study the coping styles of Mexican trauma survivors by conducting interviews in three different cities, two in Mexico and one in the United States. The four primary coping themes that emerged from the interviews were (1) seeking support, (2) seeking meaning, (3) problem solving, and (4) avoidance coping. Seeking support involved making an effort to connect and get help from friends and family and other social ties. Seeking meaning involved efforts to make sense of the event, such as using religious or spiritual guidance to decide what is important in life or reinterpret the trauma in a positive way. Problem solving involved an active effort to overcome and work out a solution. Avoidance coping involved "efforts to refuse to dwell on the problem, distracting oneself, exhibiting a stoic attitude towards life, or using emotional distancing, rationalization, fantasy, or substance abuse in order to cope with the aftermath of the disaster" (p. 74).

In all three cities, seeking social support was the most common coping strategy, although the immigrant participants reported less than the other cities. In Puerto Angel, Oaxaca, Mexico, the people also used problem solving and seeking meaning. In Guadalajara, besides social support, the people were more likely to use avoidance coping methods, and then seek meaning. In Florida, where the participants were Mexican immigrants, the interviews revealed that seeking meaning was most often cited as a coping strategy, but then followed by avoidance coping. The authors admitted that some of the limitations of their study were a small sample size, no analysis of gender, and the fact that education levels, trauma histories, and poverty levels were not obtained. Also, the interviews in Puerto Angel were conducted three months after the traumatic experience (Hurricane Paulina), whereas the interviews in Guadalajara and Florida were conducted five years after the trauma (sewer explosion and Hurricane Andrew, respectively). This difference could have contributed to recall and the difference in coping styles reported by these cities (Ibanez et al., 2004).

In their discussion of avoidance coping, the authors note that avoidance coping is more prevalent with man-made or technological disasters. Also, the more intense the trauma, the more likely the survivor will incorporate avoidance coping, which is an attempt to numb the pain and push the trauma into the unconscious. They suggest that avoidance coping can be an effective short-term method for reducing post traumatic stress, but only if the victim will allow short moments of distress. When avoidance is used as a long-term coping strategy to disengage completely from the trauma, it could have negative outcomes (Ibanez et al., 2004). Interestingly, of the four coping styles, avoidance seems to be the only that comes with significant risk.

The research indicates that Latinos seem to frequently use an avoidant coping style. One study that examined ethnic differences on the avoidance scale reported that White respondents

were least likely to exhibit avoidance coping styles (18%), and Spanish-preferring Latinos were most likely to do so (40%) (Perilla et al., 2002). Kudadjie-Gyamfi & Magai (2008) found that Latinos, specifically Puerto Ricans, reported higher avoidance coping than Blacks, Haitians, and European Americans. Some research indicates that the greater degree to which Latinos adhere to the traditions and values of their ancestors versus those of the United States, the more prevalent the PTSD symptoms (Pole et al., 2008). Marshal & Orlando (2002) found that the more loyal Latinos were to the traditional culture norms, the more likely they were to have dissociated during the trauma, which is an important difference between Latinos and other ethnic groups (as cited in Pole et al. 2008). The authors speculate that these traditional values and beliefs could be partially responsible for high rates of PTSD reported by Latinos.

In a study on acculturation and depression among Latinos, Torres and Rollock (2007) found that their sample of poorly acculturated Latinos had very high levels of depression (over 40% were at clinical levels of depression). In addition, respondents coping scores fell in the range of those with "significant psychosocial difficulties and inadequate active coping abilities" (p.13). They also found that general coping style had the highest correlation with depression, and thus was the best single predictor of depressive symptomatology for Latinos. In addition, active problem solving was strongly correlated with fewer symptoms of depression. The authors point to Diaz-Guerrero's (1979) findings that although the culture in the United States values individualism and self-assertiveness, Latinos prefer a coping style "emphasizing passive endurance or accommodative self-modification" (p.15). Torres and Rollock (2007) suggest, as a possible explanation for the high depression scores in their sample, that this passive coping style could be a particular risk for Latinos who are adjusting to the U.S. culture.

Pole et al. (2005) found that one of the variables that distinguished Latinos from other urban police officers was their coping styles. The coping style Latinos engaged in was frequently more passive and implied an external locus of control (i.e., greater wishful thinking, fatalism, and avoidance methods). Pole et al. (2005) concluded that coping style was an explanatory variable for high levels of PTSD in Latinos, explaining more that 12% of the variance. They note that ethnicity alone only accounted for 1% of the variance. They explain that this finding supports the theory that coping strategies are subject to learned cultural influences. Therefore, cultures that promote avoidance coping strategies as a culturally accepted means of managing trauma and stress would exhibit a higher prevalence of PTSD in the population. Thus, more severe symptoms of PTSD may be higher among Latinos because as a culture they endorse such an approach to coping (Pole et al., 2005).

Measurement Concerns

Up to this point, the assumption has been made that the current data is a relatively accurate depiction of the status of Latino mental health. However, it should be noted that when working cross culturally, there is a high potential for measurement errors, biases, and misdiagnosis problems (Okazaki & Sue, 1995). This may be a factor in the poorer mental health outcomes, particularly the higher PTSD symptoms reported by Latinos. Alegria et al. (2007) claim that much of the research examining the Latino population has not been well executed nor is truly representative of the Latino population. A typical problem when ethnicity is an independent variable is the assumption that the individuals within the group share common traits; however, this under-estimates within group heterogeneity (Okazaki & Sue, 1995). This is evident by the very few the studies that take into account nativity, language, immigration status, SES, social support, years of residency, etc., which are factors that could easily influence the findings

(Mendelson et al., 2008). Therefore, the inconclusive findings in the research could be the result of poorly executed research.

Another possibility for these research findings is a bias in the measurement and diagnosis of the psychological disorders for Latinos. For example, as mentioned above, criterion C for a PTSD diagnosis in the DSM-IV is the use of avoidance coping methods. This concept is measured by the Trauma Symptom Inventory (TSI; Briere, 1995) by assessing avoidance strategies, such as "trying to forget a bad time in your life," "pushing painful memories out of your mind," and "trying to block out certain memories" (TSI; Briere, 1995). Trying to control one's thoughts (i.e., *no pensar*) and push forward to overcome problems *(*i.e., *auguantar*) as a coping strategy is considered common and even culturally encouraged for Latinos. If such a strategy is prevalent among Latinos, the defensive avoidance score of the TSI would reflect this. It is possible that this strategy is actually a healthy way to cope for Latinos, but is measured as a symptom of posttraumatic stress. If this is the case, Latinos may have higher PTSD scores, not because they are actually presenting with PTSD, but because they score higher on the avoidance subscale. The common trauma symptoms assessments could be measuring a common culturally sanctioned coping method instead of an actual symptom of PTSD. While it is possible that engaging in avoidance coping strategies is particularly harmful for Latinos, it is also possible that the diagnosis criteria for PTSD are not accurate for Latinos, considering cultural differences. What is clear, however, is that there are enough unanswered questions and ambiguity in the current body of research to warrant further study in this area of Latino mental health. In addition, attaining a greater understanding of the role and prevalence of culturally sanctioned coping mechanisms for Latinos and how they affect mental health would be a necessary step in filling the gap of knowledge within the available body of research literature.

Literature Summary

Research regarding the mental health of ethnic minorities is a relatively new topic in the social sciences. In recent years, important studies have been conducted to reveal the needs and risks specific to the Latino population in the United States. There have been findings suggesting that Latinos are at risk for poorer mental health, especially for PTSD. While, it is still unclear if this is the case, why this is happening has yet to be answered completely. Researchers have begun to explore the role culture and beliefs play in the mental health of minority groups. While stressful life events and traumas may contribute to poor mental health outcomes, these alone are not considered enough to account for the differences between Latinos and other ethnic minorities. Considering the influence of culturally learned coping styles may further explain poor mental health outcomes in Latinos. Although research has shown that avoidance coping is linked to poorer mental health, it is not clear if this coping style is significantly linked to Latino's mental health. It is possible that this aspect of the Latino culture could be significantly influencing the negative mental health diagnosis (e.g., PTSD, depression, etc.) of Latinos in the United States who are faced with trauma and other stressors. Thus, it remains unclear whether high PTSD scores for Latinos is simply the evidence of a cultural bias, (e.g., labeling normative coping mechanisms of the Latino culture as pathological) or that in reality Latinos are experiencing more severe symptoms of mental illness compared to other racial/ethnic groups.

Purpose

The current study was focused on the prevalence of avoidance coping strategies for Latinos and the influence of such methods on their mental health. The primary purpose of this research was to assist in closing the gap in the literature regarding the mental health of Latinos so that clinicians might have access to accurate information to guide them in their culturally

sensitive practice. This study attempted to close the gap in the literature in two ways. First, the study examined the prevalence of a culturally accepted style of coping among Latinos, referred to in the mental health literature as avoidance coping. The use of this coping strategy by Latinos was compared to White and Black respondents in order to explore whether Latino's PTSD scores would be affected by the use of avoidance coping methods. Second, this study examined whether the association between avoidance coping and mental health would be the same for Latinos and Black and White respondents.

Although this project was a non-exhaustive study, it was a preliminary step toward gaining greater understanding about the possible culturally normative coping styles for Latinos and their association with mental health. The findings of this study can be meaningful to researchers and clinicians alike in providing information specific to the Latino population. Further research regarding the way Latinos typically deal with stress and trauma and how these coping methods are connected to their mental health may aid practitioners in more effectively serving their Latino clients.

Hypotheses

The present study examined the occurrence of avoidance coping among Latinos, White, and Black participants, as well as investigating a possible cultural bias in the diagnosis of PTSD. In addition, the relationship between these coping styles and depression was explored. The following are the research questions that guided the study and the specific hypotheses that were tested:

First Research Question

Do Latinos exhibit more avoidance coping behaviors than other racial/ethnic groups?

- It was hypothesized that Latinos would report higher cognitive avoidance coping techniques ("defensive avoidance") when compared to White and Black participants.
- In addition, it was hypothesized that on the remaining items of the trauma symptoms inventory, referred to from here on as "trauma symptoms," there would be no significant difference among groups.

Second Research Question

To what degree are avoidance coping strategies associated with symptoms of mental illness, namely depression, for Latinos, Black, and White participants?

- It was hypothesized that there would be an interaction effect between race/ethnicity and coping strategies, such that avoidant coping strategies are less strongly associated with depression for Latinos than for White and Black respondents.

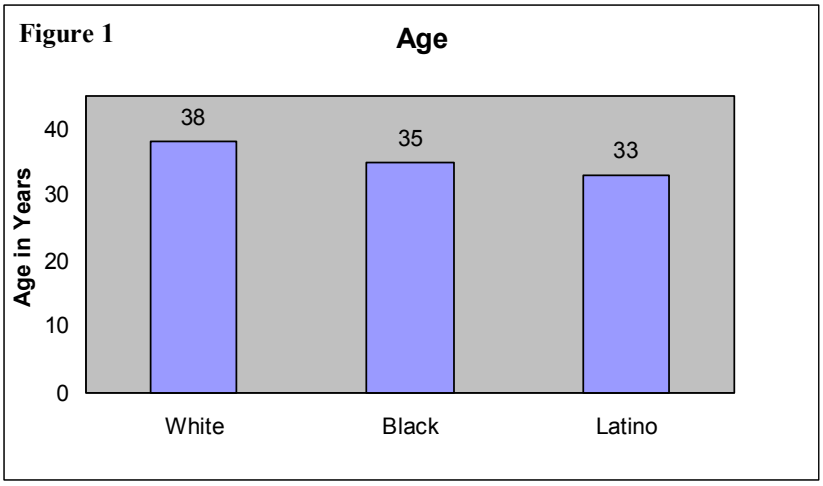
Chapter III Methodology

Sample

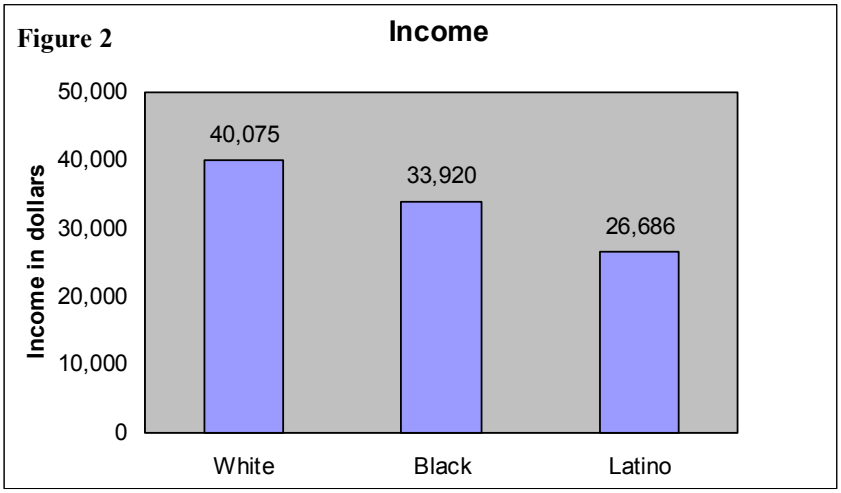
The present study used a sample from a pre-existing dataset of 429 participants (35.4% male, 64.3% female) who requested couple, family, and/or individual therapy at the Center for Healthy Families (CHF), a therapy training facility within the Department of Family Science at the University of Maryland. The Center for Healthy Families provides individual, couple, and family therapy services to a diverse population of clients in the surrounding communities of Washington, DC. The clinic offers their services on a sliding fee scale to accommodate those clients of lower socioeconomic status. These clients sought treatment between August 2005 and August 2008.

Only data from individuals who reported their race/ethnicity as Black (n = 150), Latino (n = 129), or White (n = 150) were used. The term "Black" was used as an indentifying term because the subsample contained participants who were not only African American, but from African, Caribbean, and other origins. The mean age of this sample was 36 years old, although the mean age varied somewhat according to race/ethnicity (see Figure 1).

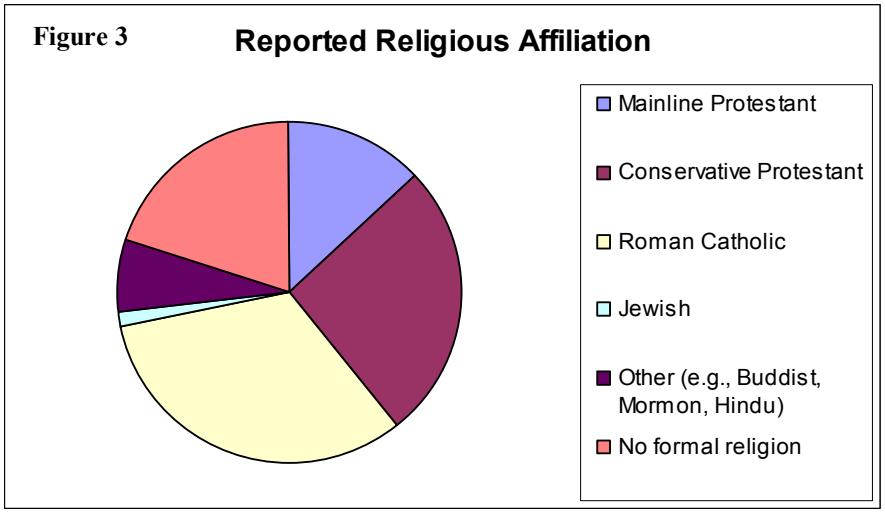
Figure 1



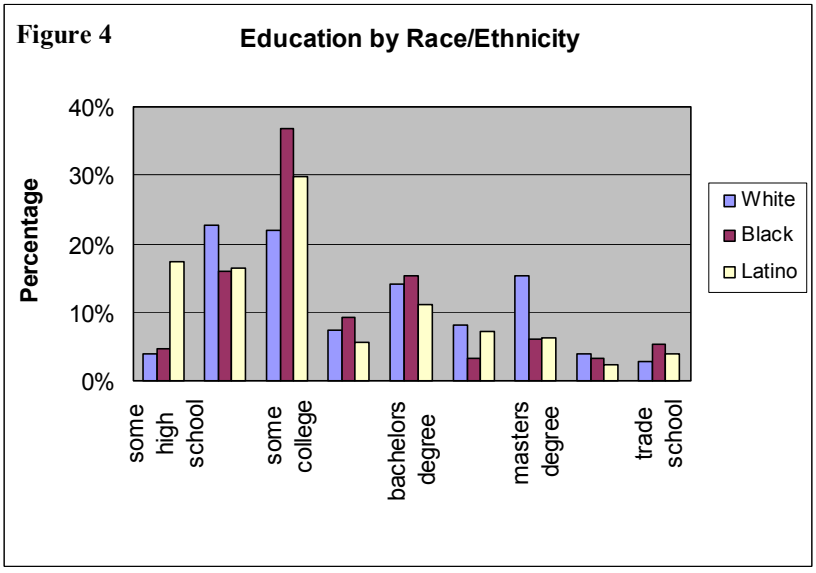
Many of the participants reported being in some form of committed relationship; 30.5% were married, 14.0% separated, 8.4% divorced, 10.0% cohabitation, 4.7% dating, 6.8% single, and 0.2% widowed. Those who were in a relationship reported an average of 9.7 years together with their partner. The majority of the subjects were employed; 60.8% of the sample was employed full time, 16.1% employed part-time, 3.7% homemakers, 4.7% students, 1.4% retired, and 11.9% were unemployed.



The average income for this sample was $33,902, although this also varied by racial/ethnic group (see Figure 2). The majority of the sample (69.1%) reported having some type of college education, although 29.4% never finished: 7.5% ended with an associate degree, 13.5% earned a bachelors degree, 6.1% had some graduate school experience, 9.3% earned a masters degree, and 3.3% earned a doctoral degree. Religion was reported by 40.5% to be "very important," yet 64.5% of respondents attend religious services less than once a month, including 34.0% who rarely or never attend. The participants vary in religious preference as seen in Figure 3 below.

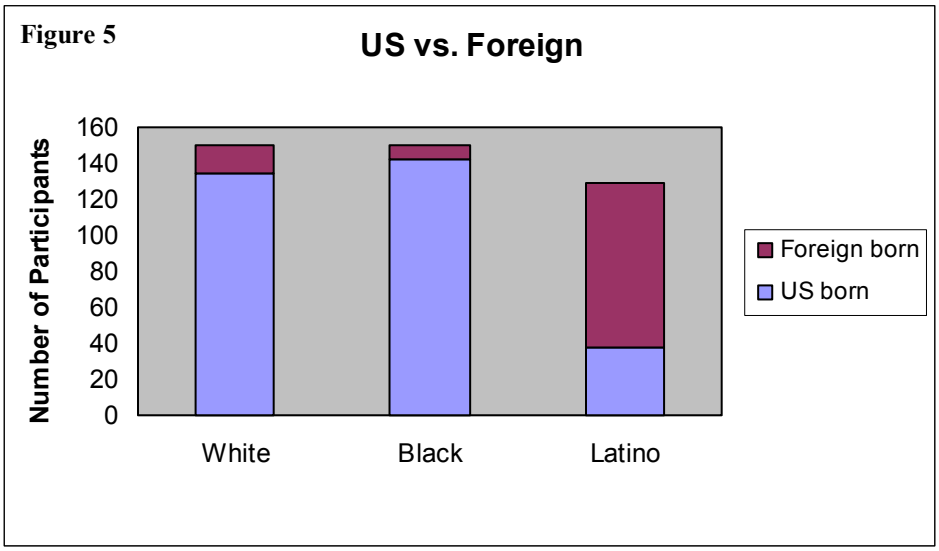


Because the Latino group is the focus of this study, additional information regarding this group was reported. The Latinos in this sample (*n=129)* were several years younger than the overall cohort average, with a mean age of 33 years (see Figure 1). This average is older than the average age of the Latinos in the general population (25.9 years; Guzman, 2001). Over 56% of Latino subjects were employed full time, 22.0% were employed part time and 10.0% were unemployed, yet their mean income was merely $26,686— lower than the income of the other two racial groups (see Figure 2). Over 60% of the Latinos claimed to be Roman Catholic, and 69.1% reported that religion was either important or very important. The statistics regarding education show that 17.3% did not finish high school, almost 30% attended some college, and 15.8% attended some graduate school (see Figure 4).



The cohort included Latinos originating from 15 different foreign countries, with over 70% born outside of the United States (see Figure 5). For this reason, the assessments were administered in both English and Spanish, and 15% of the Latinos (*n*=17*)* preferentially chose to fill out the assessments in Spanish.

Figure 5



Procedure

The participants in this study were clients of the Center for Healthy Families. These participants tended to be referred by school counselors or the court system. Alternatively, they may have found the clinic through internet searches, flyers posted at local schools and businesses, or recommendations from friends and family. Each participant in the study initiated therapy services at the Center for Healthy families by first calling the center, at which point the new clients completed a required intake interview. An intake worker gathered information such as the presenting problem, demographic information, and family make-up. Once the intake was completed, the family or individual was assigned to a therapist intern, a masters-level graduate student in the Couple and Family Therapy program at the University of Maryland. The therapist then contacted the client(s) and explained over the phone that the first meeting would involve extensive assessments and paperwork, but the session would be free of charge.

During the first session, the clients signed an informed consent document as well as a fee schedule agreement form. The center requires that all clients older than 13 years of age must complete questionnaires that assess variables such as depression, trauma symptoms, relationship styles, issues of conflict, family issues, social support, drug and alcohol use, relationship distress, partner violence, and parenting techniques. All of the assessments were stripped of identifying information and given a code number to ensure confidentiality. Once completed, the information on the assessments were then coded and entered into a large SPSS database containing all the assessment data from all clients seen at the center. For the purposes of this study, the dataset was reduced to include only those clients who are of Latino, White, or Black race/ethnicity. In addition, only data from the demographics questionnaire, the Trauma Symptoms Inventory, and the Beck Depression Inventory were used. When the data collection began in August of 2005, these measures were available in both English and Spanish. To meet the needs of a growing Spanish-speaking Latino population, the measures had been translated into Spanish previously and used in the assessment and data collection process (see Appendix D, E, and F). However, there were periods of time when, because no Spanish speaker was available at the clinic, assessments were only offered in English. These measures are described in greater detail below.

Measures

Demographics Questionnaire

The Family/Individual Information & Instructions questionnaire, a demographic questionnaire developed for new clients at the Center for Healthy Families, was provided to clients at the clinic in both English and Spanish (see Appendix A and D). The items regarding race/ethnicity and country of origin will be utilized in this study to classify the race/ethnicity of the participant. The participant self-identifies as 1) Caucasian, 2) African American, 3)

Hispanic/Latino, 4) Asian, 5) Native American, or 6) other. This questionnaire did not allow for a selection of multiple or alternative categories of race/ethnicity. In other words, the participant could not self identify as merely "African" and not African American, neither could one identify as both White and Latino. Therefore, it is possible that the options forced respondents to make coices about their race or ethnicity that do not accurately reflect how they self-identify. For the purposes of this study, all those who are identified as Caucasian, African American, or Latino were included.

The Trauma Symptom Inventory

In order to measure avoidance coping styles and trauma symptoms, the Trauma Symptom Inventory (TSI-A; Briere, 1995) was used (see Appendix B and E). This measure was created for use in clinical settings to assess trauma symptoms of PTSD. The original 100 item TSI has 13 subscales, three validity scales, and ten clinical scales. Due to the extensive battery of assessments required for therapy by each client at the Center for Healthy Families, the administration decided to utilize a shorter version of the TSI, which contains 42 items and includes five clinical subscales. For the purposes of this study, this abbreviated version was used. Intrusive experiences, defensive avoidance, and the dissociation subscales represent avoidant and intrusive experiences of PTSD. The anger irritability and anxious arousal subscales reflect the mood states of trauma survivors. These five subscales reflect the DSM-IV diagnostic criteria for PTDS (A, traumatic experience; B, intrusive experiences; C, defensive avoidance; D, anxious arousal; E, lasts more than one month, F, significant distress). The clinical subscales are internally consistent (mean alpha coefficients range from .84 to.87) and have sufficient convergent and predictive validity (predicting PTSD status in over 90% of the cases). Also the

TSI has high incremental validity, meaning its scores predicted the "victimization variance" beyond what was accounted for by other trauma symptom measures (Briere, 1995, p.43).

The measure includes instructions that ask the participant to answer how often each item has occurred in the past six months. The participant then answers based on a scale of 0 to 3; with 0 and 3 corresponding to never and often respectively. The raw scores for each subscale are totaled, converted to T scores, and then compared to normative T scores. Higher raw and T scores generally indicate greater degrees of symptomatology, with a T score above 65 being clinically significant (Briere, 1995). Normative data on TSI outcomes exist for the general population (men and woman, 18 years and older), clinical, university, and Navy samples. Briere (1995) reports that race accounts for only 2.2% of the amount of variance in the TSI scales. Based on this small variance, he recommends that the TSI clinical scales not be adjusted for race.

The defensive avoidance (DA) subscale includes eight items such as "trying to forget about a bad time in your life," "stopping yourself from thinking about the past," and "pushing painful memories from your mind" (TSI-A; Briere, 1995). These questions were designed to assess the avoidance responses that are part of the criteria for a PTSD diagnosis (criterion C). This clinical subscale has been show to be reliable (α range from 0.90 to 0.87) (Briere, 1995). The convergent and discriminate validity for defensive avoidance was supported when the subscale correlated best with the avoidant subscales of the IES (0.69) and the SCL (0.68) measures (Briere, 1995). Those who generally score high on the defensive avoidance subscale have a history of "aversive internal experiences" they try to avoid, frequently attempt to block painful thoughts and memories, and desire to neutralize these negative feelings. Briere (1995) clarifies that defensive avoidance is not an intrusive experience (e.g., something beyond control), but a "conscious, intentional process of cognitive and behavioral avoidance" as a way of

managing or coping with distress (p.14). Thus, the full scale defensive avoidance score was used to measure avoidance coping for the hypothesis (1a) in which avoidance coping was the dependent variable. For the hypothesis in which avoidance coping was one of the independent variables (hypothesis 2), a categorical defensive avoidance score was created. These categories, "low" (0-9) and "high" (10-44) were determined by a median split.

The other four subscales in the TSI are considered "other trauma symptoms" in this study. These items measure symptoms commonly associated with PTSD, such as intrusive experiences and dissociation. In addition, these items measure the mood and anxiety of the respondent; high anxiety, intense anger, and irritability are generally symptoms of PTSD. Thus, in order to understand the prevalence of these symptoms, all items, excluding the defensive avoidance subscale, were totaled to determine the occurrence of other PTSD symptoms.

The Beck Depression Inventory.

The presence or absence of depression in the sample was determined by using the Beck Depression Inventory (BDI; Beck, 1996) (see Appendix C and F). The BDI was the result of clinical observations of depressed psychiatric patients and non depressed psychiatric patients (Beck, Steer, & Garbin, 1988). The assessment includes 21 items that reflect the symptoms and attitudes typically exhibited by depressed patients. The participant rates his or her mood in the past week on each of these 21 items on a scale from 0 to 3, higher scores indicating more severe depression. The items are totaled and the overall score indicates the level of depression: none to minimal depression is <10, mild to moderate is 10-18, moderate to severe is 19-29, and severe depression is 30-63. The BDI has been proven to be a reliable measure in terms of internal consistency (mean coefficient alpha = .86) and stability (correlation coefficients .48-.86). The validity of the BDI was determined to be sufficient by five types; content, concurrent,

discriminate, construct, and factorial validity (Beck, Steer, & Garbin, 1988). The BDI scores have also been shown to be related to suicidal ideation, alcoholism, adjustment, and anxiety. Scores were similar between Black and White respondents (<1 point difference), however information on the Latino population is not available. In this study the BDI was be used to measure depression symptoms as part of the overall assessment of mental health functioning.

Variables

Independent Variables

For the present study, the assignment of independent and dependent variables depended on which of the two research questions was under discussion. For the first research question ("Do Latinos exhibit more avoidance coping than other racial/ethnic groups?"), the independent variable was race/ethnicity. Race/ethnicity was determined by the self-report questionnaire described above. For the second question (To what degree are avoidance coping strategies associated with symptoms of mental illness, namely depression, for Latinos, Black, and White participants?), there were two independent variables, namely race/ethnicity and defensive avoidance coping. In this case, avoidance coping was operationally defined as reported efforts to reduce emotions and ignore thoughts regarding the traumatic event and/or stressor. Avoidance coping was measured by using the subscale "defensive avoidance" of the Trauma Symptoms Inventory (TSI-A; Briere, 1995).

Dependent Variables

There were two dependent variables used to evaluate the first research question, namely avoidance coping strategies and trauma symptoms. Avoidance coping was operationally defined as discussed above, (i.e., efforts to reduce emotions and ignore thoughts regarding the traumatic event and/or stressor) and was measured by the subscale "defensive avoidance" of the Trauma

Symptoms Inventory (TSI-A; Briere, 1995). Trauma symptoms were operationally defined as other symptoms associated with PTSD (e.g., dissociation, intrusive experiences, anxious arousal, anger, irritability, etc.), but not including defensive avoidance coping. This variable was measured by totaling all 34 items on the TSI-A except for the items on the defensive avoidance subscale. For the second research question, regarding the association between avoidance coping styles for each racial/ethnic group (i.e., White, Black, Latino) and their reported mental health, the dependent variable was the symptoms of depression as measured by the Beck Depression Inventory (BDI; Beck, 1996).

Table 1

Variables	Operational Definitions
Defensive Avoidance Coping (continuous)	Total Defensive Avoidance subscale score on Trauma Symptoms Inventory (questions # 2, #4, #11, #26, #30, #34, #37, #39, see Appendix B and E) 0-1 = Never/Sometimes 2-3 = Sometimes/Often
Defensive Avoidance Coping (categorical)	Defensive Avoidance scores (see previous) divided into two groups at the median. 0-9 = "low" 10-44 = "high"
Other Trauma Symptoms	The total Trauma Symptoms Inventory score, minus the total Defensive Avoidance subscale score (see previous)
Depression	The total score on the Beck Depression Inventory (see Appendix C and F) 0-9 none to minimal 10-18 mild to moderate 19-29 moderate to severe 30-36 severe
Race/Ethnicity	Question (#14) self identification of race/ethnicity on demographic questionnaire

Chapter IV Results

The present study was designed to examine the occurrence of avoidance coping among Latino, White, and Black participants, as well as to investigate the relationship between the use of this coping style and depression. The following are the research questions that guided the study, and the specific hypotheses that were tested:

1. Do Latinos exhibit more avoidance coping behaviors than other racial/ethnic groups?
    a. It was hypothesized that Latinos would report higher cognitive avoidance coping techniques ("defensive avoidance") when compared to White and Black participants.
    b. In addition, it was hypothesized that on the remaining items of the trauma symptoms inventory, referred to as "trauma symptoms," there would be no significant difference among groups.
2. To what degree are avoidance coping strategies associated with symptoms of mental illness, namely depression, for Latinos, Black, and White participants?
    a. It was hypothesized that there would be an interaction effect between race/ethnicity and coping strategies, such that avoidant coping strategies are less strongly associated with depression for Latinos than for White and Black respondents.

Primary Analysis

Hypothesis 1

For the first question regarding the use of avoidance coping based on race/ethnicity, two separate one-way ANOVA tests were conducted, one for the full scale defensive avoidance coping variable (hypothesis 1a) and the other for the remaining trauma symptoms (hypothesis 1b). The dependent variable tested for hypothesis 1a was the total defensive avoidance score, while the dependent variable for hypothesis 1b was the total remaining trauma symptoms. The independent variable for both tests was race/ethnicity.

The results indicated a significant difference in the level of defensive avoidance between the racial/ethnic groups, F (2, 417) = 3.01, p = .05. In order to understand which groups were significantly different in the use of avoidance coping methods, a Tukey HSD post hoc test, was conducted. This test revealed that, contrary to the stated hypothesis, the Latino participants' use of avoidance coping (M=10.25, SD=7.38*)* did not differ significantly from the White *(*M=8.65*,* SD=6.94) or Black (*M=10.53, SD*=6.92) participants (see Table 2). However, the Tukey HSD post hoc comparison indicated a trend for a significant difference between Black participants and White participants in their use of avoidance coping (t=1.89, p=.059).

Table 2

Mean Differences of Defensive Avoidance Coping by Race/Ethnicity

Race/Ethnicity	Latino	White
Black	.28	*1.89
White	1.61	

***p*=.059**

The results of the second ANOVA (hypothesis 1b), testing the prevalence of other trauma symptoms by race/ethnicity, showed no significant differences among groups (F (2, 398) =.001, p=.999*)*. In fact, the mean score of other trauma symptoms for each group were almost identical (Black, M=32.71*,* SD=22.97; White, M=32.70, SD=20.09; Latino, M=32.59, SD=20.59*)*. These results were in accordance with the stated hypothesis (1b).

Hypothesis 2

Table 3
Mean Differences of Depression by Race/Ethnicity

Race/Ethnicity	Latino	White
Black	-1.65	-1.24
White	.41	

***p<.05**

A two-way ANOVA was used to test the hypothesis of an interaction effect between race/ethnicity and coping on depression. For this analysis, the defensive avoidance coping score was divided in two categories based on a median split between "low scores" (i.e., score of 0-9) and "high scores" (i.e., score of 10-44)[1]. The results indicated a trend for race/ethnicity (F (5,395) = 2.57 p=.08*)*. However, although the race/ethnicity factor approached significance for depression, according to the post hoc Tukey HSD comparisons, no two-way comparison between any of the three groups was significant (see Table 3).

The main effect for defensive avoidance coping on depression was highly significant *(F (*5,395) = 114.24, p=.000). The lowest level of depression was found for those who reported low levels of avoidance coping (M=8.30, SD=6.89) and the depression scores were higher at high levels of avoidance coping *(*M=17.17*,* SD=9.75*)* (see Table 4). Although the coping variable was

[1] All analyses were also run with a three categorical variable (i.e., high, medium, low), but there were no cases in which the findings were different than the two categorical variable. Thus only the high/low variable was reported here.

highly significant and the race/ethnicity variable approached significance, no significant interaction effect between race/ethnicity and avoidance coping on depression was found (F (5, 395) =.81, p=.45).

Table 4

Depression Scores by Defensive Avoidance Scores (high/low) and Race/Ethnicity

DA Scores	Race/Ethnicity	Mean	Std. Deviation	N
Low (0-9)	**Black**	6.37	5.94	65
	White	9.84	6.85	81
	Latino	8.30	7.51	56
	Total	8.30	6.89	202
High (10-44)	**Black**	16.45	9.42	75
	White	17.43	10.10	58
	Latino	17.58	9.91	66
	Total	17.17	9.75	199
Total	**Black**	11.77	9.43	140
	White	13.01	9.13	139
	Latino	13.41	10.04	122
	Total	12.70	9.52	401

Additional Analyses

After reviewing the findings for the proposed hypotheses, further analyses were conducted to explore two additional questions. The first of these questions is focused on the definition of defensive avoidance coping. Examining Falicov's (1998) explanation, it seemed that behavioral avoidance methods are not included in her description of Latino's coping style (e.g., avoiding places that remind the victim of the traumatic event). This distinction raised the question of whether the culturally normative coping style for Latinos could be more cognitive or emotionally based than behavioral. Thus, even though the first analysis showed no significance in the difference of use of defensive avoidance between the Latinos' and any other racial group, it was decided to conduct a further analysis of avoidance coping without the behavioral variable.

The second question explored the role nativity in the United States played for Latinos in their use of avoidance coping and in their mental health (e.g., trauma symptoms, depression). This question arose after considering research that indicated that greater acculturation and time in the United States was linked to poorer mental health for Latinos (Alegria et al., 2007). Thus it is reasonable to wonder how nativity in the United States might play a role or perhaps could have confounded these analyses. For both questions, the same ANOVA tests were conducted as above, but with slight variations on the dependent and independent variables.

Defensive Avoidance Redefined

The defensive avoidance subscale of the Trauma Symptom Inventory contains items that test three different aspects of avoidance coping, specifically cognitive avoidance (i.e., avoiding distressing thoughts), emotional avoidance (i.e., avoiding feelings surrounding the trauma), and avoidance behavior (e.g., avoiding a location where trauma occurred) (TSI; Briere, 1995). In order to explore these more specific types of defensive avoidance coping, a new variable was created, namely non-behavioral coping variable (i.e., the total score of the cognitive and emotional defensive avoidance items, without the items regarding behavioral avoidance). In addition to this variable, coping was further explored by creating one variable with only the items regarding avoiding thoughts (cognitive avoidance), and another with the items regarding avoiding feelings (emotional avoidance). These three variable, non-behavioral avoidance, cognitive avoidance, and emotional avoidance, were analyzed in place of the defensive avoidance variable. The independent variable for these tests remained race/ethnicity.

When the defensive avoidance variable was replaced with the non-behavioral avoidance variable in the ANOVA regarding coping and race/ethnicity, the findings were again significant (F (2, 417) $=3.65$, p=.027). The post hoc comparisons (Tukey HSD) indicated that the only

significant difference between groups for non-behavioral avoidance was still between White and Black groups (t= 1.85, p=.025). Thus, even when the behavioral variable was removed, the levels of avoidance coping for Latinos were not significantly different from any other group. This same pattern of findings (a main effect for race/ethnicity, but Blacks and Whites exhibiting the only significant difference) was found for cognitive avoidance (F (2, 419) = 3.04, p=.049) and emotional avoidance (F (2, 423) = 4.65, p=.01).

Due to the highly significant difference among racial/ethnic groups in their use of emotional avoidance coping, a two way ANOVA was conducted to determine whether an interaction effect existed on levels of depression. There was a highly significant main effect for the use of emotional avoidance coping (F (5, 401) =57.52, p=.000); those with emotional avoidance coping reported higher scores of depression (M=16.98, SD=9.86) and those who reported a lower use of emotional avoidance coping reported lower scores of depression (M=10.22, SD=8.33). Only a trend for a main effect for the race/ethnicity variable on depression was evident (F (5, 401) =2.83, p=.06) and there were no significant interaction effects (F (5, 401) =.14, p=.87). Thus, although the emotional avoidance coping variable was more highly significant than the defensive avoidance coping variable, how these two coping styles affect depression and its interaction with race/ethnicity is no different.

Nativity in the United States

The second focus of the additional analyses was the role of nativity in the United States for Latinos and its link to depression, trauma symptoms, and coping. For these analyses, only the Latino sample was utilized. Two groups were created from within the Latino sample (N=129), namely USA born Latinos (n=37) and foreign born Latinos (n=91). This was determined by the country of origin question on the demographics questionnaire. A one-way analysis of variance

(ANOVA) was conducted to explore the use of avoidance coping by Latino group and the occurrence of trauma symptoms.

The results indicated that there was no significant difference between USA born Latinos and foreign born Latinos in their use of defensive avoidance coping strategies *(F (*1, 124) = .04, *p*=.85). Similarly, there was no significant difference between Latino groups in their use of non-behavioral coping (*F (*1, 125) =.002, *p*=.97), cognitive avoidance coping (*F (*1, 125) =.023, *p*=.88) or emotional avoidance coping (*F* (1, 126) =.23, *p*=.63). When the trauma symptoms without defensive avoidance coping were examined, the results indicated no significant difference between groups *(F (*1, 119) = .98, *p*=.32). Because these findings regarding the role of nativity and coping were not significant, no additional analysis of the interaction effects was needed.

Table 5

Variables for Additional Analysis	**Operational Definition for Additional Analysis**
Cognitive Avoidance Coping	Sum total of only the items on the Trauma Symptoms Inventory regarding avoiding thoughts (question #2, #4, #11, #30)
Emotional Avoidance Coping	Sum total of only the items on the Trauma Symptoms Inventory regarding avoiding feelings (questions #34, #37, #39)
Non-behavioral Avoidance Coping	The total score of the Defensive Avoidance subscale without the items regarding behavioral avoidance (Questions #2, #4, #11, #30, #34, #37, #39)
Nativity for Latinos	The question regarding one's country of origin (#15) on the demographics questionnaire. US born – United States, or America Foreign born – Any other country (note: this subgroup was made of only those who indicated that they were Latino on question 14)

Chapter V Discussion

The primary purpose of this study was to gain greater understanding regarding the way Latinos in the United States deal with emotional stress and trauma and how these methods affect their mental health, specifically depression. Previous studies found Latinos to be at risk for depression, anxiety, and PTSD, and pointed to many factors that could have been contributing to the high rates of mental illness in this group (Asner-Self & Marotta, 2005; Mendelson et al., 2008), yet very few had explored cultural factors such as coping style. As some researchers tried to discover the root of these high rates of mental illness, many reported findings that indicated Latinos were doing no worse or better than other racial/ethnic groups (Adams & Boscarino, 2005; Aneshensel, Clark, & Frerichs, 1983; Penk et al., 1989). With so many differences in the current research, it can be difficult for clinicians to interpret and appropriately apply the findings to the benefit of their clients. So, the hope for this research project was to offer some clarification regarding Latinos' mental health and their coping strategies. Based on the writings of Falicov (1998), it was hypothesized that Latinos would cope more frequently using an avoidance coping style. With this assumption, it was postulated that perhaps high use of avoidance coping by Latinos could be contributing to an inaccurate measurement and therefore a misdiagnosis of PTSD in this population. It was also important to explore how the use of avoidance coping differed by racial/ethnic group, to determine if perhaps this method could function differently by race/ethnicity. The hypothesis was that the use of avoidance coping for Latinos would be higher than the other groups, but that this coping style would not be detrimental to their mental health (i.e., depression).

Summary of the Results

The findings, as reported in greater detail in the previous chapter, indicated that despite much of the findings in the current literature (Constantine, et al., 2005; Ibanez, et al., 2004; Kudadjie-Gyamfi & Magai, 2008; Perilla et al., 2002; Pole et. al., 2005), the Latinos in this sample did not report higher rates of avoidance coping than the other two groups. As for the remaining trauma symptoms (i.e., the TSI total score minus defensive avoidance), again there were no significant difference among groups; in fact, the mean scores were practically identical. So, contrary to the findings of many previous studies that indicated that Latinos were at a greater risk for PTSD (see Pole et al., 2008; Perilla et al., 2002; Galea et al., 2002; Ortega & Rosenheck, 2000), the trauma symptoms of the Latinos in this sample were no higher than the other two groups. The purpose of using this analysis was to determine if a measurement error or diagnosis bias existed, on the assumption that Latinos would report higher levels of defensive avoidance coping. However, because the first hypothesis was not supported these data offered no reason to suspect a cultural bias in the measurement instruments or the diagnosis for PTSD, at least for Latinos.

Additionally the function of avoidance coping seemed to be the same for all racial/ethnic groups; high use of avoidance coping was linked to high depression scores. There was a trend towards a main effect for race/ethnicity, meaning that the distinct attributes or characteristics of each racial/ethnic group could be slightly contributing to the rates of depression. However, there was no race/ethnicity by coping style interaction; in other words, the effect of avoidance coping on depression did not vary among racial groups.

In an attempt to further investigate the meaning and function of avoidance coping, this variable was redefined to include only cognitive and emotion avoidance (excluding behavioral avoidance). But these findings were almost identical to the findings of the original defensive

avoidance variable. In addition, the possible effect of nativity in the United States for Latinos was examined. These findings indicated, contrary to research literature that suggests Latinos differ by factors such as time in the United States and acculturation (see Alegria et al., 2007; Torres & Rollock, 2007), there was no difference between Latinos born in the United States and those born elsewhere on any of the variables (i.e., depression, trauma, avoidance coping).

Discussion of Findings

The finding indicated that when it came to avoidance coping, Latinos were not significantly different from the other racial/ethnic groups. These findings raise the question of whether the culturally unique coping style discussed by Falicov (1998) and others actually exists. In other words, the style of coping that is described by Falicov (1998) may not actually be prevalent enough among Latinos to be considered uniquely Latino. One possible explanation is that there is more heterogeneity within the Latino group than between Latinos and other groups. That is, there may be more differences between some Latinos in the way they cope than between a Latino and an African American. One basic assumption behind comparative research is that one ethnic group is distinct from the other group, rather than having more variability within the group; if the later is the case, then making between group comparisons is irrelevant. Thus, the possibility of greater heterogeneity among Latinos would contradict the assumptions of much of the research regarding Latinos.

A second possibility is that the construct that Falicov (1998) was describing was simply not accurately measured by the defensive avoidance subscale from the Trauma Symptoms Inventory (TSI; Briere, 1995). Although the concepts seem to be very similar, the culturally normative way of dealing with stress for Latinos may in fact be qualitatively different from avoidance coping as defined by the DSM-IV. The literature regarding coping describes many

variations of coping that seem to fall under two categories; an external locus of control/ avoidance coping and an internal locus of control/problem-solver coping (Blalock & Jointer, 2000). With an external locus of control, individuals may perceive their problems or the trauma symptoms as outside their control. Thus, a person may be passive and assume his or her only defense is to try and avoid uncomfortable feelings and thoughts. In contrast, the internal locus of control implies a feeling of choice or control over the problems facing the person. Thus, in this case, the individual might engage in more proactive methods of solving the problem. This framework has been generally constructed from the context of the United States mainstream culture.

Using this framework, Pole et al. (2005) described the Latino coping style as more passive and implied an external locus of control (i.e., greater wishful thinking, fatalism, and avoidance methods). It is possible that a more culturally appropriate description of how Latinos cope is needed. According to Falicov (1998), even while holding strong fatalistic beliefs, Latinos still believe that some degree of control is possible (i.g., *controlarse)*. Although Latinos may readily insist that the best way to deal with problems is to "*no pensar*" (i.e., don't think about it), this form of coping may not be the same thing as avoidance coping with an external locus of control as defined above. Perhaps, a third category of coping exists, one that includes a sense of internal control and avoidance behavior. Instead of assuming these "avoidance methods" used by Latinos automatically means avoidance coping as understood in American culture, it may be that these efforts to "press forward and endure" are experienced by Latinos as something within his or her control (i.e., internal locus of control). Perhaps, it is not the behavior as much as the lack of the individual's sense of control that is detrimental to mental health. Thus, the coping strategies that Falicov (1998) described could be something quite different from what avoidance

coping was previously understood to be, and it is possible that for this reason the measure did not indicate a higher use of this external locus of control/avoidance coping for Latinos.

A third possible reason for the finding indicating a similar use of avoidance coping for Latinos compared to other groups is due to the characteristics of the sample. The data that were included in this study were selected at random from a pool of individuals who sought therapy. It makes sense that, a clinical sample can be qualitatively different from the general population of Latinos. The mere act of seeking therapy is to some degree contrary to avoidance coping. Thus it is logical to assume that these participants may be engaging in more proactive problem solving coping as opposed to avoidance coping as evident by their seeking out therapy services.

This raises the question of what type of Latino would engage in less avoidance coping and seek out therapy, assuming the general population is engaging in more avoidance coping as hypothesized. This particular group of Latinos may have chosen more proactive coping methods merely because of the resources available to them in the community. Ingledew, Hardy and Cooper (1997) found that individuals, regardless of race/ethnicity, chose coping styles based on the resources available to them and for those individuals who did not have many resources (e.g., fiscal or social), avoidance coping was the most commonly utilized method. In another study, one that focused specifically on Latinos, the findings indicated that Latinos from different cities in the United States and Mexico engaged in different types of coping (Ibanez, Buck, Khatchinkian, & Norris 2004). For the Latinos in Florida, who were primarily immigrants, avoidance coping was used over social support, perhaps because they did not have the same social support as the Latinos in the Mexican cities. For the immigrants, it was as if avoidance coping was their last resort. Thus, if better alternatives are available, perhaps as suggested above, people will choose to cope using those resources.

In the community from which the sample for the present study was drawn, the Center for Healthy Families has become a great resource for mental health services for the Latino population, especially for those who do not speak English and/or are of lower socioeconomic status. Thus, by simply living in this community, Latinos may be engaging less in avoidance coping methods due to the inexpensive mental health resources that are available. Although this present study does not include data to support this finding, it is certainly worth considering in further research. It could mean that in addition to culture, there are stronger factors involved in a Latino's choice of coping, such as the availability of resources. If a sample of Latinos from the general population had been included, these findings might have been very different.

The analysis of the trauma symptoms, not including defensive avoidance coping, indicated that there were no difference between groups in the severity and occurrence of trauma symptoms. Other than providing further evidence against the argument that Latinos are at a higher risk for developing PTSD than other racial/ethnic groups (see Pole et al., 2008; Perilla et al., 2002; Galea et al., 2002; Ortega & Rosenheck, 2000), this finding has important implications for the trauma inventory itself. It is important to note that the race/ethnicity variable was only significant for the defensive avoidance subscale and not trauma symptoms in general. In other words the avoidance coping variable was the only aspect of the trauma inventory where a racial difference was found. This difference between Black and White groups may warrant further study.

Finally, although the hypotheses about Latinos were not supported by the results of this study, these findings offer further evidence that the use of avoidance coping by individuals of any race/ethnicity is linked to higher depression scores. It could be that avoidance coping contributes to depression or that having depression actually encourages the use of avoidance

coping; the direction and causal link is not certain. Pole, et al. (2008) suggests that avoidance coping methods are harmful because they interfere with the cognitive processing of trauma-related memories and inhibit the individual from regulating strong emotions related to the trauma, both of which can contribute to other symptoms of PTSD. According to Cukrowicz, et al. (2008) chronic thought suppression and avoidance of emotions can lead to more intense feelings of hopelessness, despair, and even suicidal ideation. Whether avoidance coping is a symptom of trauma or a causal factor for depression, it is clear from these findings and others that this avoidance coping style is quite detrimental to mental health (Holahan, et al., 2005) regardless of ones race/ethnicity.

Race/ethnicity is also a factor in the occurrence of depression, in that the Black group had a lower mean depression score than the other two groups, although the findings just approached significance. Even though there is a trend for the race/ethnicity variable as contributing to depression and avoidance coping was significantly linked to depression, there was no interaction effect. This means that regardless of race/ethnicity, the use of avoidance coping functioned the same. Interestingly, the Black group reported the highest scores for avoidance coping, but consistently reported the lowest scores for depression, a finding that seems to be contradictory in light of the statistical findings. However, upon further consideration, it was determined that within each racial/ethnic group, as the scores of defensive avoidance increases, so do the scores for depression. Thus, even though the overall mean for the Black group's use of avoidance coping was the highest and their average mean for depression scores was the lowest, the pattern within this group was the same (i.e., those Black participants with the highest avoidance coping scores reported higher depression scores than those Black participant with lower avoidance coping). Thus, it can be inferred that even though some groups may have lower rates of

depression (i.e., trend for main effect by race/ethnicity), because there was no interaction effect, avoidance coping methods are similarly detrimental to individuals across race/ethnic groups. While not the primary focus of this study, one additional finding merits attention. These results indicate that Latinos are no more likely to engage in avoidance coping than the other groups, however the surprising finding was that the Black group was significantly different from the White group, but not from the Latino group in terms of avoidance coping. Some research findings have indicated that the significant difference on factors of mental illness was not between Latinos and other groups, but between minority groups and the White group, thus pointing to a minority group experience as a significant variable in the occurrence of mental illness (Plant & Sachs-Ericsson, 2004; Rosenthal & Schreiner, 2000). In the present study, although the Latino group was not significantly different from either Blacks or Whites on avoidance coping, their means on avoidance coping appeared to be more similar to Blacks. This raises the question as to whether the lack of significant findings may have been, in part, a function of the smaller sample size for Latinos. Had the Latino sample equaled the Black sample, statistical significance might have been reached and thus might have supported the ethnic minority experience explanation. Of course, this is simply speculation at this point, but it certainly argues for more study.

Limitations of the Study

When reviewing the findings of this study it is important to consider the following limitations. The first limitation was a possible language barrier during the assessment phase, when these data were collected. This sample included both Latinos who spoke English fluently and those who did not. During some stages of data collection, only English assessments were offered to all clients due to a lack of Spanish speaking clinicians. This means that at times

Latinos who were not proficient in English either completed the assessments in English or were not included in the study. For those assessments that were completed, due to the potential language barriers, some items may not have been answered appropriately. To remedy this problem, beginning in 2007, assessments routinely were offered in Spanish to the Latino client population.

A second limitation of this study was due to the fact that this research was a secondary analysis of a previously existing dataset. For this reason there was no control over what type of data were gathered. Thus, important information, which could have helped to understand the Latino clients in greater depth (e.g., immigration status, years in the United States, previous trauma, etc.) was not available. In addition, a variety of measures to assess "mental health" were not available for this sample. Ideally a broader investigation on the mental health of Latinos would have included measures for anxiety, mania, somatoform, and other disorders. But because the BDI was the only option, only the depression variable was analyzed.

Finally, the fact that the sample was drawn from a clinical population may have influenced these findings. A clinical sample may be distinct from the general population in level of mental illness and distress, but also it is possible that a clinical sample may be engaging less in avoidance coping than those who do not seek therapy. In addition, as mentioned briefly above, the sample size may have been too small to determine significant patterns of behavior as a group. With a larger sample, particularly of Latinos, it is suspected that the Latino group would be significantly different from the White group in avoidance coping, as was the Black group, who had a larger sample.

Implications for Further Research

The focus of this study was primarily on Latinos in general compared to other groups, yet as discussed above, this sample was clinical in nature. The implications of these findings beg the question regarding the difference between Latinos who seek therapy and those who do not. It is possible that Latinos, or clients in general, who seek therapeutic services are less likely to be engaging in avoidance coping. Therefore, it is suggested that further study be conducted regarding the coping behaviors of Latinos in the general population, as compared to a clinical sample. With additional research a greater understanding about how seeking therapy influences and perhaps reduces the use of avoidance coping.

It might also be necessary to conduct further study regarding the interaction of other variables on depression and coping. Although there was no interaction effect for the race/ethnicity variable, there may be interaction effects with other variables, such as social support or previous trauma. It is possible that social support could act as a buffer against the effects of avoidance coping, while previous trauma may exacerbate the effects of avoidance coping. Another possibility is the effects of gender. Although this present study did not control for gender differences, it is likely that the use and reporting of avoidance coping may differ by gender and race/ethnicity. For example, as mentioned above, in the Latino culture the roles and expectations for each gender are still quite distinct (e.g., marianismo, machismo). Thus, a Latino male may cope or at least report his coping style differently that a Latino woman. At this point these are only speculations that warrant further study.

As discussed above, the construct of avoidance coping for Latinos is still unclear. Thus, in order to gain greater understanding regarding this style, a qualitative study might be a more appropriate first step. Individual interviews with Latinos from different groups (e.g., immigrants, citizens of the United States, natives, etc.) would be helpful in discovering themes in coping

behaviors. Additionally such a study could further investigate the meaning of avoidance coping, as described by Falicov (1998), in order to understand its prevalence and role among Latinos in the United States.

Finally, because these findings have interesting relevance for Black individuals and potentially for other ethnic minorities, an additional study is needed to understand the role and meaning of avoidance coping for people in this racial/ethnic group. It is unclear from these findings why these hypotheses were not true for Latinos, but instead were true for Black participants. Further investigation would be needed regarding the coping styles of Black persons in the United States and their role in the Black culture and community as well as their function in the mental health of Black persons. Additionally, because there were no significant differences between Latinos and Blacks in this study, additional examinations regarding the role of a minority experience might be beneficial. These questions are beyond the scope of this present research, but are very important to investigate.

Implications for Clinical Application

One of the primary purposes for conducting this research was to provide resources and information to clinicians regarding the Latino population in order to assist them in providing a culturally sensitive practice. As is common in the field, this research was focused on searching for the differences among groups rather than highlighting the instances where the groups do not vary. Cultural competence can easily be misinterpreted as the efforts to know the differences among racial/ethnic groups. Yet it could be that such a list of differences only exacerbates previously held stereotypes instead of opening the clinical dialogue to culturally sensitive conversations. This research challenges what is typically considered cultural competence and

proposes that in some cases, such as avoidance coping, the use of which can be detrimental to any group regardless one's race/ethnicity.

These findings have important implication for the work of mental health clinicians. Research regarding avoidance coping is especially meaningful for clinicians because these variables are to some degree within one's control, thus potentially influenced by therapy. Briere (1995) explains that defensive avoidance is not an intrusive experience (e.g., something beyond control), but a "conscious, intentional process of cognitive and behavioral avoidance" as a way of managing or coping with distress (p.14). Clinicians should pay particular attention to the influence of such coping styles when engaged in therapy.

The findings of this study add further evidence to the theory that such coping can be detrimental to a client's mental health. Specifically, the use of avoidance coping methods is linked to depression for the people in general, regardless their race/ethnicity. Thus, clinicians might be wise to appropriately assess all their clients, regardless of their race/ethnicity, for the use of avoidance coping methods, and if necessary, offer suggestions or explore additional alternative forms of coping. It would be necessary for the clinician to verbally assess the client's coping methods because culturally distinctive coping styles may not be caught by standardized assessments, such as the TSI (Briere, 1995). Such questions may focus on the individual's awareness of their coping style, and whether or not he or she feels in control of the management of their emotions and thoughts.

With that said, it is interesting that many of the therapeutic techniques and skills taught in cognitive behavioral trauma therapy encourage "avoidance-like" behaviors. For example, an early phase of trauma therapy is focused on affect regulation and identifying and countering negative thoughts. The theory is that by recognizing cognitions that often exacerbate negative

emotionality, one can begin to control the thoughts and in turn the associated emotions (Briere & Scott, 2006). When working with a client who has experienced trauma, a therapist might teach the client how to "contain" those negative thoughts and emotions so that they are only experienced in the safety of the therapy room. Another skill is called "thought stopping," which literally means that the client actively tries to stop intrusive and negative thoughts. The technique of "going to a safe place" in your mind (i.e., imagining yourself away from the negative thought or stimulus) or "intentional avoidance/time outs" during extremely stressful moments may also seem very similar to the construct of defensive avoidance coping (Briere & Scott, 2006). The difference between these skills and defensive avoidance coping may be in the client's sense of control (i.e., internal locus of control) over allowing the experience of negative thoughts and feelings and avoiding them. Therefore, with such a therapy, it may be that as the client learns more cognitive control, the other trauma symptoms may be reduced while the defensive avoidance scores may continue to increase. Thus, a clinician should be aware that the defensive avoidance subscale may be a measure of two kinds of coping, one that is detrimental and another that is therapeutic.

Being culturally sensitive and well informed regarding issues involving different racial/ethnic group is important for all clinicians. Currently, it is unclear whether Latinos engage in a culturally normative coping technique that appears like avoidance coping, but is something qualitatively different. Further research is needed to answer this question. Therefore, clinicians must continue to be sensitive to cultural differences and be open-minded to possibly healthy alternatives to coping than the "problem-solving" techniques that are common in mainstream culture in the United States (Blalock & Jointer, 2000). This may also be true for Black clients, considering the finding that indicated their high use of avoidance coping and low depression

scores. Thus, a clinician should engage the client in a dialogue that encourages him or her to express more about the coping methods used, yet these questions should come from a place of open-mindedness and respect.

Another consideration for clinicians in light of these findings is the possibility that Latinos who seek therapy may not be engaging in traditional or culturally normative methods of coping. Seeking this type of help may be a new experience for this individual and also members of their family who are not attending therapy. While it may be true that Latinos in a clinical sample are not engaging in avoidance coping more than other groups, according to these data, it is not yet determined if this is the case in the general population. Therefore, a clinician should be sensitive to this possible difference when working with Latino individuals and families.

Conclusion

The purpose of this study, to offer further understanding into the Latino group and their mental health, was fulfilled. In many ways the findings of this research were surprising because they indicated that Latinos, in terms of coping, trauma, and depression, are not significantly different from White or Black groups. Much of the current research has reported the opposite, and has perhaps unduly pathologized the Latino group. It could be that there are a disproportional number of studies that are published reporting Latinos as having higher rates of mental illness than those who find no difference, as this study did. Yet, it may be just as meaningful to understand that in certain situations (e.g., clinical settings) Latino clients may not be any better or worse than a client of another race/ethnicity. Had there been a larger sample of Latinos this study may have produced more solid findings regarding the role of minority status in the use of avoidance coping. Perhaps, this research can be a jumping off point for others to conduct further research to explore in greater depth Latinos as a group as well as study the

connection of avoidance coping and other factors and to continue to understand its connection with mental illnesses.

Appendix A: Family/Individual Information & Instructions

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FAMILY/INDIVIDUAL INFORMATION & INSTRUCTIONS

This is the first in a series of questionnaires you are being asked to complete that will contribute to the knowledge about individual and family therapy. In order for our research to measure progress over time we will periodically re-administer questionnaires. Please answer the questions at a relatively fast pace, usually the first response that comes to mind is the best one. **There are no right or wrong answers.**

4. Date: _____

1. Case #:_____
2. Therapist's Code:

The following information is gathered from each family member separately.

Name: (Print) _____

Address: _____

E-mail address: _____

Phone Numbers: _____

5. Gender: M F

6. SSN _____ - ____ - _____

7. Age (in years): _____

8. You are coming for: a.) Family _____ b.) Couple _____ c.) Individual _____ therapy.

9. **Relationship Status** _____

1. Currently married, living together
2. Currently married, separated, but not divorced
3. Divorced, legal action completed
4. Living together, not married
5. Separated, not married
6. Dating, not living together
7. Single
8. Widowed/ Widower
9. Domestic partnership

10. **Years** Together: _____

11. What is your **occupation?** _____

1. Clerical sales, bookkeeper, secretary
2. Executive, large business owner
3. Homemaker
4. None – child not able to be employed
5. Owner, manager of small business
6. Professional - Associates or Bachelors degree
7. Professional – master or doctoral degree
8. Skilled worker/craftsman
9. Service worker – barber, cook, beautician
10. Semi-skilled worker – machine operator
11. Unskilled Worker
12. Student

12. What is your **current employment status?**_____

1. Employed full time
2. Employed part time
3. Homemaker, not employed outside home
4. Student
5. Disabled, not employed
6. Unemployed
7. Retired

13. Personal **yearly gross income**:$_____
(before taxes or any deductions)

14. **Race**: _____

1. Native American
2. African American
3. Asian/Pacific Islander
4. Hispanic
5. White
6. Other (specify)_____

15. What is **your country of origin**? _____

What was **your parent's country of origin**? 16._____(father's) 17._____(mother's)

18. Highest Level of **Education** Completed: _____

1. Some high school
2. High school diploma
3. Some college
4. Associate degree
5. Bachelors degree
6. Some graduate education
7. Masters degree
8. Doctoral degree
9. Trade school

19. Number of **people in your Household**:_____

20..Number of **children** who **live at home** with you: ___

21..Number of children who **do not live** with you: ___

Names and Phone Numbers of **Contact People** in case of emergency (minimum 2):

_____

_____

22. What is your **religious** preference? _____

1. Mainline Protestant (e.g., Episcopal, Lutheran, Methodist, Presbyterian, Unitarian)
2. Conservative Protestant (e.g., Adventist, Baptist, Pentecostal)
3. Roman Catholic
4. Jewish
5. Other (e.g., Buddhist, Mormon, Hindu) Please Specify _____
6. No affiliation with any formal religion

23. How often do you **participate in organized activities of a church or religious group**?____

1. several times per week
2. once a week
3. several times a month
4. once a month
5. several times a year
6 one or twice a year
7 rarely or never

24. How **important is religion or spirituality** to you in your daily life? ____

1. Very important 2. Important 3. Somewhat important 4. Not very important 5. Not important at all

25. **Medications**: _____Yes _____No. If yes, please list the names, purpose, and quantity of the **medication(**s) you are currently taking. Also list the name and phone number of the medicating physician(s) and your primary care physician:

Medications:

Primary Care Physician: **Phone:**

Psychiatrist? Yes/No Name & Phone, if yes. **Phone:**

Legal Involvement:

26. Have you ever been involved with the police/legal authorities? Yes/No (circle)

If yes, please explain:

_____

_____

27. Have formal, legal procedures (e.g., ex-parte orders, protection orders, criminal charges, juvenile offenses) been brought against you? Yes/No (circle) If yes, please explain:

_____

28..If formal procedures were brought, what were the results (e.g., eviction, restraining orders)?_____

29. Many of the questions refer to your "family." It will be important for us to know what individuals you consider to be your family. Please list below the names and relationships of the people you will be including in your responses to questions about your family. Circle yourself in this list.

(Number listed in family) _____.

Name	Relationship

List the concerns and problems for which you are seeking help. Indicate which is the most important by circling it. For each problem listed, note the degree of severity by checking (√) the appropriate column.

	4 - Severe	3 -Somewhat Severe	2 - Moderate	1 - Mild
30.	31.			
32.	33.			
34.	35.			
36.	37.			

38. The most important concern (circled item) is # _____.

Appendix B: Trauma Symptoms Inventory (Abbreviated Version)

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TSI-A

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

Instructions: The items that follow describe a number of things that may or may not have happened to you. Read each one carefully, and then indicate on the answer sheet how often it has happened in the last **6 months** by circling the correct number. Circling a 0 means it hasn't happened at all in the last 6 months. Circling a 3 means it has happened often in the last **6 months**. Circling a 1 or 2 means it has happened in the last 6 months, but has not happened often.

Never			**Often**
0	1	2	3

Please answer each item as honestly as you can. **Be sure to answer every item.**

*In the last **6 months**, how often have you experienced:*

		Never			**Often**
1/1.	Nightmares or bad dreams	0	1	2	3
2/2.	Trying to forget about a bad time in your life	0	1	2	3
3/3.	Irritability	0	1	2	3
4/4.	Stopping yourself from thinking about the past	0	1	2	3
5/8.	Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
6/10.	Feeling like you were outside your body	0	1	2	3
7/12.	Sudden disturbing memories when you were not expecting them	0	1	2	3
8/15.	Becoming angry for little or no reason	0	1	2	3
9/20.	Your mind going blank	0	1	2	3
10/22.	Periods of trembling or shaking	0	1	2	3
11/23.	Pushing painful memories out of your mind	0	1	2	3
12/26.	Feeling like you were watching yourself from far away	0	1	2	3
13/27.	Feeling tense or "on edge"	0	1	2	3
14/29.	Not feeling like your real self	0	1	2	3
15/31.	Worrying about things	0	1	2	3
16/34.	Being easily annoyed by other people	0	1	2	3
17/35.	Starting arguments or picking fights to get your anger out	0	1	2	3
18/37.	Getting angry when you didn't want to	0	1	2	3
19/38.	Not being able to feel your emotions	0	1	2	3
20/41.	Feeling jumpy	0	1	2	3
21/42.	Absent-mindedness	0	1	2	3

22/45.	Yelling or telling people off when you felt you shouldn't have	0	1	2	3
23/51.	High anxiety	0	1	2	3
24/54.	Nervousness	0	1	2	3
25/57.	Feeling mad or angry inside	0	1	2	3
26/59.	Staying away from certain people or places because they reminded you of something	0	1	2	3
27/62.	Suddenly remembering something upsetting from your past	0	1	2	3
28/63.	Wanting to hit someone or something	0	1	2	3
29/66.	Suddenly being reminded of something bad	0	1	2	3
30/67.	Trying to block out certain memories	0	1	2	3
31/70.	Violent dreams	0	1	2	3
32/72.	Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
33/74.	Frightening or upsetting thoughts popping into your mind	0	1	2	3
34/83.	Not letting yourself feel bad about the past	0	1	2	3
35/84.	Feeling like things weren't real	0	1	2	3
36/85.	Feeling like you were in a dream	0	1	2	3
37/87.	Trying not to have any feelings about something that once hurt you	0	1	2	3
38/88.	Daydreaming	0	1	2	3
39/89.	Trying not to think or talk about things in your life that were painful	0	1	2	3
40/91.	Being startled or frightened by sudden noises	0	1	2	3
41/93.	Trouble controlling your temper	0	1	2	3
42/97.	Feeling afraid you might die or be injured	0	1	2	3

Appendix C: Beck Depression Inventory

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BDI

Gender: _____Date of Birth: _____ Therapist Code _____ Family Code _____
On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the ***PAST WEEK*, INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel I am worse than anybody else.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
    1 I cry more than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I have ever been.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time now.
    3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decision than before.
    3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I have to push myself very hard to do anything.
    3 I cant' do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired more doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.
I am purposely trying to lose weight. Yes ___ No ___

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches, pains, an upset stomach or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Appendix D: Información e Instucciones Familiar/Individual

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INFORMACIÓN E INSTRUCCIONES FAMILIAR/INDIVIDUAL

Este es el primero de una serie de cuestionarios que le pedimos que complete y que contribuirá a ampliar nuestros conocimientos sobre la terapia individual y familiar. A fin de medir el progreso a través del tiempo, volveremos a administrar cuestionarios periódicamente. Por favor responda las preguntas relativamente rápido, generalmente la primer respuesta que le viene a la mente es la mejor. **No hay respuestas correctas o incorrectas**.

1.) Código de la familia: _____ 2.) Código del terapeuta (s):
4.)Fecha: _____ 3.)

La siguiente información se le pide a cada miembro de la familia por separado.
Nombre: **Domicilio:**
_____

_____

Dirección de correo electrónico: _____ _____

Código Postal_____

Números de Teléfono: (casa) _____ (trabajo) _____

(celular)_____ (fax) _____

5.) Género: M F 6.) SSN _____-_____-_____ 7.) Edad (en años): _____

8.) Viene por terapia: a.) Familiar _____ b.) De pareja _____ c.) Individual _____

9.) **Estatus de la relación** con la persona que está en terapia de pareja con usted: 10.) **Años** juntos: _____

1. Actualmente casado/a, viviendo juntos
2. Actualmente casado/a pero separado
3. Divorciado/a
4. Viviendo juntos, no casados
5. Separados, no casados

11.) Cuál es su **ocupación**? _____
actualmente?_____

3. Vendedor/a, administrativo/a, contador/a, secretaria/o
4. Ejecutivo, propietario de gran comercio
5. Ama/o de casa
4. Ninguna- niño que no puede ser empleado
13. Propietario, gerente de un negocio pequeño
14. Profesional - Título Asociado o de Bachiller
15. Profesional – Título de master o de doctorado
16. Trabajador/a artesanal
17. Trabajador en servicios – peluquero/a, cocinero/a
18. Trabajador semi-calificado – maquinista
19. Trabajador no calificado
20. Estudiante

12.) Cuál es su **estatus en su trabajo**

1. Empleado a tiempo completo
2. Empleado a medio tiempo
3. Ama/o de casa, no empleado/a fuera de la casa
4. Estudiante
5. Discapacitado, no empleado
6. Desempleado
7. Jubilado

13.) **Ingreso personal anual bruto**: $_____

14) **Raza**: _____

1. Nativo americano
2. Afro-americano
3. Asiático/ Isleño del Pacífico
4. Hispano
5. Blanco
6. Otro (especifique): _____

15.) Cuál es **su país de origen**? _____

Cuál fue **el país de origen de sus padres**? 16.)_____(del padre) 17.)_____(de la madre)

18.) Nivel máximo de **educación** completado?: _____

1. Escuela secundaria incompleta
2. Escuela secundaria completa
3. Universidad incompleta
6. Título asociado
7. Título de bachiller
6. Posgrado
7. Título demaster
8. Título doctoral
9. Negocios

incompleto

19.) Número de personas que viven en la casa: _____
20.) Número de niños que viven en la casa: _____

21.) Número de niños que **no viven** en la casa: _____

Nombres y números de teléfono de **Personas a Contactar** en caso de emergencia (mínimo 2):

1. _____
2. _____

22.) Cuál es su preferencia **religiosa**?

1. Principales Líneas Protestantes (Ej.: Episcopal, Luterana, Metodista, Presbiteriana, Unitaria)
2. Protestante Conservadora (Ej.: Adventista, Bautista, Pentecostal)
3. Católica Romana
4. Judía
5. Otra (Ej.: Budista, Mormona, Hindu)
6. Ninguna afiliación a una religión formal

23.) Con cuánta frecuencia participa en **actividades organizadas por la iglesia o en un grupo religioso**?

1. varias veces por semana
2. una vez por semana
3. varias veces al mes
4. una vez al mes
5. varias veces por año
6. una o dos veces al año
7. raramente o nunca

24.) Que **importante es la religión o espiritualidad** en su vida diaria? ____

1. Muy importante 2. Importante 3. Más o menos importante 4. No muy importante 5. Para nada importante

25.) **Medicaciones**: _____Sí _____No.

Si respondió afirmativamente, por favor indique en una lista los nombres, el propósito, y la cantidad de la **medicación**(es) que está tomando en el presente. También indique en una lista el nombre y el numero telefónico del médico que le prescribió la medicación y el de su médico de cabecera.

Medicaciones:

Médico de Cabecera: **Teléfono:**

Psiquiatra? Si _____
No _____

Si respondió afirmativamente **Nombre:** **Teléfono :**

Causas Legales:

26.) Ha estado alguna vez involucrado en cuestiones policiales/legales? Si No (indique con un círculo)

Si respondió afirmativamente, por favor explique:

_____
_____

27.) Alguna vez le han iniciado formalmente procedimientos legales contra usted (Ej.: órdenes ex-parte, órdenes de protección, cargos delictivos, delitos como menor) ? Si No (indique con un círculo)

Si respondió afirmativamente, por favor explique:

_____

_____

28.) Si se le iniciaron procedimientos formales, cuáles fueron los resultados (Ej.: órden de desalojo, órden de restricción)?

_____

29.) Muchas de las preguntas que le haremos se referirán a su "familia". Es importante para nosotros saber cuáles individuos usted considera como su familia. Por favor haga una lista con los nombres y la relación de la gente que usted incluirá en respuestas acerca de su familia. Haga un círculo alrededor de su nombre en la lista.

Nombre Relación

(Número de personas incluidas en la lista como familia) _____.

_____

Haga una lista con los asuntos y problemas por los cuales esta buscando ayuda. Indique cuál es el más importante y realice un círculo alrededor. Para cada problema en la lista, indique el grado de severidad chequeando (√) la columna correspondiente.

	4 - Severo	3 –Más o menos severo	2 - Moderado	1 - Leve
30.				
31.				
32.				
33.				

34. El problema más importante (con círculo alrededor) es # _____.

Appendix E: TSI-A (Spanish Translation)

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TSI-A

Género _____ Fecha de nacimiento _____ Código del terapeuta _____ Código de la familia _____

Instrucciones: Los enunciados que siguen describen un número de cosas que pueden o no haberle pasado a usted. Lea cuidadosamente cada enunciado, y luego indique en la hoja de respuestas con qué frecuencia esto ha pasado en los últimos **6 meses,** encerrando en un círculo el numero correspondiente. Encerrar un 0 en un círculo significa que esto no ha pasado en absoluto en los últimos 6 meses. Encerrar un 3 en un círculo significa que esto ha pasado a menudo en los últimos 6 meses. Encerrar en un círculo un 1 o un 2 significa que esto ha ocurrido en los últimos 6 meses, pero no con frecuencia. Por favor responda cada enunciado tan honestamente como pueda.

*En los últimos **seis meses**, con qué frecuencia usted ha tenido:*

		Nunca			Con frecuencia
1/1.	Pesadillas o malos sueños	0	1	2	**3**
2/2.	Tratar de olvidar un mal episodio en su vida	0	1	2	**3**
3/3.	Irritabilidad	0	1	2	**3**
4/4.	Impedirse a si mismo/a pensar sobre el pasado	0	1	2	**3**
5/8.	Flashbacks (imágenes o recuerdos repentinos sobre cosas perturbadoras)	0	1	2	**3**
6/10.	Sentirse como si estuviera por fuera de su cuerpo	0	1	2	**3**
7/12.	Recuerdos perturbadores repentinos cuando usted no los esta esperando	0	1	2	**3**
8/15.	Enojarse por una razón mínima o sin razón alguna	0	1	2	**3**
9/20.	Su mente se puso en blanco	0	1	2	**3**
10/22.	Periodos de temblor o sacudida	0	1	2	**3**
11/23.	Tratar de sacar recuerdos dolorosos de su mente	0	1	2	**3**
12/26.	Sentimiento de estarse viendo a si mismo/a desde lejos	0	1	2	**3**
13/27.	Sentirse tenso/a o “al límite”	0	1	2	**3**
14/29.	No sentirse como su ser verdadero	0	1	2	**3**
15/31.	Preocuparse por las cosas	0	1	2	**3**
16/34.	Ser fácilmente fastidiado/a por otras personas	0	1	2	**3**
17/35.	Comenzar discusiones o peleas para desahogar la rabia	0	1	2	**3**
18/37.	Enojarse cuando usted no quería	0	1	2	**3**
19/38.	No ser capaz de sentir sus emociones	0	1	2	**3**
20/41.	Sentirse nervioso/a	0	1	2	**3**

		Nunca			Con frecuencia
21/42.	Estar distraído(a)	0	1	2	**3**
22/45.	Gritar o regañar a las personas cuando usted sintió que no debía	0	1	2	**3**
23/51.	Alto nivel de ansiedad	0	1	2	**3**
24/54.	Nerviosismo	0	1	2	**3**
25/57.	Sentirse enojado/a o furioso/a por dentro	0	1	2	**3**
26/59.	Alejarse de ciertos lugares y personas porque le recuerdan algo	0	1	2	**3**
27/62.	Recordar repentinamente algo perturbador de su pasado	0	1	2	**3**
28/63.	Querer golpear a alguien o a algo	0	1	2	**3**
29/66.	Recordar de repente algo malo	0	1	2	**3**
30/67.	Tratar de bloquear ciertos recuerdos	0	1	2	**3**
31/70.	Sueños violentos	0	1	2	**3**
32/72.	Solo por un momento, ver o escuchar algo perturbador que pasó antes en su vida	0	1	2	**3**
33/74.	Pensamientos aterradores o perturbadores apareciendo súbitamente en su mente	0	1	2	**3**
34/83.	No permitirse a si mismo/a sentirse mal por el pasado	0	1	2	**3**
35/84.	Sentir que las cosas no son reales	0	1	2	**3**
36/85.	Sentir que usted está en un sueño	0	1	2	**3**
37/87.	Tratar de no tener ningún sentimiento sobre algo que alguna vez lo lastimó	0	1	2	**3**
38/88.	Soñar despierto/a	0	1	2	**3**
39/89.	Tratar de no pensar ni hablar sobre cosas del pasado que fueron dolorosas	0	1	2	**3**
40/91.	Sentirse asustado/a o aterrorizado/a por sonidos repentinos	0	1	2	**3**
41/93.	Problemas controlando su temperamento	0	1	2	**3**
42/97.	**Sentirse asustado/a de que usted pueda morir o resultar herido**	**0**	**1**	**2**	**3**

Appendix E: BDI (Spanish Translation)

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BDI

Género: _____ Fecha de Nacimiento: _____ Código de la Familia: _____ Código del Terapeuta:
Este cuestionario presenta grupos de enunciados. Por favor lea con cuidado cada grupo de enunciados. En cada grupo seleccione el enunciado que mejor describa la manera en que usted se ha sentido desde la ***SEMANA PASADA, INCLUYENDO EL DIA DE HOY***! Marque con un circulo el numero de la frase que usted ha seleccionado. Si dentro de un grupo mas de un enunciado parece representar lo que usted ha sentido, marque todos los que correspondan. **Lea todos los enunciados en cada grupo antes de seleccionar su respuesta.**

1. 0 No me siento triste.
   1 Me siento triste.
   2 Estoy triste todo el tiempo y no puedo animarme.
   3 Estoy tan triste e infeliz que no puedo soportarlo.

2. 0 No me siento particularmente desalentado(a) sobre el futuro.
   1 Me siento desalentado(a) sobre el futuro.
   2 Siento que no tengo nada que esperar del futuro.
   3 Siento que el futuro no tiene esperanza y que las cosas no van a mejorar.

3. 0 No me siento fracasado (a).
   1 Siento que he fracasado mas que el común de la gente.
   2 Al mirar mi pasado, todo lo que veo es fracaso.
   3 Siento que soy un fracaso como persona.

4. 0 Encuentro satisfacción en las cosas como antes.
   1 No disfruto las cosas de la misma manera que antes.
   2 Ya no encuentro real satisfacción en nada.
   3 Estoy descontento(a) o aburrido(a) con todo.

5. 0 No me siento particularmente culpable.
   1 Me siento culpable buena parte del tiempo.
   2 Me siento culpable la mayor parte del tiempo.
   3 Me siento culpable todo el tiempo.

6. 0 No siento que estoy siendo castigado(a).

1 Siento que puedo ser castigado(a).
2 Espero ser castigado(a).
3 Siento que estoy siendo castigado(a).

7. 0 No estoy desilusionado(a) de mi mismo(a).
1 Estoy desilusionado(a) de mi mismo(a).
2 Estoy disgustado(a) conmigo mismo(a).
3 Me odio a mi mismo(a).

8. 0 No siento que soy peor que otras personas.
1 Me critico a mi mismo(a) por mis debilidades o errores.
2 Me culpo por mis errores todo el tiempo.
3 Me culpo por todo lo malo que pasa.

9. 0 No tengo ideas acerca de matarme.
1 Tengo ideas de matarme pero no lo voy a hacer.
2 Me gustaría matarme.
3 Me gustaría matarme si tuviera la oportunidad.

10. 0 No lloro mas que lo usual.
1 Ahora lloro mas que antes.
2 Ahora lloro todo el tiempo.
3 Antes podía llorar, pero ahora no puedo aunque quiera.

11. 0 No estoy mas irritado(a) que antes.
1 Ahora me molesto o irrito mas fácilmente que antes.
2 Me siento irritado(a) todo el tiempo.
3 No me irrito por las cosas que antes me irritaban.

12. 0 No he perdido interés en la gente.
1 La gente ya no me interesa como antes.
2 He perdido casi todo el interés por la gente.
3 He perdido todo el interés por la gente.

13. 0 Puedo tomar decisiones más o menos igual que antes.
1 Evito tomar decisiones más que antes.
2 Tengo mas dificultad para tomar decisiones que antes.
3 Ya no puedo tomar decisiones.

14. 0 No creo que mi aspecto sea peor que antes.

1 Me preocupa que mi aspecto sea el de una persona vieja o poco atractivo(a).
2 Siento que hay cambios permanentes en mi apariencia que me hacen ver poco atractivo(a).
3 Creo que soy feo(a).

15. 0 Puedo trabajar tan bien como antes.
1 Me toma un esfuerzo extra empezar a hacer algo.
2 Tengo que esforzarme mucho para poder hacer algo.
3 No puedo hacer ningún trabajo.

16. 0 Puedo dormir tan bien como antes.
1 No duermo tan bien como antes.
2 Me levanto 1-2 horas mas temprano que lo usual y es difícil reconciliar el sueno.
3 Me levanto varias horas mas temprano que lo usual y no puedo reconciliar el sueno.

17. 0 No me agoto más de lo usual.
1 Me agoto más fácilmente que antes.
2 Me agota hacer cualquier cosa.
3 Estoy muy cansado para hacer cualquier cosa.

18. 0 Mi apetito no es peor que de costumbre.
1 Mi apetito no es tan bueno como antes.
2 Ahora mi apetito es mucho peor.
3 No tengo apetito alguno.

19. 0 Últimamente, no he perdido mucho peso.
1 He perdido más de 5 libras.
2 He perdido más de 10 libras.
3 He perdido más de 15 libras.

Estoy tratando de perder peso. Si_____ No _____

20. 0 Me preocupo igual que antes por mi salud.
1 Me preocupan los malestares físicos como dolores de cabeza, del estómago y la constipación.
2 Estoy tan preocupado por los problemas físicos que es difícil pensar en algo diferente.
3 Estoy tan preocupado por los problemas físicos que no puedo pensar en algo diferente.

21. 0 No he notado ningún cambio reciente en mi interés por el sexo.
1 Estoy menos interesado en el sexo que antes.
2 Ahora estoy mucho menos interesado en el sexo.
3 He perdido completamente el interés por el sexo.

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