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Posttraumatic Stress Disorder (PTSD) in the Latino Culture: A Proposed Culturally-Responsive Intervention Program for Latinas

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CLAREMONT McKENNA COLLEGE

**POSTTRAUMATIC STRESS DISORDER (PTSD) IN THE LATINO CULTURE:
A PROPOSED CULTURALLY-RESPONSIVE INTERVENTION PROGRAM
FOR LATINAS**

SUBMITTED TO

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AND

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FOR

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Abstract

The goal of this dissertation is to investigate the factors that increase risk for posttraumatic stress disorder (PTSD) in Latinos. Although the overall rates of psychiatric disorders in the Latino community are similar to Caucasian Americans, the risk for PTSD among Latinos is higher. This thesis discusses the general components of trauma and stress, as well as the prevalence of PTSD in various Latino subgroups. This thesis also covers a number of cultural-specific values, stressors, and help-seeking attitudes that increase the risk of PTSD among Latinos. Moreover, a culturally-responsive intervention program treating PTSD among Latinas who are victims of intimate partner violence (IPV) is proposed.

The High Prevalence of Posttraumatic Stress Disorder (PTSD) in the Latino Culture

Posttraumatic Stress Disorder (PTSD) is one of the most common mental health disorders in the United States. Approximately 7% to 8% of the U.S. population will develop PTSD at some point throughout their lives (U.S. Department of Veteran's Affairs, 2012). The U.S. Department of Veteran's Affairs (2012) also estimates that the one-year prevalence rate of PTSD in the United States will affect 5.2 million adults. In addition to the psychiatric and emotional burden, PTSD also has major consequences for the U.S. economics system. For example, about 200,000 veterans suffering from PTSD receive disability compensation, which annually costs about 4.3 billion dollars. Although these numbers may appear as an alarming dilemma to the U.S population, these statistics only cover a small portion of those individuals who have actually experienced a trauma or traumatic event. Depending on the severity of the traumatic experience, individuals are also likely to develop an onset of subsequent psychological disorders, which may generate dysfunctional behavioral patterns, as well as worsening an individual's overall quality of life.

PTSD is a universal disorder that affects people of all ages, genders, and ethnic backgrounds. Men evidence a higher rate of PTSD in the military because of their over-representation and greater likelihood to be in combat situations than that of women. However, since women are more likely to be exposed to traumas (five out of ten women report an experienced traumatic event) such as rape and/or domestic violence, not only are they at a higher risk than men to develop PTSD, but they are also more likely to develop ongoing symptoms of PTSD (U.S. Department of Veteran's Affairs, 2012). About 10% of women, in comparison to 5% of men, will develop PTSD at some point in

their lives (U.S. Department of Veteran's Affairs, 2012). Although prevalent in the general U.S. population, the rate of PTSD among women is higher overall.

Although a great deal is known about PTSD in Caucasian Americans, relatively little research has been conducted on the development of PTSD among Latinos. This is highly problematic because Hispanic-Americans are now “the largest and fastest growing minority group in the United States” (Pole, 2005). Additionally, Latinos evidence a higher rate of PTSD than the White population; Kulka et al. (1990) estimated that the Hispanic PTSD prevalence rate was 27.9% in comparison to the 13.7% PTSD prevalence rate among non-Hispanic Caucasians. Hence, the high prevalence of PTSD among Latinos has generated many studies in attempt to conceptualize the probable factors that place Latinos at higher risk for developing PTSD.

This dissertation initially reviews the overall literature of PTSD. The next goal of this thesis is identifying the main factors that contribute to the high prevalence of posttraumatic stress disorder (PTSD) among Latinos. In doing so, this thesis will analyze PTSD as a key psychological stress disorder, as well as reevaluate the findings of various PTSD prevalence studies in relation to the Latino culture. Furthermore, this dissertation will recognize Latinos cultural-specific core values of salience, stressors, and perceptions of mental health that may also place Latinos at higher risk for developing PTSD. These findings and reevaluations may be significantly important to prevent higher prevalence rates of other mental illnesses among members of the fastest growing ethnic group in the United States. To conclude this dissertation, a culturally-responsive PTSD intervention program for Latina women suffering from intimate partner violence (IPV) is proposed.

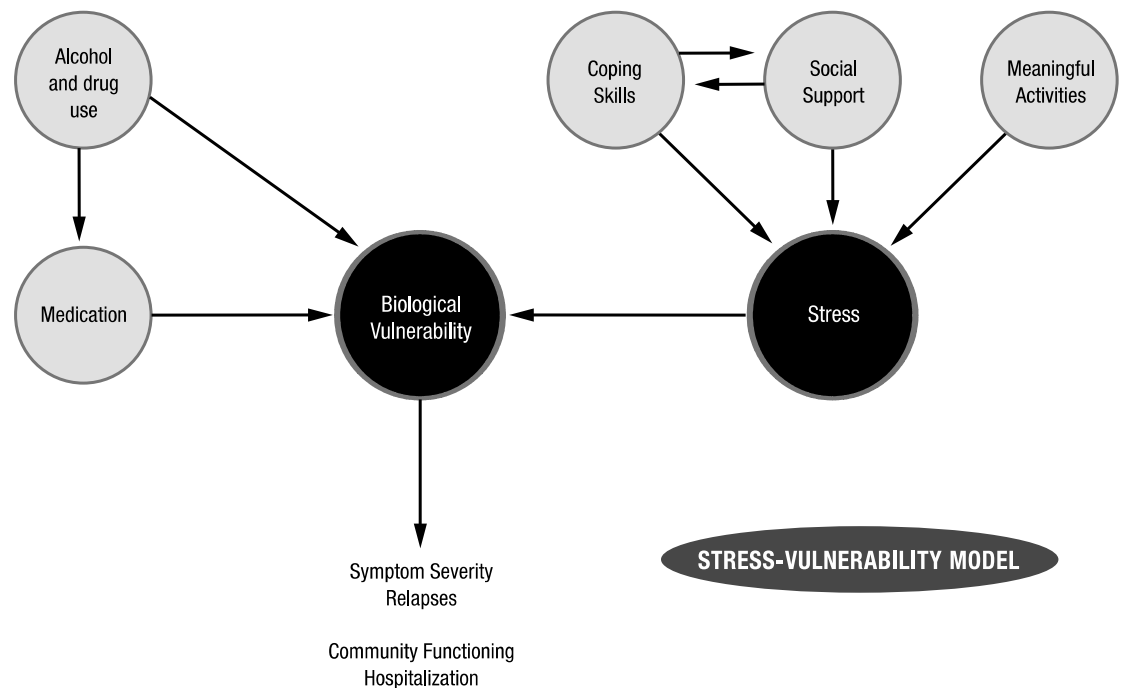
Key Components of Trauma, Psychological Stress Disorders, and Treatment

There are two diagnoses, or types of psychological stress disorders that are most prevalent in the United States: Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD). ASD and PTSD are similar disorders characterized by fear and related symptoms experienced after a trauma or traumatic event. The sole difference between ASD and PTSD is the amount of time before stress surfaces after the traumatic event. The general symptoms of ASD typically begin within four weeks of the traumatic event and persist for about four weeks, whereas PTSD symptoms begin either shortly after the traumatic event, or even months and years afterwards. As ASD and PTSD are similar disorders, studies indicate that about 80% of individuals diagnosed with ASD eventually develop PTSD (Bryant et al., 2005). Hence, symptoms of ASD should be immediately treated to prevent any further, prolonged symptoms of PTSD. Surveys also indicate that at least 3.5% of individuals in the United States experience at least one psychological stress disorder in a given year, and of those individuals, about 7% to 9% suffer from a psychological stress disorder throughout the course of their lifetimes (Burijon, 2007). Not only do ASD and PTSD cause individuals to experience high levels of stress, but they also increase the potential onset of depression, anxiety disorders, substance abuse, and/or suicidal thoughts, in addition to affecting one's personal, familial, and occupational lives (Koch & Haring, 2008).

To comprehend the structural development of acute stress disorder (ASD) and posttraumatic stress disorder (PTSD), stress, as the underlying factor of these disorders, must be specifically defined. Unfortunately, stress (distress) abruptly occurs in various forms, which has the potential to threaten an individual's wellbeing; its profound effect

on psychological and physical functioning requires an individual to develop a new cognitive and emotional organization to accommodate the challenging experience or irretrievable loss (Cardena et al., 2013). Stress comprises two main elements: the stressor, or an event that creates the demands, and the stress response, which refers to the individual's reaction to the demands of the stressor(s) (Comer, 2010). Stressors can range from common, everyday hassles to traumatic events; hence, the individual's response to the stressor will predict the severity of the physical, emotional, and cognitive reactions (Comer, 2010). The individual's initial reaction to the stressor is extremely important, because such stressors and stressful events will not only guide the individual to develop a psychological stress disorder, but will also potentially place the individual at a higher risk to the development of another ongoing anxiety disorder.

Another important concept, or model, that may help determine an individual's susceptibility to the development of a psychological stress and/or anxiety disorder is the Stress-Vulnerability Model of Co-occurring Disorders. This model can help with understanding the fundamental causes of psychiatric disorders, how addiction can influence psychiatric disorders, and how to manage and/or treat co-occurring disorders (Hazelden Foundation, 2008). Displayed below, this model is currently used to help identify the contributing factors of stress susceptibility:



There are two key factors included in the Stress-Vulnerability Model: biological vulnerability and stress. Both factors are influenced by additional external factors which individuals have the ability to control: alcohol and drug use, as well as an individual's coping skills, social support, and chosen pleasurable activities (Hazelden Foundation, 2008). Since alcohol and drug use can trigger an individual's pre-existing biological vulnerability to a psychiatric disorder, an individual should decrease substance abuse to prevent future relapses, which will generally improve the course of an individual's co-occurring disorder(s) (Hazelden Foundation, 2008). Furthermore, by adopting efficient self-coping skills, creating a large social support network, and increasing pleasurable and/or meaningful activities, an individual can lessen his or her likelihood of experiencing high levels of stress. These steps will also reduce an individual's biological vulnerability of symptom relapses and/or future hospitalization.

Aside from the notion that stress and biological vulnerability are crucial to the

development of psychological stress disorders, there are unfortunately many other factors that may trigger the potential onset of a psychological stress disorder. In addition to biological vulnerability, an individual who may have experienced a trauma or traumatic event may also experience physical alterations in the brain and body that can eventually increase his or her susceptibility to the development of a psychological stress disorder. Studies indicate that those individuals who have experienced a severe traumatic event (i.e. combat soldiers and rape victims) have abnormal activity of cortisol and norepinephrine in their urine, blood, and saliva (Burijon, 2007). Brain studies also show that once a psychological stress disorder officially sets in, individuals will undergo further biochemical arousal in the brain; when the arousal continues, there is a high possibility that key brain areas will be damaged (Carlson, 2008).

These brain areas, such as the hypothalamus and amygdala, play a major role in human brain functioning. The hypothalamus works with memory recollection and the regulation of stress hormones and the amygdala controls various emotional responses (Comer, 2010). Due to their vital roles in brain functioning, dysfunction of the hypothalamus and amygdala may lead to the production of intrusive memories, ongoing arousal, intense emotional arousals, and repeated emotional symptoms, which highly correlate to the onset of posttraumatic stress disorder (Bremner et al., 2004) (Protopopescu et al., 2005).

Aside from genetic and biological factors that potentially initiate high levels of stress, an individual's personality, childhood experiences, and social support system are also very relevant to the potential onset of psychological stress disorders. Certain personality profiles, attitudes, and coping styles are particularly likely to develop stress

disorders (Burijon, 2007). For instance, those individuals who generally view life's negative events as being beyond their control are more prone to develop severe stress symptoms (Taylor, 2006). Additionally, individuals who have difficulty deriving anything positive from negative situations will adjust more poorly after experiencing traumatic events (Bonanno, 2004). Early childhood experiences can also produce various personality styles and/or attitudes that are linked to stress disorders. Children with negative childhood experiences such as living in poverty, suffering from abuse, or experiencing a particular catastrophe at an early age are more likely to develop stress disorders as an adult after facing a new trauma (Koch & Haring, 2008). Lastly, as previously demonstrated in the Stress-Vulnerability Model, social support networks hypothetically play a supplemental role in the development of psychological stress disorders. Studies indicate that individuals with weak social and familial support systems are more likely to develop a stress disorder after experiencing a traumatic event, especially among combat and/or rape victims (Charuvastra & Cloitre, 2008).

Already stated, ASD and PTSD exhibit many similarities in which the two disorders present nearly identical psychological and physical symptoms. The general symptoms of both ASD and PTSD generate a growing sense of fear from a past traumatic event, abnormal and or dysfunctional behaviors, and uncontrollable levels of arousal, anxiety, and depression (Comer, 2010). Individuals with either psychological stress disorder will also experience four main symptoms in addition to the aforementioned symptoms: constantly re-experiencing the trauma or traumatic event, general avoidance, reduced responsiveness, and an increased amount of arousal, anxiety, and guilt. Since ASD cases have an 80% chance of converting to PTSD, the DSM-IV-TR further

articulates these symptoms in a checklist format. For PTSD diagnosis, an individual must have a history of an experienced, witnessed, or confronted event(s), involving death, serious injury, or a threat to the physical integrity of oneself or others. Common PTSD reactions are intense fear, helplessness, and/or horror (APA, 2000). The DSM-IV-TR checklist also emphasizes that the traumatic event is re-experienced in at least one of the following ways: recurrent distressing collections, dreams, illusions, and/or flashbacks, as well as induced bodily distress and arousal by the reminders of the event (APA, 2000). Additionally, an individual must persistently avoid reminders of the event by suffering from physical numbing, feelings of detachment, and/or emotional unresponsiveness (APA, 2000). The fourth symptom of PTSD in the DSM-IV-TR accounts for experiencing at least two symptoms of increased arousal: difficulty sleeping, irritability, poor concentration, hyper-vigilance, and an exaggerated startled response (APA, 2000). Lastly, the individual must demonstrate constant distress or impairment with symptoms lasting at least one month.

Since the aforementioned material examines general statistics, components, and symptoms of both acute stress disorder (ASD) and posttraumatic stress disorder (PTSD), it is important to consider these disorders' general recovery treatment techniques. Clinicians tend to treat these disorders differently depending on the severity of the traumatic event, yet all treatment programs aim for similar end results. Clinicians attempt to gain the patient's perspective on the traumatic experiences, help the patient end his or her stressful symptom reactions, and also help the patient return to a more constructive lifestyle (Bryant et al., 2005). Asnis et al.'s (2004) study found that about half of all PTSD cases improve within six months with appropriate treatment, but symptoms can

hypothetically persist for many years afterwards. Correspondingly, Kessler and Zhao found that PTSD symptoms last about an average of three years with treatment and five and half years without treatment (1999). For this reason, individuals who experienced a traumatic event should immediately seek appropriate treatment.

Since PTSD treatments vary based on the differences of trauma severities, there are numerous treatment approaches. PTSD treatment for combat veterans typically includes drug therapy, behavioral exposure techniques, and/or insight therapy; however, therapists are likely to use a combination of these treatment techniques. Other popular treatment techniques for combat veterans include eye movement desensitization and reprocessing (EMDR), as well as proposing engagement in in-group, or rap therapy (Comer, 2010). For traumatized victims of natural disasters, victimization, and/or accidents, therapists will use many of the aforementioned treatment techniques as well as incorporating community intervention programs. Community intervention programs approach treatment in the form of psychological debriefing, or critical incident stress debriefing (Comer, 2010). This particular technique enables trauma victims to talk extensively among each other by sharing their personal feelings and reactions within days of the traumatic event (Mitchell, 1983). Although psychological debriefing is found to be quite favorable by trained clinicians, some studies question its effectiveness. Findings suggest that some patients either exemplified the same amount or an increased amount of PTSD symptoms post- psychological debriefing treatment (Comer, 2010). Tramontin and Halpern also noted that when treating ethnically diverse patients, clinicians should demonstrate a sense of cultural competency in order to completely understand the client's cultural background, as well as ensuring the client's comfortableness in a clinical setting (2007).

Prevalence of PTSD among Various Latino Subgroups

As previously mentioned, Latinos are the fastest growing ethnic minority group in the United States. In fact, three years ago, 1 out of 5 American civilians identified as Latino individuals, concurrently averaging about 25% of America's total population by 2050 (Pole et al., 2008). Since the Latino culture comprises a large group of diverse individuals whose heritages are derived from a variety of Latino subgroups, Latinos are considered an "ethnic" group rather than a "racial" group (Pole et al., 2008). The Latino "ethnicity" is therefore categorized by Latinos' common, yet different nationalities, geographical origins, cultures, and language (Matsumoto & Juang, 2004). As an aggregation of subgroups, Latinos diversified culture mainly originates from these subgroups: Mexico (7.3%), Central America (4.8%), South America (3.8%), Dominican Republic (2.2%), Puerto Rico (1.2%), Cuba (.4%), and Spain (4.3%).

This cultural diversity signifies that each Latino subgroup encounters a variety of unique experiences, stressors, and vulnerabilities that may or may not be similar to that of other Latino subgroups. Not only will particular subgroups react differently to various stressors and experiences, but each subgroup's collectivistic levels of perceived psychological distress will also vary. Hence, particular Latino subgroups may be more or less vulnerable to the development of PTSD (Pole et al., 2008). Additionally, Latinos' cultural norms, values, strengths, prominence, meaning of ethnic identity, and attitudes associated with minority status (Phinney, 1996) significantly vary across subgroups. Such cultural diversity within the Latino culture is not only beneficial for future studies in cross-cultural psychology, but also for assisting psychologists in recognizing the various Latino identifications of their subjective cultural elements such as familial roles,

communication patterns, affective styles, values regarding personal control, individualism, collectivism, spirituality, and religiosity (Benancourt & Lopez, 1993).

To further demonstrate Latinos vast cultural diversity, unique experiences, stressors, and vulnerabilities among various subgroups, the cross-cultural psychological studies discussed below attempt to not only distinguish the cultural diversity within particular subgroups, but also attempt to explain why certain Latino subgroups are placed at a higher risk for the potential development of PTSD. In Pole et al.'s (2005) study, researchers noted that it is important to understand "the mechanisms by which geographic status translates into elevated risk for developing a trauma-related psychiatric disorder" (i.e., PTSD). Similarly, Ortega and Rosenheck found that Caribbean Latinos tend to be more affected by PTSD than other Latino subgroups; Puerto Rican Vietnam Veterans reported more severe PTSD symptoms than non-Latino European Americans (2000). Nine years prior to Ortega and Rosenheck's study, Wilcox, Briones, and Sues performed a relatively similar study to that of Ortega and Rosenheck's (2000), which led to comparable results; Puerto Rican veterans also had more severe PTSD symptoms than Mexican-American veterans (1991).

Aside from sole PTSD symptom severity variances between Puerto Rican and Mexican American veterans, Kulka et al. (1990) concluded similar results to the aforementioned studies; although Kulka et al.'s study reported on a national, representative sample of male combat veterans, the results indicated that the current, unadjusted rate for PTSD was 27.9% for Hispanics, as compared to 20.6% for non-Hispanic Blacks and 13.7% for non-Hispanic Caucasians (Kulka et al., 1990). Although these results signify rather similar findings to Ortega and Rosenheck's (2000) and Wilcox

et al.'s (1991) studies, the precise explanations as to why PTSD prevalence rates differ among Latino subgroups are somewhat unclear. However, other evidence indicates that PTSD prevalence rates may also be related to higher levels of known risk factors, such as poor social support and culture-bound syndromes (Galea et al., 2004).

Contributing to aforementioned studies, Perilla et al. (2002) found similar results when comparing the different PTSD prevalence rates among Latino subgroups after Hurricane Andrew. Hurricane Andrew Latino victims displayed the highest rate of PTSD symptoms at 38% when compared to both Hurricane Andrew Caucasian and African American victims. Most importantly, Perilla et al. identified that these prevalence rates among victims differed in terms of differential exposure and vulnerability to the trauma. Each subgroups' cultural-specific responses and varied psychological responses to Hurricane Andrew suggest further investigation on Latinos adaptive nature of political, social, economic, and historical behaviors and perspectives (2002). Hence, future cross-cultural research should persist to investigate Latinos vast cultural diversity, as well as examining specific subgroups' various behaviors, perspectives, and vulnerabilities. Thus will supplement evidence as to why particular Latino subgroups are placed at a higher risk for the potential onset of PTSD.

Core Latino Cultural Values

In addition to general factors that all humans experience and increase risk for the development of PTSD, a number of cultural-specific factors deserve attention. In 1954, American linguist and anthropologist, Kenneth Pike developed two neologisms, or approaches to further investigate a society's cultural system: the "emic" and "etic" model approaches. The emic approach solely concentrates on the various cultural distinctions

relevant to the members of a given society, in which members of the specific culture are only “able to judge the validity of an emic description” (Pike). Conversely, the etic approach comprises “the extrinsic concepts and categories meaningful to scientific observers...only scientists can judge the validity of an etic account” (Pike). The emic approach correspondingly relates to many aspects within the Latino culture; since Latinos collectively respect key cultural-specific core values, Latinos are the sole members to judge the significance of these core values within their culture.

Although many of the aforementioned cross-cultural studies exemplify cultural diversity and within-group variability of PTSD prevalence across Latino subgroups, most Latinos are unified by a similar set of core values that have traditionally been passed down from generation to generation. The Latino culture is universally recognized for placing high value on this set of cultural-specific core values, which also contributes to Latinos’ collectivistic perceptions of mental health. As Pole et al. mentioned, “the variation of cultural diversity amongst these subgroups are key for hypothesizing why certain groups are more or less prone to the development of PTSD symptoms” (2008). Hence, the corresponding importance of each core value will not only vary across Latino subgroups, but will also potentially differentiate each subgroups unique vulnerabilities to the development of PTSD, as well as possibly explaining why Latinos generally hesitate to seek external sources of psychological treatment.

An essential component of Latinos is the concept of *familismo*. *Familismo* generally refers to the importance of prioritizing the needs of the family over the needs of the individual (Pole et al., 2008), as well as valuing family members’ close relationships (Jakobsons & Buckner, 2007). As the average Latino family unit is larger than the

average Anglo family unit (Fierros & Smith, 2006), Latino families tend to include several generations of extended Latino family members. It is also common for Latino family members to emphasize their interdependence within the concept of *familismo*, as well as providing both material and social support for each family member (Fierros & Smith, 2006).

Unfortunately, *familismo* may increase the development of PTSD or another psychological mental health disorder. For example, if a particular Latino family member were to experience a traumatic event, he or she may tend to withhold the experience from outside sources of support, because *familismo* encourages family members to discuss personal issues strictly within the family unit. Not only does *familismo* potentially discourage Latinos from seeking external sources of support or psychological treatment, it can possibly create inter-familial conflicts regarding the option to seek psychological treatment; typically, Latinos interpret seeking external support as a sign of weakness. Thus, *familismo* may cause an onset of PTSD symptoms after a traumatic event to eventually increase overall PTSD prevalence rates among Latinos, as many Latinos will hesitate to seek appropriate treatment options immediately after a traumatic experience. Additionally, because *familismo* may prohibit Latino family members from ever seeking appropriate treatment, the severity of PTSD symptoms may increase to potentially cause subsequent psychological and mental health problems.

Another central concept in Latinos' set of core values is the culture's general view on religion. Core values such as *spiritualismo*, *fatalismo*, and collective ideologies on folk religions are not only highly valued, but again, may potentially increase the chances for an individual to develop PTSD. Although culturally diverse, most Latinos are unified

by Christianity, which is demonstrated by the cultural-specific core value of *spiritualismo*. Since spirituality among Latinos is extremely relevant to most aspects of their life, it is also incorporated into Latino familial philosophy (*familismo*); in fact, about three-quarters of Latinos attend a weekly religious activity (Latina females outnumbering the attendance of Latino males). Hence, *spiritualismo* strongly correlates with Latinos' sense of interconnectedness; by attending religious activities, engaging in prayer, and/or participating in confessional actions, Latinos are encouraged to trustfully share their personal conflicts with God (Fierros & Smith, 2006), rather than with other people. As a result, *spiritualismo* may also contribute to the development of PTSD, since Latinos often use their religious affiliations as a form of therapy.

Many Latinos, especially foreign-born immigrants, use the church as a source of support to help adjust to an entirely different lifestyle while being separated from the unconditional love of their immediate family (Fierros & Smith, 2006). *Spiritualismo* among Latino immigrants may also particularly foster the development of PTSD symptoms; both before and after immigration to the U.S, Latino immigrants will unfortunately face a variety of cultural-specific stressors such as acculturation, assimilation, acculturative stress, differing educational backgrounds, political affiliation, etc., which in turn will lead to difficult adjustments for most Latino immigrants. Since Latino immigrants may think they are gaining support by prayer and confessional actions, they are not necessarily receiving the unconditional social support they need post-immigration to the United States. Unfortunately, this correspondingly relates to Escobar et al.'s findings in the sense that Latinos will display more intense PTSD symptoms, as

Latino immigrants tend to lose their familial and social support networks post-immigration (1983).

The Latino culture also values the concept of *fatalismo*, or the belief that certain outcomes are predetermined and unalterable, (Pole et al., 2008) which are destined by God's will. Perilla et al. (2002) found that Latinos who maintain strong cultural ties to their country of origin are more likely to endorse fatalistic beliefs, which may cause high levels of stress to encourage the development of PTSD. Since America's cultural norms, values, and beliefs are dissimilar to the particular fatalistic beliefs of Latinos, *fatalismo* may also present as a cultural-specific stressor (increasing PTSD symptoms) for Latinos. Lastly, Latinos collectivistic ideologies on folk religions also play a conjunctive role with *spiritualismo*; Latinos tend to combine certain aspects of their religious beliefs (*spiritualismo*) with particular beliefs derived from other cultures' religious rituals and beliefs. Also known as culture-bound syndromes, these particular religious beliefs may create high amounts of stress, since most Latino religious rituals are not commonly practiced in the U.S.

Simpatia and *respecto* are other cultural-specific core values that have the potential to increase the onset of PTSD among Latinos. *Simpatia* represents the idea of valuing interpersonal harmony (Pole et al., 2008), as well as producing a strong sense of connection by highlighting a person's ability to identify with other Latinos. *Simpatia* is commonly demonstrated when Latinos formally, yet respectfully meet other people; Latinos will also attempt to minimize confrontational situations, maintain agreement, encourage harmonious social relationships, and prefer cooperation over competition (Pole et al., 2008). *Respecto*, a similar core value to that of *simpatia*, translates to the deference

and respect for those individuals who are in higher position of authority; age, gender, social position, title, and economic status all contribute to a higher means of authority in the Latino culture (Carteret, 2011).

Aside from *familismo*, *simpatia*, and *respeto*, both *confianza* and *personalismo* are other cultural-specific core values within the Latino culture. Latinos tend to illustrate *confianza* when revealing personal and/or emotional problems strictly within a family setting, rather than confiding in external sources (Fierros & Smith, 2006). *Confianza* is particularly important, because it creates the aspect of *personalismo*, which translates to valuing warm and emotionally involved social relationships (Pole et al., 2008). Hypothetically speaking, if therapists and/or clinicians were to combine both *confianza* and *personalismo* in a therapeutic and/or treatment setting, Latino families may be more likely to share more personal information with their clinician(s), that they would normally keep within the familial unit. If an equal combination of *confianza* and *personalismo*, or “formal friendliness” (Carteret, 2011), is not taken into account via the therapeutic/treatment setting, Latinos will often avoid disclosing any family information that may cast the family in a negative light; Latinos will often feel as though they are betraying their family by disrespecting their familial privacy (Fierros & Smith, 2006).

Additional cultural-specific core values that are commonly exemplified in Latino relationships are *marianismo* and *machismo*. *Marianismo*, or a woman’s sense of selflessness and self-sacrifice, is a cultural and religious description of the ideal Latina woman as a self-abnegating mother. This core value plays a strong role in a Latina’s Christian faith, as the Latina will model similar characteristics to that of the Virgin Mary. Conversely, *machismo* signifies the importance of the Latino male’s role as his wife’s

protector and provider in the construct of his personal identity (Fierros & Smith, 2006). *Machismo* also dictates that it is solely the Latino male's responsibility to protect and provide for his family. Torres notes that *machismo* is a "complex interaction of social, cultural, and behavioral components forming male-gender role identity in the sociopolitical context of the Latino society" (1998). Neither *marianismo* nor *machismo* should be viewed as inflexible gender roles, but rather as guidelines for interactions between Latino men and women (Torres, 1998). However, these gender roles have the potential to place Latinas, in particular, at higher risk for the development of PTSD. For example, if a Latina were to experience sexual abuse in the workplace, she may keep her abusive experience in secrecy from her spouse to either establish her own sense of self-sacrifice or to simply avoid her spouse's anticipated feelings of anger and guilt (*machismo*).

All of the aforementioned core values potentially place Latinos at higher risk for the development of PTSD. For example, some of these core values may interact with stressors specific to the Latino culture; upon experiencing traumatic events and/or cultural-specific stressors, such as immigration, acculturation, assimilation, etc., the aforementioned core values can potentially intervene with the severity of the stressor to further initiate symptoms of distress. Similarly, these core values may also prevent Latinos from seeking appropriate, professional care after experiencing a traumatic and/or stressful event. This general sense of hesitation in seeking professional psychiatric care will not only hinder Latinos from effectively processing traumatic events, but may also foster suppressing feelings and/or symptoms of distress to further place Latinos at higher risk for the development of PTSD.

Cultural-Specific Stressors Affecting Latinos

The previous chapter discussed Latinos' cultural-specific core values and how the significance of particular core values may place Latinos at higher risk for the development of PTSD post a traumatic event and/or experience. These traumatic events and experiences Latinos constantly face are also known as cultural-specific stressors; common stressors pertinent to the Latino culture mainly concern adapting to a new environment or culture. Since the United States is known throughout the world for its unlimited opportunities for socioeconomic success and overall improved quality of life, many Latinos leave their home countries to immigrate to the United States. Although an increasing number of Latinos are born in the United States, many Latinos still decide to immigrate or have family members planning to immigrate to the U.S. Despite the opportunities for prosperity presented by immigration, moving to America not only increases the number of Latinos' cultural-specific stressors, but also generates high levels of individual psychological distress.

Dynamics pre- and post-immigration affect an individual's stress level, which may be enhanced by many external factors such as one's educational level and political affiliation, as well as one's citizenship, acculturation, immigration, and socioeconomic statuses. Immigration also increases problems of economic survival and social mobility in a new and unfamiliar socioeconomic system, as well as many adaptation problems to a new language, behavioral norms, and values of the new environment (Rogler et al., 1991). Conversely, Roberts et al.'s (2011) study indicates that factors such as higher socioeconomic statuses and higher levels of education have been found to reduce the conditional risk of developing PTSD. These cultural-specific stressors play a huge role in

placing Latinos' at higher risk for the development of PTSD as well as potentially encouraging the onset of an additional psychological disorder (Roberts et al., 2011).

Latino immigrants preeminently experience high levels of acculturative stress when moving or planning to move to the U.S. Individuals display acculturative stress when experiencing a dilemma or complications throughout the acculturation process; acculturative stress may stem from assimilation issues, as well as contrasting cultural values and practices (Crockett et al., 2007). However, depending on the Latino's age upon acculturation, the amount of acculturative stress may vary. Since "the children of immigrants acculturate more quickly than their parents, second-generation youth may feel caught between the opposing values of their parents and peers or experience conflict between their own values and those of their less acculturated parents" (Crockett et al., 2007). Hence, this additional distress can create interfamilial tension to further conflict new cultural practices and conflicting valuing systems (Crockett et al., 2007).

Supplementing acculturative stress, cross-cultural psychology studies indicate that Latinos who more strongly endorse values and traditions native to their ancestral or personal countries of origin are less acculturated or familiar to the United States' cultural norms and routines. As an important moderator to the onset of PTSD, a Latino's acculturation status suggests that their cultural values and/or traditions may partially be responsible for his or her elevated rates of PTSD (Pole et al., 2008). In Berry's report, *Conceptual Approaches to Acculturation*, he agrees with the aforementioned findings; he notes that acculturative change may be derived from "ecological or demographic modification induced by an impinging culture" (2003). An individual's acculturation status may be delayed because of one's internal adjustments following the acceptance of

unfamiliar traits or patterns (Berry, 2003). For example, if a Latino immigrant had trouble adjusting to his or her new cultural characteristics, not only will various levels of psychological distress surface, but it may also result as a personal traumatic event post-acculturation. Therefore, if recognized as a traumatic event, an individual will eventually develop feelings of distress or general symptoms of a psychological stress disorder, which may also induce posttraumatic stress disorder (PTSD). Thus, due to Latinos' rapid migration to and growth in the United States, PTSD prevalence rates may increasingly rise to further heighten overall PTSD statistics among Latinos.

Additionally, one of the most difficult acculturation challenges Latinos face when immigrating to the United States is the language barrier. Since almost all Latinos speak Spanish (65% to 87% of first to third generation Latinos identify as Spanish speakers), it acts a comfortable and unifying means of communication for Latinos. Irrespective of Latinos acculturation level or desire for assimilation (Fierros & Smith, 2006), Latinos continue to share the desire to preserve their culture through language, as the Spanish language plays a key role in Latinos' cultural identities (Gonzalez, 1997). However, in order to successfully adapt to the United States' societal norms, Latinos must attempt to efficiently learn the English language. If, for some reason, Latinos decide to not sufficiently learn the English language, it will hinder opportunities for prosperity and future employment, as well as create higher levels of acculturative stress.

Other common cultural-specific stressors Latinos often face post- immigration are perceived racism and discrimination. Ethnic minorities who endure ongoing discrimination are more prone to chronic stress, making them more susceptible to experiencing traumatic events (Pole et al., 2005). In Ruef et al.'s (2000) study regarding

the prevalence of racism among African American and Hispanic Vietnam War veterans, results indicated that although African Americans reported more experiences of racism than Latinos did, Latinos still experienced more elevated symptoms of PTSD. Pole et al. (2005) also investigated perceived racism and discrimination among Latino, African American, and Caucasian police officers, which showed similar results to Ruef et al.'s (2000) study; Latino police officers consistently reported higher levels of PTSD symptoms. Additionally, in Roberts et al.'s (2011) study, results revealed that perceived discrimination, race-related verbal assault, and racial stigmatization have been linked to PTSD symptoms, which may partially account for the higher conditional risk of PTSD. Also, Phinney and Chavira (2005) concluded that Latinos generally receive little parental preparation for coping with racial discrimination once situated in the United States, which again furthers an individuals' chances of developing PTSD symptoms.

Aside from pre- and post- immigration induced cultural-specific stressors, culture-bound syndromes are yet another probable cause as to why Latinos are potentially more prone to the development of PTSD. Varying across Latino subgroups, culture-bound syndromes are "limited to specific societies and are localized as folk categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations" (O'Neill, 2010). Additionally, Levine and Gaw define culture-bound syndromes as having all of the following criteria: a culture-bound syndrome must "be discrete and well-defined, recognized as a specific illness in the culture with which it primarily associated, must be expected, recognized, and to some degree sanctioned as a response to certain precipitants in the particular culture, and must have a higher incidence or prevalence of the disorder existing in the culture, which is

culturally recognized and culturally compared with other societies” (1995). Hence, depending on the geographic origin of the Latino subgroup, the significance and affects of each culture-bound syndrome will vary across subgroups.

Normally, culture-bound syndromes are seen as “idioms of distress,” in the sense that individuals communicate distress in a culturally understood and accepted way. A common culture-bound syndrome, specifically related to individuals whose heritage derives from Latin America, the Latin Mediterranean, and the Caribbean, is *Ataque de Nervios*. *Ataque de Nervios*’ symptoms include uncontrollable shouting, crying attacks, and frequent trembling, as well as verbal and physical aggression. A key feature of this syndrome is a sense of being out of control, which is usually triggered by a stressful event within the family (O’Neill, 2010). Another common cultural-bound syndrome is *Colera*, the symptoms of which include anger and rage that disturb an individual’s body balances. It may also cause individuals to experience headaches, screaming attacks, stomach pains, a loss of consciousness, and fatigue (Paniagua, 2000).

O’Neill (2010) identifies *Locura* and *Nervios* as two other culture-bound syndromes within the Latino culture. *Locura* is typically found among individuals from Latin America and Latinos in the U.S and is defined as a chronic state of severe psychosis that is attributed to multiple life stressors, inherited vulnerability, or a combination of both (O’Neill, 2010). *Nervios* similarly refers to a sense of vulnerability resulting from stressful life experiences for individuals from various Latino subgroups. O’Neill also recognizes *mal puesto* as another culture-bound syndrome within the Latino culture. Also known as *hex*, *root work*, or *voodoo death*, *mal puesto* is strongly valued by Latinos, African Americans, and individuals from the Caribbean and southern U.S. *Mal*

Puesto is the belief that unnatural diseases and death result from the power of people who use evil spirits (Paniagua, 2000). Latinos may also associate *mal puesto* with *spiritualismo*, since it is noted as a conviction that illnesses are brought on by supernatural means, such as witchcraft, voodoo, or evil influence. Symptoms may include anxiety, gastrointestinal complaints, and/or the fear of being poisoned or killed (O'Neill, 2010).

Also common throughout Latino societies, *susto* is another culture-bound syndrome in which fright generally prevails from supposed natural or supernatural origins; natural origins are typical cultural stressors and are more likely to affect Latino women than men, whereas supernatural origins are believed to be sent by a sorcerer or ghost (O'Neill, 2010). *Susto* symptoms include fatigue and weakness resulting from frightening and startling experiences. Although Latinos avidly respect certain core values like *spiritualismo*, *fatalismo*, and certain folk religions, upon immigration, acculturation, and other traumatic experiences, these culture-bound syndromes may pose as cultural-specific stressors across various Latino subgroups. Likewise, as Perilla et al.'s (2002) study concluded, Latinos who maintain strong cultural ties to their country of origin are more likely to endorse fatalistic beliefs (culture-bound syndromes). Hence, depending on the Latino individual's acculturation status and cultural ties to their country of origin, PTSD symptoms may foster post- immigration to the United States.

Perceptions of Mental Health and Help-Seeking Attitudes of Latinos

As already stated in previous chapters, depending on the significance and traditional ties to various cultural-specific core values, it is likely that Latinos will experience different levels of perceived distress pre- and/or post- experiencing a

traumatic event. Additionally, Latinos' cultural core values potentially shape their general perceptions of mental health, as well as their help-seeking attitudes towards receiving psychotherapeutic care. As previously mentioned, it is very common for Latinos to confide their personal and emotional problems via religious activities; aside from *familismo*, Latinos use *spiritualismo* as a coping mechanism to trustfully share their personal conflicts with God (Fierros & Smith, 2006), rather than sharing with external sources of care. As a result, *spiritualismo*, among other cultural-specific core values, potentially place Latinos at higher risk for the development of PTSD.

Aside from Latino's emphasis on *spiritualismo*, Latinos often misuse the cultural core value of *familismo*. Since Latinos generally place strong value on the familial unit, many Latinos will confide in family members as a social support system, rather than seeking professional, external sources of psychotherapeutic care. Traditionally, as a culture based on collectivistic values, Latinos generally have a large, social support system that cushions the effects of distress, as well as traumatic stress (Solomon et al., 1987). As previously mentioned, it is important to consider that upon immigration to the United States, many Latinos will no longer have an extensive network of family members to support them, thus lessening and altering their social support system. In doing so, Escobar et al. (1983) found that Latinos with poor familial and social relationships had the most intense PTSD symptoms. Since Latinos initially rely on various core values (*spiritualismo*, *familismo*) for support, Latinos are not necessarily receiving the best source of support and therapeutic care when dealing with a traumatic event and/or symptoms of distress.

As previously mentioned, Latinos tend to substitute their cultural-specific core values as professional help when dealing with personal mental health problems. Since Latinos generally do not seek external sources of care in an effort to improve their overall mental health, their help-seeking attitudes potentially contribute to their rather negative perceptions of mental health. However, some Latinos do decide to seek treatment, in which case most generally prefer psychotherapy as an acceptable form of treatment (Cooper et al., 2003). Conversely, Latinos tend to hold negative attitudes regarding the use of psychotropic medication as Latinos tend to believe that psychotropic medication use is ineffective and addictive (Cooper et al., 2003). However, some Latinos do value psychotherapy in conjunction with pharmacotherapy, instead of using psychotropic medication alone (Fierros & Smith, 2006). Due to Latinos' past experiences of medication use, Latinos not only respond to lower doses of medication (when compared to Caucasians), but also report more medication side effects, which possibly explains their negative view of medication use, as well as contributing to their general perceptions and help-seeking attitudes towards seeking mental healthcare.

In addition to Latinos' general avoidance of psychotropic medication, they rarely seek mental healthcare services. As previously mentioned, Latinos will often confide in family members (*familismo*) and religious activities (*spiritualismo*) for support rather than working with healthcare professionals. Hence, most Latinos will only seek services during an emergency or crisis setting due to socioeconomic difficulties and their perceived cultural view that seeking treatment is a sign of weakness. These issues not only limit the treatment options available to Latinos, but also render Latinos less likely to continue treatment once the crisis is resolved (Fierros & Smith, 2006). Although Latinos

are often willing to seek aid in an emergency or crisis situation, they are still less likely than Caucasians to receive mental health care (Lasser et al., 2002). This negative association felt by the Latino culture towards medical healthcare not only prevents Latinos from seeking appropriate treatment, but also promotes an internalization of problems and symptoms to potentially worsen the severity of PTSD symptoms.

Furthermore, the aforementioned set of cultural-specific core values, exposure to cultural-specific stressors, perceptions, and help-seeking attitudes towards seeking mental healthcare, unfortunately encourages Latinos to adopt rather inefficient self-coping strategies when dealing with PTSD, as well as other mental health disorders. These self-coping mechanisms may work to combat day-to-day stress, but they are less than likely to be effective in dealing with extreme pre- and post- traumatic experiences. Additionally, in Pole et al.'s (2005) study, evidence indicated that different self-coping techniques can predict the psychological consequences of traumatic stress and severity of PTSD symptoms.

Latinos are known for demonstrating inefficient self-coping strategies such as peritraumatic disassociation, avoidance, and somatization. Peritraumatic disassociation, a detachment technique that alters one's psychical states of consciousness during the time of the traumatic event, is often used to minimize or tolerate Latinos' stress levels. Peritraumatic disassociation is also another inefficient self-coping mechanism when dealing with PTSD, because it encourages avoidance, as well as the internalization of potential PTSD symptoms. Avoidance is another common and inefficient PTSD self-coping mechanism, which enables Latinos to unrealistically come to terms with a traumatic or stress-induced event. Avoidance also counteracts an individual's daily

routine to strictly avert any memory that reminds an individual of the posttraumatic event.

Aside from peritraumatic disassociation and avoidance, somatization is considered another inefficient self-coping mechanism among Latinos. Somatization is defined as a “tendency to experience and communicate psychological distress in the form of physical symptoms” (Feder, 2012); somatization’s symptoms often surface as reactions to particularly stressful situations or traumatic events. Although cross-cultural studies indicate that Latinos have a higher tendency to exhibit medically “unexplained” symptoms, recent research shows that somatization exists across cultures (Feder, 2012). Additionally, Van der Kulk et al.’s (1996) study concluded that patients who meet PTSD criteria will endorse more somatic manifestation than those individuals who are no longer diagnosed with PTSD.

Since somatization is the most common manifestation of psychological stress among Latinos (Canive et al., 1997), it is more common for Latinos to view their mental and physical health with an attitude of wholeness. Thus implies that Latinos cannot make the distinction between the health of their mind and their body, but rather view both as intimately connected (Fierros & Smith, 2006). Since somatization influences physical manifestations when experiencing psychological distress, it not only induces additional physical and mental distress, but also potentially creates high levels of emotional distress, as well as dysfunctional and irrational behaviors. Hence, if Latinos with PTSD symptoms chose to not seek treatment, somatization, as an inefficient self-coping mechanism, or rather belief, will not only lead to more somatic manifestations, but may also increase the severity of both stress and PTSD symptoms.

Culturally-Responsive Treatment Approaches for Treating PTSD in Latinos

Despite Latinos' perceptions and help-seeking attitudes of mental health, as well as the misuse of various cultural core values when dealing with stress and/or a traumatic event, some Latinos will actually decide to seek treatment. As previously mentioned, *simpatia* and *respeto* are very important cultural-specific core values to Latinos, especially when used in a therapeutic or clinical setting. Both *simpatia* and *respeto* are also equally important when confronting healthcare providers, doctors, and/or psychiatrists. As healthcare providers, doctors, and psychiatrists are generally viewed as authoritative figures to Latinos, Latino patients will typically display respectful behaviors in the healthcare environment (Carteret, 2011). Unfortunately, Latinos may be hesitant or unwilling to raise questions about their psychological disorder, as such curiosity is sometimes thought of as disrespectful to doctors (Carteret, 2011).

This cautious, timid behavior is disadvantageous for Latinos in that they may not fully understand a doctor's specific recommendations for treatment, which will not only decrease the treatment's effectiveness, but will also lead to lower treatment return rates. For example, if a Latino suffering from PTSD is too scared to initiate PTSD treatment because of a "not-so-good" first impression with their doctor(s), not only will the severity of PTSD symptoms increase, but the Latino will also begin to internalize those symptoms to potentially enhance another onset of an additional psychological mental health disorder. Additionally, Latinos expect *respeto* to be practiced in a reciprocal manner with healthcare professionals, and elder Latinos in particular expect to be treated with the same respectful behavior with which they treat healthcare professionals. Hence, since *respeto* and *simpatia* are frequently practiced within most aspects of the Latino culture,

if reciprocated in a psychotherapeutic setting, Latinos will be more likely to continue the psychotherapeutic treatment process.

It is very important that a clinician and therapist treating Latinos are aware of the intricacies of the Latino culture. The clinician and therapist should have a strong background in treating Latinos and be aware of these cultural-specific core values and stressors specifically relating to the Latino culture. If clinicians and therapists acquire this level of cultural competence, they will not only create a comfortable and trustworthy therapist-client relationship, but will also be better prepared to determine the best course of treatment. Marmar et al.'s (1996) findings indicate that being active or engaging in problem-solving coping leads to better mental health outcomes than passive or avoidance coping. Therefore, clinicians and therapists should not only incorporate these cultural factors into Latinos' treatment options, but also find an appropriate treatment approach that specifically fits with the Latino patient and/or subgroup, as well as with the Latino patient's family.

Aside from displaying cultural competence in the therapeutic and/or clinical setting, it is also important that the clinician and therapist attempt to establish a more culturally-responsive program or setting. An established culturally-responsive program thrives off the importance of social and organization contexts, including consistent administrative support and program leadership (Rodriguez et al., 1992). A clinic that provides a value-free environment in which patients from all different cultural backgrounds can feel comfortable will most likely encourage Latino patients to adhere to treatment (Jakobsons & Buckner, 2007). Rodriguez et al. (1992) also found that programs with interethnic competition and lack of coordination between departments hinder the

development of a culturally-responsive program. As far as understanding the social context of the Latino patient, it is important that the clinician and therapist are well aware of the patient's geographical background, socioeconomic status, and politico-economic status to further understand the depth of what the patient has previously experienced, as well as other important elements in the individual's case. Lastly, a culturally-responsive program with clinicians and therapists fluent in Spanish will not only lead to clearer understanding and interpretation of the context of the conversation and situational problem, but will also establish a more comfortable therapist-client relationship to hopefully continue the treatment-healing process.

Research also suggests a particular positive approach for treating Latino clients affected by PTSD. Although there is no empirical evidence suggesting some forms of psychotherapy are superior than others when working with Latino patients, several dimensions of cognitive-behavioral therapy (CBT) seem to be particularly beneficial to Latino patients (Organista, 2006). CBT's educational approach works quite well with Latinos' traditional cultural characteristics and social experiences when orienting and conceptualizing Latino patients to CBT therapy and other mental disorders (Organista, 2006). CBT also integrates *role preparation*, in which the clinician and therapist informs both the Latino patient and family what is expected in the treatment process, as well as what is expected of the patient (Orlinsky & Howard, 1986). Organista also emphasizes the idea of replicating a classroom-like setting within CBT; the use of therapy manuals, homework assignments, and other materials will help Latinos generally de-stigmatize the individualistic or collectivistic perception of mental health disorders (2006). Lastly, CBT particularly relates to the needs of Latino patients in the sense that the treatment therapy

is rather short-term, which seems to fit better with the lives of low-income individuals who are extremely affected by poverty-related problems, frequent crises, and limited resources (Organista, 2006).

Other forms of therapy treatment options tend to vary, but also show improving results. According to Jakobsons and Buckner (2007), the promotion of empirically informed treatments combined with the application of principles from the self-determination theory (SDT) results in successful outcomes among Latino patients. Another treatment option specifically related to trauma-induced stress (PTSD) is the use of social involvement; Solomon et al. (1987) concluded that social involvement would differentially mediate the effects of exposure on the mental health of male and female disaster victims, in a sense that both females and males rely heavily on social involvements or networks. Other forms of treatment clinicians and therapists may utilize include collaboration with indigenous healers or helpers and the use of prayer in psychotherapy. As the Latino culture highly values Christianity (*spiritualismo*), prayer combined with cognitive-behavioral therapy may be beneficial to some Latinos, particularly Latinas.

Unfortunately, if Latinos decide to completely ignore psychological mental health disorders and/or symptoms, especially after being exposed to a traumatic event, there may be a variety of physical consequences. It is known that if one is exposed to a traumatic event, the chances of having a smaller hippocampus are quite high. The hippocampus is a region the brain that plays a significant role in memory. Hence, if an individual does not seek treatment, Latinos may have problems developing new memories about new life events. Also, whether or not Latinos go on to develop PTSD,

Latinos may be at higher risk to use marijuana and cigarettes, as well as an increased use of substance abuse. Most importantly, if untreated, PTSD can be detrimental to Latinos' functioning levels, familial and social relationships, as well as emotional issues.

A Proposed Culturally-Responsive PTSD Intervention Program for Latina Women Suffering from Intimate Partner Violence (IPV)

The aforementioned chapters discuss probable factors that increase risk for PTSD among Latinos. Unfortunately, few studies have examined the effectiveness of empirically validated treatments in treating Latinos (Jakobsons & Buckner, 2007). It is important to note that Latinos are very diverse and that a single-treatment approach will not address all subgroup's cultural complexities. Nevertheless, there are general themes that tie the Latino culture together that can be addressed when developing culturally-responsive (competent) treatments, which can potentially improve patient treatment outcomes.

This chapter proposes an intervention program for Latinas suffering from posttraumatic stress disorder (PTSD) that is caused by intimate partner violence (IPV) or domestic violence (DV). *Una Nueva Vida*, a recently developed and culturally-responsive intervention program, primarily aims to provide a safe environment for Latina women and children who have been exposed to intimate partner violence and currently suffer from PTSD. Located in the greater Los Angeles area, *Una Nueva Vida* is a five-week intervention program that promotes educating Latinas on various topics regarding PTSD and the disorder's symptoms, intimate partner violence, and domestic violence, as well as self-help strategies when experiencing an IPV or DV episode. *A Nueva Vida* intervention program provides a comprehensive treatment approach that covers structural details,

including information regarding the location, days, times, sessions, therapists, and other details. Before addressing the goals and outline of *A Nueva Vida's* culturally-responsive intervention program, this chapter initially discusses intimate partner violence (IPV) and its prevalence among women in the U.S, as well as its high prevalence among Latinas.

Intimate partner violence (IPV) is a threatened or completed attempt of physical or sexual violence, as well as potential emotional abuse by a current or former intimate partner (Adverse health conditions, 2005). Although IPV plagues communities of all races, socio-economic status, and geographical locations (Aguilar et al., 2000), women ages sixteen to twenty-four (regardless of ethnicity), are nearly three times more vulnerable to IPV (Lemon, 2013). Hence, approximately 1.5 million women are raped and or physically assaulted by an intimate partner each year (Tjaden & Thoennes, 2000). As previously mentioned, it is important to note that these IPV statistics significantly vary amongst many ethnic groups and cultures. The different research methodologies, questions asked, and social conditions of where these studies were conducted will not only impact the results of each study, but may also help researchers distinguish the cultural differences between each ethnic group and shed light on the reasons for a varied prevalence of IPV amongst particular ethnic groups.

Some communities, such as Latinos, are more vulnerable to IPV because victims have nowhere else to go after the violence occurs, making it difficult to leave the abusive relationship (Aguilar et al., 2000). According to Tjaden and Thoennes' (2000) study, approximately one in four Latina women will experience IPV during their lifetime, while Rodriguez's (1998) study estimated that 34% of Latina women experience IPV in either their country of origin, the United States, or in both. It is also noted that in a survey of

three hundred Latina women, 70% reported IPV experiences, while 43% reported multiple episodes of IPV (Alianza national latino, 2010). Meanwhile, these IPV episodes cause most Latina women to undergo many new emotional, cognitive, and physical repercussions, as well as experiencing extreme amounts of stress following the IPV episodes.

Intervention Program: *A Nueva Vida*

Both intimate partner violence (IPV) and domestic violence (DV) are two topics that few people wish to discuss or realistically come to terms with. Most victims of IPV or DV in particular wish to never even speak about the violence that they once lived with. A cultural-responsive intervention program is modeled in respect to the Latina victims of IPV, who currently suffer from PTSD symptoms. The purpose and mission of this intervention program is to not only create a safe and comfortable space for Latina victims of IPV, but to also help Latinas acknowledge their cultural-specific values, stressors, and barriers in which enhance the severity of their PTSD symptoms. Ultimately, *A Nueva Vida's* intervention program anticipates providing Latinas with new, social support networks to enhance their personal recovery of posttraumatic stress disorder (PTSD) and end any future episodes of intimate partner violence.

Desired Goals and Outcomes:

Aside from promoting personal recovery of posttraumatic stress disorder (PTSD) amongst Latina victims of IPV, *A Nueva Vida* will merge personal recovery by educating Latinas about general mental health information; this will hopefully reduce the stigma of having a mental disorder. The intervention program also encourages Latinas to break the cycle of engaging in abusive relationships. Denisek (2010) notes that on average, it takes Latinas six to eight times to finally leave the abusive relationship. Rather than having

Latinas return back to their abusive relationships, *A Nueva Vida* intends to break that unhealthy pattern to further engage in more healthy and loving relationships in the future. By incorporating the concept of *familismo* in therapy sessions, the intervention program will encourage Latinas to converse with one another and create effective communication skills. Not only will the development of communication skills among Latinas create a sense of community, it will also concurrently provide a safe, social support network for Latinas. Lastly, *A Nueva Vida's* intervention program will heighten Latinas' awareness of available resources when experiencing an episode of intimate partner violence (IPV) or domestic violence (DV).

Location Cite:

Los Angeles County is typically known as one of the most culturally diverse environments in California. In 2011, the U.S. Census Bureau estimated that 48.1% of civilians in Los Angeles County were of Hispanic/Latino origin. Given that Latinos are the largest and fastest growing minority group in the United States (Pole, 2005), *A Nueva Vida* will be based out of the greater area of Los Angeles. As *A Nueva Vida* is a recently developed intervention program, *A Nueva Vida* will position its intervention program at a pre-existing, local domestic violence shelter. Since domestic violence shelters not only house groups of culturally diverse individuals with similar DV experiences, domestic violence shelters also hold the highest rates of PTSD, when compared to individuals in other temporary housing shelters (Dillon, 2001). Therefore, *A Nueva Vida* will temporarily utilize the facilities of a local nonprofit, community-based organization: *Su Casa ~ Ending Domestic Violence*. *Su Casa*, based out of Long Beach, California, strives to empower individuals and families to live free from domestic abuse, while

simultaneously building and maintaining partnerships with other local communities to end domestic violence (DV). Since both *Su Casa* and *A Nueva Vida* encompass similar mission philosophies, *Su Casa* agreed to complimentary host their facilities to *A Nueva Vida's* intervention program for Latina victims of IPV who currently suffer from PTSD.

Su Casa's facilities contain emergency and transitional housing shelters. The program's Emergency Shelter Program is a thirty-day emergency shelter that houses twenty-two individuals, as well as providing daily meals. The program also provides individual and group counseling sessions, as well as transportation, CalWORKs assistance, etc. The Transitional Shelter Program, on the other hand, assists individuals and families transitioning from crisis to independent living. The program residentially houses a maximum of twenty-four people (limiting their stay to a one-year max), while also providing counseling sessions, job skills training, etc. Since *Su Casa's* Emergency Shelter Program provides just enough time for individuals to typically adjust and regain control of their violent-free lives, it would be beneficial for *A Nueva Vida* to base the intervention program out of *Su Casa's* Emergency Shelter to not only increase one's awareness of external resources, but to also provide Latinas with enough knowledge to officially break the repeating cycle of engaging in future abusive relationships. Lastly, since the city of Los Angeles has a public transit system, including *Su Casa's* free modes of transportation, *A Nueva Vida's* intervention program will be extremely accessible to Latinas.

Therapists and Volunteers:

Although the Latino culture shares many cultural-specific elements of tradition, language, customs, religion, and moral values, it is important to recognize that each

Latina is in some ways like no other Latina; there are various subgroups of Latinos that are quite different from one another (Organista & Munoz, 1996). Therefore, the more clinicians who know about the different subgroups of Latinos, the more they can conceptualize and treat mental health problems of that particular subgroup in a culturally sensitive manner (Organista & Munoz, 1996).

A Nueva Vida's intervention program for Latina victims of IPV who currently suffer from PTSD will have both trained graduate student therapists and volunteers. Volunteers will help organize the structure of the intervention program, as well as assisting the program's therapists and *Su Casa's* staff. Prior to joining *A Nueva Vida*, grad-student therapists will be required to fluently speak the Spanish language and understand the relative background information of the Latino culture. Both therapists and volunteers will be required to attend a mandatory training session, where they will learn various cultural skills to enhance expertise in this area, in hope to develop a sense of cultural sensitivity and competence. Lastly, therapists will learn how to efficiently execute culturally-sensitive assertiveness training; this sense of assertiveness and sensitivity in a therapeutic setting will enable therapists to show their sensitivity towards Latinas, while simultaneously pushing the boundaries of traditional cultural norms in the best interest of the client (Organista, 2006). Since therapists at *A Nueva Vida* are graduate school students, they will not get paid for their time spent working at the intervention program. Rather, they are participating in the intervention program to gain more field experience when working with culturally diverse clients.

Participants:

A Nueva Vida's intervention program is open to all Latina victims of IPV who currently suffer from PTSD at *Su Casa's* domestic violence shelter, as well as those Latinas who do not attend *Su Casa*. For entry screening and evaluations, *A Nueva Vida's* culturally competent and bilingual trained staff members will apply two methodological strategies to obtain assessment data: the Diagnostic Interview Schedule (DIS) and psychometric measurements. In comparison to a structured clinical interview (SCI), the DIS is more appropriate for *A Nueva Vida's* staff because it's an instrument that can be administered by nonprofessionals. The DIS will be very helpful for diagnosis as it is similar to the typical structured clinical interview. Quintana (1997) identified that professionals and nonprofessionals who used the DIS as an assessment tool found that between professional and nonprofessional interviewers, there was a diagnostic agreement at .69. Hence, the DIS is a suitable measurement tool for *A Nueva Vida's* initial evaluations. In addition to the DIS, staff members will also distribute the Impact of Event Scale (IES), in which the client will rate the severity or impact of the traumatic and/or stressful event (Quintana, 1997). If further assessments are needed, staff members will also use the Short Post-Traumatic Stress Disorder Rating Interview (Connor & Davidson, 2001), as well as the PTSD Checklist-Civilian Version (Weathers, 1993).

The expected number of Latinas that are willing to participate in *A Nueva Vida's* intervention program will be unpredictable. Since the Latino culture highly respects their cultural-specific values of *personalismo* and *confianza*, as well as having rather inefficient help-seeking attitudes, it would make sense to assume that a small amount of Latinas will initially want to participate in the program. Therefore, *A Nueva Vida* aims to

place about ten Latinas per intervention cohort in an attempt to mirror Latino familial dynamics of *familismo*, while simultaneously supplementing what they left at their home environment. This will hopefully encourage Latinas to communicate and share their similar experiences with each other.

Program Intervention Sessions:

According to the *California Partnership to End Domestic Violence* (2012), the temporary nature of a victim's stay in domestic violence shelters is thirty-four days on average; over half of DV victims stay one to two months. Hence, to apply a time-realistic intervention program similar to the thirty-four night average stay in DV shelters, *A Nueva Vida's* intervention program will have a total of five, one hour weekly sessions (about a month in total; last session is optional). Since 82% of Latinas religiously identify as Christian (Navarro-Rivera, 2010), all intervention program sessions will be held on Saturdays, so the sessions won't conflict with the typical religious-affiliated activities held on Sundays.

Safety: Session one of the intervention program will primarily focus on the aspect of safety. This session will help Latinas plan and execute an escape route that will not put her or her family at harmful risk. Therapists will also emphasize the importance of preparing an emergency bag; an emergency bag is a pre-packed bag that contains all the necessary supplies in case of an emergency. The emergency bag should be in a safe place within the house, as well as being accessible in the case of an emergency (episode of DV, IPV). At the end of the session, *A Nueva Vida's* staff will distribute a handout with important phone numbers in case of an emergency: 911, police, fire station, DV hotlines,

DV shelters, etc. Latinas must memorize these contact numbers to advance to session two.

Cultural-Specific Stressors: Session two will cover the cultural-specific stressors Latinas constantly face. Latinas frequently face a combination of cultural-specific stressors; Latinas may feel ashamed or embarrassed from their previous episodes of domestic violence, including fears of emotional and physical retaliation. To overcome these barriers, therapists will stress the effects of male gender roles in the Latino culture. As an integral part of Latino culture, Latino men commonly display the male gender role of *machismo*. As previously mentioned in the chapter regarding cultural-specific core Latino values, *machismo* is a “complex interaction of social, cultural, and behavioral components forming male-gender role identity in the sociopolitical context of the Latino society” (Torres, 1998). *Machismo* should not be viewed as inflexible gender role, but rather as guidelines for interactions between Latino men and women. Although *machismo* is prevalent within some Latino relationships, it is not always misused as a negative manner. However, in a relationship where *machismo* is used as an abusive behavior, it is extremely important for Latinas to realize that they don’t have to reside in the relationship and should immediately seek external sources of help. Therapists will also acknowledge the cultural-specific stressors Latinas face: discrimination, acculturation, and lack of knowledge of human rights and immigration laws.

Communication Strategies: Session three stresses the importance of effective communication strategies. Aside from creating social support networks throughout the course of the intervention program, therapists will promote communication with all family members. Although Latinas will be generally hesitant to share their unfortunate

and negative experiences with their family, it will encourage Latinas to avoid internalization by learning to communicate with their family members. Not only will the Latina's family serve as a backbone to her support network, she will potentially rid the burden she's been carrying. Therapists will also guide a roleplaying activity with the women. Roleplaying, as an open-ended activity, will enable the women to express their thoughts and desires with one another (Organista, 2006) in a less stressful manner. This session will also replicate a particular non-violent communication approach presented in Perilla et al.'s (1994) study: mutuality. Mutuality involves different aspects of a relationship, such as empathy, communication, understanding, and mutual respect. These key characteristics of mutuality will not only be incorporated into the group setting, but will also enhance each Latina's communication and negotiation skills that may inhibit or prevent the reoccurrence of spousal/partner abuse (Perilla et al., 1994). Towards the end of this session, Latinas will be paired in groups of two to practice the various communication strategies covered in the session to promote Latino's cultural value of *confianza*.

Effective Coping Strategies: As an alternative to having rather inefficient health-seeking attitudes, session four will offer rather appropriate, treatment-effective coping strategies such as spiritual prayer, physical exercise, and personal diary writing. Given the centrality of spirituality with the Latino culture, prayer can be used to facilitate the therapeutic process; many Latinas rely on prayer, the Bible, and the church community to meet their daily needs (Abernethy et al., 2006). In Gillum et al.'s (2006) study, it emphasized that Latinas trust in a higher power (*spiritualismo*) and the support they receive from their faith community is essential to their healing. In addition, Gillum et

al.'s (2006) study found that the majority of Latina women (98%) noted that spirituality or God was a source of strength or comfort for them. Aside from spirituality, physical exercise, such as yoga and walking, are very beneficial for both one's physical health and mental stability. In Dixon-Peters (2007) study investigating the effectiveness of yoga on decreasing the psychological symptoms of depression and posttraumatic stress disorder of female survivors of domestic violence, the results indicated that participants found yoga useful and enjoyable, as well as noting changes within themselves and their relationships. Lastly, a simple way for Latinas to express their thoughts and emotions is by diary or journal entry. Diary and journal entry promote externalization, rather than an internalization of feelings, which will enable Latinas to easily articulate their current feelings or emotions.

Guest Speaker: Session five will conclude the last session of *A Nueva Vida's* intervention program for Latina victims of IPV who currently suffer from PTSD. This session will initially host a guest speaker; the female speaker will be a local, community resident as well as being a past survivor of domestic violence. By inviting a guest speaker to the intervention program, she will not only serve as a role model to Latinas, but will also encourage Latinas that they are never alone in the recovery process. Latinas are also allowed to invite one member from their current social network to attend the closing session. After the speech, Latinas who participated in *A Nueva Vida's* intervention program are required to retake the initial assessments they took prior to enrollment to see if there were any improving symptom results, as well as providing *A Nueva Vida's* staff with specific information to make the intervention program more successful in the future.

Latinas will also have the option to continue their therapeutic treatment process at *Su Casa* with trained therapists on a more individual level.

Limitations of the Intervention:

Although *A Nueva Vida's* intervention program has a number of strengths (i.e. addressing culturally salient issues), a number of limitations deserve attention. For example, one of the bigger limitations is that the five-session program is quite limited, in a sense that the intervention program is time-limited and short-termed. Since a longer intervention program is generally preferred, participants may benefit more from longer sessions. Also, since *A Nueva Vida's* intervention program has a lack of funds, it potentially limits the program to use other beneficial resources. With more funds, the program could potentially pay licensed psychiatrists and psychologists to work with Latinas. Another limitation to the intervention program is whether or not all the women will actively participate and use the provided information to improve their overall quality of life. Some Latinas may or may not have connected with the other women, which would somewhat disrupt the whole intervention process. This limitation questions the effectiveness of the program to participants; the program may have been beneficial to some, but not to others.

Conclusion

Posttraumatic stress disorder (PTSD) is a rather common psychological mental health disorder among individuals of all ethnicities throughout the United States. The U.S. Department of Veteran's Affairs indicates about 7% to 8% of the U.S. population will have PTSD at some point throughout their lives; about 5.2 million adults will have PTSD at any given point in their lives (2012). Many of the aforementioned research

studies, such as Pole et al. (2005), Ortega and Rosenheck (2000), and Wilcox et al. (1991) confirm that Latinos comprise a large population of Latino subgroups that face a variety of cultural-specific core values and stressors. However, depending on the subgroup's geographical location and intensity of cultural ties to traditional values, certain cultural-specific stressors will affect each Latino subgroup in a variety of ways.

In order to decrease the prevalence of posttraumatic stress disorder (PTSD) within the Latino culture, Latinos should initially acknowledge that psychological mental health disorders are very common amongst all individuals in the United States, as well as understanding that psychological mental health disorders play a vital role in any individual's physical, social, mental, and emotional stability when treated in an appropriate and timely manner. Latinos should also recognize that their cultural-specific core values may play a potential role as underlying causes of distress when experiencing a traumatic event. If Latinos temporarily disregarded their cultural ties and traditional core values, perhaps the Latino culture will perceive mental health and its recovery in a more positive manner. Hence, the Latino culture will potentially de-stigmatize their view of mental health to ultimately seek external, professional psychotherapeutic care when dealing with symptoms of a psychological mental health disorder.

In addition to Latinos' embedded cultural-specific core values, Latinos are rapidly migrating to the United States, which unfortunately exposes a variety of cultural-specific stressors that they inevitably must face. As previously mentioned, there are many adapting acculturation and immigration cultural stressors, as well as other cultural-specific factors that Latinos encounter such as the language barrier, political affiliation, educational background, racism, discrimination, etc.; Latinos must realize that these

cultural stressors pose as idioms of distress upon immigration to the U.S. Unfortunately, by confiding in family members (*familismo*) and the Christian faith (*spiritualismo*) when experiencing a stressful or traumatic event, Latinos commonly suppress confusing emotions and psychological symptoms. Alternatively, Latinos should comprehend that internalizing psychological symptoms is only a temporary inefficient coping mechanism, which is solely detrimental to an individual's overall health.

Hence, this cultural-specific abnormality within the Latino culture is extremely relevant to the current practice of psychiatry and psychotherapeutic therapy as the Latino population continues to grow at a rapid pace (Fierros & Smith, 2006). As previously mentioned in *A Proposed Culturally-Responsive PTSD Intervention Program for Latina Women Suffering from Intimate Partner Violence (IPV)*, the importance of a culturally-responsive psychotherapeutic program and/or intervention program for Latino subgroups are key to promote overall psychological treatment success and return rates within the Latino culture. By incorporating the fluency of the Spanish language and cultural-specific core values such as, *familismo*, *confianza*, *simpatia*, *personalismo*, and *respeto* within psychotherapeutic sessions (Pole et al., 2008), as well as integrating various aspects of cognitive-behavioral therapy (Organista, 2006), the more likely Latinos will continue the treatment process. Also, as the Latino culture is very diverse, not all treatment programs will be similar; most programs will vary to specifically meet the particular needs of the Latino subgroup. However, since cognitive-behavioral therapy (CBT) is a short-term treatment and particularly fits better with the lives of low-income individuals who are extremely affected by poverty-related problems, frequent crises, and limited resources (Organista, 2006), Latinos may be more likely to not only relate to the therapist on an

individual level, but also feel more comfortable in confiding personal information to continue the therapeutic treatment process.

Other forms of treatment such as applying various aspects of the self-determination (Jakobsons & Buckner, 2007), the use of social involvement (Solomon et al., 1987), and collaborating with indigenous healers or helpers, as well as using prayer in psychotherapy, may also be more applicable to Latino patients, depending on the patient's origin of subgroup. Not only should psychiatrists, therapists, and clinicians consider these different treatment options, they should also address and effectively understand Latinos' cultural-specific values and stressors in a culturally competent and sensitive manner to confidently understand the context of the situation. Thus, psychiatrists, therapists, and clinicians should ultimately incorporate a culturally-responsive environment into their therapeutic setting. By successfully addressing the aforementioned recommendations, posttraumatic stress disorder (PTSD), as well as other psychological mental disorders, may become less prevalent within the Latino culture.

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