MEXICAN AMERICAN CULTURAL VALUES AS PROTECTIVE FACTORS AGAINST PSYCHOPATHOLOGICAL SYMPTOMS AFTER CHILDHOOD TRAUMA

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Master of Arts

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by

Mayra B. Ramos

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DEDICATION

Quiero darles las gracias a mis padres por haberme apoyado y haberme dado la inspiración de seguir mis metas, a pesar de las dificultades. Son mi roca y mi motivación para seguir adelante. Este logro no hubiera sido posible sin sus palabras de animo y amor. Los quiero mucho.

I would like to thank my thesis advisor, Dr. Hillary Langley, who not only provided guidance throughout the development, creation, and completion of my thesis, but provided much needed emotional support throughout the process. Thank you for always challenging me and providing insight to all my naive questions and concerns. I have greatly appreciated not only our mentor-mentee relationship, but the friendship we have developed throughout our time together.

I want to give a special thank you to my cohort, who were always able to cheer me up in moments where I felt like giving up and breaking down. I will forever hold our memorable moments together with genuine happiness. Graduate school was bearable because of you all.

ABSTRACT

Ramos, Mayra B., *Mexican American Cultural Values as Protective Factors Against Psychopathological Symptoms After Childhood Trauma*. Master of Arts (Clinical Psychology), May, 2020, Sam Houston State University, Huntsville, Texas.

Previous research has addressed the association between childhood trauma and psychopathology, but few studies have assessed potential cultural protective factors in a Hispanic population regarding the development of psychopathological symptoms after experiencing childhood trauma. The current study's primary aim is to identify Mexican American cultural values that serve as protective factors against psychopathological symptoms after experiencing childhood trauma in a sample of young-adult Hispanics. We hypothesize that Mexican American cultural values (MACV) will moderate the link between childhood trauma and psychopathological symptoms, such that as MACV increase, the association between childhood trauma and psychopathological symptoms will decrease. The second aim of this study is to explore levels of acculturation that could potentially serve as a buffer or a catalyst for developing psychopathological symptoms in the Hispanic community after experiencing childhood trauma. Assessing for this will provide important information about how acculturation impacts levels of psychopathology in young adults who experienced childhood trauma. Findings from this study may give us a better understanding of the impact cultural values can have on mental health, specifically in regard to childhood trauma and psychopathological symptoms. Embracing and promoting cultural values in the Mexican American community could potentially serve as a more effective and beneficial way of fostering resilience and coping skills against the development of psychopathological symptoms.

KEY WORDS: Childhood trauma, Psychopathological symptoms, Mexican American cultural values, Acculturation

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CHAPTER I

Introduction

According to the U.S. Census Bureau (2018), as of 2016, an estimated 57.5 million of the United States population was Hispanic, making Hispanics the largest minority group in the country. The National Institute of Mental Health (NIMH; 2019) reported about one in five U.S. adults live with a mental illness (46.6 million in 2017). Furthermore, Hispanics/Latinx (gender-neutral or nonbinary alternative to Latino or Latina) account for 15.2% of adults living with a mental illness (NIMH, 2019). As this minority group continues to grow, we can assume that the prevalence rates of mental disorders will grow along with it, thus it is important to address mental health issues that may arise in this population early on before those numbers increase. One particular group that would benefit from addressing the potential increase in mental health problems in the Hispanic community would be individuals who have suffered from childhood trauma. Unfortunately, there has been relatively little research looking at potential factors that can serve as a buffer between experiences of overall childhood trauma and psychopathological symptomology in a Mexican American population. Given the fact that Hispanics make up about 25% of the child population in America (The Annie E. Casey Foundation, 2018), it is important to see how these effects can be buffered in the Mexican American community.

Childhood trauma can be categorized into several different types. It can range from experiencing maltreatment (i.e., domestic violence, physical abuse, neglect, emotional abuse, bullying, or sexual abuse), experiencing other interpersonal violence (i.e., community violence, witnessing a friend or family member being murdered), experiencing non-interpersonal violence (i.e., natural disasters, medical trauma, or

refugee trauma), to experiencing other traumas (i.e., any stressful life event or experience that was not covered in the previous categories, such as traumatic grief, divorce or familial disruption, witnessing a suicide, etc.; National Child Traumatic Stress Network, 2018). According to the Substance Abuse and Mental Health Services Administration (2015), by the age of 16, more than two thirds of children reported experiencing at least one traumatic event, and as of 2016, there were an estimated 74 million children in the United States (Child Trends, 2018). From the previous information, we can infer that 49 million children could have potentially already experienced a traumatic event in their lives. Being aware of the detrimental effects that trauma can have on the development of an individual is an important aspect to consider when looking at children who have been exposed to trauma.

Childhood Trauma and Psychopathology

Several studies have found evidence to support the theory that different types and amount of trauma leads to differing types and levels of internalizing symptoms, such as depression, anxiety, and posttraumatic stress disorder (PTSD) symptoms (Agorastos et al., 2014; Dunn et al., 2017; Hovens et al., 2010; Mandelli et al., 2015; Wang et al., 2018; Ying et al., 2014). In their study, Dunn, Nishimi, Powers, and Bradley (2017) looked at 2,892 African-American adults who experienced different types of initial trauma during different developmental stages of their childhood, classified as early childhood (ages 0-5), middle childhood (ages 6-10), adolescence (ages 11-18), and adulthood (ages 19+). They found that regardless of the first type of trauma or the age at which the trauma occurred, individuals who experienced childhood trauma had higher depressive and PTSD symptoms in comparison to individuals who had not been exposed to trauma.

Some limitations to this study included the fact that their sample was composed of African-American females who were low income, so generalizability is limited (Dunn et al., 2017). In 2014, Agorastos and colleagues looked at types of trauma and how the number of different types of trauma a person experienced could lead to internalizing symptoms. They found that for PTSD, a history of multiple childhood trauma types increased the likelihood of PTSD symptomology, but for depression, the risk of developing depressive symptoms was the same for individuals who had experienced one or multiple types of childhood trauma (Agorastos et al., 2014). Hovens and colleagues (2010) looked at 1,931 adults from the Netherlands and found that childhood trauma was related to anxiety disorders. Furthermore, they established that the higher the trauma score, the stronger the association was with psychopathology (Hovens et al., 2010), thus not only can childhood trauma affect adolescents' likelihood of developing psychopathology, but the effects can also carry on into adulthood.

Additionally, there have also been studies that look at how childhood trauma can impact the development of externalizing symptoms. In a recent study, Carliner, Gary, McLaughlin, and Keyes (2017) reported that childhood trauma was associated with the development of externalizing disorders in adolescents. Utilizing a sample of 6,379 adolescents, they found that adolescents with a prior history of trauma were more likely to develop externalizing disorders in comparison to those who had not experienced trauma, such as substance abuse disorder and conduct disorder (Carliner et al., 2017). These findings indicate that childhood trauma is predictive of the development of externalizing disorders, which can ultimately hinder a child's social skills and ability to function in society. Looking into both externalizing and internalizing symptoms, Manly,

Kim, Rogosch, and Cicchetti (2001) looked at a large sample of maltreated children with well-documented information regarding the type of maltreatment they experienced and found that maltreated children displayed more behavior problems and were more aggressive, more withdrawn, and less cooperative than non-maltreated children. These studies emphasize the life-long impact that childhood trauma can have on an individual.

Mexican American Cultural Values

In the Hispanic/Latinx mental health literature, there have been studies looking at how cultural values can potentially serve as a safeguard against mental health problems. Corona et al. (2017), for example, found that cultural values, such as *familismo* (familism; a Mexican American cultural value that emphasizes the importance of family unity and interdependency), *respeto* (respect; a Mexican American cultural value that emphasizes maintaining respect for your elders and courtesy in interpersonal relationships), and *religiosidad* (religiosity; an individual's strong religious belief or feeling) buffered the impact of cultural stressors (i.e., acculturative stress and discrimination) on mental health symptoms (i.e., anxiety, depression, and stress) in a sample of 198 Latinx college students living in the U.S.

In regard to *familismo*, specifically, there have been several studies showing empirical support of its high protective value in Hispanic communities against mental health problems (Garza and Petite, 2016; Zeiders, et al., 2013; Smokowski, Rose, and Bacallao, 2010). One study in particular found that it was the highest predictor of levels of resilience among Mexican American college students (Morgan Consoli & Llamas, 2013). In their meta-analysis, however, Valdivieso-Mora, Peet, Garnier-Villarreal, Salazar-Villanea, and Johnson (2016) found small effect sizes in the relationship between

familism and depression, suicide, and internalizing behaviors. Additionally, they found no significant effects for substance abuse and externalizing behaviors. Thus, further investigation on whether or not familism serves as a protective factor is warranted. In summary, finding evidence to support how Mexican American cultural values, specifically familism and religiosity, could potentially moderate the relationship between childhood trauma and the development of psychopathological symptoms would be an important contribution within this literature, as not a lot of research has been conducted to address this particular question.

The Acculturation Model

As new generations of Mexican Americans continue to adapt to their environment, it is understandable that some may not maintain or practice their cultural values as they acculturate. Acculturation can be defined as when an individual comes into constant contact with another culture and subsequently decides to incorporate or reject aspects from either their own or both cultural groups into their own personal worldview (Berry, 1997). Berry (1997) proposed a model of acculturation to explain how people from different ethnic/cultural backgrounds adapt to new cultures that are considered a majority. In his model, two dimensions are offered to be important when assessing an individual's perception of culture. The two dimensions are measured by asking the following questions: how important is it to preserve one's connection with their original culture, and how important is it to preserve relationships with the majority group (Berry, 1997)? By answering these questions, individuals can be classified as integrated (i.e., high in heritage culture and also high identification with majority culture), assimilated (i.e., low in heritage culture, but high in identification with majority

culture), marginalized (i.e., low in heritage culture and low in identification with majority culture), or separated (i.e., high on heritage culture, but low in identification with majority culture) when faced with the process of acculturation (Figure 1).

In regard to studies looking at how acculturation can serve as a protective factor against the development of mental health problems, relatively little research has been done on the case, specifically within the Hispanic/Latinx population. Berry, Phinney, Sam, and Vedder (2006) found that immigrant youths who integrated (maintained their cultural heritage as well as adopted the majority culture) into society had the highest levels of psychological health (personal well-being/good mental health) and sociocultural adaptations (an individual's ability to manage their daily life in an intercultural environment). However, in a more recent study looking at migrant youth from six different countries (Australia, Canada, China, New Zealand, South Africa, and United Kingdom), Wu et al. (2018) found that acculturation had no significant direct effects on mental health, but, in comparison to their integrated counterparts, assimilated-oriented youths exhibit lower levels of resilience, resulting in poorer mental health. In a meta-analysis looking at acculturation and alcohol use in Asian Americans, Lui and Zamboanga (2018) found that alcohol use was positively associated with acculturation, but negatively associated with enculturation (orientation towards Asian heritage). The role of acculturation in regard to the potential development of mental health problems remains unclear. Furthermore, with relatively little research available to see how this variable comes in to play on the subject of childhood trauma and the development of

psychopathological symptoms, exploration is warranted to fill this gap in the literature, specifically within the Hispanic community.

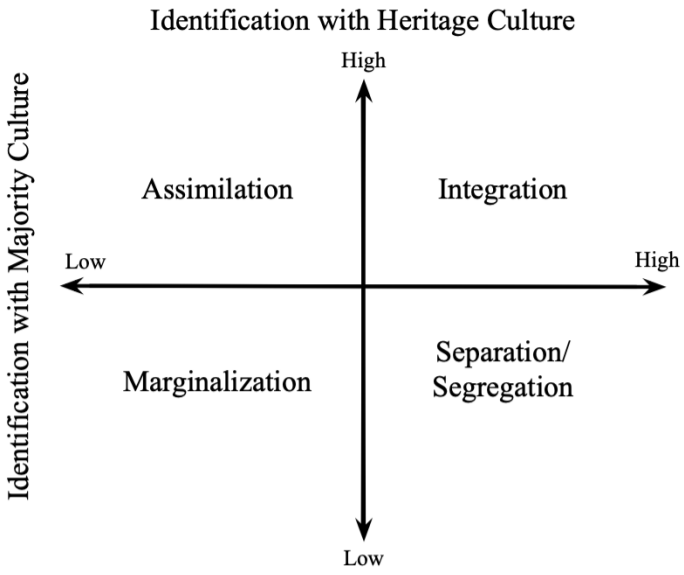

Figure 1. *The Acculturation Model.*

The Present Study

The primary aim of the current study is to identify Mexican American cultural values (e.g., familism and religiosity) that can serve as protective factors against psychopathological symptoms (i.e., somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) after experiencing childhood trauma (i.e., child maltreatment, other interpersonal violence, non-interpersonal violence, and other trauma). Previous research has looked at the link between childhood trauma and psychopathology (Dunn et al., 2017; Hovens et al., 2010; Carliner et al., 2017), as well as Mexican American cultural values and their implications for resilience and risk-reducing behavior (Corona et al., 2017; Morgan Consoli & Llamas, 2013; Castro, Stein, & Bentler, 2009; Guilamo-Ramos, 2009); thus, one primary purpose of this study is to bridge these two areas of literature and extend the research in order to determine the potential moderating effect of Mexican

American cultural values on the relationship between childhood trauma and psychopathological symptoms. It is hypothesized that Mexican American cultural values (MACV) – particularly familism and religiosity – will moderate the link between childhood trauma and psychopathological symptoms, such that as MACVs increase, the association between childhood trauma and psychopathological symptoms will decrease (Figure 2).

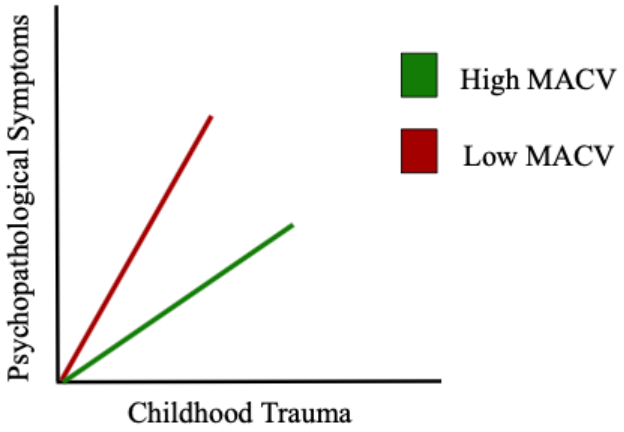

Figure 2. *Hypothesized Moderation Effect of MACVs on Psychopathological Symptoms After Experiencing Childhood Trauma.*

The second aim of this study is to explore whether or not acculturation will moderate the association between childhood trauma and psychopathological symptoms. This part of the study will solely be exploratory in nature, as the literature on this topic has been mixed and unclear, specifically regarding the Mexican American population. Assessing how levels of acculturation differentially impact the development of psychopathological symptoms after childhood trauma is an important factor to consider, as it could potentially influence the way researchers and clinicians look at this population in terms of treatment development and management. Although this exploratory aim will not provide definitive answers to this question, assessing for this will hopefully provide

support or opposition to what has been stated in previous literature regarding acculturation levels overall.

In the end, the overarching goal of the current study is to provide a better understanding of what factors could potentially serve as a buffer against the adverse psychological effects of childhood trauma. Overall, these results may provide insight regarding how to approach mental illness in the Mexican American population and to what extent using cultural values can serve as protective factors against the development of psychopathology. Embracing and promoting cultural values in the Mexican American community could potentially serve as a more cost-effective and beneficial way of counteracting the development of psychopathological symptoms after experiencing childhood trauma.

CHAPTER II

Method

Participants

Individuals who identified as being 18 years or older and an undergraduate student at Sam Houston State University were eligible to participate in the study. Five hundred and twenty-five participants initiated the online survey; however, two participants refused to consent and were automatically redirected to the end of the survey. Fourteen participants completed less than 100% of the survey and 34 participants failed two or more validity items and were therefore removed from the data set, leaving us with a final sample of 475 participants. Three hundred and ninety-eight participants identified as female (83.8%), 76 participants identified as male (16.0%), and one participant identified as a transgender male (0.2%). The average age in the sample was 20.40 years (*SD* = 4.03). Four hundred and thirty-six participants identified as single, never married (91.8%), 33 participants identified as being married (6.9%), with the remaining 6 participants reporting being divorced, separated, or refusing to answer (1, 1, 4 participants respectively). Two hundred and five participants identified as White/Caucasian (43.2%), 131 participants identified as Hispanic or Latinx (27.6%), 93 participants identified as Black or African American (19.6%), 32 participants identified as Mixed race (6.7%), 13 participants identified as Asian (2.7%), and one participant identified as American Indian or Alaskan Native (0.2%).

In terms of length in the U.S., the average years lived in the U.S. was 19.86 years (*SD* = 4.70), with 15 individuals refusing to answer. Regarding the participants who identified as Hispanic or Latinx, only 74 participants identified their country of origin as

Mexico (15.6%). Thirty-three participants identified as first generation immigrants (born in the country of origin, but immigrated to the U.S.; 6.9%) and 97 participants identified as second generation immigrants (born in the U.S., but parents immigrated from country of origin; 20.4%), 9 participants refused to answer, and the remaining 336 participants marked did not apply. As for religion, 252 participants identified as Christian/Protestant (53.1%), 94 participants identified as Catholic (19.8%), 72 individuals identified as having no religion (15.2%), with the remaining 57 participants identifying as other religion classifications (Agnostic, Atheist, Buddhist, Mormon, Muslim, or Other) or refusing to answer.

Procedure

Participants were recruited through Sam Houston State University's (SHSU) Psychology Experimental Research Participation (PeRP) program. Only participants who identified as 18 years or older were eligible to participate in the study. Once informed consent was obtained, all participants submitted the one-time online survey, which included a series of questionnaires regarding demographics, childhood trauma, psychopathological symptoms, cultural values, and acculturation. Individuals who identified as Mexican American completed the original scale of the Acculturation Rating Scale for Mexican Americans-II: English Version (ARSMA-II), which assesses for levels of acculturation. All other participants received an adapted version of this scale. Individuals had an hour and a half to complete the questionnaires. Participants had the option to decline to answer any question(s) they did not want to answer, as some questions were sensitive in nature. All participants who completed the survey were awarded either course credit or extra credit. Additionally, a final item was included at the

end of the survey in order to verify that participants were aware of the complimentary counseling services provided by SHSU.

Measures

Demographics. A demographic questionnaire was included at the beginning of the survey. The questionnaire inquired about the participants' age, sex, ethnicity/race, immigration generation, time in United States, religious affiliation, marital status, and parental education level. Age was measured in an open-ended format.

Childhood Trauma. The Trauma History Questionnaire (THQ; Green, 1996) is a self-report questionnaire that assesses different types of trauma, as well as the number of times each reported type of trauma has occurred and approximate age at which each occurred. Traumatic events are separated into three different categories, which include crime-related events (4 items), general disaster and trauma (13 items), and unwanted physical and sexual experiences (7 items) for an overall total of 24 items. In previous research, the test-retest reliability alpha coefficient has been reported to be high (0.70) for items recorded across administrations (Hooper, Stockton, Krupnick, & Green, 2011). In the current study, the number of items endorsed were totaled for an overall score, where a higher overall score reflects a greater number of types of traumatic events experienced. The Cronbach's alpha for this study was 0.70, which suggests an adequate score for internal consistency of the items in the survey.

Psychopathology. The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983) is a 53-item self-report questionnaire that was designed to measure symptoms of psychopathology and has been utilized in clinical settings for rapid assessment purposes. The instrument has been tested for reliability, validity, and utility in over 400 research

studies (Pearson, 2019). The items are rated on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*extremely*; Derogatis & Melisaratos, 1983). Due to a technical error, however, the scale that was provided in the survey was a 4-point Likert scale, with the middle option "Moderately" being omitted. The BSI measures nine different primary dimensions of psychopathological symptoms, which include somatization (SOM), obsessive-compulsive (O-C), interpersonal sensitivity (I-S), depression (DEP), anxiety (ANX), hostility (HOS), phobic anxiety (PHOB), paranoid ideation (PAR), and psychoticism (PSY). These dimensions fall under three global indices of distress, which include the General Severity Index (GSI; measures the overall current distress level); the Positive Symptom Distress Index (PSDI; assesses the intensity of the distress); and the Positive Symptom Total (PST; totals the symptoms the patient is experiencing to any degree; Derogatis & Melisaratos, 1983). In previous research, the internal consistency reliability alpha coefficients have ranged from 0.71 (psychoticism dimension) to 0.85 (depression), and the test-retest reliability alpha coefficients have ranged from 0.68 (somatization) to 0.91 (phobic anxiety), with the GSI stability coefficient being 0.90, which Derogatis & Melisaratos (1983) argues is a strong indicator of reliability. The Cronbach's alpha for this study was 0.97, which suggests this survey has a very high level of internal consistency. For the purpose of this study, the PST was used to assess psychopathological symptoms, wherein higher number of symptom endorsement signifies higher levels of psychopathology symptoms. Post-hoc analyses were also conducted to assess for unique contributions of the interaction between trauma endorsement and MACV on specific dimension scores (i.e., SOM, I-S, DEP, ANX,

HOS), which are calculated by summing the values for the items included in that dimension and dividing by the number of items endorsed in that dimension.

Mexican American Cultural Values Scale (MACVS; Knight et al., 2010). The MACVS is a 50-item measure that assesses traditional Mexican/Mexican American cultural values (MACV) and American mainstream values. The measure has 9 subscales (6 scales measuring traditional Mexican/Mexican American values and 3 scales measuring American mainstream values). For the purpose of this study, we only be focused on four of the subscales, specifically the three subscales designed to assess aspects of familism, as well as the religiosity subscale. The other subscales (i.e., respect, traditional gender roles, material success, independence & self-reliance, and competition & personal achievement) were not hypothesized to moderate the association between childhood trauma and psychopathological symptoms, and thus are not included in any analyses.

Familism is made up of three different subscales, which includes Familism Support (6 items), Familism Referent (5 items), and Familism Obligation (5 items). The Religiosity subscale is composed of 7 items. The items are rated on a 5-point Likert-type scale ranging from 1 (*not at all*) to 5 (*completely*) with a higher score representing a higher presence of cultural values. In previous research, the Cronbach's alphas for the three Familism subscales have been reported at 0.67 (Support), 0.61 (Referent), and 0.65 (Obligation; Knight et al., 2010); the Religiosity subscale has been reported to have a Cronbach's alpha of 0.78, according to Knight et al. (2010). A total score was calculated, where higher scores signified higher levels of MACV. The Cronbach's alpha for Familism Support, Familism Referent, Familism Obligation, and Religiosity were 0.88,

0.87, 0.81, and 0.98, respectively, indicating very high levels of internal consistency within each subscale.

Acculturation Rating Scale for Mexican Americans-II: English Version (ARSMA-II; Cuéllar et al., 1995). The ARSMA-II is composed of two independent scales (Acculturation Scale and Marginality Scale) and measures four different domains: (a) language use and preference, (b) ethnic identity and classification, (c) cultural heritage and ethnic behaviors, and (d) ethnic interaction. In comparison to its previous version, ARSMA-II makes an effort to measure the four levels of acculturation, which includes integration, assimilation, separation, and marginalization (Cuéllar, Arnold, & Maldonado, 1995). As the secondary aim of this study is exploratory in nature, acculturation scores will be used to see how levels of acculturation moderate the association between childhood trauma and psychopathological symptoms.

For the first scale, which is composed of 30 items, a Mexican Orientation Score (composed of 17 items) and an Anglo Orientation Score (composed of 13 items) can be independently calculated, which identifies levels of integration, separation, and assimilation, in the context of the host culture, which in this case would be American culture. The items are rated on a 5-point Likert-type scale ranging from 1 (*not at all*) to 5 (*extremely often or almost always*). The Mexican Orientation Scale has been reported to have a coefficient alpha of 0.83 and the Anglo Orientation Scale has reported a coefficient alpha of .88 in previous research (Cuéllar et al., 1995). Using Cuéllar et al.'s (1995) formula (see Table 1), acculturation scores were calculated, where high scores represented very assimilated individuals and low scores were representative of individuals who were very separated (see Table 1 for reference). Unfortunately, due to a

technical error, individuals who identified as mixed race were omitted from taking the ARSMA-II scale. The Cronbach's alpha for the original scale in this study was 0.85 and the Cronbach's alpha for the adapted scale in this study was 0.88.

Table 1. *Cutting Scores for Determining Acculturation Level (Cuéllar et al., 1995)*

Acculturation Levels	**Description**	**ARSMA-II Acculturation Score***
Level I	Very Mexican oriented	< -1.33
Level II	Mexican Oriented to approximately balance bicultural	≥ -1.33 and ≤ -.07
Level III	Slightly Anglo oriented bicultural	> .07 and < 1.19
Level IV	Strongly Anglo oriented	≥ 1.19 and < 2.45
Level V	Very assimilated; Anglicized	> 2.45

*Raw score means were used to calculate the Acculturation Scores. The choices selected for each item are added and divided by the number of items on the MOS and the AOS scales separately to obtain the raw score mean for each scale. The means were used in the formula: Acculturation Score = AOS (mean) – MOS (mean).

CHAPTER III

Results

Preliminary Data Analysis

A post hoc statistical power analysis was performed for sample size estimation using the G*Power 3.1 software (Erdfelder, Faul, & Buchner, 1996). With a sample size of 475 participants, an alpha level of .05, and a medium effect size (Cohen's f^2 =.15), the post hoc analysis revealed a power of 1.00; therefore, this study had adequate power to conduct the hypothesized moderation effect.

The Statistical Package for the Social Sciences Version 25 software (SPSS; IBM Corp, 2016) was used to analyze the data collected to ensure that no violations of the assumptions of linearity, normality of errors, multicollinearity, and homoscedasticity were present. Each independent variable and dependent variable were entered into a scatterplot. Linearity was established by visual inspection of the scatterplots. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.972. There was homoscedasticity, as assessed by visual inspection of a plot of standardized residuals versus standardized predicted values. Residuals were normally distributed as assessed by visual inspection of a normal probability plot. In conclusion, the data met all four assumptions of linear regression and inferences may be made with confidence.

Descriptive Data. Intercorrelations, means, and standard deviations were analyzed using SPSS (IBM Corp, 2016) for all variables of interest (see Table 2). The means and standard deviations for each variable are as follows: Brief Symptom Inventory Positive Symptom Total (BSI PST; *M* = 22.93, *SD* = 13.18), Number of Items Endorsed on the Trauma History Questionnaire (NIE THQ; *M* = 3.63, *SD* = 2.86),

Mexican American Cultural Values Total Score (MACV TS; *M* = 79.33, *SD* = 19.63), Somatization Dimension Score (SOM; *M* = 1.37, *SD* = .47), Interpersonal Sensitivity Dimension Score (IS; *M* = 1.57, *SD* = .61), Depression Dimension Score (DEP; *M* = 1.60, *SD* = .59), Anxiety Dimension Score (ANX; *M* = 1.76, *SD* = .75), Hostility Dimension Score (HOS; *M* = 1.60, *SD* = .61), Acculturation Score for Non-Mexican Americans (AS; *M* = 2.06, *SD* = 1.00), Acculturation Score for Mexican Americans (AS MA; AS; *M* = .35, *SD* = .99).

In regard to correlations between the variables of interest, BSI PST was correlated with all but two of the variables: NIE THQ ($r = .34$, $p < .01$), MACV TS ($r = -.18$, $p < .01$), SOM ($r = .28$, $p < .01$), IS ($r = .48$, $p < .01$), DEP ($r = .47$, $p < .01$), ANX ($r = .21$, $p < .01$), HOS ($r = .22$, $p < .01$). Number of Items endorsed on the Trauma History Questionnaire was correlated with MACV TS ($r = -.09$, $p < .05$), SOM ($r = .25$, $p < .01$), IS ($r = .15$, $p < .01$), DEP ($r = .47$, $p < .01$), and ANX ($r = .17$, $p < .01$). Mexican American Cultural Values scores were negatively correlated with IS ($r = -.17$, $p < .01$) and DEP ($r = -.15$, $p < .01$). The Somatization Dimension Score was positively correlated with all other dimension scores: IS ($r = .35$, $p < .01$), DEP ($r = .40$, $p < .01$), ANX ($r = .35$, $p < .01$), HOS ($r = .34$, $p < .01$). The Interpersonal Sensitivity Dimension Score was positively correlated with DEP ($r = .64$, $p < .01$), ANX ($r = .33$, $p < .01$), and HOS ($r = .36$, $p < .01$). The Depression Dimension Score was positively correlated with ANX ($r = .37$, $p < .01$) and HOS ($r = .41$, $p < .01$). The Anxiety Dimension Score was positively correlated with HOS ($r = .17$, $p < .01$).

Table 2. *Intercorrelations, Means, and Standard Deviations*

	1	2	3	4	5	6	7	8	9	10
1. BSI PST	–									

2. NIE THQ	.34**	–								
3. MACV TS	-.18**	-.09*	–							
4. SOM	.28**	.25**	-.10	–						
5. IS	.48**	.15**	-.17**	.35**	–					
6. DEP	.47**	.14**	-.15**	.40**	.64**	–				
7. ANX	.21**	.17**	-.03	.35**	.33**	.37**	–			
8. HOS	.22**	.10	.02	.34**	.36**	.41**	.17**	–		
9. AS	-.05	.00	.03	-.02	-.08	-.04	-.03	-.02	–	
10. AS MA	-.10	-.23	-.02	-.22	-.15	.06	.04	-.06	•[c]	–
Mean	22.93	3.63	79.33	1.37	1.57	1.60	1.76	1.60	2.06	.35
SD	13.18	2.86	19.63	.47	.61	.59	.75	.61	1.00	.99

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

c. Cannot be computed because at least one of the variables is constant.

Note. Brief Symptom Inventory Positive Symptom Total (BSI PST); Number of Items Endorsed on the Trauma History Questionnaire (NIE THQ); Mexican American Cultural Values Total Score (MACV TS); Somatization Dimension Score (SOM); Interpersonal Sensitivity Dimension Score (IS); Depression Dimension Score (DEP); Anxiety Dimension Score (ANX); Hostility Dimension Score (HOS); Acculturation Score for Non-Mexican Americans (AS); Acculturation Score for Mexican Americans (AS MA)

Primary Aim

Multiple Regression Model. It was hypothesized that Mexican American cultural values (MACV) would moderate the link between childhood trauma and psychopathological symptoms, such that as MACV increase, the association between childhood trauma and psychopathological symptoms will decrease. A multiple regression was run of the standardized variables of interest to predict psychopathological symptoms, as assessed by BSI PST, from the number of items endorsed of trauma in childhood, Mexican American cultural values, and the interaction between these variables. The multiple regression model statistically significantly predicted endorsement of psychopathological symptoms, $F(3, 470) = 25.11$, $p < .001$, adj. $R^2 = .13$; however, the number of items endorsed of trauma in childhood, as assessed by THQ, Mexican

American cultural values, and the interaction between these variables only accounted for 13.3% of explained variability in endorsement of psychopathological symptoms (BSI PST). Although we did not observe a significant interaction between childhood trauma and MACVs, one variable did emerge as a statistically significant predictor of mental health outcomes (MACV TS), $p < .05$. Indeed, we observed a main effect of Mexican American cultural values on psychopathological symptoms, suggesting that as levels of MACVs increased, levels of psychopathological symptoms decreased. Regression coefficients and standard errors can be found in Table 3 (below).

Table 3. *Summary of Multiple Regression Analysis*

Variable	*B*	SE_B	ß
Intercept	19.34	2.74	
NIE THQ	1.47	2.18	.11
MACV TS	-2.88	.92	-.22*
NIE THQ x MACV TS	.01	.01	.23

Note. *$p < .05$; *B* = unstandardized regression coefficient; SE_B = Standard error of the coefficient; ß = standardized coefficient

Exploratory Aim

Multiple Regression Model. As previously mentioned, the second aim of this study was to explore whether or not acculturation would moderate the association between childhood trauma and psychopathological symptoms. A multiple regression was run for two different groups (i.e., individuals who identified as Mexican Americans and individuals who identified as non-Mexican Americans), as individuals who identified as non-Mexican Americans took a difference version of the survey, to predict psychopathological symptoms, as assessed by BSI PST, from the number of items endorsed of trauma in childhood, acculturation scores, and the interaction between these variables. In regard to the Mexican American group of interest, the multiple regression model statistically significantly predicted endorsement of psychopathological symptoms,

$F(3, 70) = 3.96$, $p < .01$, adj. $R^2 = .11$; however, these variables only accounted for 11% of explained variability in endorsement of psychopathological symptoms (BSI PST). Although we did not observe a significant interaction between childhood trauma and acculturation levels, one variable emerged as a statistically significant predictor of mental health outcomes, (NIE THQ), $p < .05$. Indeed, results indicated a main effect of number of childhood trauma events endorsed on psychopathological symptoms, suggesting that as levels of NIE THQ increased, levels of psychopathological symptoms increased. Regression coefficients and standard errors can be found in Table 4 (below).

Table 4. *Summary of Multiple Regression Analysis*

Variable	*B*	SE_B	ß
Intercept	19.74	2.39	
NIE THQ	1.51	.47	.38*
AS MA	.08	2.10	.01
NIE THQ x AS MA	-.06	.43	-.02

Note. *$p < .05$; *B* = unstandardized regression coefficient; SE_B = Standard error of the coefficient; ß = standardized coefficient

As for the non-Mexican American group, the multiple regression model statistically significantly predicted endorsement of psychopathological symptoms, $F(3, 362) = 15.76$, $p < .001$, adj. $R^2 = .11$. The variables of interest only accounted for 11% of explained variability in endorsement of psychopathological symptoms (BSI PST). Much like the multiple regression analyzed in the Mexican American group, although we did not observe a significant interaction between childhood trauma and acculturation levels, NIE THQ emerged as a statistically significant predictor of mental health outcomes, $p < .05$. Results suggested a main effect of number of childhood trauma events endorsed on psychopathological symptoms, suggesting that as levels of NIE THQ increased, levels of psychopathological symptoms increased. Regression coefficients and standard errors can be found in Table 5 (below).

Table 5. *Summary of Multiple Regression Analysis*

Variable	*B*	SE_B	ß
Intercept	17.40	2.49	
NIE THQ	1.83	.56	.39*
AS	-.25	1.10	-.02
NIE THQ x AS	-.13	.25	-.07

Note. *$p < .05$; *B* = unstandardized regression coefficient; SE_B = Standard error of the coefficient; ß = standardized coefficient

Post-hoc Analyses

Post-hoc analyses were run to analyze whether Mexican American cultural values (MACV) would moderate the association between childhood trauma and specific dimensions of psychopathological symptoms. A multiple regression was run to predict each dimension of interest in terms of mental health outcomes (somatization, interpersonal sensitivity, depression, anxiety, and hostility), from the number of items endorsed of trauma in childhood, Mexican American cultural values, and the interaction between these variables. Overall, only Mexican American cultural values (as an independent variable of interest) emerged as a predictor and was statistically significant in explaining the change in two dimensions of psychopathological symptoms (interpersonal sensitivity and depression). Specifically, the multiple regression models showed that an increase in Mexican American cultural values was associated with a decrease of interpersonal sensitivity ($\beta = -.12$, $p = .02$) and depression ($\beta = -.10$, $p = .04$). Additionally, the results indicated that an increase in number of items of childhood trauma endorsed was associated with an increase of hostility ($\beta = .25$, $p = .03$).

CHAPTER IV

Discussion

Relatively few studies have assessed how Mexican American cultural values or how levels of acculturation can impact the development of psychopathological symptoms after experiencing childhood trauma. This study was designed to better understand how contextual factors – namely, values emphasized in one's culture and one's level of acculturation – impact psychological functioning after experiencing childhood trauma. This information has the potential to provide beneficial information in this gap in the literature. Overall, we were unable to provide support for either of our hypotheses that (Aim 1) Mexican American cultural values or (Aim 2) levels of acculturation moderate the link between childhood trauma and psychopathological outcomes. We were, however, able to identify significant predictors in each model. Indeed, we observed a main effect of Mexican American cultural values on psychopathological symptoms, suggesting that as levels of MACVs increased, levels of psychopathological symptoms decreased. Furthermore, results indicated a main effect of number of childhood trauma events endorsed on psychopathological symptoms, suggesting that as levels of NIE THQ increased, levels of psychopathological symptoms increased, in both the Mexican American group and the non-Mexican American group.

Post-hoc analyses revealed that an increase in Mexican American cultural values was associated with a decrease in interpersonal sensitivity and depression, two dimensions on the BSI. In regard to the depression dimension, these findings fall in line with what has been found in the literature, in which Mexican American cultural values are associated with lower levels of depression (Piña-Watson, Gonzalez, & Manzo, 2019; Zeiders, et al., 2013). Although there has been little research done on Mexican American

cultural values and its association with interpersonal sensitivity, items on this dimension can fall under the symptomology umbrella of depression and anxiety, such as “feeling inferior to others,” “feeling that people are unfriendly or dislike you,” and “feeling very self-conscious with others;” hence, it would make sense that higher levels of Mexican American cultural values would be associated with lower levels of this particular dimension, just as it was with depression. Additionally, our study found that an increase in number of items of childhood trauma endorsed was associated with an increase in the hostility dimension on the BSI. This falls in line with previous literature (Carliner et al., 2017; Podubinski, Lee, Hollander, & Daffern, 2015; Roy, 2001), as childhood trauma has been associated with higher levels of hostility and aggression.

The present study’s primary aim was to assess for the moderating effect of Mexican American cultural values on psychopathological symptoms after experiencing childhood trauma, which unfortunately was not supported in this study. It was interesting, however, to see that post-hoc analyses only found one association between trauma and one specific dimension of the BSI (i.e., hostility), but no associations were made with other specific dimensions of interest in the BSI (i.e., somatization, interpersonal sensitivity, depression, and anxiety). This finding goes against what previous literature has found, specifically in terms of the association childhood trauma has on symptoms of depression and anxiety (Agorastos et al., 2014; Dunn et al., 2017; Hovens et al., 2010; Mandelli et al., 2015; Wang et al., 2018; Ying et al., 2014). Additionally, Mexican American cultural values were not statistically significantly associated with somatization, anxiety, or hostility. Future studies would benefit from

looking into this further and evaluate these constructs with dimension-specific scales to evaluate these associations better.

Implications

The information gathered from this study provided some insight to the applicability of Mexican American cultural values as a protective factor against the development of psychopathological symptoms after experiencing childhood trauma. Our results indicated that MACV significantly predicted psychopathological symptoms, such that as MACVs increased psychopathological symptoms decreased, but it did not moderate the link between childhood trauma and psychopathological symptoms. Perhaps cultural values, such as familism and religiosity, do not play as strong as a protective factor against the endorsement of psychopathological symptoms after experiencing childhood trauma, in comparison to other constructs, such as acculturative stress, which has been assessed in previous literature (Corona et al., 2017; Piña-Watson et al., 2019) but there is something about these values that seem to guard individuals from mental health problems, such as depression and interpersonal sensitivity, as evidenced by this study's post-hoc analysis. As previously mentioned, understanding how to approach mental illness in the Mexican American population and to what extent using cultural values can serve as protective factors is crucial, as embracing and promoting cultural values in the Mexican American community could potentially serve as a more cost-effective and beneficial way of counteracting the development of psychopathological symptoms overall.

Although it was not a variable of interest in the present study, stigma surrounding mental illness is an important factor that needs to be considered when developing a

mental health treatment plan in this specific population. Turner, Jensen-Doss, and Heffer (2015) found that Hispanic-Americans that reported higher levels of mental health stigma were less likely to seek mental health treatment. These effects were unique – as this was not found in the African-American or European-American groups – indicating that perhaps Hispanic-Americans have less stigma tolerance, and as such are more distressed about the effects of being stigmatized by their social group. These findings suggest the difficulty in treating mental illness within this particular racial/ethnic group. Interestingly enough, however, Farley, Galves, Dickinson, and de Jesus Diaz Perez (2005) compared newly immigrated Mexican citizens, Mexican Americans, and non-Hispanic Whites and found that Mexican immigrants reported significantly better physical health functioning and stress-coping skills in comparison to the other groups. Furthermore, Hispanics as a group (both Mexican immigrants and Mexican Americans) reported better physical and mental health-related quality of life than non-Hispanic Whites. The researchers suggested that perhaps the stress-coping styles of Mexican immigrants (i.e., positive reframing, denial, and religion) are more beneficial, as stress-coping styles are associated with overall health-related quality of life. These findings indicated perhaps this racial/ethnic group have coping skills produced by their way of life and values, which are effective in combating symptoms of mental illnesses. If these implications are supported, perhaps taking advantage of those cultural values and promoting it within the Hispanic population would result in the significant development of protective factors against mental illness within the community.

Limitations and Future Directions

There were several limitations to the present study. First, this study gathered information based on self-report. Childhood trauma experiences and endorsement psychopathological symptoms cannot be taken as objective information, which hinders the reliability of the results from this study. Furthermore, as childhood trauma was collected based on retrospective memory, accuracy and recollection cannot be taken as completely reliable. Second, the convenience sample of college students limits the generalizability of the results from this study. Future studies would benefit from assessing a more diverse community sample. More specifically, assessing a younger age range could potentially provide more reliable recollection of childhood trauma.

Third, there were a couple technical issues/errors throughout the data collection process. As mentioned previously, the 5-point Likert scale on the Brief Symptom Inventory was incorrectly presented as a 4-point Likert scale, with the middle option "Moderately" being omitted. This error could have influenced how individuals interpreted the item and related their symptoms on the scale. Furthermore, post-hoc analyses on the specific dimensions of interest could have been more informative with the severity of the scales being more accurately represented. Another technical issue we had was the fact that individuals who identified as being mixed race were excluded from taking the acculturation scale. Although only 32 participants (6.7%) identified as being mixed race, this could have been a good opportunity to see how acculturation is represented in this sample, as a bicultural identity does not necessarily equate to full integration into the host culture. Future research should account for these technical errors and assess whether differences exists.

Fourth, although the acculturation scale was administered to individuals who identified as Mexican or Mexican American (n = 74; 15.6%), it would have been more informative to see how this scale performed using the entire sample together; comparing not just individuals who identified their country of origin as Mexico, but also the Hispanic and non-Hispanic groups. Future studies should assess the differences between these groups using the same scale throughout. Additionally, the acculturation scale was assessed as a continuous variable and the Marginality scale was not administered. Perhaps categorizing individuals by the four levels of acculturation (i.e., integration, assimilation, separation, and marginalization) could provide more insight as to how acculturation plays a role in the development of psychopathological symptoms after experiencing childhood trauma. Lastly, although information on frequency of trauma was collected, participants who experienced a lot of trauma estimated their numbers – as recollection was impaired – which caused a lot of outliers and difficulty in trying to objectively measure childhood trauma experience. Future studies should explore other accurate ways of quantifying trauma experience and reducing recollection error.

Conclusion

Overall, although we failed to find significant moderation effects of Mexican American cultural values and acculturation levels against psychopathological symptoms after experiencing childhood trauma, we did find significant associations between Mexican American cultural values and the endorsement of psychopathological symptoms, in addition to the association with specific dimensions on the BSI (i.e., depression/interpersonal sensitivity). Indeed, there is something about these specific cultural values – familism and religiosity – that seem to serve as a protective factor

against psychopathological symptoms. These findings warrant the need for further assessment of these particular cultural values and how they could potentially play a role in the relationship between specific childhood traumatic events and the development of specific psychopathologic dimensions, both internalizing and externalizing. Identifying these potential benefits could provide insight into how to approach treatment planning and management overall within the Hispanic population.

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APPENDIX A

TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (select) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

Crime-Related Events	**Select one**		***If you selected yes, please indicate***	
			Number of times	**Approximate age(s)**
1. Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2. Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3. Has anyone ever attempted to or succeeded in breaking into your home when you were <u>not</u> there?	No	Yes		
4. Has anyone ever attempted to or succeed in breaking into your home while you <u>were</u> there?	No	Yes		

General Disaster and Trauma	**Select one**		***If you circled yes, please indicate***	
			Number of times	**Approximate age(s)**
5. Have you ever had a serious accident at work, in a car, or somewhere else? (**If yes**, please specify below) _____	No	Yes		
6. Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____	No	Yes		
7. Have you ever experienced a "man-made" disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____	No	Yes		
8. Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9. Have you ever been in any other situation in which you were seriously injured? (**If yes**, please specify below) _____	No	Yes		
10. Have you ever been in any other situation in which you feared you might be killed or seriously injured? (**If yes**, please specify below) _____	No	Yes		
11. Have you ever seen someone seriously injured or killed? (**If yes**, please specify who below) _____	No	Yes		
12. Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? (**If yes**, please specify below) _____	No	Yes		
13. Have you ever had a close friend or family member murdered, or killed by a	No	Yes		

drunk driver? (**If yes**, please specify relationship [e.g., mother, grandson, etc.] below) _____				
14. Have you ever had a spouse, romantic partner, or child die? (**If yes**, please specify relationship below) _____	No	Yes		
15. Have you ever had a serious or life-threatening illness? (**If yes**, please specify below) _____	No	Yes		
16. Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**If yes**, please indicate below) _____	No	Yes		
17. Have you ever had to engage in combat while in military service in an official or unofficial war zone? (**If yes**, please indicate where below) _____	No	Yes		
Physical and Sexual Experiences	**Select one**		***If you circled yes, please indicate*** **Repeated?**	**Approximate age(s) and frequency**
18. Has anyone ever made you have intercourse or oral or anal sex against your will? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
19. Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
20. Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person	No	Yes		

tried to force you to have an unwanted sexual contact?				
21. Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22. Has anyone, including family members or friends, ever attacked you <u>without</u> a weapon and seriously injured you?	No	Yes		
23. Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		
24. Have you experienced any other extraordinarily stressful situation or event that is not covered above? (**<u>If yes</u>**, please specify below) _____	No	Yes		

APPENDIX B

BRIEF SYMPTOM INVENTORY

Below is a list of problems people sometimes have. As you read each one, select **how much that problem has distressed or bothered you during the past 7 days including today.** Please use the scale below to answer the items.

Not at all	A little bit	Moderately	Quite a bit	Extremely	Refused
0	1	2	3	4	R

During the past 7 days, how much were you distressed by:

1. Nervousness or shakiness inside
2. Faintness or dizziness
3. The idea that someone else can control your thoughts
4. Feeling others are to blame for most of your troubles
5. Trouble remembering things
6. Feeling easily annoyed or irritated
7. Pains in the heart or chest
8. Feeling afraid in open spaces
9. Thoughts of ending your life
10. Feeling that most people cannot be trusted
11. Poor appetite
12. Suddenly scared for no reason
13. Temper outbursts that you could not control
14. Feeling lonely even when you are with people
15. Feeling blocked in getting things done

16. Feeling lonely
17. Feeling blue
18. Feeling no interest in things
19. Feeling fearful
20. Your feelings being easily hurt
21. Feeling that people are unfriendly or dislike you
22. Feeling inferior to others
23. Nausea or upset stomach
24. Feeling that you are watched or talked about by others
25. Trouble falling asleep
26. Having to check and double check what you do
27. Difficulty making decisions
28. Feeling afraid to travel on buses, subways, or trains
29. Trouble getting your breath
30. Hot or cold spells
31. Having to avoid certain things, places, or activities because they frighten you
32. Your mind going blank
33. Numbness or tingling in parts of your body
34. The idea that you should be punished for your sins
35. Feeling hopeless about the future
36. Trouble concentrating
37. Feeling weak in parts of your body
38. Feeling tense or keyed up

39. Thoughts of death or dying

40. Having urges to beat, injure, or harm someone

41. Having urges to break or smash things

42. Feeling very self-conscious with others

43. Feeling uneasy in crowds

44. Never feeling close to another person

45. Spells of terror or panic

46. Getting into frequent arguments

47. Feeling nervous when you are left alone

48. Others not giving you proper credit for your achievements

49. Feeling so restless you couldn’t sit still

50. Feelings of worthlessness

51. Feeling that people will take advantage of you if you let them

52. Feeling of guilt

53. The idea that something is wrong with your mind

APPENDIX C

MEXICAN AMERICAN CULTURAL VALUES SCALE

The next statements are about what people may think or believe. Remember, there are no right or wrong answers. Using the scale below, tell me how much you believe that…

Not at all	A little	Somewhat	Very much	Completely	Refused
1	2	3	4	5	R

1. Parents should teach their children that the family always comes first.
2. Family provides a sense of security because they will always be there for you.
3. It is always important to be united as a family.
4. It is important to have close relationships with aunts/uncles, grandparents and cousins.
5. Holidays and celebrations are important because the whole family comes together.
6. It is important for family members to show their love and affection to one another.
7. Children should always do things to make their parents happy.
8. When it comes to important decisions, the family should ask for advice from close relatives.
9. Children should be taught to always be good because they represent the family.
10. A person should always think about their family when making important decisions.
11. It is important to work hard and do one's best because this work reflects on the family.
12. Children should be taught that it is their duty to care for their parents when their parents get old.
13. If a relative is having a hard time financially, one should help them out if possible.
14. A person should share their home with relatives if they need a place to stay.

15. Older kids should take care of and be role models for their younger brothers and sisters.
16. Parents should be willing to make great sacrifices to make sure their children have a better life.
17. One's belief in God gives inner strength and meaning to life.
18. God is first; family is second.
19. Parents should teach their children to pray.
20. If everything is taken away, one still has their faith in God.
21. It is important to thank God every day for all one has.
22. It is important to follow the Word of God.
23. Religion should be an important part of one's life.

APPENDIX D

ETHNIC PRIDE SCALE (ADAPTED)

Using the scale below, rate how much you agree with each item.

Not at all true	Not very true	Neutral	Somewhat true	Very true	Refused
1	2	3	4	5	R

1. You have a lot of pride in your ethnicity/race.
2. You feel good about your ethnic/racial background.
3. You like people to know that your family is from a specific ethnic/racial group.
4. You feel proud to see actors, musicians, and artists from your ethnic/racial group being successful.

APPENDIX E

ACCULTURATION RATING SCALE FOR MEXICAN AMERICANS-II:

ENGLISH VERSION

Scale 1 – Acculturation Scale

Using the scale below, select an option for each item that best applies. *(*Please note – ***Anglo(s)****: a white, English-speaking American as distinct from a Hispanic American*)

Not at all	Very little or Not very often	Moderately	Much or Very often	Extremely often or Almost always	Refused
1	2	3	4	5	R

1. I speak Spanish
2. I speak English
3. I enjoy speaking Spanish
4. I associate with Anglos
5. I associate with Mexicans and/or Mexican Americans
6. I enjoy listening to Spanish language music
7. I enjoy listening to English language music
8. I enjoy Spanish language TV
9. I enjoy English language TV
10. I enjoy English language movies
11. I enjoy Spanish language movies
12. I enjoy reading (e.g., books in Spanish)
13. I enjoy reading (e.g., books in English)
14. I write (e.g., letters in Spanish)
15. I write (e.g., letters in English)
16. My thinking is done in the English language

17. My thinking is done in the Spanish language
18. My contact with Mexico has been
19. My contact with the USA has been
20. My father identifies or identified himself as ‘Mexicano’
21. My mother identifies or identified herself as ‘Mexicana’
22. My friends, while I was growing up, were of Mexican origin
23. My friends, while I was growing up, were of Anglo origin
24. My family cooks Mexican foods
25. My friends now are of Anglo origin
26. My friends now are of Mexican origin
27. I like to identify myself as an Anglo American
28. I like to identify myself as a Mexican American
29. I like to identify myself as a Mexican
30. I like to identify myself as an American

APPENDIX F

ACCULTURATION RATING SCALE FOR MEXICAN AMERICANS-II: ENGLISH VERSION (ADAPTED)

Scale 1 – Acculturation Scale

Using the scale below, select an option for each item that best applies. *(*Please note – ***Anglo(s)****: a white, English-speaking American as distinct from a Hispanic American*)

Not at all	Very little or Not very often	Moderately	Much or Very often	Extremely often or Almost always	Refused
1	2	3	4	5	R

1. I speak Spanish
2. I speak English
3. I enjoy speaking Spanish
4. I associate with Anglos
5. I associate with Hispanics and/or Hispanic Americans
6. I enjoy listening to Spanish language music
7. I enjoy listening to English language music
8. I enjoy Spanish language TV
9. I enjoy English language TV
10. I enjoy English language movies
11. I enjoy Spanish language movies
12. I enjoy reading (e.g., books in Spanish)
13. I enjoy reading (e.g., books in English)
14. I write (e.g., letters in Spanish)
15. I write (e.g., letters in English)
16. My thinking is done in the English language

17. My thinking is done in the Spanish language
18. My contact with Mexico/Latin America has been
19. My contact with the USA has been
20. My father identifies or identified himself as ‘Hispanic’
21. My mother identifies or identified herself as ‘Hispanic’
22. My friends, while I was growing up, were of Hispanic origin
23. My friends, while I was growing up, were of Anglo origin
24. My family cooks Hispanic foods
25. My friends now are of Anglo origin
26. My friends now are of Hispanic origin
27. I like to identify myself as an Anglo American
28. I like to identify myself as a Hispanic American
29. I like to identify myself as a Hispanic
30. I like to identify myself as an American

VITA

EDUCATION

Sam Houston State University
M.A., **Clinical Psychology** August 2018-May 2020
Thesis: *Mexican American Cultural Values as Protective Factors Against Psychopathological Symptoms After Childhood Trauma*
Thesis Chair: Hillary Langley, Ph.D.
Committee: Temilola Salami, Ph.D. and Amanda Venta, Ph.D.
Cumulative GPA: 3.88

Dallas Baptist University
B.A., **Psychology** August 2014-May 2017
Graduated Cum Laude
Minored in Sociology and Spanish
Cumulative GPA: 3.84

CLINICAL EXPERIENCE

Practicum Experience, Sam Houston State University Fall 2019
Texas Department of Criminal Justice – Holiday Unit
Supervisor: Beverly Sloan, Psy.D., LPA, LPC-S, CCHP

Observed clinical interview assessments of newly transferred inmates and discussed report writing with my supervisor.

Mock Therapy Sessions, Sam Houston State University Fall 2019
Supervisor: Marsha Harman, Ph.D.

Conducted mock therapy sessions with students in order to practice and apply skills in a therapeutic setting.

Program Manager, Behavioral Innovations October 2017-July 2018
Supervisor: Arielle Abramovich, M.A., BCBA

Helped build and maintain rapport between therapists and their clients. Organized programming goals and updated programming goals for client cases. Assisted in Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP) and Assessment of Basic Language and Learning Skills (ABLLS) assessments. Created, updated, and reviewed treatment plans for clients. Assisted in parent meetings by explaining programs and updating them on their child's progress.

Registered Behavior Technician, Behavioral Innovations July 2017-July 2018
Supervisor: Arielle Abramovich, M.A., BCBA

Provided one-on-one therapy to children diagnosed with autism spectrum disorder; assisted in teaching and helping them improve their language, social, gross, and fine

motor skills through Applied Behavior Analysis (ABA). Provided social skills group therapy to children who were higher functioning with the assistance of two other therapists to teach and model prosocial behavior in everyday scenarios. Provided in-home ABA therapy to children who were having difficulty engaging in prosocial behavior at home; worked on communication skills and establishing a contingent management system to reinforce positive and appropriate behavior.

RESEARCH

Laboratory Experience

Graduate Research Assistant, Sam Houston State University Spring 2019-Present
Gratitude, Resiliency, & Overall Wellbeing after Trauma & Hardship Lab (GROWTH Lab)
Principle Investigator: Hillary Langley, Ph.D.

Lab tasks: Helping the PI and other lab members with study conceptualization/development, developing tasks and surveys for research studies, submitting IRB applications, recruiting research subjects, collecting data with participants, conducting literature reviews, running statistical analyses, writing up findings for publications, and applying for grant funding for research studies in the lab.

Graduate Research Assistant, Sam Houston State University Fall 2019-Present
Assessment of Personality Psychopathology Lab (APP Lab)
Lab director: Jaime L. Anderson, Ph.D.

Lab tasks: Proctored data collection, helped with data entry, and was in charge of material managing for the Spanish MMPI-2-RF study. This study aimed to examine the Spanish version of the MMPI-2-RF in bilingual college students to evaluate its validity.

Manuscripts in Preparation

Ramos, M.B., Langley, H. (in prep). Mexican American Cultural Values as Protective Factors Against Psychopathological Symptoms After Childhood Trauma.

TEACHING EXPERIENCE

Graduate Assistant, Sam Houston State University Fall 2019
Developmental Psychology
Instructor: Hillary Langley, Ph.D., Assistant Professor of Psychology

Facilitated exam review lectures in preparation for course exams and graded course exams. Provided support and answers to concerns/questions from students regarding the course syllabus and assignments.

Graduate Assistant, Sam Houston State University Fall 2018-Spring 2019
Research Methods Lab
Instructor: T.C. Sim, Ph.D., Assistant Professor of Psychology

Taught the lab portion of Research Methods, an undergraduate course averaging 25 students per semester, per section, covering the following topics: describing behavior objectively, organization of a manuscript, using library resources, experimental design, research variables, using SPSS to analyze data, experimental control, data collection, and preparing manuscripts APA style. Developed quizzes, presentations, and in-class assignments. Provided one-on-one consultations for preparation of independent research projects. Graded individual lab assignments and research proposals.

RELEVANT EMPLOYMENT

Medical Transcriptionist, Independent Contractor July 2018-October 2019
Northwest Georgia Oncology Centers, PC
Supervisor: Tisha Johnstone

Transcribed progress notes, consults, letters, and procedures for doctors and physician assistants.

HONORS AND AWARDS

Dean's List Spring 2015, Fall 2015, 2016, and 2017
Honor for students with a grade point average of 3.75 or higher for the semester

President's List Spring 2016 and 2017
Honor for students with a grade point average of 4.00 for the semester

COMMUNITY SERVICE

Therapeutic Assistant, Victory Therapy Center August 2016- May 2018
Roanoke, Texas

Supported clients during therapeutic riding sessions and fostered rider-horse interrelationships through positive reinforcement and continuous feedback.

Spanish Interpreter, Bethesda Health Fiesta October 2014-2017
Fort Worth, Texas

Translated for families in need of health services and accompanied them through the community health fair.

LANGUAGES

English: Native Language

Spanish: Native Language

AFFILIATIONS

Latinx Graduate Student Organization, Vice President Fall 2019-Present

Duties: Assumed the duties of the president in their absence with prior notice. Directed constitutional updating and revisions. Maintained contact with organization alumni. Facilitated election of officers. Recruited new members. Organized end-of-year celebration. Represented organization at official functions. Performed other duties as directed by the President.

Latinx Professional Development Workshop 24 September 2019
Co-organizer/Participant, Sam Houston State University

Helped organize a developmental workshop for Latinx university students to inform them how to build and maintain professional connections within their educational and work environment.

Graduate Student Psychology Organization, Member Fall 2018-Present

Alpha Chi National Honor College Society, Member Spring 2017-Present

Sigma Delta Pi, Member Spring 2017-Present