Latinas Coping With Intimate Partner Violence and Posttraumatic Stress Disorder Symptomatology

by

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ABSTRACT

Previous research indicates that survivors of Intimate Partner Violence (IPV) are at a greater risk of developing Posttraumatic Stress Disorder (PTSD) symptomatology. IPV survivors often use maladaptive coping strategies in response to IPV that place them at a higher risk for PTSD. Cultural gender roles/beliefs have been known to influence coping methods. Marianismo, a Latino/a gender role belief, has not been investigated in relation to IPV, coping strategies, and PTSD among Latinas. This study examined whether physical, psychological, or sexual abuse by a romantic partner, coping strategies, and Marianismo were associated with PTSD symptomatology among 157 college-aged Latinas. The participants completed an on-line survey that assessed IPV frequency, disengaged and engaged coping, Marianismo, and PTSD symptomatology. Hierarchical multiple regressions revealed that, regardless of IPV type, more IPV and disengaged coping strategies were the best predictors of PTSD symptomatology. Marianismo did not significantly moderate the relation between coping and PTSD. However, the strong zero-order correlation between disengaged coping and Marianismo indicated they were highly correlated variables. The study findings are consistent with previous research that suggested that coping strategies are culturally dependent on beliefs and gender role expectations. Latinas may use more disengaged coping strategies because these methods may be deemed more culturally appropriate and reflect Marianismo beliefs. Psychologists working with Latina IPV survivors need to develop culturally sensitive approaches to psychoeducation on IPV and coping strategies that empower these women within their cultural belief systems and reduce their PTSD symptomatology.

DEDICATION

Para mi madre, Leticia Rincon. Por su dedicación a mi educación y crecimiento. Por su soporte y amor he podido lograr mis sueños. Gracias por haber sido mi ejempló de lo que significa ser una mujer fuerte y valiente.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

PROBLEM IN PERSPECTIVE

Intimate partner violence is a horrifying reality that many college-aged women face. While college can be an exciting time when individuals engage in their first serious romantic relationship, college students may be more vulnerable to intimate partner violence (IPV) because of their lack of relationship experience (Kaukinen, 2014). For some college students, this time period is filled with relationship violence that has been linked to negative psychological, health, and social consequences. Intimate partner violence is most commonly defined as physical, psychological, or sexual abuse that occurs within a relationship with a current or former partner (Center for Disease Control; CDC, 2016). This study examined the impact IPV, coping strategies, and cultural gender roles had on the development of Posttraumatic Stress Disorder (PTSD) for Latina college students.

Theoretical Perspectives of Intimate Partner Violence

Theories of IPV have traditionally focused on the importance of social factors and their influence on IPV. Two important theories that describe the role of the social context in IPV are Social Learning Theory and Feminist Theory.

Social learning theory is one of the most influential theoretical explanations of IPV. This theory posits that observational learning is the mechanism through which interactional skills are achieved (Bandura, 1973). In other words, children learn behaviors through imitating behavior of adult role models or other adults in their life. Social learning theory is an extension of behaviorist theory that proposes that new

behaviors are learned through reinforcements and that behaviors can be extinguished through punishment. Specifically, Bandura (1977) described social learning theory as involving four components. The first component is attention and involves people appraising the situational factors of the modeled behavior. The second component describes people's ability to remember the modeled behavior and to implement the learned behavior in the future. The third component is imitation and involves being able to imitate physically the vicariously learned behavior. The fourth component of the theory is motivation and explains individual's decisions about whether the consequences related to the learned behavior are of personal value.

Social Learning Theory has been predominant in IPV research as it supports the intergenerational transmission hypothesis, which explains that violence is learned from past experiences from one's family of origin (O'Leary, 1988). In specific, this concept describes abuse as a learned behavior that is passed from parents to children (Egeland, 1993). Indeed, researchers have found a link between past family history of abuse and IPV (Kaukinen, 2012: Kaufman & Ziegler, 1989). For example, Wekerle and Wolfe (1999) suggested that direct or indirect (e.g., witnessing) violence in a child's family places the individual at future risk for IPV due to messages learned about the functionality of interpersonal relationships (i.e., how to express emotions, solve problems, control, and dominate). The family is often viewed as the main socializing institution and not only do children model their behavior from their parents but also begin to create scripts for intimate relationships. These relationship scripts also teach children the appropriateness and consequences of using violence as a method for conflict

resolution in relationships, increasing control, and emotion regulation (Ehrensaft et al., 2003). For example, Jacobson, Gottman, Gortner, Berns, and Shortt (1996) noted that violence in relationships may be used as a method of decreasing averse feelings related to conflict and increasing feelings of control in the relationship. Paradoxically, violence may create an initial reward as it reduces distressing feelings and increases personal agency, thus creating a cycle of violence.

It is also believed that the Social Learning Theory plays an important role in future victimization. Researcher have argued that the intergenerational transmission hypothesis may affect and influence the coping strategies survivors of IPV implement, which places them at risk for psychological concerns. Studies have found the women with a history of childhood abuse were not only at a higher risk of adult IPV victimization but also reported significantly higher psychological distress related to depression and PTSD symptomatology (Griffing et al., 2006; Ouellet-Morin, York-Smith, Fincham-Cambell, Moffitt, & Arseneault, 2015; Valentiner, Foa, Riggs, & Gershuny, 1996). Although it is commonly known that on average it takes a survivor of IPV a total of seven attempts to leave their relationship, research findings show that women with previous childhood abuse histories attempted to leave their abusive partners more times than did those without childhood abuse (Griffing et al., 2002). Specifically, Griffing et al. (2002) found that women who witnessed and/or experienced violence in their home as children reported more difficulties leaving their abusive partner compared to women without a childhood abuse history.

Although the cycle of violence hypothesis has been a focus in the literature, methodological limitations have restricted the ability to determine its validity (Windom, 1989). Evidence supporting the intergenerational transmission theory of violence has been found, however, for married couples and dating relationships for both adolescents and emerging adults/college students (Craig & Sprang, 2007; Ehrebsaft et al., 2003; Foshee et al., 1999).

According to the literature, the prevalence of college aged students witnessing some form of IPV in their home while growing up ranges from 10% to 30% (Edleson, 1999; Jankowski, Leitenberg, Henning, & Coffey, 1999). It is theorized that the intergenerational theory help explain victimization and perpetration in college-aged couples. Findings from several research studies have supported this idea and have found that witnessing IPV as a child was associated with greater likelihood of both perpetration and victimization in young adult relationships (Ehrensaft et al., 2003; Kwong, Bartholomew, Henderson, & Trinke, 2003; White & Koss, 1991). Furthermore, Foshee et al. (1999) found that social learning theory–mediating variables such as violent conflict resolution style, expecting positive outcomes, and accepting dating violence accounted for significant variance in predicting perpetration in a sample of male and female college students.

Another theory that has been advanced as an explanation of IPV is Feminist Theory and the role of the patriarchy. Dobash and Dobash (1997) identified relationship violence as gender-specific, with males as perpetrators and females as victims, except in the case of same sex relationships. Feminist theorists recognize female perpetration of

IPV; however, they attribute the violent acts to self-defense (Wekerle & Wolfe, 1999).

According to this perspective, social norms directly and indirectly support a patriarchal structure within different societies, and it is argued that the laws and customs upheld by society create a power differential between men and women. Therefore, IPV within a feminist framework explains perpetration by male partners as an act of oppression towards women. Specifically, the goal of violent perpetration by males is to instill fear in their female partners (Herman, 1992). IPV is viewed as central to the traditional power structures of male dominance and female subservience that highlight the power inequality between men and women in society. Miedzian (1995) argued that power inequality facilitates violence through the promotion of rigid gender roles. For example, males are socialized to be dominant, aggressive, and competitive (Fleming, Gruskin, Rojo, & Dworkin, 2015). In contrast, women are encouraged to be compliant, submissive, and cooperative (Werkele & Wolfe, 1999). Dutton (1995) pointed out that rigid gender norms regarding relationships influence beliefs that females are responsible for fostering the relationship, thus promoting a power imbalanced relationship. Research suggests that the more individuals believe in the patriarchal structure, the more they believe that IPV is acceptable, specifically violence against women (Dobash & Dobash, 1979; Glick, Sakalli-Ugurulu, Ferreira, & DeSouza, 2002).

Intimate Partner Violence Prevalence Rates and Definition

In one of the first studies investigating prevalence and dynamics of IPV in early dating relationships, Makepeace (1981) found that at least one of five college students had experienced, at a minimum, one incident of physical victimization. In addition,

Makepeace found that 61% of the study sample reported knowing someone who was currently experiencing or had experienced IPV in a dating relationship. Subsequent researchers (Laner, 1983; Roscoe & Callahan, 1985; Stacy, Schandel, Flannery, Conlon, & Milardo, 1994) have tried to replicate the prevalence rates reported in the Makepeace study; however, findings have been mixed. It has been estimated that the prevalence of IPV among college students ranges anywhere from 9% to 50% (Amar & Gennaro, 2005; Barrick, Krebs, & Lindquist, 2013; Kaukinen, Gover, & Hartman, 2012; Nabors, Dietz, & Jasinski, 2006). Such dissimilar prevalence rates have raised questions about the accuracy of IPV studies. Sugar and Hoatling (1989) suggested that the lack in consensus of prevalence rates in the literature is due to the difficulty of drawing comparisons between studies because of the diversity of methodology, sampling, and data analyses employed. The definition of IPV has also been brought into question as a central confound in the unclear prevalence rates (CDC, 2016). For the purposes of this study, the term intimate partner violence was used to refer to dating violence and other relationship violent acts (e.g., physical, sexual, and psychological) intentionally inflicted regardless of frequency (Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

The prevalence rates reported in the literature vary depending on the definition of IPV used. Too often, the definition of IPV is vague and can include various types of violence such as verbal abuse, threats, physical aggression, and sexual coercion (Lewis & Fremouw, 2001). In addition, definitions of IPV may not specify an age, as it is an issue that can affect individuals at various ages (Kaukinen, 2014). In order to be parsimonious, researchers have studied various forms of IPV and will usually adopt a definition that

encompasses one or more forms of IPV. For example, Sugarman and Hoatling (1989) described IPV as "the use or threat of physical force or restraint carried out with the intent of causing pain or injury to another" (p. 5). Due to the simplicity of this definition, most researchers have adopted this definition when assessing IPV (Lewis & Fremouw, 2001). Other researchers have used definitions that include physical violence, psychological abuse, emotional abuse, or sexual violence (Kaukinen et al., 2012). Researchers tend to agree that physical abuse refers to the threat or use of physical force in a relationship (Sugarman & Hotaling, 1989). Other studies, however, have broken down this definition to include specific behaviors such as hitting, slapping, kicking, or punching (Coker, Sanderson, Cantu, Huerta, & Fadden, 2008; Straus et al., 1996). Sexual abuse has been defined as the use of force or threat to engage in sexual behaviors (O'Sullivan, 2005; Straus et al., 1996), while psychological abuse has been defined differently across different studies. Examples of psychological abuse include verbal denigration (Straus et al., 1996), explicit or implicit threats of violence, controlling and/or isolating behavior, and excessive jealousy (Sonkin, Martin, & Walker, 1985).

Research on IPV includes the assessment of various victim and perpetrator characteristics (e.g., gender and ethnicity) to draw more meaningful conclusions about the prevalence of IPV across diverse young adults. For example, gender differences in prevalence of IPV for young adults have been reported in the literature. An early study (Makepeace, 1981) on partner violence pointed to a significantly higher prevalence of victimization for young women and of perpetration for young men. Subsequent researchers (Cercone, Beach, & Arias, 2005; Follette & Alexander, 1992; Krug,

Dahlberg, Mercy, Zwi, & Lozano, 2002), however, have found mixed results regarding gender differences in prevalence of victimization and perpetration. For example, Follette and Alexander (1992) found similar perpetration and victimization estimates for men and for women in a sample of 100 couples, with partners ranging in age from 18 to 27. In research assessing youth violence, males were found more likely than females to be both victims and perpetrators; however, in partner violence, females were often involved as victims of physical and sexual abuse and males as perpetrators (Krug et al., 2002). More recent studies, however, have found higher reports of physical violence perpetration by females than by males in a sample of 450 undergraduate students (Cercone et al., 2005). Exploring the nature of violent relationships among undergraduates, researchers (Cercone et al, 2005; Foshee, Bauman, Linder, Rice, & Wilcher, 2007; Kaukinen et al., 2012) have found that men and women often tend to be mutually violent (i.e., both partners perpetrate and are victimized).

Multiple explanations have been posed to explain the findings on the prevalence estimates among young men and women. For example, one explanation is that men tend to underreport their perpetration of physical violence (Stets & Straus, 1990). A second plausible explanation is that, generally, it is less acceptable for a male to hit a female than for a female to initiate physical violence against a male (Bookwala, Frieze, Smith, & Ryan, 1992). More recently, using a sample of 1,275 heterosexual young adults with an average age of 22, Herrera, Wiersma, and Cleveland (2008) noted that women's perpetration was influenced by their experience as victims and explained that women who perpetrate are significantly more likely to do so when they are in a mutually violent

relationship. Herrera et al. (2008) proposed that female victims with a higher propensity for violence and aggressive behaviors were more likely to act on these tendencies when they were involved in a relationship with a violent male partner. In contrast, females who reported violent tendencies but were in relationships with non-violent male partners did not act on these violent and aggressive behaviors. Herrera et al. concluded that a young woman's violent behavior is primarily dependent on being with a violent male partner.

In summary, the IPV literature has identified the majority of victims as females and perpetrators as males. However, when examining IPV among young adults in dating relationships, mixed results have been found (Cercone et al., 2005; Foshee et al., 2007). Several explanations have been proposed to explain the gender differences in IPV such as social norms (e.g., acceptable to hit women; Bookwala et al., 1992), and environmental context (e.g., mutually violent relationships; Herrera et al., 2008). More recently, cultural norms (e.g., machismo and Marianismo; Malhotra, Gonzalez-Guarda, & Mitchell, 2015) have been proposed as an important component in the unclear prevalence rates.

Intimate Partner Violence in the Latino Community

Despite the fact that Latinos are one of the fastest growing minority groups in the United States, few research studies have examined Latino cultural influences on intimate partner violence. Understanding cultural influences and implications can help focus future prevention efforts, research, and clinical interventions. Several studies have found that Latinos are not at a reduced risk for IPV, often face challenges seeking help and developing coping strategies, and are at risk for negative psychological outcomes

(such as, Posttraumatic Stress Disorder, depression, and anxiety; CDC, 2011; Champion, 1996; Sabina & Cuevas, 2013).

Prevalence statistics vary when ethnicity is taken into account. In a nationwide study that sampled men and women over the age of 18 and living in the United States, the CDC (2011) found different prevalence rates for different types of IPV (e.g., sexual abuse, stalking, and physical violence) for young adults and adolescents by ethnicity. For example, the CDC study reported that 43.7% of Black women, 46% of American Indian/Alaskan Native women, and 53% of White women reported being physically abused, raped, and/or stalked by a partner in the previous year. Although this CDC national survey only reported prevalence rates of sexual abuse (e.g., rape) for Latinas (15%), according to the Bureau of Justice Statistics (2002) Latinas accounted for 34% of the incidence of IPV in the US. In their national study, Strauss and Smith (1990) found that the rate of Hispanic partner abuse was 54% greater than the rate for non-Hispanic Whites. Latinos as a group have one of the highest reported rates of IPV (Champion, 1996; Kantor, Janiski, & Aldarondo, 1994; Lown & Vega, 2001). As can be seen, IPV seems to be a problem that impacts individuals from various ethnic backgrounds and merits further investigation related to the unique consequences and correlates that potentially affect each ethnic population.

When studies with sufficient participants who identify as Hispanic or Latino have stratified their findings by ethnicity, Latinas are often found to be at a higher risk for IPV (Coker et al., 2008; Lewis, 2001) than are women who self-identified as White. Sabina and Cuevas (2013) reported that prevalence rates of victimization for Latino youth range

from 15% to 40% and argued that this wide range is again due to differences in definitions of IPV among studies. As noted earlier, the lack of a consensus for a definition of IPV has led to conflicting results in prevalence rates for IPV among youth and college-aged individuals. For examples, using data from the Youth Risk Behavior Survey, Howard and Wang (2003) found that nationwide physical partner violence rates were 82% higher for young Latinas than for young White women. Other studies, however, reported that prevalence rates of IPV among youth do not differ between young White and Latina women (Halpern, Oslak, Young, Martin, & Kupper, 2001). In a sample that included 1,516 college-aged individuals, Ackard, Eisenberg, and Neumark-Sztainer (2007) found no differences in the frequency of abuse in dating relationships among non-Hispanic Whites, African Americans, and Hispanics. However, Coker et al. (2008), who studied prevalence rates of partner violence (e.g., physical abuse, sexual abuse, stalking, and psychological abuse) in college women 18 to 35 years old and who identified as Mexican American, found that 43% of Mexican American women reported experiencing some form of partner violence (e.g., physical, sexual stalking, and psychological) in the last year. When Coker et al. investigated each form of IPV in dating relationships, they found 12% of the women reported being stalked, 5% reported sexual abuse, and 90% reported psychological abuse.

Along with the examination of ethnic differences in IPV, researchers have also examined gender disparities within ethnic groups (Black et al., 2011; Kaukinen et al., 2014; Lewis & Fremouw, 2011). Reporting life-time prevalence estimates in their national study, Black et al. (2011) indicated that European American women reported

prevalence estimates of physical abuse as high as 31.7%, where as 26.6% of European American men reported being physically abused. Prevalence rates of physical abuse for Latinos were higher for Latina females than for Latino males (e.g., 37.1% and 26.6%, respectively). While IPV is prevalent across both genders and across ethnicities, higher prevalence continues to be reported for females and for Latinas.

Although prevalence rates can be potentially high, very little is known about the effects of IPV on the Latino population. Therefore, it is important to explore the cultural underpinnings that play a role in IPV for young Latina women as most studies explaining the gender differences and dynamics in partner violence have not focused on the role of culture related to gender norm expectations. Researchers have often excluded analyses that examine ethnicity due to small sample sizes of ethnic minorities (Sugar & Hotaling, 1989). More commonly, studies have included larger percentages of college students and youth who identify as White and smaller percentages of those who identify as Latino or Hispanic. The current study addressed this gap in the literature by examining IPV among Latina college students in dating relationships, specifically exploring the influence of gender norm expectations on IPV, the development of PTSD, and coping strategies. Addressing ethnic disparities is of the utmost importance because of the known consequences IPV has on survivor's physical and psychological well-being.

Biopsychosocial Consequences of Intimate Partner Violence

Empirical investigations of the biopsychosocial consequences of IPV have found that IPV has links to serious psychosocial, behavioral, and health concerns (CDC, 2009; Howard & Wang, 2003; Silverman, Raj, Mucci, & Hathaway, 2001; U.S. Department of

Health and Human Services, 2011). Several cross-sectional studies comparing women with IPV concerns and controls (women without IPV) have found psychosocial concerns to be a significant problem for IPV survivors. For example, Lipsky, Catano, Field, and Larkin (2005) compared 182 women with a history of IPV and 147 controls and found that IPV survivors reported more alcohol substance abuse and witnessed more childhood violence. Similarly, another study assessing the national incidence and mental health correlates of IPV found that female survivors were more likely to meet criteria for any Axis I disorder (e.g., depression, anxiety, and PTSD) and substance abuse disorders than were females who had not experienced IPV (Okuda et al., 2011). These studies illustrate the gravity of the mental health consequences for individuals who are victimized in dating relationships. In one of the few longitudinal studies examining psychosocial correlates in young women ranging in age from 15 to 20, this five- year study found higher reports of depressive symptoms, suicide attempts and ideation, and marijuana use for women who reported IPV in comparison to women who did not (Ackard et al., 2007). These results were consistent across test cycles and highlight the impact IPV has on psychopathology.

In addition to the psychosocial correlates, risky behaviors are common for young adults and adolescents who are engaged in violent relationships (Ackard et al., 2007; Haynie et al., 2013). For example, in their longitudinal study of 5,681 adolescents, Exner Cortens, Eckenrode, and Rothman (2013) found that survivors of IPV reported more episodic drinking and smoking five years after victimization. In addition to these behavioral and psychosocial consequences, there were also consequences for physical

health. This increased risk for physical health concerns was attributed to the fact that individuals with a history of IPV tended to engage in more high risk behaviors such as drinking, drug abuse, and risky sexual behaviors (Exner et al., 2013). For example, Eshelmen and Levendosky (2012) found that undergraduate women who reported physical, psychological, and/or sexual abuse were at the highest risk of reporting physical injury (e.g., internal injuries, cuts, bruises, and scrapes) that occurred as a result of IPV and mental health complaints (e.g., depression and PTSD). In addition, using a national sample of male and female 16-year old 10th graders, Haynie et al. (2013) found positive associations between IPV in dating victimization and reports of physical complaints such as stomach aches, headaches, backaches, and dizziness for girls but not for boys. Taken together these findings illustrate the consequences IPV can have on physical health and the somatization of symptoms.

The effects of IPV on mental health has been widely documented in the literature with most studies focusing on depression, suicidal ideation, anxiety, and PTSD (Griffing et al, 2006; Hazen, Connelly, Soriano, & Landsverk, 2008; Wolford-Clevenger, Elmquist, Brem, Zapor, & Stuart, 2016). The risk of developing depression after experiencing IPV has been noted in the literature. For example, Griffing et al. (2006), using regression analyses, found in a sample of sexual abuse survivors that abuse accounted for significant variance in predicting depressive symptoms. In a separate study, Hazen et al. (2008), using a sample of 282 Latina women ranging in age from 18 to 45, found physical and psychological abuse to be significantly associated with symptoms of depression. Along with increased reports of depression, several studies have documented

that IPV survivors may be at a higher risk of experiencing suicidal ideation as compared to the general public (Afifi, Mac Millian, Cox, Asmunson, & Sareen, 2009; Chan, Straus, Brownridge, Tiwari, & Leung, 2008; Golding, 1999; Wolford-Clevenger et al., 2016). In addition, The World Health Organization (WHO; 2016) also found IPV to be a significant predictor of suicidal thoughts among female survivors. Recently, Wolford-Clevenger et al. (2016) believed that the experience of interpersonal violence may increase suicidal ideation in college students. In testing their hypotheses, they found that the increase in suicidal thoughts was due to feelings of social disconnectedness and loneliness. In addition, they found that many survivors endorsed beliefs that suggested they were at fault for the abuse. Furthermore, findings from a study using survivors residing in a domestic violence shelter found that Latinas reported more suicidal ideation and attempts as compared to non-Latina survivors (Krishnan, Hilbert, & VanLeeuwen, 2001). Not only are depression and suicidal ideation common mental health concerns, but anxiety is a frequent correlate of IPV (Campbell, 2002; Golding, 1999; Lang, Kennedy, & Stein, 2002; WHO, 2016). When comparing IPV survivors to non-IPV survivors, Afifi et al. (2009) found that survivors were more likely to meet criteria for an anxiety disorder, including PTSD.

Another psychological correlate associated with IPV is development and severity of Post Traumatic Stress Disorder (PTSD; Eshelman, & Levendosky, 2012; Koss, 2006; Taft, Resick, Watkins, & Panuzio, 2009). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), PTSD is the development of symptomology following trauma experience(s). Characteristics of

PTSD include avoiding stimuli related to the event, intrusive memories/thoughts, distressing dreams, persistent negative thoughts and/or moods, and heightened emotional and/or behavioral reactivity (e.g., hypervigilance, irritability, exaggerated startle response, and problems with concentration and sleep).

Considering the link between IPV and PTSD, studies have found 31% to 84% prevalence reports of PTSD symptomatology in women who report relationship violence (Jones, Hughes, & Unterstaller, 2001). These high prevalence rates have been consistent across varied samples, including clinical samples and women in hospitals, shelters, or community agencies. In contrast, the PTSD prevalence rates for women in the general population are significantly lower varying from 1.3% to 12.3% (Kessler, Sonega, Bromet, Hughs, & Nelson, 1995). In their study of female high school students aged 13 to 19, Callahan, Tolman, and Saunders (2003) reported that increasing levels of severity, injury, and frequency of IPV were related to higher levels of PTSD even after accounting for demographics and history of family violence. Similarly, Taft et al. (2009) reported that women with a history of interpersonal trauma endorsed more symptoms predictive of PTSD severity. In addition, Eshelman and Levendosky (2011) investigated 499 predominately White undergraduate women who reported multiple traumas (e.g., physical abuse, psychological abuse, and sexual abuse) and discovered that these women had the highest level of PTSD and depressive symptoms when compared to women without a history of relationship violence.

While several studies have highlighted the links between IPV and PTSD in the general population, relatively little is actually known about this relationship among

Latinas. One study found that Latina sexual abuse survivors reported higher PTSD compared to Anglo-American women even after accounting for sexual abuse (McFarlane et al., 2005). Other researchers found that abused Latina immigrant women were three times more likely to meet PTSD criteria after experiencing traumatic events related to IPV (Fendovskiy, Higgins, & Paranjape, 2008). Although these investigators studied specific groups (e.g., sexual abuse survivors and immigrant women), these studies highlight that in comparison to Anglo-American women the prevalence of PTSD may be higher among Latina women and that IPV is correlated with higher reports of PTSD (Fendovskiy et al, 2008 ; McFarlane et al, 2005).

Since few studies have included a sufficient number of participants who identify as Latino or Hispanic, very little is known about ethnicity in the link between IPV and PTSD for Latina women. Therefore, this study explored this relationship for Latina undergraduate women and posited that more reports of relationship violence would be related to increased PTSD symptoms for Latinas.

Cultural Beliefs and Gender Roles

Recently, researchers (Brabeck & Guzman, 2009, Coker et al., 2008; Howard, Beck, Kerr, & Shattuck, 2004; Krug et al., 2002; Malhotra, Gonzalez-Guarda, & Mitchell, 2015; Vidales, 2010) have become interested in gender specific values and their influence on mental health outcomes. Gender norms and expectations are clearly understood in the Latino culture (Castillo & Cano, 2007). The terms Machismo and Marianismo have been used to describe gender role expectations and norms. Machismo refers to the gender role norms for men in Latino culture and is exemplified by behaviors

related to aggression, sexism, and hypermasculinity (Arciniega, Anderson, Tovar, & Tracey, 2008; Anders, 1993). Coined by Evelyn Stevens (1973), Marianismo is the cultural factor that defines traditional female gender beliefs in Latino culture and describes women's subordinate role and the culture's idealized belief in Latinas' gender expectations and responsibilities.

The term Marianismo emerged from Catholic beliefs, specifically the culture's belief in and worship of the Virgin Mary (Stevens, 1973). Theorists have drawn parallels between the reflection of the culture's worship of the Virgin Mary and the behaviors, relationship dynamics, and roles of Latina women (Castillo & Cano, 2007; Castillo, Perez, Castillo, & Ghoseh, 2010; Stevens, 1973). Thus, according to the cultural script of Marianismo, the characteristics that are held by what is considered an ideal Latina are spirituality, humbleness, and virtue (Castillo et al., 2010). In addition, women are to make extreme sacrifices for their family, to be submissive to the demands of men, and to follow the Virgin Mary as a model by remaining virginally pure and non-sexual (Castillo & Cano, 2007). Studying a sample of 327 Latina college students, Castillo et al. (2010) found the values of family pillar, being virtuous and chaste, being subordinate to others, remaining silent to maintain harmony, and being a spiritual pillar to be the five contributing factors that best fit the construct of Marianismo. Additionally, these researchers pointed out that these gender norms and expectations stem from the values of Familismo, Respeto, and Simpatia that are found in Latino culture (Castillo et al., 2010).

In addition to the gender roles and expectations that are defined by Marianismo, scholars described specific gender-related cultural values that are important in the

conceptualization of Marianismo (Gil & Vasquez, 1997). These cultural values limit Latina women in how they are able to display Latino gender-related behaviors. For example, the value of Familismo, defined as the individual's strong identification with the nuclear family, is thought to be integral to the Latina gender role (Castillo & Cano, 2007). Thus, for Latinas, adherence to familismo is exemplified by providing emotional and physical support to the family, bearing and raising children, and taking care of the housework (Castillo et al., 2010).

Respeto is another cultural value important in the roles and expectations of Latinas. Represented by obedience and deference to an individual within a hierarchical system (Castillo & Cano, 2007), respeto is manifested behaviorally in the Latino culture by maintaining a hierarchical structure in the family in which a Latina woman gives respect to those above her in the hierarchy (usually men; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Examples of this concept include not talking back and/or asserting themselves to those who are higher in the hierarchical structure. Latinas are especially expected to maintain respeto as the family's esteem and honor are related to confirming gender roles and norms (Castillo et al., 2010). Consequently, for Latinas, adherence to the value of respeto creates the gender norm that Latinas are to be subordinate and obedient to the men in their family (e.g., husband or father).

Lastly, the cultural value of simpatia or sympathy is a cultural script that guides relationship dynamics for Latinos. Specifically, simpatia describes the cultural norm that Latinos should endorse behaviors that promote pleasant and courteous relationships (Castillo et al., 2010). An important factor in the definition of simpatia is the idea that

there should be an avoidance of anything negative that could cause interpersonal conflicts or disrupt the harmony of a relationship (Triandis, Marın, Lisansky, & Bettancourt, 1984). For Latinas, simpatia is exemplified in behaviors that help maintain harmony in their relationships. Therefore, the expectation is that Latinas will endorse behaviors such as patience and forgiveness, will not discuss controversial topics including sex-related topics or issues surrounding the family dynamic, and will avoid being critical of others.

It is important to note, however, that the term Marianismo encompasses both positive and negative behavioral and cultural expectations of women. Latinas can be considered la mujer buena (the good woman), a woman who is strong and proactive in her life outside of her home (Castillo et al, 2010). Inside her home, however, she is limited in power and should focus primarily on being nurturing and caring towards her family (Rocha-Sanchez & Diaz-Loving, 2005). Consequently, exertion of power is limited to family specific roles such as motherhood and womanhood (Lavrin, 2004) with limited roles that encourage assertiveness.

Mariansimo is conceptualized on a continuum where negative extremes consist of behaviors related to dependency, submissiveness, passivity, and extreme self-sacrifice at the cost of a woman's well-being. On the other hand, the positive extreme of this continuum consists of notions of collectivism, devotion to the family, and a self-sacrifice that is re-conceptualized as compassion and empathy for others (Castillo & Cano, 2007). It is important to note that women will vary on the level of Marianismo endorsed. Cano and Castillo (2007) stated that for Mexican American women who are acculturated to United States' culture "…these constructs may vary in the degree to which they have

relevance to their lives. This could range from some relevance to no relevance at all" (p. 91). Higher endorsements of Marianismo, however, may lead to more negative consequences in violent dating relationship. For example, Latinas who experience sexual, physical, or psychological abuse may be limited in their ability to ask for help or to report the abuse due to the Marianismo cultural script that dictates that women should avoid discussing sexual topics or topics that will lead to a disharmonious relationship, that they remain submissive and passive in order not to disturb the hierarchy, and that they bring shame to their family by endorsing assertive behaviors.

To date, only one study was found that evaluated the relation between Marianismo and IPV. Moreno (2007) used qualitative methods to explore the relationship between Human Immunodeficiency Virus (HIV+) and IPV for 32 Latina women ranging from 18 to 60 years of age. From the data in this study, Marianismo emerged as a theme that speaks to the importance of cultural factors in the implication for risk of IPV, as well as HIV+. Specifically, women described that the gender norms dictated in the cultural script of Marianismo hindered their ability to leave violent relationships because of sociocultural expectations (e.g., shame, submissiveness, fear, and low self esteem) for them.

In summary, the beliefs that make up the concept of Marianismo may influence how Latinas cope with IPV. Due to the limited research evaluating the relations between Marianismo, IPV, and PTSD this study examined these concepts to derive potential clinical implications. It was believed that high levels of Marianismo may be detrimental to Latinas and place them at higher risk for PTSD.

Coping strategies

Another concept associated with intimate partner violence, culture, and PTSD is coping strategies used by abuse survivors (Arriaga & Capezza, 2005; Macy, 2007). Coping strategies have become an important area of research as some studies have found coping strategies to mediate significantly the effects of IPV and victimization (Arias & Pape, 1999; Dempsey, 2002; Merrill; Thomsen, Sinclair, Gold & Milner, 2001).

In their classic conceptualization of coping, Lazarus and Folkman (1984) defined it as the cognitive and behavioral efforts that are used to manage internal or external stressors that are perceived as taxing or beyond the individual's resources. The work outlined by Lazarus and Folkman has influenced various coping theories and definitions. Lazarus and Folkman made distinctions between coping strategies by defining them as problem-focused or emotion-focused coping. These early conceptualizations of coping strategies influenced the work of Tobin, Holroyd, Reynolds, and Wigal (1989) who conceptualized coping as a tertiary level process that includes not only problem-focused and emotion-focused coping but also encompasses approach-avoidance dimensions. Tobin et al. described their model of coping as as having three distinct levels of coping identified as, primary, secondary, and tertiary. The primary level of coping reflects specific, cognitive, behavioral, and emotional strategies that individuals use when they face a stressful situation. Furthermore, the primary level of coping can be broken down into eight strategies: 1) problem solving, 2) cognitive restructuring, 3) emotional expression, 4) social supports, 5) problem avoidance, 6) wishful thinking, 7) self criticism, and 8) social withdrawal.

The eight primary strategies that encompass the primary level of coping are grouped into four sub-groups and create the secondary level of coping; problem-focused engagement, problem-focused disengagement, emotion-focused engagement, and emotion-focused disengagement. These secondary factors are grouped in two larger sub-groups and are defined as the tertiary level of coping. The two subgroups created are described as engaged and disengaged coping. Engaged coping has been defined as coping methods that help the individual engage in active behaviors that help cope with the stressor. Whereas, the dimensions of disengaged coping reflect more problem avoidance behaviors and feelings about the stressor. According to the literature, coping seems to be situation dependent and whether a specific coping strategy will be adaptive is dependent on the type of stressor the individual is facing (Folkman, Lazarus, Dunkel-Schetter, De-longis, & Gruen, 1986; Griffing et al., 2009).

Further elaboration on the definition of coping strategies has led to the differentiation between "engagement" and "disengagement" forms of coping responses related to abuse. Tobin et al. (1989) described engagement coping as proactive measures that manage abuse and its associated consequences and includes strategies such as problem solving, cognitive re-structuring, emotional expression, and social supports. In contrast, disengagement coping refers to a more passive attempt at responding to abuse and includes problem avoidance, wishful thinking, self-criticism, and social withdrawal. Furthermore, a disengaged approach to coping has been identified as the most concerning for women in violent relationships, since it is typically linked to negative psychological outcomes (Sullivan et al., 2005).

The way in which victims respond (i.e., cope) to IPV represents an important component of the process of IPV and could be particularly susceptible to cultural influences. Diaz-Guerrero (1979) explained that throughout history human beings from different cultures have arrived at various ways of dealing with problems. Sociocultural researchers have long theorized that coping strategies vary with the context of the prescribed cultural scripts. For example, Lazarus and Folkman (1984) discussed cultural constraints on coping behavior: "culturally derived values and beliefs serve as norms that determine when certain behaviors and feelings are appropriate and when they are not . . . even allowing for a wide range of situational and individual differences, culturally derived values, beliefs, and norms operate as important constraints" (p. 165). In addition, cross-cultural researchers have proposed a similar theory by arguing that culture-specific norms may have a powerful effect on coping strategies (Cervantes & Castro, 1985; Kuo, 2013; Lee & Mason, 2014).

The differences in coping responses among different cultures (e.g., Copeland & Hess, 1995; Hastie, Riley, & Fillingim, 2004; Triandis, 1994; Wasti & Cortina, 2002) has received some research attention. Some studies have found unique coping patterns among Latinas exposed to abuse, including a tendency towards nondisclosure and less proactive help-seeking behaviors (Eubanks Fleming & Resick, 2015; Romero, Wyatt, Loeb, Carmona, & Solis, 1999). For example, examining the differences in coping response strategies among 476 Hispanic, 355 Turkish, and 447 Anglo American female sexual assault survivors, Wasti and Cortina (2002) found that Hispanic and Turkish survivors were more likely to report avoidant-type coping strategies than were their Anglo-

American counterparts. Furthermore, the Hispanic survivors were more likely to use more denial-based coping and less advocacy-seeking coping, both of which are forms of disengaged coping. The authors explained these results as being culturally bound to gender norms such as machismo and Marianismo and expectations in Latino culture. For example, Familismo, a core component of Marianismo, characterizes highly integrated and supportive families and has been associated with both positive and negative coping strategies for Latina women (Brabeck & Guzman, 2009; Marrs Fuchsel, 2013).

While Familismo may protect a woman by encouraging her to reach out for emotional support from her family, she may also be reluctant to seek support in order not to disrupt the relationship and/or family unit (Marrs Fuchsel, 2013). For example, Brabeck and colleagues (2008) found in their mixed methods study that Latinas with a history of IPV, including physical, sexual, and psychological violence, were often less likely to seek help from their family due to a desire to protect their family. In addition, their qualitative results indicated that the families of the participants often normalized abuse and were told that a "good woman" suffers and must tolerate abuse.

Exploring how cultural gender scripts such as Machismo and Marianismo influence Latina women's perceptions of IPV and coping strategies, Vidales (2010) found that Latinas with partners who adhered to traditional Machismo roles were less likely to seek help from resources in the community and engaged in more disengaged coping strategies. Furthermore, additional cultural scripts regarding sexual behavior that are stipulated in Latino culture hinder women from disclosing sexual abuse to potential advocates or support networks. Specifically, the idea dictated in Marianismo is that

women must not participate in discussions regarding sexual topics. This taboo may hinder women from seeking help when IPV involves sexual abuse. Although it is recognized that cultural scripts influence coping strategies, the relation of Marianismo to IPV, coping strategies, and the development of PTSD has not been studied.

The relation between disengaged coping and increased PTSD is especially concerning because it appears that IPV survivors are more inclined to use disengaged coping efforts in response to abuse (e.g., Coffey, Leitenberg, Henning, Turner, & Bennett, 1996b; Griffing et al., 2009; Spaccarelli, 1994). Researchers who have explored the relation between coping strategies and IPV argue that women with a history of IPV use disengagement-type coping strategies to avoid abuse-related triggers in order to reduce experiencing painful and overwhelming emotions (Iverson et al., 2013; Taft, Resick, Panuzio, Vogt, & Mechanic, 2007). In the moment of the abuse, disengagement coping may be viewed as a helpful response; however, constant use of this behavioral and/or emotional coping strategy could be associated with an increase in PTSD symptoms. The implication of several research findings is that the use of disengaged coping strategies to navigate and negotiate interpersonal violence is associated with greater levels of PTSD symptomatology (Griffing et al., 2009; Eubanks Fleming & Resick, 2015; Valentiner, Foa, Riggs, & Gershuny, 1996).

An issue in the development of PTSD for Latina IPV survivors is peritraumatic dissociation, defined as the dissociative experiences that occur during or right before a traumatic event. Peritraumatic dissociation has been found to be a strong predictor of subsequent development of PTSD and related coping responses (DePrince, Chu, &

Visvanathan, 2006; Taft et al., 2007). For example, among their sample of 388-battered woman, Taft and colleagues (2007) found disengagement coping to be significantly related to peritraumatic dissociation. Furthermore, Filipas and Ullman (2006) found that women with a history of childhood sexual abuse who reported using maladaptive coping strategies reported higher PTSD symptoms, and Brand and Alexander (2003) reported that among their sample of 101 women with a history of childhood incest those who engaged in avoidant coping strategies reported more distress and depression in adulthood. Moreover, Iverson et al. (2013), in their sample that included 69 African American and White battered women, found disengagement coping to be associated with increased risk for IPV re-victimization and associated PTSD symptoms such as dissociation. An over reliance on disengaged coping strategies (e.g., wishful thinking, avoidant thinking, and social isolation) may increase the risk of PTSD symptoms. Previous researchers have found a positive association between frequency of IPV and disengaged coping strategies, whereas the relation between frequency of IPV and engaged coping strategies has been mixed (Gibson & Leitenberg, 2001; Taft et al., 2007).

Most research studies have investigated coping strategy responses in samples of battered women or survivors of sexual abuse, yet very little is known about the link between coping strategies and negative outcomes for Latina college women in violent dating relationships. Researchers, however, have explored the influence culture has on an individual's coping response after a stressful event (e.g., Cervantes & Castro, 1985; Diaz-Guerrero, 1979; Lazarus & Folkman, 1984). Specifically, it has been posited that cultural scripts related to gender expectations and norms influence subsequent coping strategies

(Jung, 1995; Triandis, 1994; Wasti & Cortina, 2002). The role of cultural scripts in the relation between coping strategies and PTSD has not been examined empirically even though these scripts may be important (Wasti & Cortina, 2002) in understanding the process of IPV in dating relationships. Based on the literature, it was reasonable to expect that higher reports of disengaged coping strategies would be predictive of higher PTSD symptoms among college-aged Latinas. Due to the relation of Marianismo with coping strategies and the development of PTSD, it was expected that Marianismo would moderate the relation between coping strategies and PTSD symptomatology. In specific, it was expected that as Marianismo increased the relation between PTSD and disengaged and engaged coping would strengthen.

A Sociocultural Perspective

A common criticism in the literature is that many IPV studies lack a theoretical foundation for IPV and its associated factors, specifically issues related to ethnicity, culture, and gender roles. As noted previously, various theoretical perspectives have been proposed to further the understanding of IPV; however, theories such as Feminist Theory and Social Learning Theory have been criticized for not including important cultural variables (Wallace & Roberson, 2011; Wekerle & Wolfe, 1999; Zurbriggen, 2009). As ethnic minority populations grow in the United States, scholars have become increasingly aware of the importance of expanding their theoretical views of IPV to include culture. Relationship violence does not exist in a vacuum: it is not separate from an individual's culture. Zurbriggen (2010) argued that IPV "is embedded within broader cultural frameworks that support and socialize aggression and violence" (p. 30).

Consequently, the cultural and social expectations of individuals may deem relationship violence as socially acceptable and place certain ethnic groups at higher risk for IPV.

The application of the sociocultural perspective as a theory to explain IPV focuses on the roles of men and women in society as well as on cultural attitudes and beliefs about gender roles. Together, these two theoretical constructs (e.g., culture and social norms) are embedded in the sociocultural model of IPV and take into consideration issues at the macro level that are not explained by Feminist and Social Learning theories of IPV. Increasingly, the role of culture and its influence on perpetration and victimization are being recognized in the literature (Coker et al., 2008; Moreno, 2007; Wasti & Cortina, 2002). Specifically, studies are beginning to focus on constructs such as Machismo and Marianismo to help explain the role that cultural norms play in the frequency of IPV and subsequent mental health consequences.

In accordance with the sociocultural perspective, cultural customs such as Marianismo and Machismo are examples of expectations and norms that dictate specific behaviors for Latinos and Latinas that, in turn, may influence IPV. The patriarchal structure explains violence against women (e.g., IPV, domestic violence, rape, etc.) as an historical pattern that is continued due to male domination. In Latino culture, the patriarchal structure also dictates specific gender-role expectations for women. For example, the cultural gender-role expectation of Marianismo is that Latina women remain subordinate and obedient to the men in their family hierarchy (Castillo & Cano 2007). In consequence, the Marianismo cultural script puts women at risk for IPV as they are actively discouraged from asserting themselves in relationships, even at the expense of

their own physical and mental well-being (Castillo et al., 2010; Moreno, 2007; Santiago-Rivera et al., 2002).

These cultural and societal norms also influence the coping strategies used by IPV victims. The cultural expectation related to Marianismo that Latinas should avoid discussing topics related to sex and interpersonal conflicts may put Latinas at a higher risk of adopting disengagement-type coping strategies (e.g., avoidance, self criticism, and social withdrawal; Wasti & Cortina, 2002) that are often associated with greater PTSD symptoms (Fillipas & Ullman, 2006). To understand better the process of IPV and its subsequent sequelae for Latinas, the Marianismo cultural scripts by which women are bound must be taken into consideration as Marianismo may influence the relation between IPV and coping skills.

Summary and purpose of this study

Past research on IPV has established that individuals with a history of traumatization related to relationship abuse report higher symptomology of PTSD (Eshelman & Levendosky, 2011; Jones et al., 2001); therefore, it was expected that similar relations would be true for Latina undergraduates. Sociocultural researchers have argued that coping strategies are culturally bound to an individual's response strategy (Diaz-Guerrero, 1979; Lazarus & Folkman, 1989; Wasti & Cortina, 2002). In addition, the strategies that individuals use to cope with abuse have an effect on the severity of PTSD and the symptoms experienced (Filipas & Ullman, 2006). Specifically, disengaged coping strategies used to ward off PTSD symptoms after traumatization will become problematic over time; therefore, it was expected that greater use of disengaged coping

strategies would be related to increased PTSD symptomatology (Iverson et al., 2013). Although both of these relationships have been established in the literature, little is known regarding their validity for Latina undergraduates and how they are affected by the cultural roles defined by Marianismo. High levels of Marianismo have been associated with submissive and passive behaviors such as being silent and avoiding discussion of topics that could lead to interpersonal conflict or relationship distress (Castillo & Cano, 2007). Given the female gender-role expectations dictated by this cultural script, limited opportunities might exist for Latinas to use engaged coping strategies and, in contrast, more opportunities to adopt disengaged coping strategies when involved in a violent dating relationship. Therefore, endorsement of Marianismo may place Latinas at a higher risk for PTSD symptomatology due to the behaviors reflected in the construct of Marianismo (e.g., subordinate, submissive, and obedient) and culturally acceptable coping strategies.

The current study examined the extent to which IPV, coping strategies, and Marianismo predict Posttraumatic Stress Symptoms among college-aged Latinas. Although no study was found that examined the relation between the cultural construct of Marianismo and coping strategies, past studies have examined the relation between coping strategies and the role of culture and gender (Patterson & McCubbin, 1984; Wasti & Cortina, 2002). The link between Marianismo and PTSD has been reported in the qualitative literature (Moreno, 2007) but has not been evaluated empirically for college-aged Latinas. It was expected, therefore, that Marianismo would moderate the relationship between coping strategies and PTSD symptomatology.

Based on the literature, four hypotheses were posed:

H1: Disengaged and engaged coping strategies will predict PTSD symptomatology above and beyond the prevalence of physical abuse.

H2: Disengaged and engaged coping strategies will predict PTSD symptomatology above and beyond the prevalence of psychological abuse.

H3: Disengaged and engaged coping strategies will predict PTSD symptomatology above and beyond the prevalence of sexual abuse.

H4: Mariansimo will moderate the relationship between disengaged and engaged copingstrategies and PTSD symptomology.

CHAPTER 2

METHODS

Participants and Recruitment

After approval from Institutional Review Board (Study #00003155; see Appendix A), participants were recruited from various universities and colleges from across the nation using an on-line e-mail advertisement. The study was advertised as a research study focusing on relationships and looking for Latina college students who were 18 years of age or older and who were currently in a romantic relationship. Participants were directed to a secure website and were presented with an informed consent letter and the study measures (see Appendix B, C, D, E, F, and G). The current project was funded by a Arizona State University Graduate Professional Student Association research grant.

Participants who met the study criteria included 157 females who reported that they were in a romantic relationship, were 18 years of age or older, and identified as Latina. Participants' mean age was 22.4 (*SD* = 6.80) years. The majority of participants were first generation born in the United States (*n* = 139, 88.5%), with a smaller proportion identifying as foreign born (*n* = 18, 11.5%). At the time of the study, 58% (*n* = 91) were in a relationship but not living together, 20% (*n* = 32) were currently single, 13% (*n* = 20) were co-habiting with their partner, and 9% (*n* = 14) were married. Participants reported having completed 15.05 years (*SD* = 1.78) of education. In addition, participants reported an average relationship length of 36.4 months (SD = 84.45). Furthermore, 72% (*n* = 113) of the sample identified as having a Christian-based

faith, while 28% (*n* = 44) reported endorsing an 'other' religious faith. When answering the demographic questionnaire, participants self-reported their socioeconomic status from five different options based on their income. Specifically, 31% (*n* = 48) of the sample reported a lower income, 35% (*n* = 55) identified as middle/lower income, 24% (*n* = 38) identified as middle income, and 10% (*n* = 16) reported a middle/upper income, 0% (*n* = 0) reported an upper income. Complete demographic information is presented in Table 1.

Table1 Sample Descriptive	*n*	%
Sex		
female	157	100
Nationality		
USA	139	88.5
Non-USA	18	11.5
Socioeconomic Status		
Lower Income	48	30.6
Lower/Middle Income	55	35.0
Middle	38	24.2
Middle/Upper Income	16	10.2
Upper	0	0
Relationship Status		
Single	32	20.4
In relationship	91	58
Living with partner	20	12.7
Married	14	8.9
Religion		
Christianity	113	72
Judaism	1	.6
Other	42	26.8
None	1	.6

At the completion of the study, participants had the option of entering a raffle to win one of eight $25 Amazon gift cards.

Measures

In addition to the demographic questionnaire, four measures were administered in this study. These included the Conflict Tactics Scale (CTS2; Straus et al., 1996) to assess physical, psychological, and sexual abuse, the Coping Strategies Inventory (CSI; Tobin et al., 1989) to assess engaged and disengaged coping, and the Marianismo Belief Scale (MBS; Castillo et al., 2010) to assess cultural gender-role beliefs. In addition, the PTSD Symptom Check List was included to assess PTSD symptomatology (PCL-S; Weathers et al., 1996).

Conflicts Tactics Scale Revised (CTS2; Straus et al, 1996). The CTS2 is one of the most commonly used measures to assess relationship violence. This 78-item scale assesses the frequency of relationship violence occurrences initiated by the participant or experienced from a romantic partner. For the current study, only the 39 items that assess partner-initiated violence were used, as this study focused on victims of dating violence and not on perpetrators. The measure consists of 4 subscales: an 11-item psychological aggression sub-scale (e.g., verbal denigration; "My partner insulted or swore at me"); an 8-item physical assault sub-scale (e.g., hitting, throwing; "My partner punched or hit me with something that could hurt"); a 7-item sexual coercion sub-scale (e.g., using force or threat to engage in sexual behaviors; "My partner used force to make me have sex"); and a 13 item injury sub-scale (e.g., broken bones). For the purposes of this study, only the psychological aggression, physical assault, and sexual coercion sub-scales were used as

indicators of IPV. The injury subscale was not used as this study was not focused on the severity and frequency of injury due to physical abuse. Responses are made by indicating frequency of the violent event (0 = never happened, 1 = once in the past year, 2 = twice in the past year, 3 = 3-5 times in the past year, 4 = 6-10 times per year, 5 = 11-20 times per year, 6 = more than 20 times per year, 7= not in the past year but has happened in the past). The CTS2 can be scored to yield both prevalence scores (i.e., number of violent acts reported by the respondent) and chronicity (i.e., how often the violent acts occurred) total scores. Straus et al. (1996) recommended using chronicity scores with samples that do not consist of identified victims of violence (e.g., battered women living in domestic violence shelters) as prevalence and frequency scores are already known for these populations. Chronicity scores are computed by recoding the midpoint in responses to items with at least one incident of a violent act (e.g., "3-5 times" recorded to 4 and "6-10 times" to 8). These midpoint scores are then summed to reflect the frequency or number of times one or more violent incidents were experienced by the respondent in the last year, with higher scores reflecting higher frequency of the violent behavior.

Several studies have examined both the reliability and validity of the CTS2. Specifically, Straus et al. (1996) found adequate Cronbach's alpha internal consistency estimates reported for each subscale using a sample of undergraduate women: psychological aggression ($\alpha = .79$); physical assault ($\alpha = .86$); and sexual coercion ($\alpha = .87$). Furthermore, alpha reliability coefficients for responses to items in each subscale ranged from .74 to .89 in a large cross-cultural sample of 7,197 college undergraduate students from 33 different universities and 17 different countries (Straus, 2004). In their

study of Mexican American adolescent females, Cervantes, Duenas, Valdez, and Kaplan (2006) reported moderate to strong inter-item reliability coefficients for each one of the CTS2 subscales: psychological aggression α = .80; physical assault α = .79; and sexual coercion α = .65. More recently, in a sample of 73 Latinas ranging in ages from 14 to 20, Sue-Newman and Campbell (2011) found strong reliability coefficients for the three subscales of the measure that assess victimization (e.g., psychological aggression α = .83, physical assault α = .90, and sexual coercion α = .78). The Cronbach's alphas for the current study were considered strong (physical assault α = .94; psychological aggression α = .85; sexual coercion α = .84).

In addition, several studies have provided evidence of discriminant validity for the CTS2. In a study of 1,266 battered Spanish women, Calvete, Corral, and Estevez (2007) reported good discriminant validity, as the CTS2 scores for physical abuse, psychological abuse, and sexual coercion were able to distinguish between minor and severe forms of experienced violence. Furthermore, construct validity was supported in a study by Straus (2004) as the CTS2 scores for all thee abuse subscales reported by a cross-cultural sample of college students were positively correlated with a measure assessing corporal punishment and male dominance in dating.

PTSD Symptom Checklist for DSM-IV-Specific Event version (PCL-S; Weathers et al., 1996). The PCL-S is a 17-item self-report measure that assesses symptoms of PTSD that correspond to DSM-IV-TR (APA, 2000) criteria. Participants first describe a specific traumatic event they witnessed or experienced that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or

others. In addition, the traumatic event must have elicited feelings of helplessness, intense fear, or horror. Participants then rate how much they were bothered by each of the 17 PTSD-related symptoms in the past month. The items reflect the DSM symptom categories of re-experiencing, hyperarousal, and avoidance/numbing. Sample items include "Feeling emotionally numb or being unable to have loving feelings for those close to you" and "Suddenly acting or feeling as if the stressful experience were happening again [as if you were reliving it]." Ratings are made on a 5-point Likert-type scale where 1 = not at all and 5 = extremely. These ratings are summed to form a total score that can range from 17 to 85 with higher scores reflecting more PTSD symptoms. Previous studies that included samples of women with a history of sexual abuse provided evidence of concurrent validity in that the PCL-S was highly correlated with the Clinician-Administered PTSD Scale (CAPS; r = .93; Blanchard, Alexander, Buckley, & Forneris, 1996) and had strong internal consistency with a sample of 1,021 women ranging in ages from 18 to 93 years who had a history of IPV and substance abuse (r = .90; Jessup, Dibble, & Cooper, 2012). For the current study, the mean PCL-S score was 24.1 (SD = 12.45), and the Cronbach's alpha was .96.

Coping Strategies Inventory (CSI; Tobin et al., 1989). The CSI is a 72-item instrument developed by Tobin et al. (1989) to assess coping strategies that are employed in response to stressful events. The CSI is comprised of two overarching factors, engagement coping and disengagement coping. Each of these factors is comprised of four different subscales. The 36- item engagement coping scale includes four 9- item subscales: 1) problem solving; 2) cognitive restructuring; 3) express emotions; and 4)

social support subscales. The 36-item disengagement coping scale is also comprised of four 9-item subscales: 1) problem avoidance; 2) wishful thinking; 3) self-criticism; and 4) social withdrawal subscales. First, participants are asked to think about an event in the last month that they viewed as stressful and to respond to the items while thinking about the event and how they dealt with it. Sample items include, "I tackled the problem head on" (problem solving subscale and engagement coping factor) and "It was my mistake and I needed to suffer the consequences" (self-criticism subscale and disengagement factor). Responses are made on a 5-point Likert-type response format ranging from 0 = not at all to 4 = very much. Reponses across items across the four subscales within a factor are summed to create two coping (e.g., engagement and disengagement) factors total scores, each of which can range from 0 to 144. Higher scores indicate a greater likelihood of using the coping method in question.

Several studies have examined the construct and criterion validity of the CSI and have found it to be a valid measure. Specifically, Tobin et al. (1983) found that for individuals who are under high levels of stress the disengagement coping scale was able to predict mental health outcomes such as depression. In addition, adequate alpha coefficients ranging from .72 to .94 have been reported across all of the eight CSI subscales in a sample of college undergraduates (Tobin et al., 1989). Specifically, Taft et al. (2007) reported strong internal consistency for the engagement and disengagement scales of the CSI ($\alpha = .92$ and $\alpha = .91$, respectively) for their sample of 388 battered women. In the sample used for this study, Cronbach's alphas were strong for responses to both the disengagement ($\alpha = .96$) and engagement ($\alpha = .95$) items.

Marianismo Belief Scale (MBS; Castillo et al., 2010). This is a 24-item measure that assesses the degree to which an individual endorses gender-role expectations for a Latina female (Castillo et al., 2010). The measure has five different subscales: Family Pillar (5 items); Virtuous and Chaste (5 items); Subordinate to Others (5 items); Self-Silencing to Maintain Harmony (6 items); and Spiritual Pillar (3 items). Respondents are asked to rate each item on a 4 point Likert-type scale ranging from 1 = strongly disagree to 4 = strongly agree. Sample items include "A Latina should be pure" (Virtuous and Chaste subscale) and "A Latina should express her needs to her partner" (Silencing to Maintain Harmony subscale). Scores are calculated as the mean of responses to the items within each subscale and for the scale as a whole. The average score is derived by summing the responses for each item in the subscale and dividing it by the number of subscale items. For the purposes of this study total scores for the entire measure were used. In their study, Castillo et al. (2010) recommended using using total scores when studying college populations, as was done in the current study. In addition, this study was interested in assessing overall adherence to the beliefs of Marianismo and not to each belief individually. Higher scores indicate stronger endorsement of traditional Latina gender role expectations and values as exemplified by the Marianismo construct. Castillo et al. reported convergent and discriminant validity in a study including 368 Latina college students. Specifically, Castillo et al. reported the MBS was correlated with a measure of Latino enculturation (i.e., convergent validity) and not related to measures of acculturation (i.e., discriminant validity). Rodriguez, Castillo, and Gandara (2013) also reported strong alpha coefficients across the subscales (.84 to .90) with a sample of 98

Latina high school students who ranged in age from14 to 19 years old. In addition, other researchers (Piña-Watson, Castillo, Reyes, Jung, & Ojeda, 2014) reported adequate internal consistency reliability across all five subscales for Mexican American females ranging in age from 14 to 20 years: Family pillar (α =.75); Virtuous and Chaste (α =.81); Subordinate to Others (α =.83); Self Silencing to Maintain Harmony (α =.81); and Spiritual Pillar (α =.81). As noted earlier, total scores were used instead of sub-scale scores as the current study measured the adherence to overall Marianismo beliefs in a college-aged sample of Latinas. For this study, strong internal consistency reliability was found for responses to the MBS as a whole (α =.92).

Procedures

Before responding to the study survey, participants were presented with an informed consent letter (See Appendix B) that explained the purpose of the study and benefits and risks of their participation, and contact information for the primary investigator, research advisor, and Institutional Review Board (See Appendix A). All of the participants were informed that their participation was completely anonymous and voluntary and that they were able to discontinue participation in the research study at any point. Once participants consented to the study, they were given a link to a secure website to respond to the demographic sheet (Appendix C) and study measures (Appendices D, E, F, and G).

Analysis Plan

First, a pattern analysis was performed to determine the amount of missing data and it was found that 12.6% were missing. Due the amount of the missing data found

multiple imputation methods were used to create a more complete data set and to help account for missing data. As recommended by Schaeffer (1997), five different data sets were imputed. The pooled results from these five data sets were used to run all hierarchical regression and moderation analyses. This study used hierarchical linear regressions to test the first three study hypotheses. For each regression model, PTSD symptomatology was measured by the total score on the PCL-S and was used as the outcome variable. To test hypothesis 1, physical abuse was entered at step 1 and coping strategies at step 2. Frequency of physical abuse was operationalized as scores on the physical assault subscale of the CTS2. Coping strategies was operationalized as scores on the disengagement and engagement coping strategies subscales of the CSI. For the second regression model testing hypothesis 2 the variables were entered in the following steps: 1) psychological abuse and 2) coping strategies. Frequency of psychological abuse was operationalized as scores on the psychological aggression subscale of the CTS2. Coping strategies were operationalized as scores on the disengagement and engagement coping strategies scales of the CSI. The third hypothesis was also tested using a hierarchal regression model, and the variables were entered in the following order, step 1 sexual abuse and step 2 coping strategies. Frequency of sexual abuse was operationalized as scores on the sexual coercion subscale of the CTS2. Coping strategies were operationalized as scores on the disengagement and engagement coping strategies subscales of the CSI.

Regression analyses were used to evaluate the moderation effect of Marianismo on the relation between disengaged coping strategies and PTSD and between engaged

coping strategies and PTSD. The fourth hypothesis predicted that Marianismo would moderate the relationship between coping strategies (disengaged and engaged) and PTSD.

CHAPTER 3

RESULTS

A Priori Analyses

Table 2 presents means, standard deviations, and correlations among the primary study variables, namely IPV frequency, PTSD, coping strategies, and Marianismo.

Table 2
Descriptive Statistics and Correlations for Key Study Variables (N = 157)

	Mean	SD	1	2	3	4	5	6	7
1. Physical Abuse	3.68	19.30	-						
2.Psychological Abuse	9.84	21.0	.613**	-					
3. Sexual Abuse	4.46	16.2	.824**	.696**	-				
4. PTSD	24.16	12.4	.274**	.598**	.370**	-			
5 Engaged Coping	96.39	28.7	.029	-.049	.021	.086	-		
6. Disengaged Coping	86.40	33.2	.090	.256**	.148	.457**	.308**	-	
7. Marianismo	5.37	1.45	.120	.224**	.143	.392**	.238**	.930**	-

**p = .01
* p = .05

Data were cleaned and checked for accuracy in Excel, then transferred to SPSS 21 for testing of the study hypotheses. Using a missing pattern analysis it was determined that 12.6% of the data was missing. The data set was analyzed using Little's Missing

Completely at Random (MCAR) test to determine whether cases with missing variables were completely at random or followed a pattern. Little's MCAR test was not significant, implying that there was no identifiable pattern that accounted for the missing data ($X^2 = 17.89$, $df = 18$, $p = .463$). These results also indicate that a data imputation method must be chosen to help account for the missing data. This study was analyzed using Multiple Imputation, a common data imputation method utilized to examine hierarchical regression analyses (Rubin, 2004; Rubin, 1987; Schaeffer, 1997). Based on the literature, five different sets of data were imputed and used when testing the hypotheses (Schaeffer, 1997). The pooled results of all of the five data set are reported whenever possible.

Tests of Hypotheses

Hierarchical linear regressions were used to test the first three hypotheses. For each set of regressions that predicted PTSD symptomatology, frequency of abuse type (either physical, psychological, or sexual abuse) was entered on step 1. Coping Strategies (disengaged and engaged) were entered on step 2. Specifically for hypothesis one, the analysis revealed that physical abuse and coping accounted for a significant portion of the variance in PTSD symptomatology, adjusted $R^2 = .083$, F (3, 124) = 16.722, $p < .001$. For step 1, frequency of physical abuse contributed significant variance to the model ($R^2 = .076$, $\Delta F = 11.40$, $p < .001$). In step 2, coping strategies (engaged and disengaged coping strategies) accounted for significant additional variance ($\Delta R^2 = .205$, $\Delta F = 17.85$, $p < .001$). Examination of the pooled beta weights for the full model indicated that physical abuse ($B = .150$, $t = 3.38$, $p = .001$) and disengaged coping strategies ($B = .177$, t

= 5.96, $p < .001$) were significant predictors of PTSD symptomatology. The beta weight for engaged coping strategies was not significant ($B = -.027$, $t = -.793$, $p = .429$ see Table 3).

For hypothesis two, together psychological abuse and coping strategies accounted for a significant portion of the variance in PTSD symptomatology, adjusted $R^2 = .466$, $F(3, 124) = 36.23$, $p < .001$. For step 1, psychological abuse accounted for significant variance in PTSD symptomatology ($R^2 = .350$, $\Delta F = 67.80$, $p < .001$). In step 2, coping strategies (engaged and disengaged coping strategies) accounted for significant variance above and beyond that accounted for by psychological abuse ($\Delta R^2 = .117$, $\Delta F = 13.53$, $p < .001$). Pooled unstandardized beta weights for the full model indicated that psychological abuse and disengaged coping were significant predictors of PTSD symptomatology, $B = .125$, $t = 8.17$, $p = .031$; $B = .631$, $t = 4.62$, $p < .001$, respectively (see table 4). Engaged coping strategies was not a significant predictor of PTSD symptomatology ($B = .05$, $t = .029$, $p = .854$).

The regression testing hypothesis three revealed that together sexual abuse, disengaged coping strategies, and engaged coping strategies accounted for a significant portion of the variance in PTSD symptomatology, adjusted $R^2 = .350$, $F(3, 124) = 19.62$, $p < .001$. For step 1 sexual abuse contributed a significant amount of variance to the model ($R^2 = .139$, $\Delta F = 20.40$, $p < .001$). The addition of coping strategies at step 2 significantly enhanced the accounted for variance in the model ($\Delta R^2 = .183$, $\Delta F = 16.69$, $p < .001$). Examination of the pooled unstandardized beta weights for the full model indicated that sexual abuse was a significant predictor of PTSD, $B = .052$, $t = 4.49$, $p <$

.001. In addition, disengaged coping strategies (B = .029, t = 5.704, p < .000) was also a significant predictor of PTSD (see Table 5). However, engaged coping strategies was not a significant predictor PTSD (B = -.023, t = -.703, p = .482).

Table 3
IPV and Coping Strategies predicting PTSD (N = 157)

Model	Predictor	*B*	*SE*	*t*	Sig. (*p*)
Model 1					
Step 1	Physical Abuse	.174	.049	3.54	.001
Step 2	Physical Abuse	.150	.044	3.38	.001
	Engaged Coping	-.027	.034	-.793	.429
	Disengaged Coping	.177	.030	5.96	.000
Model 2					
Step 1	Psychological Abuse	.350	.038	9.29	.000
Step 2	Psychological Abuse	.302	.037	8.17	.000
	Engaged Coping	.005	.029	.184	.854
	Disengaged Coping	.125	.027	4.62	.000
Model 3					
Step 1	Sexual Abuse	.280	.057	4.95	.000
Step 2	Sexual Abuse	.233	.052	4.49	.000
	Engaged Coping	-.023	.033	-.703	.482
	Disengaged Coping	.166	.029	5.70	.000

Note: Unstandardized beta weights from pooled data are depicted.

To test the fourth hypothesis that Marianismo would moderate the relation between coping strategies (disengaged and engaged) and PTSD, two hierarchical linear regressions were conducted. In the first model, disengaged coping strategies and Marianismo were entered as step 1 and contributed significant variance to the model, adjusted R^2 = .231, F (2, 154) = 24.47, p < .001. In the second step, the addition of the interaction term did not significantly enhanced the accounted for variance, ΔR^2 = .017, ΔF (1,153) = 3.44, p = .066. Examination of the unstandardized beta weights revealed significant main effects for disengaged coping strategies (B = .245, t = 2.24, p = .040). However, neither Marianismo nor the interaction term was significant (B = -1.85, t = -.757, p = .461 and B = .033, t = 1.80, p = .072, respectively; Table 6).

The second moderation analysis was examined using hierarchical regression and tested Marianismo as a moderator in the relation between engaged coping strategies and PTSD. In this model, engaged coping strategies and Marianismo were entered in the first step and accounted for significant variance in the model, adjusted R^2 = .156, F (2, 154) = 14.21, p < .000. However, the addition of the moderator variable did not significantly increase the accounted for variance in the model, ΔR^2 = .004, ΔF (1,153) = .803, p = .371. Examination of the unstandardized beta weights revealed significant main effects for Marianismo but not engaged coping strategies (B = 3.49, t = 4.83, p < .000; B = .001, t = .016, p = .988, respectively). However, the interaction term was not significant (B = .012, t = .424, p = .673; Table 7).

Table 4
Results of Regression Predicting PTSD Moderated by Marianismo (N = 157)

Model	Predictor	*B*	*SE*	*t*	Sig. (*p*)
Model 1					
Step 1	Disengaged Coping	.269	.111	2.41	.031
	Marianismo	-2.22	2.54	-.877	.396
Step 2	Disengaged Coping	.245	.109	2.24	.040
	Marianismo	-1.85	2.45	-.757	.461
	Marianismo*Disengaged	.033	.018	1.80	.072
Model 2	Engaged Coping	-.004	.036	-.100	.920
Step 1	Marianismo	3.47	.714	4.86	.000
Step 2	Engaged Coping	.001	.038	.016	.988
	Marianismo	3.49	.723	4.83	.000
	Marianismo*Engaged	.012	.027	.424	.673

Note: Unstandardized beta weights from pooled data are depicted.

CHAPTER 4

DISCUSSION

One purpose of the current study was to examine the extent that each type of intimate partner violence (e.g., physical, psychological, or sexual abuse) and coping strategies predicted PTSD symptomatology in a sample of Latina college students. It was expected that in each hypothesis the type of intimate partner violence and coping strategies would predict higher PTSD symptomatology. In addition, the relation between coping strategies, Marianismo, and PTSD was also of interest. Specifically, the role of Marianismo as a moderator between coping strategies and PTSD symptoms was investigated. For this moderation model, it was expected that as Marianismo increased the relations between PTSD and disengaged and engaged coping would strengthen. The first three hypotheses that predicted that the different types of IPV (e.g., physical, psychological, and sexual) and coping strategies would predict higher PTSD symptomatology were partially supported by the data. Experiencing any type of IPV, whether physical, psychological, and/or sexual abuse, was predictive of PTSD symptomatology. Disengaged coping also predicted PTSD; however, engaged coping did not. In this study PTSD was defined as the development of symptomatology following a traumatic event(s). The characteristics of PTSD include avoiding stimuli related to the stressful event, intrusive memories/thoughts, nightmares or distressing dreams, persistent negative thoughts and/or moods, and heightened emotional and/or behavioral reactivity (APA, 2013). Individuals with PTSD also report feeling pervasively on-guard (e.g., hypervigilant), feeling irritable, feeling easily startled, having difficulty concentrating,

and having difficulty sleeping (APA, 2013). These symptoms can be distressing and interfere with individuals' daily life including interpersonal relationships, occupations, and daily/social functioning. The participants in this study had experienced physical, psychological, and/or sexual abuse perpetrated by a romantic partner. Due to the trauma they experienced during abuse, these women reported experiencing significant mental health sequelae, which has been well documented in the literature as manifesting as symptoms of PTSD (Kelly, 2010). Indeed, the greater the frequency of the IPV, the greater the PTSD symptomatology.

In the current study, regardless of what type of IPV the Latina participants experienced, they were just as likely to endorse increased levels of PTSD. Similar to the results found in this study, previous studies have also presented evidence for a link between IPV and PTSD using White and African American samples. Studying a sample of predominantly White female high school students, Callahan et al. (2003) found that higher IPV frequency, regardless of type of IPV, predicted increased PTSD symptoms. These results held true even after accounting for demographics and history of family violence. In a later study, Iverson et al. (2013) also found that White and African American participants who reported physical IPV also reported more PTSD symptomatology.

When the relation between psychological abuse and PTSD has been the focus of study, similar results have been reported. For example, studying a sample of 118 ethnic minority women who were pregnant, Moreland et al. (2008) found a strong association between psychological abuse and PTSD symptoms. Furthermore, they also found that

women who were psychologically and/or physically abused were not only at a higher risk for PTSD but also at-risk for miscarriage. Studying a sample 216 multi-ethnic female IPV survivors, Norwood and Murphy (2011) reported psychological abuse had the strongest association with PTSD. Specifically, verbal denigration and dominance/intimidation were the strongest predictors of re-experiencing and avoidance/numbing symptoms associated with PTSD. Norwood and Murphy suggested that survivors of psychological abuse are at higher risk for developing PTSD symptomatology because psychological abuse tends to be a more persistent form of abuse that impacts self worth and makes it difficult to recover from subsequent emotional pain. Indeed, this claim was supported by the findings of the current study. The correlations between the three types of abuse and PTSD revealed that the strongest relation was between psychological abuse and PTSD.

The current study also found that both physical and sexual abuse predicted PTSD, which supports previous research findings that PTSD is a detrimental consequence. For instance, Thompson et al. (1999) found that women who reported physical abuse were three times more likely to report PTSD symptoms and attempt suicide than were women who did not experience physical abuse. Similarly, Babcock et al. (2008) found physical abuse was not only positively correlated to PTSD symptoms but also suggested that psychophysiological reactivity may function as a mediator between physical abuse and PTSD. Assessing sexual abuse and PTSD, Bennice, Resick, Mechanic, and Astin (2003) also found that sexual abuse severity accounted for variance in PTSD symptomatology beyond what was already explained by physical abuse.

Taking all of these results together, it is clear that regardless of what type of IPV women report, the more IPV they experience the more at-risk they are for increased PTSD symptomatology. As is evident from the zero-order correlations for the current study variables, all three types of IPV were positively and significantly correlated with PTSD symptomatology with psychological abuse having the strongest relation to PTSD.

The link between IPV and PTSD has not been extensively examined for Latinas; therefore, this study explored these relations and adds to the existing body of literature on IPV. Previous research (Fendovskiy et al, 2007; Griffing et al, 2006; Ulibarri, Ulloa, & Salazar, 2015) that included women who identified as Latina indicated that Latinas were not at a reduced risk for experiencing IPV and, consequently, PTSD symptomatology. For example, in a study that included 105 Latinas, Fendovskiy et al. (2007) examined the relations between IPV, PTSD, and Major Depressive Disorder and found that regardless of the IPV type, Latina IPV survivors were three times more likely to meet criteria for a PTSD diagnosis than were Latinas who did not experience any type of IPV. More recently, Ulibarri et al. (2015), using a sample of 204 Latina sexual IPV survivors, found that sexual abuse experiences significantly predicted PTSD symptoms. The current study findings support the existing empirical literature and highlight that, similar to non-Latinas, the more IPV Latinas experience, the more likely they are to experience more PTSD symptoms.

While the findings from this study suggest that experiencing any type of IPV places Latinas at risk for PTSD, past research has also highlighted the importance of coping strategies and cultural norms as potential influential variables on PTSD

development (Griffing et al., 2006). Regardless of the type of abuse Latinas in the current study experienced, when they endorsed more disengaged coping strategies they were also more likely to experience increased PTSD symptomatology. Two types of coping strategies were examined, disengaged or engaged coping. The coping model outlined by Tobin et al. (1989) conceptualized coping as having three levels: primary, secondary, and tertiary. The tertiary level of coping was used to assess coping in this study, and items assessing problem and emotion focused coping strategies were combined to create two overarching coping strategies, Engagement and Disengagement. Disengaged coping included avoidant thoughts, behaviors, and emotions used to cope with stressors. In contrast, engaged coping reflected methods that help the individual connect with support systems and other proactive thoughts, behaviors, and feelings that help manage a stressful event. It has been posited that coping is situation-dependent and that the coping methods that are used have an adaptive purpose that will help the individual manage and regulate their thoughts, feelings, and/or behaviors (Folkman et al., 1986; Griffing et al., 2009). Coping strategies are especially important when discussing IPV in that survivors of IPV often have a tendency to use more disengaged coping strategies (Griffing et al., 2009; Eubanks, Fleming & Resick, 2015). Specifically, it has been theorized that it is adaptive for IPV survivors to use more disengaged coping strategies as this type of coping can help attenuate the painful and overwhelming emotional and physical experiences survivors endure (Iverson et al., 2013; Taft et al., 2007). The overuse of disengaged coping strategies, however, can be especially

problematic for abuse survivors because of its relation to PTSD (Fendovskiy et al., 2007) and re-victimization (Iverson et al., 2013).

The results from this current study add to previous findings related to the harmful relation between disengaged coping strategies and PTSD. Specifically, this study sheds light on the negative impact that disengaged coping strategies has on Latina college-aged IPV survivors' mental health. Previous literature suggests that when IPV survivors endorse more disengaged coping strategies, they are at higher risk of developing PTSD symptomatology (DePrince et al., 2006; Griffing et al., 2006). Researchers have also found that IPV survivors who use disengaged coping strategies reported more dissociative tendencies related to PTSD diagnostic criteria (DePrince et al, 2006; Filipas & Ullman, 2006; Taft et al., 2007). Furthermore, in their study of multi-ethnic women, Iverson et al. (2013) found that disengaged coping strategies were not only related to IPV but they also placed survivors at higher risk for re-victimization. Although disengaged coping and PTSD have been found to be consistently linked in the empirical literature, very few studies have included or focused on Latinas. For instance, because of their findings that highlighted the tendency for Latina IPV survivors compared to White IPV survivors to prefer disengaged type coping styles such as non-disclosure and avoidance, Romero et al. (1999) argued that it is important to explore these relations further.

Due to the adaptive and situation-dependent nature of coping strategies, many researchers (Brabeck & Guzman, 2009; Marrs Fuchsel, 2013; Wasti & Cortina, 2002) and theorists (Jung, 1995; Diaz-Guerrero, 1979; Lazarus & Folkman, 1984) have argued that culture plays a strong role in determining coping methods. To examine the relevance

of a Latino cultural value on the PTSD of IPV survivors, Marianismo was examined in the current study. Mariansimo refers to the gender-role norm for women in Latino culture. According to the beliefs outlined in Marianismo, women are tasked with keeping their families together at all costs, even to the detriment of their own physical and mental well-being (Castillo & Cano, 2007; Castillo et al., 2010). Women are often discouraged from discussing family matters outside of the family (Brabeck et al., 2008; Marrs Fuchsel, 2013). In addition, Latinas may be discouraged from disclosing sexual abuse because of the cultural gender-role expectation that women should not discuss sexual related topics (Castillo et al., 2010). This cultural belief (Marianismo) places great value on women being spiritual, virtuous, chaste, subordinate to others, and silent to maintain harmony (Castillo et al., 2010).

Although it was expected that Marianismo would moderate the relation between disengaged and engaged coping strategies and PTSD symptomatology, this expectation was not supported. When examining the main effects of Marianismo and engaged coping strategies, however, Marianismo, not engaged coping or the moderating variable, was a significant predictor of PTSD. This main effect for Marianismo points to the idea that disengaged coping strategies and the beliefs outlining Marianismo may be closely related. Indeed, the zero-order correlation between the two was very high (r = .93) suggesting they may be overlapping concepts. As a result, it is believed that a main effect was not found when examining Marianismo alongside disengaged coping strategies because of their overlapping relation and inability to account for unique portions of the variance in PTSD. Given the limited research that has focused on the cultural implications on IPV

and coping strategies, this study begins to shed light on the role of cultural beliefs on Latina survivors of IPV.

Similar to coping strategies, Mariansimo influences behaviors, thoughts, and emotional processes. Disengaged coping strategies center around avoidant behaviors that discourage seeking social support and discussing problems and promote avoiding feelings and thoughts related to the stressful/traumatic event. Juxtaposed to Latino culture, disengaged coping strategies mirror the beliefs that are promoted for Latinas. These cultural beliefs directly relate to the disengaged coping strategies that promote isolation and avoidance (Cano & Castillo, 2007; Castillo et al, 2010; Vidales, 2010). The beliefs outlined in Marianismo also parallel disengaged coping strategies in that individuals who endorse both of these concepts may be less inclined to seek social supports and to leave abusive relationships (Romero et al., 1999; Vidales, 2010). Furthermore, Marianismo may also place Latinas at a disadvantage for finding empowering support networks within their families and communities that might encourage them to seek help.

Although disengaged coping strategies was positively related to PTSD, engaged coping strategies did not predict PTSD. It is possible that the behaviors, thoughts, and emotions associated with engaged coping strategies are not encouraged in the Latino community, especially for Latinas who have experienced IPV. Endorsing engaged coping strategies requires women to seek social support and resources, discuss stressors, process feelings, and assert themselves. Many of these behaviors directly contradict the beliefs of Marianismo and consequently inhibit women from using coping strategies that may promote mental health. It should be noted, however, that previous research has not

reported a relation between engaged coping strategies and PTSD. Gibson and Leitenberg (2001) found that engaged coping strategies were not related to re-victimization in a sample of undergraduate female students with a history of sexual abuse. In addition, Merril et al. (2001), with a sample of female navy recruits, did not find an association between mental health, psychological functioning, and lower levels of engaged coping strategies. The results of the current study suggest that Latina college students' use of engaged coping strategies may not be encouraged by their community and family due to cultural gender-role norms. It is possible that disengaged coping strategies were viewed as more culturally appropriate even though this type of coping placed participants at higher risk of PTSD symptomatology.

Limitations and Future Directions

While results from this study provide useful information regarding the specific predictors of PTSD symptomatology for college-aged Latina IPV survivors, there are several limitations that should be noted. The current study did not assess level of IPV severity and its relation not only to PTSD but to other mental health consequences such as depression and anxiety. The questionnaires were administered in an on-line format with structured questionnaires that did not provide an opportunity for participants to elaborate on their experiences. Prospective studies that include mixed methods to gather quantitative and supportive qualitative data could increase understanding of the more entrenched cultural experiences Latina IPV survivors face. Furthermore, the coping strategy instruments that were used did not assess specific IPV-related experiences and asked participants in general regarding their coping styles to stressful events. Coping

styles are adaptive and situation-dependent; therefore, Latina IPV survivors may cope differently when confronted with IPV than when facing general life stressors.

Other methodological limitations of this study are that participants self-selected into the study and the sample only included undergraduate Latinas. These limitations affect the generalizability of the results to other populations. Finally, the financial incentive of winning a gift card may have attracted participants for whom this financial incentive was important. In consequence, the breadth in Latina income may not be well represented. Specifically, the current study had a large proportion of Latinas who reported having a low to lower-middle socioeconomic status.

Clinical Implications

Although the relations between IPV types, coping strategies, and PTSD symptomatology have been established in the literature, few studies have examined these relations using Latina samples. This study makes an important contribution to the knowledge base related to IPV among Latinas as it highlights the parallels between disengaged coping strategies and the cultural gender-role beliefs of Marianismo and their impact on PTSD, regardless of type of IPV experienced. The current findings inform not only therapy interventions but also psychologists' clinical conceptualizations when working with Latina IPV survivors. In this study, Latinas who experienced any type of physical, psychological, and/or sexual abuse were at a higher risk for PTSD symptomatology.

The findings in this study also revealed that disengaged coping strategies placed women at a higher risk of PTSD-related symptoms. These findings suggest that it is

important for psychologists to provide culturally sensitive treatments for Latinas experiencing PTSD. Therapists may face resistance among Latinas when attempting to use an evidenced-based treatment such as Prolonged Exposure due to the requirements of having to discuss in detail the nature of the trauma. Latinas may resist this type of treatment because of their cultural belief that women should not discuss issues related to the family/marriage and sexual topics including sexual abuse.

The current findings highlight the importance of assessing PTSD diagnostic criteria regardless of the IPV reported. In addition, these findings indicate that psychologists must take into account the cultural beliefs that dictate gender-role behaviors and the client's adherence to these gender roles beliefs. Due to the similarity between Marianismo and disengaged coping strategies, Latina women cope with abuse by using more avoidant-type coping methods that place them at risk of not seeking help and for developing PTSD symptomatology. Thus, it is imperative that psychologists provide culturally sensitive psychoeducation regarding IPV, PTSD, and the cultural influences on Latina's gender-role beliefs and subsequent coping methods when facing any type of IPV. By providing supportive environments, psychologists can help Latinas feel empowered to seek help and to discuss and process IPV experiences and symptoms related to abuse. Additionally, psychologists need to validate the negative pressure Latinas may encounter because of culturally based gender-role beliefs such as Marianismo. A challenge is to help Latina clients develop coping strategies that are culturally congruent and to provide support as they navigate the negative consequences of IPV. It is hoped that the findings from this study will help inform research that

investigates further the various ways in which Latina IPV survivors cope after experiencing abusive relationships, how these coping strategies may be influenced by cultural scripts, and their impact on mental health.

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APPENDIX A

IRB APPROVAL

EXEMPTION GRANTED

Sharon Kurpius
CLS - Counseling and Counseling Psychology
480/965-6104
sharon.kurpius@asu.edu

Dear Sharon Kurpius:

On 9/11/2015 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	The Role of Intimate Partner Violence, Coping Strategies, and Marianismo and the Development of PTSD for Latinas
Investigator:	Sharon Kurpius
IRB ID:	STUDY00003155
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• Torres Dissertation IRB application Revised, Category: IRB Protocol; • Recruitment email Revised, Category: Recruitment Materials; • Informed Consent for IRB REVISED , Category: Consent Form; • Dissertation Survey For IRB.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions);

The IRB determined that the protocol is considered exempt pursuant to Federal Regulations 45CFR46 (2) Tests, surveys, interviews, or observation on 9/11/2015.

In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,

APPENDIX B

INFORMED CONSENT LETTER

Informed Consent

TITLE OF RESEARCH PROJECT

The Role of Intimate Partner Violence, Coping Strategies, and Marianismo and the Development of PTSD for Latinas

INTRODUCTION

One purpose of this form is to provide you with information about the research project described below. In addition, the form provides information that may affect your decision whether or not to participate in the project. Those who agree to be involved in the project may do so by responding to the online questionnaire.

INVESTIGATORS

Dhannia Torres, M.A. and Sharon Robinson-Kurpius, Ph.D.

WHY AM I BEING INVITED TO TAKE PART IN A RESEARCH PROJECT?

If you are a Latina woman, 18 years-old or older, in a heterosexual relationship, we invite you to take part in this research project. Your participation will assist in better understanding how cultural gender roles, coping strategies, and intimate partner violence may contribute to the development of Posttraumatic symptoms.

WHY IS THIS RESEARCH BEING DONE?

Understanding cultural gender roles and cultural factors of diverse groups may be helpful in informing intervention and prevention efforts. Few research projects have focused on how culturally bound gender roles and coping strategies contribute to the development of Posttraumatic Stress Disorder for Latina women with a history of intimate partner violence. This research aims to expand on our understanding of how the development of posttraumatic symptoms may be uniquely shaped by different types of intimate partner violence (e.g., physical, sexual, and emotional abuse), coping strategies endorsed, and cultural gender roles in order to inform the development of culturally appropriate intervention and prevention efforts tailored to this specific population.

HOW MANY PEOPLE WILL PARTICIPATE IN THIS STUDY?

We expect about 120 women will participate in this research project.

WHAT HAPPENS IF I SAY "YES, I WANT TO BE IN THIS RESEARCH"?

If you decide to participate in this research project, your participation will involve responding to an online questionnaire. We expect that individuals will spend approximately 15-30 minutes responding to the online questionnaire.

WHAT HAPPENS IF I SAY "YES," BUT I CHANGE MY MIND LATER?

You can choose to withdraw your participation in the research at any time and may do so by discontinuing your responses to the online questionnaire. There is no penalty for changing your mind or discontinuing your participation.

RISKS AND DISCOMFORT

There are no foreseeable risks however, if you decide to participate, you may experience some emotional discomfort while going through the online questionnaire.

WILL BEING IN THIS STUDY HELP ME IN ANY WAY?

Although there may be no direct benefits to you, the possible benefits of your participation in the study are that the information that gained from this research may help improve prevention and intervention programs geared for Latina women. We cannot guarantee that you will receive any specific benefits from this study.

WHAT HAPPENS TO THE INFORMATION COLLECTED FOR THE RESEARCH?

Information obtained in this study is strictly confidential. You will not be asked to provide any identifying information. You will only be asked to provide demographic information such as age, ethnicity, and relationship status. The results of the research project may appear in publications or presentations, but no link will be made to any personally identifying information. In order to keep your responses confidential, Sharon Robinson-Kurpius, Ph.D. will keep all project records in locked files. Only the research project staff will have access to these files. Precautions will be taken to ensure the protection of the privacy of each research participant. All participants will be assigned a participant code and will not be asked to provide their name. Project records will be secured in the Counseling and Counseling Psychology Program at Arizona State University until January 2017, at which point they will be destroyed.

PAYMENT

There is no cost to you for your participation in this research project. These researchers would like your decision to participate in the project to be absolutely voluntary. Yet, they recognize that your participation may pose some inconvenience. You may choose to provide your e-mail address if you wish to enter a drawing for the opportunity to win one of eight $25 amazon.com gift cards. If you choose to provide your e-mail address, researchers will keep your e-mail address until the drawing is held. The researchers will contact the winner and delete the e-mail addresses that participated in the drawing.

WHO CAN I TALK TO?

If you have any questions or concerns please contact: Dhannia Torres, M.A. at Dhannia.torres@asu.edu or Sharon Robinson-Kurpius, PhD at sharon.kurpius@asu.edu. This research has been reviewed and approved by the Social Behavioral IRB (00003155). You may talk to them at (480) 965-6788 or by email at research.integrity@asu.edu.

APPENDIX C

DEMOGRAPHIC SHEET

DEMOGRAPHIC SHEET

1. Please list your age? _____
2. Please select your gender?
    a. Male
    b. Female
    c. Other
3. Would you describe yourself as Hispanic, Latina, or Chicana?
    a. Yes
    b. No
4. If you would not describe yourself as Hispanic, Latina, or Chicana what would you describe yourself as? _____

5. I was born in the United States of America
    a. Yes
    b. No
6. If not born in the United States of America, what country were you born in?_____
7. Number of years of education (High school = 12; One year of college = 13; etc.) _____
8. How would you describe your household's current income level?
    a. Lower income
    b. Lower/middle income
    c. Middle income
    d. Upper/middle income
9. What option best describes your current relationship status?
    a. Single
    b. In a relationship, not living together
    c. In a relationship, living with romantic partner
    d. Married
    e. Previously married; now separated
    f. Previously married; now divorced
    g. Other (Please specify)
10. If currently in a relationship, how long have you been in the relationship? _____
11. What are your religious/spiritual affiliations?
    a. Christianity
    b. Judaism
    c. Islam
    d. Buddhism
    e. None
    f. Other (please specify) _____

12. How often do you attend religious services?
    a. I do not attend
    b. On religious holidays
    c. About once per month
    d. About 2 times per month
    e. Once per week
    f. More than once per week
13. How strong are your religious/spiritual beliefs?
    a. 0= Not Strong at all
    b. 1= A little
    c. 2= Somewhat strong
    d. 3= Neutral
    e. 4= Very Strong
    f. 5= Extremely strong
14. How much has your faith helped you cope with your problems?
    a. 0 = Not all important
    b. 1= A little important
    c. 2= Somewhat important
    d. 3= Neutral
    e. 4 = Very Important
    f. 5 = Extremely Important
15. (0-5; Not at all important – Extremely important)

APPENDIX D

CONFLICT TACTICS SCALE 2

No matter how well a couples gets along, there are times when they disagree, get annoyed with one another, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or are upset for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. These questions will be about you and others are about your partner. Please circle the response that describes how many times these things happened in the past year. If one of these things did not happen in the past year, but it happened before that check "7

1= Once
2 = Twice
3 = 3-5 times
4 = 6-10 times
5 = 11-25 times
6 = More than 20 times
7 = Not in the past year but it did happen before
8 = Never

How often did this happen in the past year?

1.	**My partner insulted or swore at me.**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
2.	**My partner threw something at me that could hurt.**	1	2	3	4	5	6	7	8
3.	**My partner twisted my arm or hair.**	1	2	3	4	5	6	7	8
4.	**I had a sprain, bruise, or small cut because of a fight with my partner.**	1	2	3	4	5	6	7	8
5.	**My partner made me have sex without a condom.**	1	2	3	4	5	6	7	8
6.	**My partner pushed or**	1	2	3	4	5	6	7	8

	shoved me.								
7.	**My partner used force to make me have oral or anal sex.**	1	2	3	4	5	6	7	8
8.	**My partner used a knife or gun on me.**	1	2	3	4	5	6	7	8
9.	**I passed out from being hit on the head by being in a fight.**	1	2	3	4	5	6	7	8
10.	**My partner called me fat or ugly.**	1	2	3	4	5	6	7	8
11.	**My partner punched or hit me with something that could hurt.**	1	2	3	4	5	6	7	8
12.	**My partner destroyed something belonging to me.**	1	2	3	4	5	6	7	8
13.	**I went to a doctor because of a fight with my partner.**	1	2	3	4	5	6	7	8
14.	**My partner choked me.**	1	2	3	4	5	6	7	8
15.	**My partner shouted or yelled at me.**	1	2	3	4	5	6	7	8
16.	**My partner slammed me against a wall.**	1	2	3	4	5	6	7	8
17.	**I needed to**	1	2	3	4	5	6	7	8

see a doctor because of a fight with my partner, but I didn't.								
18. My partner beat me up.	1	2	3	4	5	6	7	8
19. My partner grabbed me.	1	2	3	4	5	6	7	8
20. My partner used force to make me have sex.	1	2	3	4	5	6	7	8
21. My partner stomped out of the room or house or yard during a disagreement.	1	2	3	4	5	6	7	8
22. My partner insisted that I have sex when I didn't want to (but didn't use physical force).	1	2	3	4	5	6	7	8
23. My partner slapped me.	1	2	3	4	5	6	7	8
24. I had a broken bone from a fight with my partner.	1	2	3	4	5	6	7	8
25. My partner used threats to make me have oral or anal sex.	1	2	3	4	5	6	7	8
26. My partner burned or scalded me on purpose.	1	2	3	4	5	6	7	8
27. My partner	1	2	3	4	5	6	7	8

insisted I have oral or anal sex (but did not use physical force).								
28. My partner accused me of being a lousy lover.	1	2	3	4	5	6	7	8
29. My partner did something to spite me.	1	2	3	4	5	6	7	8
30. My partner threatened to hit or throw something at me.	1	2	3	4	5	6	7	8
31. I felt physical pain that still hurt the next day because of a fight with my partner.	1	2	3	4	5	6	7	8
32. My partner kicked me.	1	2	3	4	5	6	7	8
33. My partner used threats to make have sex.	1	2	3	4	5	6	7	8

APPENDIX E

PTSD CHECKLIST

After experiencing some of the relationship events listed above a lot of times people have reported problems and complaints in response to these stressful relationship experiences. Below is a list of these common problems or complaints. On a scale of 1 to 5, how much you have been bothered by each problem ***IN THE PAST MONTH.***

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	"Repeated, disturbing memories, thoughts, or images of the stressful experience?"	1	2	3	4	5
2.	"Repeated, disturbing dreams of the stressful experience?"	1	2	3	4	5
3.	"Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?"	1	2	3	4	5
4.	"Feeling very upset when something reminded you of the stressful experience?"	1	2	3	4	5
5.	"Having physical reactions (e.g., heart pounding, trouble, breathing, sweating) when something reminded you of the stressful experience?"	1	2	3	4	5
6.	"Avoiding thinking about or talking about the stressful experience or avoiding having feeling related to it?"	1	2	3	4	5
7.	"Avoiding activities or situations because they reminded you of the stressful experience?"	1	2	3	4	5
8.	"Trouble remembering important parts of the stressful experience?"	1	2	3	4	5
9.	" Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10.	"Feeling distant or cut off from other people?"	1	2	3	4	5

11.	"Feeling emotionally numb or being unable to have loving feelings for those close to you?"	1	2	3	4	5
12.	"Feeling as if your future will somehow be cut short?"	1	2	3	4	5
13.	"Trouble falling or staying asleep?"	1	2	3	4	5
14.	"Feeling irritable or having angry outbursts?	1	2	3	4	5
15.	"Having difficulty concentrating?"	1	2	3	4	5
16.	"Being super alert or watchful or on guard?"	1	2	3	4	5
17.	"Feeling jumpy or easily startled?"	1	2	3	4	5

18. Overall, for how long would you say you've experienced these symptoms:___

APPENDIX F

COPING STRATEGIES INVENTORY

The purpose of this questionnaire is to find out the kinds of situations that trouble people in their day-to-day lives and how people deal with them. Take a few moments and think about an event or situation that has been very stressful for you during the last month. By stressful we mean a situation that was troubling you, either because it made you feel bad or because it took effort to deal with it. It might have been with your family, with school, with your job, or with your friends. Once again, take a few minutes to think about your chosen event. As you read through the following items please answer them based on how you handled your event. Please read each item below and determine the extent to which you used it in handling your chosen event.

a. 1 = Not at all
b. 2= A Little
c. 3= Somewhat
d. 4 = Much
e. 5 = Very much

1. I just concentrated on what I had to do next; the next step.	**1**	**2**	**3**	**4**	**5**
2. I tried to get a new angle on the situation.	1	2	3	4	5
3. I found ways to blow off steam.	1	2	3	4	5
4. I accepted sympathy and understanding from someone.	1	2	3	4	5
5. I slept more than usual.	1	2	3	4	5
6. I hoped the problem would take care of itself.	1	2	3	4	5
7. I told myself that if I wasn't so careless, things like this wouldn't happen.	1	2	3	4	5
8. I tried to keep my feelings to myself.	1	2	3	4	5
9. I changed something so that things would turn out all right.	1	2	3	4	5

10. I looked for the silver lining, so to speak; tried to look on the bright side of things.	1	2	3	4	5
11. I did some things to get it out of my system.	1	2	3	4	5
12. I found somebody who was a good listener.	1	2	3	4	5
13. I went along as if nothing were happening.	1	2	3	4	5
14. I hoped a miracle would happen.	1	2	3	4	5
15. I realized that I brought the problem on myself.	1	2	3	4	5
16. I spent more time alone.	1	2	3	4	5
17. I stood my ground and fought for what I wanted.	1	2	3	4	5
18. I told myself things that helped me feel better.	1	2	3	4	5
19. I let my emotions go.	1	2	3	4	5
20. I talked to someone about how I was feeling.	1	2	3	4	5
21. I tried to forget the whole thing.	1	2	3	4	5
22. I wished that I never let myself get involved with that situation.	1	2	3	4	5
23. I blamed myself.	1	2	3	4	5
24. I avoided my family and friends.	1	2	3	4	5
25. I made a plan of action and followed it.	1	2	3	4	5

26. I looked at things in a different light and tried to make the best of what was available.	1	2	3	4	5
27. I let out my feelings to reduce the stress.	1	2	3	4	5
28. I just spent more time with people I liked.	1	2	3	4	5
29. I didn't let it get to me; I refused to think about it too much.	1	2	3	4	5
30. I wished that the situation would go away or somehow be over with.	1	2	3	4	5
31. I criticized myself for what happened.	1	2	3	4	5
32. I avoided being with people.	1	2	3	4	5
33. I tackled the problem head-on.	1	2	3	4	5
34. I asked myself what was really important, and discovered that things weren't so bad after all.	1	2	3	4	5
35. I let my feelings out somehow.	1	2	3	4	5
36. I talked to someone that I was very close to.	1	2	3	4	5
37. I decided that it was really someone else's problem and not mine.	1	2	3	4	5
38. I wished that the situation had never started.	1	2	3	4	5
39. Since what	1	2	3	4	5

happened was my fault, I really chewed myself out.					
40. I didn't talk to other people about the problem.	1	2	3	4	5
41. I knew what had to be done, so I doubled my efforts and tried harder to make things work.	1	2	3	4	5
42. I convinced myself that things aren't quite as bad as they seem.	1	2	3	4	5
43. I let my emotions out.	1	2	3	4	5
44. I let my friends help out.	1	2	3	4	5
45. I avoided the person who was causing the trouble.	1	2	3	4	5
46. I had fantasies or wishes about how things might turn out.	1	2	3	4	5
47. I realized that I was personally responsible for my difficulties and really lectured myself.	1	2	3	4	5
48. I spent some time by myself.	1	2	3	4	5
49. It was a tricky problem, so 1 had to work around the edges to make things come out OK.	1	2	3	4	5
50. I stepped back from the situation and put things	1	2	3	4	5

into perspective.					
51. My feelings were overwhelming and they just exploded.	1	2	3	4	5
52. I asked a friend or relative I respect for advice.	1	2	3	4	5
53. I made light of the situation and refused to get too serious about it.	1	2	3	4	5
54. I hoped that if I waited long enough, things would turn out OK.	1	2	3	4	5
55. I kicked myself for letting this happen.	1	2	3	4	5
56. I kept my thoughts and feelings to myself.	1	2	3	4	5
57. I worked on solving the problems in the situation.	1	2	3	4	5
58. I reorganized the way I looked at the situation, so things didn't look so bad.	1	2	3	4	5
59. I got in touch with my feelings and just let them go.	1	2	3	4	5
60. I spent some time with my friends.	1	2	3	4	5
61. Every time I thought about it I got upset; so I just stopped thinking about it.	1	2	3	4	5
62. I wished I could have changed what happened.	1	2	3	4	5

63. It was my mistake and I needed to suffer the consequences.	1	2	3	4	5
64. I didn't let my family and friends know what was going on.	1	2	3	4	5
65. I struggled to resolve the problem.	1	2	3	4	5
66. I went over the problem again and again in my mind and finally saw things in a different light.	1	2	3	4	5
67. I was angry and really blew up.	1	2	3	4	5
68. I talked to someone who was in a similar situation.	1	2	3	4	5
69. I avoided thinking or doing anything about the situation.	1	2	3	4	5
70. I thought about fantastic or unreal things that made me feel better.	1	2	3	4	5
71. I told myself how stupid I was.	1	2	3	4	5
72. I did not let others know how I was feeling.	1	2	3	4	5

APPENDIX G

MARIANISMO BELIEF SCALE

*The statements below represent some of the different expectations for Latinas. For each statement please mark the answer that best describes what you **believe** rather than what you were taught or actually practice.*

A Latina…

	Strongly Disagree	Disagree	Agree	Strongly Agree
must be source of strength for her family.	1	2	3	4
is considered the main source of strength of her family	1	2	3	4
mother must keep the family unified.	1	2	3	4
Should teach her children to be loyal to the family.	1	2	3	4
Should do things that make her family happy.	1	2	3	4
Should (should have) remain(ed) a virgin until marriage.	1	2	3	4
Should wait until after marriage to have children.	1	2	3	4
Should be pure.	1	2	3	4
Should adopt the values taught by her religion.	1	2	3	4
Should be faithful to her partner.	1	2	3	4

Should satisfy her partner's sexual needs without argument.	1	2	3	4
Should not speak out against men.	1	2	3	4
Should respect men's opinions even when she does not agree.	1	2	3	4
Should avoid saying no to people.	1	2	3	4
Should do anything a family in the family asks her to do.	1	2	3	4
Should not discuss birth control.	1	2	3	4
Should not express her needs to her partner.	1	2	3	4
Should feel guilty about telling people what she needs.	1	2	3	4
Should not talk about sex.	1	2	3	4
Should be forgiving in all aspects.	1	2	3	4
Should always be agreeable to men's decisions.	1	2	3	4
Should be the spiritual leader of the family.	1	2	3	4
Is responsible for taking	1	2	3	4

family to religious services.				
is responsible for the spiritual growth of the family.	1	2	3	4

105