2-2020

Shame, Trauma, Resiliency and Alcohol Related Behaviors in Puerto Rican Populations

Manuel Blasini-MéndezB

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by

Manuel Blasini-Méndez

Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

February 16, 2020

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By Manuel Blasini-Méndez

Has been approved
at the
Graduate Student of Clinical Psychology
George Fox University

Signature:

Winston Seegobin, PsyD

Members:

Glena Andrews, PhD

Kathleen Gathercoal, PhD

Date: 9.20.19

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Manuel Blasini-Mendez

Graduate School of Clinical Psychology at

George Fox University

Newberg, Oregon

Abstract

Puerto Rico has endured horrendous natural disasters in the last few years, leaving thousands to cope with the aftermath; a mental health crisis. Therefore, understanding how Puerto Ricans navigate adversities, be that childhood adversity, natural disasters or daily stress is of utmost importance. Understanding the role resilience and drinking play in Puerto Rico will help us to further understand how they navigate adversities. Hence the reason why in this study we looked at how Adverse Childhood Experiences, Perceived Stress, Natural Disaster Adversity and Shame relate to each other and to Drinking behaviors and Resiliency. Data were collected on Puerto Rico via an online survey. Several individuals participated in the study (N = 189). Modifying variables included, age, place of residence on the island, gender, ethnicity, education, occupation and socio economic status. The results demonstrated significant differences between some modifying variables. Differences were seen between men and women in levels of Shame and ACES. No significant differences were found between ethnicities in levels of Shame, Stress, ACES, Hurricane Adversities and Resiliency. Similarly, no relationship was found between

respondents level of drinking and SES. When looking at the sample as a whole there was no relationship between ACES and hurricane adversities as well as with drinking. However, there appears to be a positive relationship between ACES and Shame, and a small positive relationship between drinking and Shame. On the other hand, a negative relationship was found between Shame, ACES and Resiliency. However, a small positive relationship was found between the number of drinks people have and Resiliency. Additional analysis was conducted to further understand these variables and their relationships. Additional research, exploratory research, is needed to understand the variables and the relationship between them. Exploratory research is needed as a way to further understand the role culture plays in understanding Shame, ACES, Stress, Hurricane Adversities, Drinking and Resiliency in Puerto Rico.

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Chapter 1

Introduction

For years, the Puerto Rican community has been neglected in American psychological research. While there are a lot of psychological research opportunities on the island, few decide to do this work. Most recently, Puerto Ricans endured two of the most impactful events in its history, Hurricanes Irma and Maria. Since then Puerto Rico has been facing one of the biggest mental health crisis in its history (Barbaro, 2018; Barbot, 2018; Carr, 2018). Dr. Silma Quiñones, a Puerto Rican psychologist "urges psychologists to investigate resilience in Puerto Rico" (Lybarger, 2018, p. 23). Dr. Quiñones says that "Puerto Rico is a special place to look at how communities are strengthened, how people survive catastrophic events" (Lybarger, 2018, p. 23). As Dr. Quiñones suggests, the passing of Hurricanes Irma and Maria through Puerto Rico gives the opportunity for a countless amount of research around a variety of mental health issues. The opportunity for research is endless, but most importantly, the opportunity to help this community is even more needed.

To help Puerto Ricans face this mental health crisis, research is needed as a way to identify the best practices for mental health issues on the island. Research is also needed to understand how Puerto Ricans cope with stressful life events like Hurricane Maria and the aftermath (e.g., loss of power, water, and mass property destruction). Puerto Ricans are said to cope with adversities by having high levels of resiliency (Blasini-Méndez, Gathercoal, Seegobin & Lytle, 2018); however, they also cope with adversity by engaging in drinking behaviors

(Ramos-Olazagasti, Bird, Canino, & Duarte, 2017). “Five in 100 adults 18 to 64 in Puerto Rico (5.2%, 118, 585 adults) meet DSM IV criteria for alcohol abuse disorder and 1.5% (34,207 adults) met criteria for alcohol dependence” (Canino et al., 2016). These numbers do not include the number of individuals who don’t find their drinking to be problematic, because of the normative cultural component problematic drinking has in Puerto Rican culture. Nevertheless, these numbers have probably increased since the trauma caused by Hurricanes Irma and Maria. Resiliency and drinking, these opposites in ways of coping cause confusion in understanding Puerto Ricans. It is because of this confusion that further research is needed to understand the complexities of this population. Hence the reason why, in this research, the relationship between trauma/stress, resilience, shame and alcohol use will be studied amongst Puerto Ricans.

Resiliency

Tedeschi and Calhoun (2004) define resiliency as the ability to continue living a purposeful life after hardship and adversity. People high in hardiness, a core aspect of resiliency, believe they can influence any life events; they expect to be presented with challenges, but they meet those challenges with personal development (Tedeschi & Calhoun, 2004).

Gucciardi, Jackson, Coulter, and Mallett (2011) proposed that there are two central conditions needed in order to conceptualize resilience. "The first is exposure to a significant risk or adversity and secondly is the fulfillment of a positive adjustment or competence" (p. 423). Bonanno conceptualized resilience in a similar way. He argued that resilient people are able to experience stress or trauma and not succumb to it, therefore reducing the risk of developing mental disorders like PTSD (as cited in Zerach, Solomon, Cohen & Ein-Dor, 2013). People who are resilient "have coping capacities that will allow them to be less challenged with the trauma"

(Tedeschi & Calhoun, 2004, p. 4). However, in research conducted to evaluate the effects of post traumatic growth and resiliency on a Puerto Rican population after hurricane Maria, the results showed that although Puerto Ricans have high levels of resiliency, an inverse relationship between post traumatic growth and resiliency was not found (Blasini-Méndez et al., 2018). Therefore, while Puerto Ricans are very resilient, they still experienced Hurricane María as a traumatic event; which goes against what Tedeschi and Calhoun (2004) proposed (Blasini-Méndez et al., 2018).

Trauma and Stress

A debate exists around the topic of trauma (Weathers & Keane, 2007). On the one hand, the *Diagnostic and Statistical Manual for Mental Disorders- 5* (*DSM-5*, APA, 2013) stated that to fall under the category of trauma the person must have had exposure to actual or threatened death, serious injury or sexual violation. On the other hand, some researchers like Calhoun and Tedeschi (2006) argue that if the event led to a disruption to the person's narrative, and the person to remember their narrative as "before and after" the event, it was a traumatic event. In other words, if the event caused a significant amount of distress and stress that led to a change in the person's narrative then it was traumatic; regardless if it was an event that led to exposure to serious injury, actual or threatened death or sexual violation.

Natural disaster trauma and stress. Researchers suggest that disaster exposure can be measured as traumatic if the person has experienced injury, threat of death or significant property loss (Briere & Elliott, 2000). However, others suggest that any type of exposure to a natural event can lead to mental health issues (Weathers & Keane, 2007). If the natural disaster exposure disrupted the person's narrative, then this event would meet the criteria of trauma defined by

Calhoun and Tedeschi (2006). It is also important to note that the characteristics of the exposure (loss of property, loved one, electricity, water, etc.) to the disaster rather than the type of disaster (earthquakes, tornados, hurricanes floods or fires) are related to mental health outcomes (Harville, Jacobs & Boyton-Jarret, 2015).

An increase in mental health-related problems like PTSD, anxiety, mood disorders, suicidal ideation and serious mental illness was shown following Hurricane Katrina in 2005 (Kessler et al., 2008). Briere and Elliott (2000) also found that after a natural disaster, increases in "Anxious Arousal, Depression, Intrusive Experiences, Defensive Avoidance, Dissociation, Impaired Self Reference" (p. 674) were seen, which are common symptoms for PTSD. Briere and Elliott's (2000) findings also suggest that regardless of the type of natural disaster, there is a persistence of disaster-related effects over time while also showing greater symptom reports from people whose exposure was significantly further in the past than those who experienced a recent exposure.

Human made trauma and stress. Human-made trauma and stress, in the context of adverse childhood experiences that include childhood maltreatment and family dysfunction, has been shown to have a significant negative health effect at a social, behavioral, emotional and cognitive level (Felitti et al., 1998; Kendall-Tackett, 2002). On a behavioral level, individuals who have experienced an adverse childhood experience are more likely to engage in harmful behaviors like substance abuse, suicidal behaviors, eating disorders, and high-risk sexual behaviors (Kendall-Tackett, 2002). Subsequently, research conducted with a Puerto Rican population indicated that Puerto Ricans who reported having experienced an adverse childhood experience, either conventional or sociocultural experiences, developed an early initiation of

alcohol use (Ramos-Olazagasti et al., 2017). Danielson et al., (2009) suggest that having any type of history of a traumatic experience might lead to alcohol and drug abuse.

Out of the negative health effects of an adverse childhood experience, most research is focused on the way an adverse childhood experience can affect one emotionally (Kendall-Tackett, 2002). Morera-Fumero and Gonzalez de Rivera (1983) argued that the accumulation of stressful life events might lead to the development of pathology. The research also showed that having a past adverse experience will commonly lead individuals to develop depression or PTSD (Kendall-Tackett, 2002).On a social level, people who report an adverse childhood experience are more likely to engage in maladaptive relationships (Kendall-Tackett, 2002). On a cognitive level, it affects a person's "beliefs and attitudes that shape their day-to-day existence; these attitudes and beliefs can have a substantial impact on the persons overall health" (Kendall-Tackett, 2002, p. 722). Smith (2017) argued that shame plays a significant role on the cognitive, emotional, behavioral and social levels of trauma. Hence the reason why Smith (2017) says, that in order to better understand trauma we must also understand shame.

Shame

In a qualitative research study conducted by Brené Brown, she reported the definition of shame as "an intensely painful feeling or experience of believing we are flawed and therefore unworthy of acceptance and belonging" (2006, p. 45). Brown (2006) proposed that shame is a psycho-social-cultural construct. Psychologically speaking, shame has an emotional and cognitive component to it (Brown, 2006). The social element refers to the interpersonal/ relational aspect of shame and how it is experienced in these aspects (Brown, 2006). The cultural

component refers to the cultural traditions, norms, and expectations that might lead to experiencing shame (Brown, 2006).

Brown (2006) conducted research with women and found that a failure for women to meet the socio-cultural expectations (whom they were expected to be and what was their role based on their identity) led them to experience shame. These expectations are often expressed or enforced by individuals and groups and reinforced by the media (Brown, 2006). Brown (2006) discovered that the main concern most individuals have regarding shame are feeling trapped, powerless, and isolated. However, Brown (2006) argued that there is a "Shame Web" where the socio-cultural expectations are "far-reaching, reinforced at every turn and woven through numerous experiences and relationships" (p. 46). Brown (2006) also proposed that there may not be a universal trigger to shame, rather the experiences, individuals, and expectations that lead to shame are unique to each. However, there is a shared experience on how socio-cultural expectations are enforced by individuals, groups, and media (Brown, 2006).

There is significant evidence suggesting that shame looks different cross-culturally, in particular when comparing shame between individualistic cultures and collectivistic cultures (Wong & Tsai, 2007). Wong and Tsai (2007) suggested that in collectivistic cultures, shame plays a bigger role in everyday life; in some collectivistic cultures it is mainly used for educating children. This is particularly common in Latino cultures where parents mainly use shame-inducing practices as a way to control their children (Fontes, 2007). Fontes (2007) also said that using these shaming practices to gain control is not unique to parenting but also is found in business settings where bosses control their employees, with community leaders, and even clergy. Fontes (2007) further on said:

> In much of Latin America, one of the worst names a person can be called is a sin vergüenza, which means "without shame." This term is used to describe people who do not have enough of a moral compass to experience the appropriate self-critique when their own behavior fails to meet community standards. (p.64)

While Fontes (2007) might argue that vergüenza is a word that grasps the essence of shame in Latino cultures, in some instances it does not. Hurtado de Mendoza, Fernandez-Dols, Parrott and Carrera (2010) suggested that while vergüenza is the direct translation of the word shame, it does not capture the essence of shame to the fullest. However, even though there is no word in the Spanish language that captures the complexity of shame, it is evident that people in collectivistic cultures, including Latinos, experience it (Fontes, 2007; Wong & Tsai, 2007).

Resiliency, Trauma/Stress and Levels of Shame: Effect on an Individual's Alcohol Use

Resiliency and alcohol use. The relationship between resiliency and alcohol use is one that is important to understand. Long et al., (2016) evaluated resiliency by studying the individual's social maturity, interest, psychological energy, home environment, and emotional control. The results showed that these five components, while in varying strength, reduced the risk of individuals developing alcohol use disorders (Long et al., 2016). Similar to Long et al.'s, (2016) results, in a study conducted in Spain, people who self-reported drinking less alcohol scored higher on the resiliency scale (Becoña, Míguez, López, Vázquez, & Lorenzo, 2005).

Trauma, stress, and alcohol Use. While having high levels of resiliency is negatively correlated with levels of trauma and alcohol use, the relationship between trauma and alcohol use is positively correlated (Ertl, Saile, Neuner & Catani, 2016; Iglesias et al., 2005). On a cross-sectional study in Uganda, researchers found that participants having experienced general and

war-related traumatic events and emotional abuse in their family developed higher levels of alcohol-related symptoms, indicating a high correlation between trauma and alcohol related symptoms (Ertl et al., 2016,). Further, a longitudinal study, conducted to collect data from Puerto Rican households in Puerto Rico and in the US, suggested that childhood adversities such as physical, emotional and neglectful maltreatment, parental maladjustment and sociocultural stressors were highly associated with early alcohol use (Ramos-Olazagasti et al., 2017). Also, as childhood adversities increase so does the risk for early alcohol use (Ramos-Olazagasti et al., 2017).

There is a significant difference in trauma-related risk factors for alcohol abuse in men and women (Danielson et al., 2009). Men, who have a traumatic event history, when compared to women, who also have a traumatic event history, are more at risk to develop alcohol abuse (Danielson et al., 2009). However, women between the ages of 18-20, who experienced a traumatic event had a higher risk factor than men, for developing alcohol abuse (Danielson et al., 2009).

One of the first prospective studies used to assess the impact of a natural disaster on individual alcohol use, indicated an association between the impact of the disaster with individual levels of alcohol use. (Cerdá, Tracy & Galea, 2011). Cerdá et al. (2011) found that exposure to a hurricane-related traumatic event was associated with an increase in drinking and binge drinking. Cerdá et al. (2011) findings also suggest that while property damage or loss of sentimental possessions was not associated with alcohol use, other stressors like, loss of electricity, fear of crime, and a shortage of water and food were associated with alcohol use. Also, findings indicate that among those who reported having high levels of lifetime trauma,

exposure to hurricane-related trauma was associated with an increase in alcohol use (Cerdá et al., 2011).

Ayer, Harder, Rose and Helzer (2011) found that the major motivation for alcohol consumption is as a self-medication for perceived stress. In a recent longitudinal study conducted to examine the linkages between stressful life events and alcohol abuse and dependence (AAD), the researchers found that individuals with high stressful life events had higher levels of alcohol abuse and dependence (Boden, Fergusson & Horwood, 2014). The findings suggest a causal process in that exposure to stressful life events increased the probability of AAD (Boden et al., 2014). Cuenya (2007) found similar results in Argentina between occupational stress and alcohol consumption. The results indicated that individuals who reported higher levels of occupational stress showed moderate levels of alcohol consumption (Cuenya, 2007). Therefore, it is evident that there is a relationship between stress and alcohol consumption (Ayer et al., 2011; Boden et al., 2014; Cuenya, 2007).

Shame and alcohol use. Much as trauma plays a role in alcohol use, shame also plays a significant role in it (Smith, 2017). Quantitative research conducted by Patock-Peckman, Canning and Leeman (2018), with an undergraduate population, suggested that alcohol is consumed as a form of relief from negative affect such as shame. Shame was found to be significantly related to an increase in alcohol use and problems; it was related to more impaired control over drinking and negative urgency (Patock-Peckman et al., 2018).

In a study comparing shame and drinking between undergraduate students and inmates, the results showed that both of these populations proved to have a positive link between shame-proneness and problematic alcohol and drug use (Dearing, Stuewig & Tangney, 2005). The

results of this comparison also indicated that with the inmate population shame proneness was specifically associated with alcohol abuse problems but not with predicting frequency of use (Dearing et al., 2005). Furthermore, Dearing et al. (2005) speculated that shame-prone individuals use alcohol and other substances as a way to cope with shame.

Purpose of Study

While there is psychological research that has worked to understand Puerto Ricans better (Ramos-Olazagasti et al., 2017; Blasini-Méndez et al., 2018) there are still very few research studies that evaluate the relationship between trauma and stress, shame, resiliency, and drinking alcohol with Puerto Ricans. Puerto Ricans experienced a stressful life event with Hurricane Maria. It is a shame and binge-drinking culture also known to be highly resilient people. This study proposes to examine the relationship of shame, trauma, and resiliency with drinking behaviors. My hope is to provide information that will help Puerto Rican psychologists realize that there is more to addiction than compulsive behaviors and that shame and trauma may play a more significant role in it.

Hypothesis 1

Human-made and natural disaster trauma are positively correlated with more drinking behaviors.

Hypothesis 2

Shame will be correlated with higher levels of drinking behaviors. Hence shame and trauma will also be positively correlated.

Hypothesis 3

Having low levels of trauma and/or shame and/or drinking behaviors will be negatively correlated with resiliency.

Demographic Hypothesis

Shame and trauma. Puerto Ricans' level of shame and trauma responses will be negatively correlated with immigrants on the island. Puerto Ricans level of shame will be significantly different than minority groups (Dominicans, Americans, Cubans, etc.). Women will have significantly higher levels of shame and trauma responses than men.

Resiliency. Puerto Ricans will significantly have higher resilience than minorities on the island.

Drinking. Individuals with a lower SES will be significantly higher in drinking behaviors.

Chapter 2

Methods

Participants

Of the 189 participants, 12 do not identify as Puerto Ricans, 177 identify as Puerto Rican, 106 identify as women and 81 as men. Of the 189 participants, $N = 58$ are considered young adults (18-35-year-olds), $N = 64$ fall under the category of middle-aged adults (36-55 year olds) and $N = 61$ are late adults (ages 56 and up). Of the 189 participants, $N = 61$ report having at least a doctorate, 92% of these have a Medical Degree, $N = 42$ report having a master's degree, $N = 57$ report having a bachelor's degree, and $N = 29$ report having either an associate's degree, high school degree or less. Additional information on the participants' education and occupation is found in Table 1. Similarly, additional information of the current place of residence of the participants is found in Table 2.

Table 1

Degree's Earned

	Frequency	**Percent**
Less than or equivalent to a High School Degree	29	15.3
Bachelor's Degree	57	30.2
Master's Degree	42	22.2
Doctorate Degree	61	32.3
Medical Degree	58	30.7
Science Degree	66	35.0
No job	16	8.5
Currently a Student	14	7.4

Table 2

Respondents Region on the Island

Region on the Island	Frequency	Percent
Oeste/West	10	5.3
Norte/North	19	10.1
Metro Norte/ Metro North	64	33.9
San Juan	59	31.2
Sur-Oeste/ South West	10	5.3
Sur-Este/ South East	3	1.6
Este/ East	10	5.3
Nor-Este/ North East	14	7.4

Similarly, of the 189 participants, $N = 3$ identify with low SES, $N = 31$ with low-middle SES, $N = 71$ with middle SES, $N = 53$ with middle-upper SES and $N = 31$ with upper SES. More information of socio economic status is found in Table 3.

Table 3

Respondents Socio Economic Status

Socio Economic Status	Frequency	Percent
Low SES	3	1.6
Low-Middle SES	31	16.4
Middle SES	71	37.6
Middle-High SES	53	28
High SES	31	16.4

Materials

The materials used in this study include a demographic questionnaire, questions regarding hurricane adversities, the 10-Item Connor-Davidson Resilience Scale, The Other as Shamer Scale, Adverse Childhood Experiences (ACES) and the Perceived Stress Scale-10.

10-Item Connor-Davidson Resilience Scale (Campbell-Sills & Stein, 2007)**.** This scale is a briefer version (10-item scale) of the 25 item Connor-Davidson Resilience Scale (CD-RISC). In the 10-item CD-RISC participants are asked to rate 10 statements as; not true at all, rarely true, sometimes true, often true, or true nearly all of the time. In order to shorten the CD-RISC, the researchers applied exploratory and confirmatory factor analytic methods to the 25 item CD-RISC (Campbell-Sills & Stein, 2007). The items that were retained in the 10-item CD-RISC reflect a person's ability to tolerate painful feelings, change, personal problems, illness, failure and pressure (Campbell-Sills & Stein, 2007). Additionally, Campbell-Sills and Stein (2007) offered preliminary support for construct validity by demonstrating that the "10- item CD-RISC measures a characteristic that differentiates individuals who are functioning well after adversity from those who are not" (p. 1026). Campbell-Sills and Stein (2007) argue that the 10-item CD-RISC captures the primary aspects of resiliency by showing high correlation (r =.92) with the CD-RISC. Also, this instrument is highly reliable by having a Cronbach's alpha of .85 (Campbell-Sills & Stein, 2007). Similar results on reliability were also obtained on a Spanish version of the 10-item CD-RISC, Cronbach alpha of .88 (Notario-Pacheco et al., 2014). The Cronbach alpha obtained in this current sample was of .80. The score for the 10-item CD-RISC is calculated by adding the total of all items; the higher the total score, the more resilient a person has.

The Other as Shamer Scale (OAS; Goss, Gilbert & Allan, 1994)**.** The Other as Shamer Scale (Goss, Gilbert, & Allan, 1994) is comprised of 18 statements; each participant is asked to rate these statements in accordance with the frequency they occur. These are rated using a 5-point rating scale from 0 (*never*) to 4 (*almost always*). Goss et al. (1994) chose the 18 items from the Internalized Shame Scale (Cook, 1993) "to measure global judgments about how the self is evaluated by others" (Balsamo et al., 2014, p. 3). The scale is highly reliable, with a Cronbach's alpha of .92 (Goss et al., 1994). The Italian version of the OAS had a Cronbach's alpha of .87 (Balsamo et al., 2014). A factor analysis was used to determine subscales using a varimax rotation and inclusion of .4 and higher (Goss et al., 1994, p.715). The solution of this produced three core factors that accounted for 60.4% of the variance (Goss et al., 1994). Factor 1 consisted of items related to someone being seen as inferior (Goss et al., 1994). Factor 2 consisted of items relating to emptiness (Goss et al., 1994). Factor 3 consisted of items relating to "how others react when they see me make mistakes" (Goss et al., 1994, p. 715). The Cronbach's alpha obtained in this research was of .90. The score for the OAS is calculated by adding the total of all items; the higher the total score, the more shame the person experiences.

For this study, the Other as Shamer Scale is going to be translated into Spanish. Initially, a forward translation will be done, and afterward, an expert panel of individuals who are both culturally and linguistically knowledgeable about the concept of shame in Latinos will be consulted. Further on, a back translation will be conducted to guarantee that the essence of the items is fully grasped. Afterward, a group of Puerto Ricans will receive the translated document and will participate in a pre-test; this will also be accompanied with an interview about the questionnaire. Once these steps have been taken the final version will be drafted and used.

Adverse Childhood Experiences (Felitti et al., 1998)**.** The Adverse Childhood Experience Questionnaire is comprised of 10 questions that measure childhood maltreatment and family dysfunction (Felitti et al., 1998). The questions of childhood maltreatment include questions on psychological, physical, and sexual abuse as a child (Felitti et al., 1998). The family dysfunction category includes questions on childhood exposure to drugs or alcohol, mental illness in the household, mother experiencing violence, and exposure to any criminal behavior in the household (Felitti et al., 1998). Felitti et al., (1998) found this questionnaire to have an adequate internal validity of .77. However, for the purposes of this study, a Spanish version of the questionnaire was used (n.d.); unfortunately no research on the psychometric properties of such measure was found. However, the Cronbach's alpha obtained in this current sample was of .50. When it comes to scoring the ACES, for every answer the participant responded as yes, he/she will earn score of one. The ACES score is calculated by adding the total of all the answers; the higher the score, the more adverse childhood experiences the person has had.

Perceived Stress Scale-10 (Lee, 2013)**.** The Perceived Stress Scale is one of the most widely used instruments to measure stress (Lee, 2013). This measure focuses on bringing to awareness how unpredictable, overloaded, and uncontrollable respondents find their lives (Lee, 2013). In research conducted to study the psychometric qualities of the translations of the PSS, the results showed that for all translations of the PSS-10 the Cronbach's alpha is greater than .70. Also the hypothesis tests of the PSS showed a consistency in its ability to have a correlation (Lee, 2013). PSS-10 scores are obtained by reversing responses of items 4, 5, 7, and 8, and then summing across all scale items; the higher the scores, the more stressed the participant has been.

With regards to the Spanish version of the PSS-10, the reliability is that of .82 (Remor, 2006). Remor (2006) conducted a concurrent validity and results showed that the PSS-10 was highly correlated with other instruments that measure similar constructs. However, The Cronbach's alpha obtained in this research was of .89.

Obsessive Compulsive Drinking Scale (Valladolid & Ruiz, 1999)**.** The OCDS was developed to measure compulsivity and obsessiveness related to cravings and drinking behaviors (Anton, Moak & Latham, 1995). The OCDS is a self-administered questionnaire comprised of 14 items and scored by totaling all items (Anton et al., 1995). The validity of the Spanish version of the OCDS is good, with a correlation of the test re-test of $r = .95$ (Valladolid & Ruiz, 1999). With regards to the reliability of the Spanish version of the OCDS, the researchers calculated internal consistency (Valladolid & Ruiz, 1999). Valladolid and Ruiz's (1999) results show that the subscale that measures the obsession of craving and drinking behaviors has a Cronbach's alpha of .85. The subscale that measures compulsions around cravings and drinking behaviors has a Cronbach alpha of .71 (Valladolid & Ruiz, 1999). The Cronbach alpha for all the instrument is of .87 (Valladolid & Ruiz, 1999). The Cronbach's alpha obtained in this research is of .73. The score for the OCDS is calculated by adding the total of all items; the higher the total score, the more obsessionality and compulsivity related to cravings and drinking behaviors. Subsequently, by adding items one to six the total score for the obsessive subscale will be obtained and by adding items seven to fourteen the total score for the compulsive subscale will also be obtained.

Procedure

Approval was obtained from the George Fox University IRB. People from the island of Puerto Rico were invited via a snowball sampling technique to answer the questionnaires on a paper or electronic form; people were invited to participate from the summer of 2018 until December 2018. Snowball sampling was principally implemented using social media, in particular Facebook. At the end of the electronic questionnaire, participants were asked to share the link to the questionnaire with other people who live on the island. Additionally, community and organizational leaders were recruited in order to distribute the questionnaire via email,. However, to guarantee the participation of people who do not have access to social media, paper forms were also distributed. Like the electronic forms, community/organizational leaders were provided paper forms to distribute to participants who had no access to the electronic format. These community and organizational leaders distributed and collected such forms.

On the first page of the electronic and paper questionnaires, participants were provided with the informed consent. After agreeing to participate, they were asked to complete the demographic questionnaire, including questions regarding the participant's ethnicity, gender, age and parental occupations. For those completing the electronic form, a question regarding their current place of residence was included, to insure they reside on the island. Subsequently, participants answered the Other as Shamer Scale, The 10-item Connor Davidson Resilience Scale, The Adverse Childhood Experiences Questionnaire, Perceived Stress Scale-10 and the Obsessive Compulsive Drinking Scale. Finally, they answered questions regarding the effect and impact of Hurricane Maria (Harville et al., 2015).

Data Analysis

Pearson's R correlations was used to evaluate the correlation between shame, trauma-stress responses, resiliency and drinking behaviors. Once the correlations were obtained, a regression analysis was conducted. Independent t or One-way ANOVA were used to analyze the modifying effect of the demographic variables on the independent and dependent variables of shame, resiliency, trauma-stress response and drinking behaviors. The independent variables for this study are trauma (ACES), life stress (PSS-10), shame (OAS) and resiliency (10-item CD-RISC). The dependent variable is drinking behaviors (OCDS). Modifying variables are gender, SES, ethnicity, and education. All of the measurements used to measure the variables, both independent and dependent, are scaled.

Chapter 3

Results

Descriptives

Table 4 lists the descriptive statistics for the variable used in the study including; faith levels, adverse childhood experiences, levels of hurricane adversities, current stress, shame and resiliency.

Table 4

Descriptive Statistics

	n	*M*	*SD*
Faith	189	3.10	1.63
ACES	189	1.38	1.53
Hurricane Adversities	189	25.22	9.56
Stress	189	14.21	6.78
Shame	189	14.32	11.804
Resilience	189	31.54	6.639

Of the total sample, 73% reported that faith is important to them. 63 % reported having experienced at least one childhood adversity.

Looking at Table 4 more closely, the mean ACES score is consistent with previous research done in Puerto Rico, but it is a low score (Ramos-Olazagasti et al., 2017). In terms of stress scores the mean score is consistent with the norm for Hispanic individuals (*M*(*SD*) = 14.7(7.2) . Looking at hurricane adversities the mean score falls in the below average range. In

terms of shame the mean score for this sample is slightly lower than the mean score for the norm (*M*(*SD*) = 20 (10.1)).

Drinking. A total of 183 participants responded to the Obsessive Compulsive Drinking Scale (OCDS), 30.2% reported they do not consume any alcohol, and 24 % reported that, when they drink, they consume more than 12.5 drinks per week. Table 5 includes additional information on drinking behaviors. Results were different than those of the norm for people who have alcohol use dependency (*M*(*SD*) = 23(6), *M*(*SD*) = 25(5)).

Table 5

Drinking Between Ethnicities

	N	*M*	*SD*
OCDS	183	3.06	3.05
OCDS Minorities	12	1.25	1.215
OCDS Puerto Ricans	117	3.20	3.09
Total Amount of Drinks	183	3.13	4.92
Total Amount of Drinks Minorities	12	1.92	1.78
Total Amount of Drinks Puerto Ricans	117	3.86	3.203

Note. Minorities are those individuals who do not identify as Puerto Rican.

Correlations

Hypothesis 1. A Pearson Product Moment correlation was used to assess the first hypothesis in which it stated that there would be a positive relationship between the ACES scores and the total score for hurricane adversities and drinking behavior. There was no relationship between ACES and hurricane adversities ($r(183) = .042$, $p = .569$), and ACES and drinking behavior, ($r(183) = .047$, $p = .530$). However, when people who have a medical degree

are evaluated separately, a positive relationship exists between total ACES score and the number of drinks people have when they drink, ($r(58) = .335$, $p = .011$).

Hypothesis 2. The second hypothesis was that shame would be positively correlated with higher levels of drinking behaviors (OCDS) and trauma. There was a small positive relationship between the total shame score and the total score of the OCDS ($r(189) = .162$, $p = .025$). When divided into specific groups, this relationship appears only in late adults ($r(67) = .327$, $p = .010$), medical doctors ($r(58) = .363$, $p = .005$), participants with doctoral degrees ($r = .282$), and men ($r(61) = .228$, $p = .027$). However, there is no relationship between the total shame score and the weekly number of drinks people take when they drink ($r(183) = .023$, $p = .758$). The results indicated that a positive correlation exists between the ACES scores and the total shame scores ($r(189) = .375$, $p < .001$).

Hypothesis 3. Having low levels of trauma and/or shame and/or drinking behaviors will be negatively correlated with resiliency. The Pearson correlation indicated that a small negative relationship exists between resiliency and the ACES scores ($r = (189) = -.175$, $p = .016$), as seen in Table 6, demonstrating that people who have experienced fewer ACES have higher resilience. Similarly, a significant negative relationship exists between resiliency and shame ($r(189) = -.356$, $p < .001$). However, the results indicated a positive relationship between resilience and the number of drinks people have, when they drink on a given week, exists ($r(183) = .149$, $p = .010$) (See Table 6 and Figure 1).

Similarly, a significant relationship was also seen with doctors ($r(59) = .271$, $p = .038$) (See Figure 2). Additionally, a positive relationship was seen between resilience and the total OCDS in, middle-aged adults ($r(64) = .257$, $p = .041$). Furthermore, there is a positive

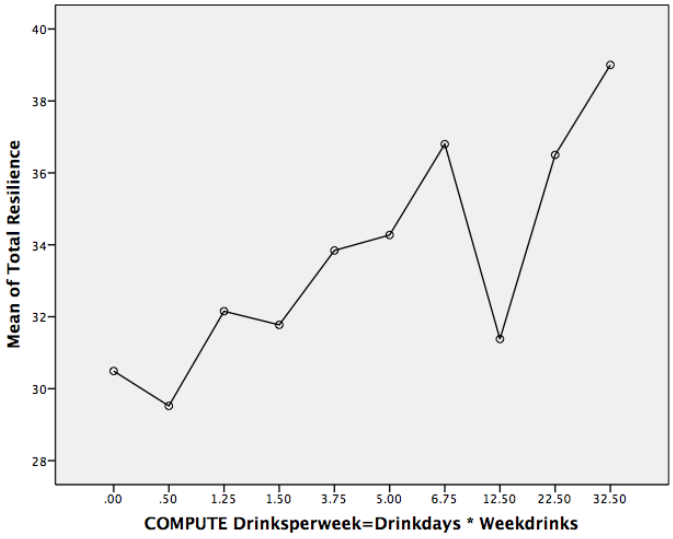

Figure 1. Number of drinks consumed per week and resilience in general sample.

Table 6

Table of Correlations

	1	*2*	*3*	*4*	*5*	*6*
1 Total hurricane	--					
2 Total Stress	.215**	--				
3 Total Aces	.064	.360**	--			
4 Total Shame	.100	.542**	.375**	--		
5 Total Resilience	.114	-.352**	-.175*	-.356**	--	
6 Drinks per week	.047	-.021	.042	.023	.149*	--

*Note. * p < .05; ** p <.01*

relationship between resilience and hurricane-related adversities for specific groups within the sample, women ($r(106) = .242$, $p = .013$), doctors ($r(61) = .256$,$p = .046$), medical doctors ($r(58) = .295$, $p = .025$) and middle-aged adults ($r(64) = .371$, $p = .003$).

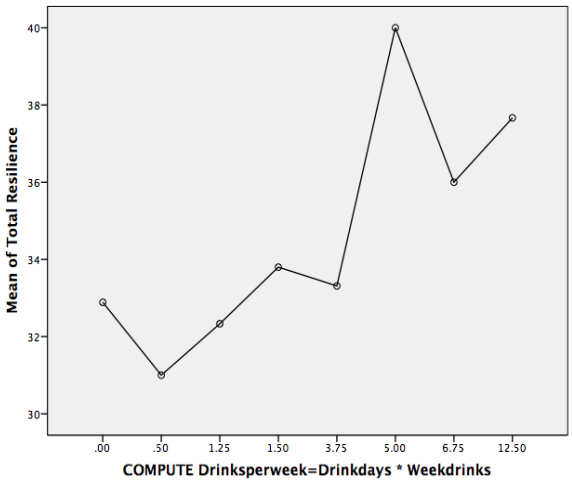

Figure 2. Number of drinks consumed per week and resilience in doctors

Demographic hypothesis.

Shame and trauma. Puerto Ricans' level of shame and trauma responses would be significantly different from minority groups (Dominicans, Americans, Cubans, etc.) according to the first hypothesis. I also hypothesized that women would have significantly higher levels of shame and trauma responses than men.

An Independent Sample *t*-test failed to find any significant differences between people who identify as Puerto Rican and other ethnic groups in their reported shame levels ($t(11.7) = -.373$, $p = .676$; $M(SD) = 14.23(11.532)$; $M(SD) = 16(16.153)$) in their ACES total score ($t(11.8) = -.205$, $p = .643$; $M(SD) = 1.38(1.507)$; $M(SD) = 1.5(1.977)$), in their total hurricane adversities score ($t(12.517) = -1.092$, $p = .965$; $M(SD) = 25.40(9.576)$; $M(SD) = 22.25(9.668)$) and in their total perceived stress score ($t(12.102) = -.016$ $p = .602$; $M(SD) = 14.2(6.73)$; $M(SD) = 14.25(8.08)$). However, a significant difference was found, between minorities and Puerto Ricans, in the number of drinks they take per week when they drink ($t(24.77) = -3.160$, $p = .031$; $M(SD) = 3.28(5.049)$; $M(SD) = 1.27 (1.67)$); while also finding a significant difference in the

total score of the OCDS (t(22.597) = -4.625, p = .05; M(SD) = 3.06(3.05)). Puerto Ricans had higher mean drinking-related behaviors than minorities on the island.

When it comes to the differences between genders; significant differences were found between men and women in ACES score (t(182.086) = 3.649, p = .001) and in their shame levels(t(183.467) = 1.933, p = .008). This shows that women reported having higher ACES (M(SD) = 1.73(.1.71)) and shame levels (M(SD) = 15.79(13.345)) than men (M(SD)= .96(1.145); M(SD)= 12.59(9.272)).

Resiliency. It was also hypothesized that Puerto Ricans would have higher resilience than minorities on the island. An Independent Sample t-test failed to indicate a significant difference in resiliency scores between Puerto Ricans and minority groups, t(12.885) = -.146, p = .944. However, further analysis was completed to understand the differences in resiliency levels in other groups. Using a MANOVA a main effect was found between age groups in levels of resilience (F (2,171) = 4.198, p = .017, n^2 = .047). A Post Hoc demonstrated significant differences in resiliency scores between young adults and middle-aged adults (p = .000; M(SD) = 29.14(6.191); M(SD) = 33.31(6.394)) and young adults and late-life adults (p = .030; M(SD) = 29.14(6.191); M(SD) = 31.74(6.855)). There is not a main effect between middle-aged adults and late-life adults in their level of resilience (p = .091; M(SD) = 33.31(6.394); M(SD) = 31.74(6.855)).

SES. Additionally, it was hypothesized that individuals with a lower SES would be significantly higher in drinking behaviors. The results show that a correlation does not exist between SES and drinking behaviors(r(183) = -.019, p = .801). However, further analysis did indicate that SES correlates with the level of ACES (r(189) = -.315, p < .000), showing a

negative relationship, and between the level of stress ($r(183) = -.372$, $p < .000$), showing a negative relationship as well.

Further Analyses

ACES. Further analysis was done to understand the hypotheses. Such analysis resulted in a positive correlation between the ACES scores and perceived stress ($r(183) = .360$, $p < .001$). This relationship indicates that people who have higher ACES history are currently are currently experiencing increased stress. Similarly, people who reported more hurricane-related adversities have higher perceived, current stress ($r(183) = .215$, $p = .003$).

A main effect was found between age groups in levels of ACES($F(2,171) = 4.495$, $p = .013$, $n^2 = .050$). A LSD Post Hoc demonstrated that young adults have significantly different ACES scores than late-life adults ($p = .010$).Young adults had higher ACES scores, $M(SD)$ = 1.72 (1.725) than late-life adults $M(SD) = 1(1.2)$.

Hurricane related adversities. An ANOVA was used to analyze the effect obtained, when trying to understand hurricane related adversities further. This analysis resulted in a main effect for the region where the respondent lives with the hurricane-related adversities, $F(7,1) = 2.104$, $p = .034$. Post Hoc's indicated the people who reported living on the East side of the island ($n = 10$) had the highest level of adversities due to hurricanes, $M(SD) = 32(5.715)$. The people who reported living on the South West part of the island had the lowest level of adversities due to hurricanes $M(SD) = 19.20(10.119)$.

Stress and shame. Further analysis demonstrated that there was a significant positive relationship between perceived stress and shame levels ($r(189) = .542$, $p < .001$). A one-way multivariate analysis of variance was conducted to determine any differences between age

groups and the variables being measured. A statistically significant MANOVA effect was obtained, Pillais' Trace = .002. Main effects were found between age groups in levels of shame ($F(2,171) = 11.644$, $p < .001$, $n^2 = .120$). Furthermore, an ANOVA analysis (Post Hoc Test) demonstrated a significant difference in shame levels between young adults and middle-aged adults ($p < .001$) and young adults and late adults ($p < .001$). This indicates that young adults have higher shame levels, $M(SD) = 21.62(14.850)$, than middle-aged adults, $M(SD) = 10.86(9.419)$, and late adults, $M(SD) = 11.57(7.49)$. Similarly, significant differences exist between young adults and middle-aged adults ($p < .001$), and young adults and late adults ($p < .001$) in their self-reported levels of stress; there was no difference between the other age groups. This difference shows that young adults have higher stress levels, $M(SD) = 17.7(6.87)$, than middle-aged adults, $M(SD) = 12.68(6.8)$, and late adults, $M(SD) = 12.58(5.55)$.

SES. A statistical significant MANOVA effect was obtained, $F(8, 356) = 4.96$, $p < .001$, Pillais' Trace = .009. A one-way analysis of variance was calculated, the analysis found significance in between SES levels and levels of stress ($F(4,178) = 8.212$, $p < .001$), and ACES($F(4,184) = 5.84$, $p < .001$). A Post-Hoc analysis demonstrated a significant difference in ACES scores between individual who identify as low class and middle class ($p = .029$), high middle class ($p = .008$) and high class ($p = .005$). These differences demonstrate that individuals who identify as low class have higher ACES scores, $M(SD) = 3.33$ (4.163), than middle class, $M(SD) = 1.53(1.45)$, high middle class, $M(SD) = .93(1.09)$ and high class, $M(SD) = .82$ (.905). There also appears to be a significant difference in Stress scores between individuals who identify as lower class and low middle class ($p = .037$), middle class ($p = .003$), high middle class ($p = .001$) and high class ($p < .001$). These differences demonstrate that individuals who are lower class

have higher stress, *M*(*SD*)= 25.667(2.51), than low middle class, *M*(*SD*)= 17.67(7.02), middle class *M*(*SD*)= 14.53(7.14), high middle class, *M(SD*)= 13.4(5.49) and high class, *M*(*SD*)= 10.133(4.65). Similarly there appears to be significant differences in Stress levels between individuals who identify as low class and low middle class ($p = .037$), middle class ($p = .003$), high middle class ($p = .001$) and high class ($p < .001$); indicating that people who are low class have higher stress than low middle, middle, middle high and high class.

Career choice. Furthermore, a one-way multivariate analysis of variance was conducted to determine any differences between individuals who are pursuing a career in medicine and those that are not. A statistical significant MANOVA effect was obtained, $F(3, 179) = 5.59$, $p = .001$, Pillais' Trace =.001. v

A main effect was found between the career of medicine and a non-medical career in the respondents level of ACES ($F(1,187) = 13.1$, $p < .001$) and stress ($F(1,181) = 10.19$, $p = .002$). No main effect was found between the career of medicine and non-medical career in respondents level of resilience ($F(1, 187) = 3.01$, $p = .080$). Individual pursuing a career in medicine have lower stress scores, *M*(*SD*) = 11.83(5.03), and ACES scores , *M*(*SD*) = .79(.98) than individuals who are not in the field of medicine (*M*(*SD*) = 15.24(7.18); *M*(*SD*) = 1.68(1.63)).

Chapter 4

Discussion

Puerto Ricans have endured years of trauma caused by natural disasters, colonialism, wars, and adverse experiences. Therefore, Puerto Ricans have are faced with finding ways to cope with current and historical adversities without understanding the impact these have had in their lives. This study investigated the various relationship between trauma, drinking, shame, stress, and resiliency in Puerto Rico. People in Puerto Rico are experiencing a mental health crisis, in part due to the multiple disasters in the past few years. The primary disaster contributing to such mental health crisis was the passing of Hurricane Maria. Hurricane Maria entered through the East side of the island and left through the North-West area, indicating that it was at a higher intensity entering the island and at a lower intensity leaving it (Sostre, 2018). The participants' self-reported level of distress and adversities due to Hurricane Maria is consistent with the hurricane's trajectory. People who experienced the initial impact of the hurricane reported higher levels of hurricane-related adversities, whereas people who reported living in the South-West part of the island reported the fewest. One year after such disasters, people reported that hurricane-related adversities were in the average range, consistent with previous research conducted only a few months after the hurricane (Blasini-Méndez et al., 2018). Puerto Ricans are a very empathic and resilient group of people and report having lower hurricane-related adversities when they are aware that someone is worse off (Blasini-Méndez et al., 2018).

People living on the island who were affected by the hurricanes and have an ACES history seem to experience more current stress than those individuals with fewer ACES. This is consistent with current literature; individuals who have an ACES history experience current life stressors with more difficulty, they report having more life stressors (Kendall-Tackett, 2002). Similarly to Blasini-Méndez et al.'s (2018) findings in individuals' reported levels of hurricane-related adversities, people in Puerto Rico reported having fewer ACES than expected by researchers. However, overall ACES scores were consistent with the literature (Ramos-Olazagasti et al., 2017). Women on the island reported experiencing more childhood adversities than men on the island. These differences in ACES scores between men and women might be because men tend to under-report their experiences of ACES or because women tend to experience adversities due to sexist components of the Puerto Rican culture. This is consistent with Police Department Statistics and Puerto Rican local media outlets (Estadisticas sobre violencia domestica, 2017; Tighe & Gurley, 2018). Women in Puerto Rico have had to endure years of domestic violence due to the lack of attention to such issues by the government. Recently, the Puerto Rican governor declared the island in a state of emergency because of the overwhelming amount of cases of domestic violence, mainly aimed towards women.

Not only is Puerto Rico experiencing a domestic violence crisis but also experiencing an economic crisis. Due to the economic crisis, many Puerto Ricans struggle to provide for themselves and loved ones. Poverty is a struggle that is not new for the island. Poverty has a lasting impact on the lives of people as well as on many Puerto Ricans. Stress affects individuals who are in varying SES's differently. A negative relationship was seen between SES and stress scores, which is consistent with the literature (Felitti et al., 1998). This is indicative that being in

a higher SES prevents individuals from experiencing specific life stressors. These results might be indicating that an area of significant stress for Puerto Ricans is job security and financial stability. These results were also prevalent when looking at the differences between participants who are medical students or medical doctors and those who are not. It is likely that the reason why participants who are pursuing a career in medicine exhibit less stress than those who are not is because of job security and financial stability. Puerto Ricans who have a lower SES have a higher ACES score which is consistent with the literature (Felitti et al., 1998). Individuals who come from a more privileged home tend to have more opportunities and experience fewer ACES. Many participants who are pursuing a career in medicine reported lower ACES scores than those who are not pursuing a career in medicine. Being in a higher SES appears to protect individuals from experiencing specific life stressors and from experiencing adversities.

When looking at age groups and exploring the differences in ACES levels, young adults reported having higher ACES scores than late adults. Culturally, this new generation of young adults are fighters and advocates for social justice; hence they are not only able to recognize adversity but they fight against it. Previous generations, late- adults, were taught that adversity is normal and hence they did not report as much adversity because they received the message that it was not an adversity. These are the reasons why young adults reported higher ACES than other age groups. Also, an elevation in childhood adversities might be more common in young adults because, for the last few years, Puerto Rico has been facing an economic crisis and an increase in violence. It was also found that ACES occur to individuals regardless of their ethnicity; childhood adversities do not seem to discriminate among individuals who come from a variety of cultural backgrounds (i.e., Dominican, Cuban, Spanish, etc.).

Subsequently, there is no relationship between ACES and Hurricane adversity which is consistent with what Inoue et al. (2017) propose. Inoue et al. (2017) argue that people who have an ACES history are able to respond better to natural disaster adversities. While having an ACES history does not seem to affect if individuals experience a natural disaster negatively, having had experienced a hurricane in the past affects individuals' current experience of life stress. Hurricane season seems to play a role in participants' reported level of stress. Data was collected during the hurricane season, people who reported having had higher hurricane-related adversities had elevated current stress. Stress affects everyone differently. However, there were no significant differences in the levels of stress between ethnic groups, indicating that ethnicity did not influence this variable.

I was also interested in the effect of shame on Puerto Ricans. Stress and shame have a positive relationship with each other in this research and previous research (Brown, 2006; Smith, 2017). However, these two variables have significant differences within age groups. Young adults reported having higher levels of shame and stress than middle and late adults. These results are consistent with the idea that social and cultural components play a role in an individual's level of shame (Brown, 2006). Similarly, shame is a fairly new concept in the psychology field. It is likely that young adults have more language to talk about shame than their older counterparts. Therefore, it is likely that middle and late adults are underreporting their levels of shame because they struggle to recognize, put words to, shame.

Similarly, due to the current economic, mental health and violence crisis that Puerto Rico is facing (Barbaro, 2018; Barbot, 2018; Carr, 2018; Montoya-Galvez, 2019; Walsh, 2017), young adults have socio-cultural pressures, and expectations to solve such crises, hence the reason why

they might be experiencing higher levels of shame and stress than other adults. One possibility is that in light of the crises the island is facing, young adults are likely experiencing more shame and stress because they are proposing new ideas and fighting against oppressive forces to solve such crises that are causing the older generations to use shaming practices as a way to regain control of these young adults.

I found a positive relationship between shame and trauma which is consistent with what Smith (2017) proposes. While young adults seem to exhibit more shame than older generations, the participants in this study expressed an overall level of shame significantly lower than other populations (Goss et al., 1994). These results are inconsistent with Wong and Tsai's (2007) proposal about collectivistic cultures, where shame plays a much more significant role than individualistic culture. However, within the collectivistic culture of Puerto Rico, men and women experience shame differently. The data shows that women experience more shame than men. This is consistent with the idea that since men and women have different socio-cultural expectations, they experience shame differently (Brown, 2006). It does call into question the experience of increased shame in a collectivistic culture.

People who experience shame, stress, and trauma engage in various ways of coping. Historically drinking has played a crucial role in Puerto Rican culture; the Puerto Rican man consumes and average of 16.9 drinks a week, and women and average of 9.5 drinks per week (Ramisetty-Mikler, Caetano, & Rodriguez, 2010). Puerto Ricans engage in more drinking behaviors than other minorities (Ramisetty-Mikler et al., 2010). Some might say that drinking is one of the ways Puerto Ricans cope with adversities. However, hurricane-related adversities and ACES scores did not have a significant relationship with drinking behaviors which is

inconsistent with previous research (Cerdá et al., 2011; Ertl et al., 2016; Iglesias et al., 2005; Ramos-Olazagasti et al., 2017). This suggests that, when it comes to Puerto Ricans, alcohol might not be used to numb or self-medicate when coping with a traumatic event. These results might be inconsistent with previous research due to the cultural role alcohol use has in Puerto Rican culture. A relationship between ACES and drinking is only seen when looking at individuals who have a medical degree. This specific population likely exhibited this type of relationship due to the stronger American influence (i.e., American medical literature and American education) in their field of work.

While a positive relationship was not observed between ACES and drinking within the sample as a whole, a positive relationship exists between shame and the total score of the OCDS; these results are consistent with the literature (Patock-Peckman et al., 2018; Smith, 2017). On the other hand, shame was not correlated with the number of drinks people consumed when they drink. The amount of drinks individuals take does not dictate if they are engaging in problematic drinking, but the *thinking* behind the drinking is what dictates problematic drinking. Hence, the reason why there is a relationship with the total OCDS score and not with the number of drinks. This might indicate that some Puerto Ricans use drinking to cope with shame. However, a positive correlation between OCDS scores and shame is only observed in men, late adults, medical doctors, and people with doctorate degrees. This might indicate that these particular groups use alcohol in a culturally problematic way to cope with shame. Looking at the results in more detail, they failed to support a relationship between SES and drinking

To further understand the role drinking has in Puerto Rico, I studied the relationship between resilience and drinking. A positive relationship occurred between resilience and the

number of drinks people have when they drink on a given week. This is inconsistent with the previous research (Becoña et al., 2005; Long et al., 2016). Culturally, alcohol use is viewed as a way to connect with others and develop interpersonal relationships. Thus, one might expect that this positive relationship is due to the cultural role drinking has in Puerto Rico; facilitating a sense of community with others, and fostering resiliency, because the more connected people are to others the more supported they feel and consequently higher their resilience. However, Maté (2018) and Hari (2015) might argue that addiction serves as a temporary relief, and might give a false idea of connection to Puerto Ricans. It is possible that these results were found because drinking is giving some participants the false idea of having a connection, they are developing a connection with the substance, and hence are reporting higher resilience because they think they are connected to others.

Continuing to look at the role drinking has in Puerto Rico, I found that when looking at a specific age group, middle-aged adults, there is also a positive relationship between resiliency and the OCDS. These results might suggest that, when compared to other groups, middle-aged adults engage in more culturally problematic drinking. This might be due to the developmental stage they are at; mid-life crisis and being care-takers of the young and old.

While Puerto Ricans seem to have a unique relationship between drinking and resiliency, when looking at other variables and their relationship with resilience, I can further understand the role resilience plays on the island. Interestingly, even though the island is facing a mental health crisis, the resilience scores are significantly high, which is consistent with previous research done with this population (Blasini-Méndez et al., 2018). It was interesting how various groups of people might respond differently or have different levels of resilience. Young adults

have lower levels of resilience than middle and late adults. This might be since young adults report higher levels of stress, shame, and ACES. Participants that exhibited higher levels of shame and trauma exhibited lower levels of resilience, which is consistent with what the literature concludes (Tedeschi & Calhoun, 2004; Zerach et al., 2013), therefore, indicating that resilience might serve as a protective factor from these issues. Looking at natural disaster trauma more specifically, it was interesting how various groups (women, people with doctorates, medical doctors and middle-aged adults) responded in a way that a positive relationship between resiliency and hurricane-related adversities was seen. However, there were no significant differences between Puerto Ricans' level of resiliency and other minorities, which indicates that, when it comes to levels of resiliency in Puerto Rico, ethnicity does not matter.

Limitations and Future Research

The limitations of this study are apparent. Most of the measures, except for resiliency, were not normed with a Puerto Rican population. Likely, these did not capture how shame, childhood, and hurricane-related adversities, drinking behaviors, and overall stress looks in this particular cultural group. This might also explain the reason for the mean scores for shame, ACES, OCDS, and other drinking-related behaviors scores being low. Therefore, future researchers are encouraged to study these constructs qualitatively; in particular exploratory research. By doing qualitative research, a more in-depth understanding of shame, adverse childhood experiences, hurricane-related experiences, and drinking-related behaviors can occur. It is also highly encouraged for future researchers to study the physiological differences/responses between Puerto Ricans who engage in culturally appropriate problematic

drinking behaviors and those who do not. Such studies will add to an understanding of these factors in Puerto Rico.

Subsequently, this research is not representative of the Puerto Rican's economic struggles. A significant percentage of the Puerto Rican population falls under what the United States Government considers poverty. The sample for this study had a tiny percentage of individuals who considered themselves part of a lower SES. Therefore, future research must be done with a sample that truly represents the Puerto Rican population. Similarly, most of the data were collected online, which prohibits individuals, who do not have access to social media or do not have the resources to own a computer, from participating in the research.

Clinical Implications

Due to the lack of research around problematic drinking in Puerto Rico and the cultural role drinking has, therapists are recommended to carefully use their clinical judgment to determine if a patient's drinking is problematic. Due to the cultural implications around drinking, it is essential to note that the number of drinks an individual takes does not dictate if they are engaging in problematic drinking. Some culturally sensitive ways to detect if a person is engaging in problematic drinking is if people around them worry about their drinking, and if their drinking is causing distress to those around them. Another way to determine if patients are engaging in problematic drinking is if individuals are drinking to numb or avoid life stressors, situations or pain. Some questions therapist might ask themselves when assessing this are: What is the function of the drinking? What good are they taking out of the drinking? It is encouraged that therapists not treat the drinking and treat the pain, trauma, or shame that is correlated to their drinking; symptoms will likely dissipate if they do. Another culturally sensitive way to determine

if someone is engaging in problematic drinking is if, from a physiological perspective, their body is responding negatively to their drinking.

Young adults appear to exhibit higher shame and stress than other age groups. Therapists must be aware of the socio-cultural factors that might be playing a role in young adults' level of shame and stress. Such therapists need to be mindful of the interplay of these factors and provide a therapeutic environment without judgment and with empathy as a way for them to explore their stressors and feel accepted and cared by someone who does not have the same expectations others have of them. Similarly, it is likely that middle and late adults don't have the language to talk about shame and ACES. It is likely that through being in a therapeutic relationship these groups of people might be able to gain insight in the impact shame and ACES have had in their lives.

It is also essential to recognize that Puerto Ricans are highly resilient. When working with Puerto Ricans, it is crucial to have this in mind because some individuals might not be aware of their ability to overcome hardship. Sometimes patients are not aware of strengths they have that might help them overcome life challenges. Hence therapists need to bring these strengths into the patients' awareness as a way for the patient to lean into such strengths and have quicker and better outcomes.

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Appendix A

Informed Consent

I, _____(please write your name), agree to participate in the dissertation study under the direction of Manuel Blasini and under the supervision of Dr. Winston Seegobin. The purpose of the study is to better understand the relationship between trauma/stress, resiliency, shame and drinking behaviors in Puerto Rico. I will be asked to fill out questionnaires about trauma/stress, resiliency, shame and drinking. I understand that I may feel some discomfort. Some of the questions I am asked may negatively affect my mood. I understand that I can choose to not participate in this study. I understand that my information will remain confidential. The information gathered in this study will be stored securely. No information identifying me will ever be published in connection with this study. I am 18 years of age or older and can provide my consent. I consent to participate in the research described above.

_____ _____

Participant Signature Date

Consentimiento

Yo, _____ (escriba su nombre), acepto participar en el estudio de disertación bajo la dirección de Manuel Blasini y bajo la supervisión del Dr. Winston Seegobin. El propósito del estudio es comprender mejor la relación entre trauma / estrés, resiliencia, vergüenza (shame) y conductas de consumo de alcohol en Puerto Rico. Se me pedirá que complete cuestionarios sobre trauma / estrés, resiliencia, vergüenza (shame) y consumo de alcohol. Entiendo que puedo sentir algo de incomodidad al contestar las preguntas. Algunas de las preguntas que me harán pueden afectar negativamente mi estado de ánimo. Entiendo que puedo elegir no participar en este estudio. Sin embargo, si decido participar y siento que las preguntas me an afectado negativamente voy a llamar al siguiente numero, 1 (800) 273 8255 (crisis hotline). Entiendo que mi información será confidencial. La información recopilada en este estudio se guardare de forma segura. No se publicará ninguna información que me identifique con este estudio. Tengo 18 años de edad o más y puedo dar mi consentimiento. Doy mi consentimiento para participar en la investigación descrita anteriormente.

_____ _____

Firma de Participante Fecha

Apendix B

Test Instruments

English Questionnaires

Demographics:

1. Where do you currently live?
    a. Puerto Rico
    b. USA
    c. Not in Puerto Rico or USA
2. If you live in the US in what region do you live?
    a. New England
    b. Middle Atlantic
    c. South Atlantic
    d. East North Central
    e. East South Central
    f. West North Central
    g. West South Central
    h. Pacific
    i. Hawaii or Alaska
3. If you live in PR, in what region do you live?
    a. North
    b. Metro North
    c. West
    d. South West
    e. San Juan
    f. South East
    g. North East
    h. East

4. Which is your country of origin?
    a. _____
5. With which ethnic group do you identify with?
    a. _____
6. What is your gender?
    a. _____
7. What is your age?
    a. _____
8. In your childhood, what was your dad's occupation?
    a. _____

9. In your childhood, what was your mother's occupation?
    a. _____
10. If you have any occupation, write it in the line? If you don't have any occupation write none. If you have a job and also are a student write your occupation/ student.
    a. _____
11. Which is your highest obtained degree?
    a. None
    b. Elementary school
    c. High school
    d. Associate's degree
    e. Bachelor's degree
    f. Master's degree
    g. Doctorate degree
    h. Other
12. How would you describe your socio economic status?
    a. Lower class
    b. Middle-lower class
    c. Middle class
    d. Upper-middle class
    e. Upper class
13. How true is the following statement? "My faith is very important to me"
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly disagree

Maria/ Irma

Read the following sentences and say how true they are, in light of your experiences during and after hurricane Irma or María.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I felt like my life was in danger when the hurricane/flood struck or during the aftermath					
The hurricane caused me to					

have an illness or injury					
The hurricane caused some other member in my family to have an illness or injury					
The hurricane damaged my home					
I lost belongings that were/will be expensive to replace					
I lost things of sentimental value					
The hurricane caused significant damages to the property and belongings of my family					
Someone close to me died as a consequence of the hurricane					
I saw someone die as a consequence of the hurricane					
I walked in through floodwaters					
I did not have access to portable water for a long time					

I had issues with the electricity of my home					
I was without power for more than a month					
I did not have acces to food					

Adverse Childhood Experience (ACE) Questionnaire Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ... Swear at you, insult you, put you down, or humiliate you? **or** Act in a way that made you afraid that you might be physically hurt?

- Yes
- No

2. Did a parent or other adult in the household **often** ... Push, grab, slap, or throw something at you? **or Ever** hit you so hard that you had marks or were injured?

- Yes
- No

3. Did an adult or person at least 5 years older than you **ever**... Touch or fondle you or have you touch their body in a sexual way? **or** Try to or actually have oral, anal, or vaginal sex with you?

- Yes
- No

4. Did you **often** feel that ... No one in your family loved you or thought you were important or special? **or** Your family didn't look out for each other, feel close to each other, or support each other?

- Yes
- No

5. Did you **often** feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **or** Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

- Yes
- No

6. Were your parents **ever** separated or divorced?

- Yes
- No

7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **or Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **or Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?

- Yes
- No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

- Yes
- No

1. Was a household member depressed or mentally ill or did a household member attempt suicide?
   - Yes
   - No
2. Did a household member go to prison?
   - Yes
   - No

OCDS

Directions: The questions below ask you about your drinking alcohol and your attempts to control your drinking**.** Please circle the number next to the statement that best applies to you.

3. How much of your time when you're not drinking is occupied by ideas, thoughts, impulses or images related to drinking?

(0) None
(1) Less than 1 hour a day
(2) 1-3 hours a day
(3) 4-8 hours a day
(4) Greater than 8 hours a day

4. How frequently do these thoughts occur?

(0) Never
(1) No more than 8 times a day
(2) More than 8 times a day but most hours of the day are free of those thoughts
(3) More than 8 times a day and during most hours of the day
(4) Thoughts are too numerous to count and an hour rarely passes without several such thoughts occurring

5. How much do these ideas, thoughts, impulses or images related to drinking interfere with your social or work (or role) functioning? Is there anything you don't or can't do because of them? (If you are not currently working, how much of your performance would be affected if you were working?

(0) Thoughts of drinking never interfere – I can function normally.
(1) Thoughts of drinking slightly interfere with my social or occupational activities, but my overall performance is not impaired
(2) Thoughts of drinking definitely interfere with my social or occupational performance, but I can still manage.
(3) Thoughts of drinking cause substantial impairment in my social or occupational performance.
(4) Thoughts of drinking interfere completely with my social or work performance.

6. How much distress or disturbance do these ideas, thoughts, impulses, or images related to drinking cause you when you're not drinking?

(0) None
(1) Mild, infrequent and not too disturbing
(2) Moderate, frequent and disturbing, but still manageable
(3) Severe, very frequent and very disturbing
(4) Extreme, nearly constant, and disabling distress

7. How much of an effort do you make to resist these thoughts or try to disregard or turn your attention away from these thoughts as they enter your mind when you're not

drinking? (Rate your effort made to resist these thoughts, not your success or failure in actually controlling them.)

(0) My thoughts are so minimal, I don't need to actively resist. If I have thoughts, I make an effort to *always* resist.
(1) I try to resist most of the time.
(2) I make some effort to resist.
(3) I give in to all such thoughts without attempting to control them, but I do so with some reluctance.
(4) I completely and willingly give in to all such thoughts.

8. How successful are you in stopping or diverting these thoughts when you're not drinking?

(0) I am completely successful in stopping or diverting such thoughts.
(1) I am usually able to stop or divert such thoughts with some effort and concentration.
(2) I am sometimes able to stop or divert such thoughts.
(3) I am rarely successful in stopping such thoughts and can only divert such thoughts with difficulty.
(4) I am rarely able to divert such thoughts even momentarily.

9. How many drinks do you drink each day?

(0) None
(1) Less than 1 drink per day
(2) 1-2 drinks per day
(3) 3-7 drinks per day
(5) 8 or more drinks per day

10. How many days each week do you drink?

(0) None
(1) No more than 1 day per week
(2) 2-3 days per week
(3) 4-5 days per week
(4) 6-7 days per week

Insert the Higher Score of Question 7 or 8 here ___

9. How much does your drinking interfere with your work functioning? Is there anything that you don't or can't do because of your drinking? (If you are not currently working, how much of your performance would be affected if you were working?)

(0) Drinking never interferes – I can function normally

(1) Drinking slightly interferes with my occupational activities, but my overall performance is not impaired.
(2) Drinking definitely interferes with my occupational activities, but I can still manage.
(3) Drinking causes substantial impairment in my occupational performance.
(4) Drinking problems interfere completely with my work performance.

10. How much does your drinking interfere with your social functioning? Is there anything that you don't or can't do because of your drinking?

(0) Drinking never interferes – I can function normally.
(1) Drinking slightly interferes with my social activities, but my overall performance is not impaired.
(2) Drinking definitely interferes with my social performance.
(3) Drinking causes substantial impairment in my social performance.
(4) Drinking problems interfere completely with my social performance .

Insert the Higher Score of Questions 9 or 10 here ____

1. If you were prevented from drinking alcohol when you desired a drink, how anxious or upset would you become?

(0) I would not experience any anxiety or irritation.
(1) I would become only slightly anxious or irritated.
(2) The anxiety or irritation would mount but remain manageable.
(3) I would experience a prominent and very disturbing increase in anxiety or irritation.
(4) I would experience incapacitating anxiety or irritation.

2. How much of an effort do you make to resist consumption of alcoholic beverages? (Only <u>rate your effort to resist</u>, not your success or failure in actually controlling the drinking).

(0) My drinking is so minimal, I don't need to actively resist. If I drink, I make an effort to always resist.
(1) I try to resist most of the time.
(2) I make some effort to resist.
(3) I give in to almost all drinking without attempting to control it, but I do so with some reluctance.
(4) I completely and willingly give in to all drinking.

3. How strong is the drive to consume alcoholic beverages?

(0) No drive
(1) Some pressure to drink
(2) Strong pressure to drink

(3) Very strong drive to drink
(4) The drive to drink is completely involuntary and overpowering.

4. How much control do you have over the drinking?

(0) I have complete control.
(1) I am usually able to exercise voluntary control over it.
(2) I can control it only with difficulty.
(3) I must drink and can only delay drinking with difficulty.
(4) I am rarely able to delay drinking even momentarily.

Insert the higher score of Question 13 or 14 here _____

Other as Shamer Scale

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below.

0	**1**	**2**	**3**	**4**
Never	**Seldom**	**Sometime**	**Frequently**	**Almost Always**

1.I feel other people see me as not good enough.	0 1 2 3 4
2. I think that other people look down on me	0 1 2 3 4
3. Other people put me down a lot	0 1 2 3 4
4. I feel insecure about others opinions of me	0 1 2 3 4
5. Other people see me as not measuring up to them	0 1 2 3 4
6. Other people see me as small and insignificant	0 1 2 3 4
7. Other people see me as somehow defective as a person	0 1 2 3 4
8. People see me as unimportant compared to others	0 1 2 3 4
9. Other people look for my faults	0 1 2 3 4

10. People see me as striving for perfection but being unable to reach my own standards 0 1 2 3 4

11. I think others are able to see my defects 0 1 2 3 4

12. Others are critical or punishing when I make a mistake 0 1 2 3 4

13. People distance themselves from me when I make mistakes 0 1 2 3 4

14. Other people always remember my mistakes 0 1 2 3 4

15. Others see me as fragile 0 1 2 3 4

16. Others see me as empty and unfulfilled 0 1 2 3 4

17. Others think there is something missing in me 0 1 2 3 4

18. Other people think I have lost control over my body and feelings 0 1 2 3 4

Perceived Stress Scale:

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4=Very Often

1.In the last month, how often have you been upset because of something that happened unexpectedly? 0 1 2 3 4

2. In the last month, how often have you felt that you were unable to control the important things in your life? 0 1 2 3 4

3. In the last month, how often have you felt nervous and "stressed"? 0 1 2 3 4

4. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4

5. In the last month, how often have you felt that things were going your way? 0 1 2 3 4

6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0 1 2 3 4
7. In the last month, how often have you been able to control irritations in your life?	0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things?	0 1 2 3 4
9. In the last month, how often have you been angered because of things that were outside of your control?	0 1 2 3 4
10.In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0 1 2 3 4

Resilience scale CD-RISC

For each statement give the response that best describes your experience: **not true at all** (0), **rarely true** (1), **sometimes true** (2), **often true** (3), **true nearly all of the time** (4)

	Not true				**True**
Able to adapt to change	0	1	2	3	4
Can deal with whatever comes	0	1	2	3	4
See the humorous side of things	0	1	2	3	4
Stress makes me stronger	0	1	2	3	4
Bounce back after illness or injury	0	1	2	3	4
Believe I can achieve goals despite obstacles	0	1	2	3	4
Under pressure I stay focused	0	1	2	3	4
Not easily discouraged by failure	0	1	2	3	4
Think of myself as a strong person facing challenges	0	1	2	3	4
Able to handle unpleasant feelings	0	1	2	3	4

Spanish Questionnaire

Datos Demográficos:

1. ¿En que región de la isla usted vive?
    - Norte
    - Metro Norte
    - San Juan
    - Suroeste
    - Oeste
    - Sureste
    - Este
    - Noreste
2. ¿Cuál es su país de nacimiento?
    - _____
3. ¿Con que grupo étnico usted se identifica?
    - _____
4. ¿Cuál es su genero?
    - _____
5. ¿Cual es su edad?
    - _____
6. ¿En su niñez, cuál fue la ocupación de su padre?
    - _____
7. ¿En su niñez, cuál fue la ocupación de su madre?
    - _____
8. ¿Usted, de tener alguna ocupación, cuál tiene? Si no tiene ninguna escriba ninguna. Si es un estudiante a tiempo completo escriba estudiante. Si tiene un trabajo y es estudiante escriba su ocupación/estudiante.
    - _____
9. ¿Cuál es el grado educativo mas alto que a obtenido?
    - Ninguno
    - Escuela Primaria
    - Escuela Secundaria
    - Grado Asociado
    - Bachillerato
    - Maestría
    - Doctorado
    - Otro
10. ¿Cómo usted describiría su estatus socioeconómico actual?
    - Clase baja
    - Clase media-baja
    - Clase media
    - Clase media-alta
    - Clase alta

11. ¿Cuan cierta es la siguiente oración? “Mi fe es importante para mi”
    - Muy en desacuerdo
    - En desacuerdo
    - Neutral
    - De acuerdo
    - Muy de acuerdo

Maria/Irma

Lea cada oración y diga cuan cierto fue a la luz de su experiencia durante y después del huracán María o Irma.

	Muy en Desacuerdo	En Desacuerdo	Neutral	De Acuerdo	Muy de Acuerdo
Yo sentía que mi vida corría peligro durante o después del huracán					
El huracán causó que tuviese alguna enfermedad o lesión					
El huracán causo que algún miembro de mi familia tuviese una enfermedad o lesión					
El huracán causó daños en mi hogar					
Perdí pertenencias que fueron/serán caras en reponer					

Perdí algo de valor sentimental					
El huracán causo daños significativos en la propiedad y pertenencias de miembros de mi familia					
Alguien cercano a mí falleció como consecuencia del huracán					
Ví a alguien morir como consecuencia del huracán					
Caminé en un área inundada					
No tuve acceso a agua potable por mucho tiempo					
Tuve problemas con la electricidad de mi hogar					
Estuve sin luz por mas de un mes					
No tuve acceso a comida					

OCDS

Conteste a las siguientes preguntas indicando la cantidad de alcohol que bebe y sus intentos para controlar su bebida. Marque la contestación que sea más apropiada a su caso.

1. ¿Cuándo no está bebiendo alcohol cuanto tiempo tiene su mente ocupada con pensamientos, deseos, o imágenes relacionadas con el alcohol?
    a. Nunca
    b. Menos de 1 hora diaria
    c. De 1 a 3 horas diarias
    d. De 4 a 8 horas diarias
    e. Más de 8 horas diarias
2. ¿Con qué frecuencia tiene esos pensamientos?
    a. Nunca
    b. No más de 8 veces al día
    c. Más de 8 veces al día, pero estoy libre de ellos la mayor parte del tiempo
    d. Mas de 8 veces al día y durante la mayor parte del tiempo
    e. Los pensamientos son tan frecuentes que no se pueden contar y/o raramente pasa una hora sin que ocurran
3. ¿Cuánto tiempo interfieren estos pensamientos, deseos o imágenes en sus actividades (o responsabilidades) sociales o laborales?. Esta pregunta se refiere a si existe algo que no pueda llevar a cabo o deje de hacer por ellos. (Si en el momento actual no trabaja indique cómo cree que se vería afectado su rendimiento si estuviese trabajando).
    a. Pensar en la bebida no interfiere nunca. Puedo desenvolverme perfectamente.
    b. Los pensamientos sobre la bebida interfieren un poco en mis actividades sociales o laborales, pero mi rendimiento no se ve perjudicado.
    c. Los pensamientos sobre la bebida definitivamente interfieren en mi desenvolvimiento social o laboral, pero aún puedo bregar.
    d. Los pensamientos sobre la bebida causan discapacidades significativas en mi rendimiento ocupacional o social.
    e. Los pensamientos sobre la bebida interfieren totalmente en mi rendimiento laboral o social.
4. ¿Cuánta ansiedad o preocupación le causan estos pensamientos, deseos o imágenes relacionadas con la bebida durante el tiempo en que no está bebiendo alcohol?
    a. Nunca
    b. Leve, infrecuente y no causa demasiada molestia.
    c. Moderada, frecuente y perturbadora, aunque el malestar es manejable
    d. Intensa, muy frecuente y causa mucha molestia
    e. Malestar extremo, casi constante e incapacitante.

5. Durante el tiempo en que no bebe ¿Cuánto esfuerzo le cuesta resistirse o ignorar estos pensamientos, deseos o imágenes?. (Señale los esfuerzos que hace para resistirse a estos pensamientos, no si tiene éxito o fracaso en controlarlos).
    a. Mis pensamientos son tan mínimos que no necesito enfrentarme a ellos. Si tengo pensamientos siempre me enfrento a ellos.
    b. Trato de resistirme a ellos la mayor parte del tiempo.
    c. Hago algún esfuerzo para resistirme.
    d. Cedo a todos los pensamientos sin intentar controlarlos, pero lo hago con cierto rechazo.
    e. Cedo voluntaria y completamente a tales pensamientos.
6. Cuando no está bebiendo ¿En qué medida tiene éxito al intentar parar o alejar tales pensamientos?
    a. Siempre consigo parar o alejar tales pensamientos.
    b. Normalmente soy capaz de parar o desviar tales pensamientos con algún esfuerzo y concentración.
    c. A veces soy capaz de parar o desviar tales pensamientos.
    d. Raramente consigo parar tales pensamientos y solamente puedo desviarlos con dificultad.
    e. Rara vez soy capaz de desviar tales pensamientos, incluso momentáneamente.
7. Cuando bebe alcohol ¿Cuantas bebidas alcohólicas se toma al día?
    a. Ninguna
    b. Menos de una diaria
    c. 1-2 al día
    d. 3-7 al día
    e. 8 ó más al día
8. Cuando bebe alcohol ¿Cuantos días a la semana bebe?
    a. Ninguno
    b. No más de un día a la semana
    c. 2-3 días a la semana
    d. 4-5 días a la semana
    e. 6-7 días a la semana
9. ¿En qué medida su consumo de alcohol interfiere en su trabajo? Esta pregunta se refiere a si existe algo que no hace o no pueda hacer debido a su consumo de alcohol. (Si en el

momento actual no trabaja ¿En qué medida cree se vería afectado su rendimiento si estuviese trabajando?

a. Mi consumo de alcohol nunca interfiere. Puedo desenvolverme perfectamente.
b. Mi consumo de alcohol interfiere un poco en mi trabajo, pero mi rendimiento en general no se ve perjudicado.
c. Mi consumo de alcohol definitivamente interfiere en mi trabajo pero aún puedo bregar
d. La bebida produce daños grave en mi desempeño ocupacional.
e. Los problemas de la bebida interfieren totalmente en la realización de mi trabajo

10. ¿En qué medida interfiere su consumo de alcohol en sus actividades sociales?. Esta pregunta se refiere a si existe algo que no hace o no pueda hacer debido a su consumo de alcohol.
    a. La bebida nunca interfiere. Puedo desenvolverme perfectamente.
    b. La bebida interfiere un poco en mis actividades sociales, pero en conjunto mi comportamiento no se ve perjudicado.
    c. La bebida definitivamente interfiere en mis actividades sociales.
    d. La bebida causa daños graves en mi desempeño social.
    e. Los problemas de la bebida interfieren totalmente en mis actividades sociales.
11. Si se le impidiese beber cuando desea una bebida alcohólica ¿En qué medida se encontraría nervioso o molesto?
    a. No estaría nada nerviosos o irritado.
    b. Estaría un poco nerviosos o irritado.
    c. La inquietud o irritación aumentaría, pero podría controlarla.
    d. Estaría muy nervioso o irritado.
    e. Mi ansiedad o irritaciones serían incontrolables.
12. ¿Cuánto esfuerzo realiza para resistirse a beber alcohol?. (Solamente anote sus esfuerzos para resistirse, no su éxito o fracaso en controlar realmente la bebida)
    a. Mi consumo de alcohol es tan leve que no necesito resistirme. Si bebo, estoy todo el tiempo resistiéndome a beber.
    b. Trato de resistirme la mayoría del tiempo.
    c. Hago algún esfuerzo para resistirme.
    d. Cedo a casi todas las copas sin intentar controlarme, pero lo hago con cierto rechazo.
    e. No hago ningún esfuerzo para resistirme a ninguna bebida.

13. ¿Cómo es de fuerte su deseo para consumir bebidas alcohólicas?
    a. No tengo ninguno.
    b. Algún deseo de beber.
    c. Fuerte deseo de beber.
    d. Muy fuerte deseo de beber.
    e. El deseo hacia la bebida es incontrolable e irresistible.
14. ¿Cómo es su control sobre el consumo de alcohol?
    a. Tengo un control completo.
    b. Normalmente soy capaz de controlar mi consumo.
    c. Solo puedo controlar el consumo con dificultad.
    d. Tengo que beber y solo puedo retrasar el consumo con dificultad
    e. Rara vez soy capaz de retrasar el consumo, incluso por poco tiempo.

Adverse Childhood Experience (ACE) Questionnaire Finding your ACE Score

Responda a las siguientes preguntas a la luz de sus experiencias vividas antes de cumplir 18 años:

1. ¿Alguno de sus padres u otros adultos en su casa con frecuencia o con mucha frecuencia... Lo ofendían, lo insultaban, lo menospreciaban, o lo humillaban?**o** Actuaban de tal forma que temía que lo fueran a lastimar físicamente?
    a. Si
    b. No

2. ¿Alguno de sus padres u otros adultos en su casa con frecuencia o con mucha frecuencia... Lo empujaban, lo jalaban, lo cacheteaban, o le tiraban cosas? **o** Alguna vez lo golpearon con tanta fuerza que le dejaron marcas o lo lastimaron?
    a. Si
    b. No

3. ¿Algún adulto o alguna otra persona, al menos 5 años mayor que usted alguna vez... Lo tocó o acarició indebidamente o le pidió que usted lo tocara de alguna forma sexual? **o** Intentó tener relaciones sexuales orales, anales o vaginales con usted?
    a. Si
    b. No

4. ¿Se sentía usted con frecuencia o con mucha frecuencia que...Nadie en su familia lo quería o pensaba que usted era especial o importante? **o** En su familia no se cuidaban unos a los otros, no sentían que tenían una relación cercana, o no se apoyaban unos a los otros?
    a. Si
    b. No

5. ¿Se sentía usted con frecuencia o con mucha frecuencia que...No tenía sufiente comida, tenía que usar ropa sucia, o no tenía nadie que lo protegiera? **o** Sus padres estaban demasiado borrachos o drogados para cuidarlo o llevarlo al medico si es que lo necesitaba?
    a. Si
    b. No

6. ¿Tus padres se separaron o divorciaron?
    a. Si
    b. No

7. ¿A su madre o madrastra: Con frecuencia o con mucha frecuencia la empujaban, jalaban, golpeaban, o le tiraban cosas? **o** A veces, con frecuencia, o con mucha frecuencia le pegaban, la mordían, la daban puños, o la golpeaban con algún objeto duro?
   o Alguna vez la golpearon durante varios minutos seguidos o la amenazaron con una pistola o un cuchillo?
    a. Si
    b. No

8. ¿Vivió usted con alguien que era un borracho o alcohólico, o que usaba drogas?
    a. Si
    b. No

9. ¿Algún miembro de su familia sufría de depresión o enfermedad mental, o alguien en su familia trató de suicidarse?
    a. Si
    b. No

10. ¿Algún miembro de su familia fue a la cárcel?
    a. Si
    b. No

Other as Shamer Scale

Lea cada oración cuidadosamente, indique la frecuencia en el cual usted se siente o experimenta lo que está escrito en la oración.

0	1	2	3	4
Nunca	**Raramente**	**A veces**	**Frecuentemente**	**Casi Siempre**

1.Siento que otras personas me ven como si no soy suficientemente bueno	0 1 2 3 4
2. Pienso que otras personas me menosprecian	0 1 2 3 4
3. Otras personas me ponen por el piso mucho	0 1 2 3 4
4. Me siento inseguro sobre las opiniones que los demás tienen sobre mi.	0 1 2 3 4
5. Otras personas me ven como si no les llego ni a los tobillos	0 1 2 3 4
6. Otras personas me ven como pequeño e insignificante	0 1 2 3 4
7. Otras personas me ven como una persona defectuosa	0 1 2 3 4
8. En comparación con los demás, la gente me ve como no importante	0 1 2 3 4
9. Otras personas buscan mis fallas	0 1 2 3 4
10. La gente me ve esforzándome para obtener la perfección, pero se dan cuenta que no puedo llegar a mis propios estándares.	0 1 2 3 4
11. Creo que otros pueden ver mis defectos	0 1 2 3 4
12. Otros son críticos o castigadores cuando cometo un error	0 1 2 3 4
13. Las personas se distancian de mí cuando cometo un error	0 1 2 3 4
14. Otras personas siempre recuerdan mis errores	0 1 2 3 4
15. Otros me ven como frágil	0 1 2 3 4

16. Otros me ven como vacío y sin realizarme	0 1 2 3 4
17. Otros piensan que hay algo que falta en mí	0 1 2 3 4
18. Otras personas piensa que he perdido el control de mi cuerpo y mis sentimientos	0 1 2 3 4

Perceived Stress Scale:

Las siguientes preguntas hacen referencia a sus sentimientos y pensamientos durante el último mes. En cada caso, por favor indique cómo usted se ha sentido o ha pensado en cada situación.

0 = Nunca 1 = Casi Nunca 2 = De Vez en Cuando 3 = A Menudo 4=Muy A Menudo

1.	En el último mes, ¿con qué frecuencia ha estado afectado por algo que ha ocurrido inesperadamente?	0 1 2 3 4
2.	En el último mes, ¿con qué frecuencia se ha sentido incapaz de controlar las cosas importantes en su vida?	0 1 2 3 4
3.	En el último mes, ¿con qué frecuencia se ha sentido nervioso o estresado?	0 1 2 3 4
4.	En el último mes, ¿con qué frecuencia ha estado seguro sobre su capacidad para manejar sus problemas personales?	0 1 2 3 4
5.	En el último mes, ¿con qué frecuencia ha sentido que las cosas le van bien?	0 1 2 3 4
6.	En el último mes, ¿con qué frecuencia ha sentido que no podía bregar todas las cosas que tenía que hacer?	0 1 2 3 4
7.	En el último mes, ¿con qué frecuencia ha podido controlar las dificultades de su vida?	0 1 2 3 4
8.	En el último mes, ¿con qué frecuencia se ha sentido al control de todo?	0 1 2 3 4
9.	En el último mes, ¿con qué frecuencia ha estado enfadado porque las cosas que le han ocurrido estaban fuera de su control?	0 1 2 3 4
10.	En el último mes, ¿con qué frecuencia ha sentido que las dificultades se acumulan tanto que no puede superarlas?	0 1 2 3 4

Resilience scale CD-RISC

Por favor indique cuál es su grado de acuerdo con las siguientes frases en su caso durante el mes último. Si una situación particular no le ha ocurrido recientemente, responda de acuerdo a cómo cree que se habría sentido. Lea cuidadosamente. A continuación, por favor seleccione la respuesta que mejor lo describa a usted. **absolutamente falso** (0), **rara vez**(1), **a veces** (2), **a menudo** (3), **Casi siempre** (4)

	Falso				**Cierto**
Soy capaz de adaptarme cuando surgen cambios	0	1	2	3	4
Puedo enfrentarme a cualquier cosa	0	1	2	3	4
Cuando me enfrento a los problemas intento ver el lado cómico de ellos	0	1	2	3	4
Enfrentarme a las dificultades puede hacerme más fuerte	0	1	2	3	4
Tengo tendencia a recuperarme pronto luego de enfermedades, heridas u otras dificultades	0	1	2	3	4
Creo que puedo lograr mis objetivos, incluso si hay obstáculos	0	1	2	3	4
Bajo presión me mantengo enfocado/a y pienso claramente	0	1	2	3	4
No me desanimo fácilmente ante el fracaso	0	1	2	3	4
Creo que soy una persona fuerte cuando me enfrento a los desafíos y dificultades de la vida	0	1	2	3	4
Soy capaz de manejar sentimientos desagradables y dolorosos como tristeza, temor y enfado	0	1	2	3	4

Appendix C

Curriculum Vitae

EDUCATION

PsyD Graduate School of Clinical Psychology,
George Fox University **Expected Graduation: 2021**
Newberg, Oregon
Dissertation: "Shame, Resiliency, Trauma-Stress and Alcohol Related Behaviors in Puerto Rico" **Defended: September 20, 2019**
Committee: Winston Seegobin, PsyD. (Chair), Glena Andrews, PhD., Kathleen Gathercoal, PhD.

MA Graduate School of Clinical Psychology, **2018**
George Fox University
Newberg, Oregon

CAT IV National Association of Drug and Alcohol Interventionists & Education Commission of Intervention Institute **2018-2020**

BS **Universidad del Sagrado Corazón, Natural Science** **2016**
Santurce, Puerto Rico
Graduated Summa Cum Laude
Minored in Psychology

LANGUAGES SPOKEN

Spanish: Native Language
English: Distinguished levels in Listening, Speaking and Reading

CLINICAL EXPERIENCE

Practicum Therapist **Current**
Behavioral Health Clinic
Newberg, Oregon

- Conduct clinical interviews with clients
- Conduct urgent need intakes for people who were referred by the ED with Suicidal ideations.
- Provide English and Spanish individual and couples therapy for the people

in the community.
- Administer two assessment batteries.
- Engage in Program Development
- Administer ORS, SRS assessments and other screeners.

Supervisor: Joel Gregor, PsyD; Sylvia Ramirez, MA

Therapist **Current**
Portland Mercado/United Methodist Church
Portland, Oregon
- Provide Spanish individual therapy to individuals of the community; in particular Latino/a individuals.
- Facilitate a support group for Latino/a parents.

Supervisor: Glena Andrews, PhD

Practicum Therapist **2018-2019**
Oregon State University CAPS
Corvallis, Oregon
- Co-lead an Interpersonal Process group & SMART Recovery group.
- Provided Spanish and English individual therapy to students from variety of ethnicities, backgrounds and mental health concerns.
- Reviewed Counseling Center Assessment of Psychological Symptoms (CCAPS) with each individual client.
- Work in triage and on call services for students and people of the community.
- Conducted intake interviews with clients
- Worked with a diverse population (i.e. international students, LGBTQ, ethnic minorities)

Supervisors: Stephanie Shippen, PsyD; Erin Crozier, PhD; Jordan Torri, MA
Spanish Supervisor: AJ Millet, PhD

Clergy Assessment Assistant **2017-2019**
George Fox University, Doctorate in Clinical Psychology Program
Newberg, Oregon
- Administer and interpret Personality Assessments for diaconal/pastoral candidates.
- Conduct clinical interviews with diaconal/pastoral candidates.
- Serve as a translator for Spanish speaking candidates.

Supervisor: Nancy Thurston, PsyD

Practicum Therapist **2017-2018**
Warner Pacific University
Portland, Oregon
- Provide therapy to students struggling with Eating Disorders, Schizophrenia, Trauma, Addiction, Anxiety, Depression and Interpersonal Issues; from a variety of backgrounds.

- Conduct clinical interviews with clients.
- Worked with a diverse population (i.e. international students, LGBTQ, ethnic minorities, military veteran)

Supervisor: Glena Andrews, PhD

Pre-Practicum Therapist **Fall 2017**
George Fox University, Doctorate in Clinical Psychology Program
Newberg, Oregon

- Conducted clinical intake with two undergraduate students
- Provided simulated therapy to two undergraduate students at George Fox University using a person-centered perspective.
- Administered ORS, SRS and MMSE assessments
- All sessions were video recorded and reviewed by supervisors.

Supervisors: Glena Andrews, PhD and Cynthia Song, MA

CONSULTATION

Organizational Consultant **2018-2019**
Non-Profit Organization
Portland, Oregon

- Create and administer a qualitative and quantitative organizational Needs Assessment (communication, power dynamics, employee satisfaction, burnout) to a Non-profit organization in Portland, Oregon.
- Provided feedback and recommendations to the organization.

Supervisors: Marie Goodworth, PhD

Hurricane María Aftermath Mental Health Consultation **2018**
Bayamon, Puerto Rico

- Prepared, conducted and collected data on resiliency and post traumatic growth of the employees of two companies.
- Used the results to advise the executives of the company on ways to better support employees in times of hardship, in particular after a natural disaster.

Supervisor: Winston Seegobin, PsyD; Kathleen Gathercoal, PhD

Undergraduate Minority Consultation **2016-2017**
George Fox University
Newberg, Oregon

- Developed and administer a questionnaire to find out which were the needs of the ethnic minority students.
- Provided consultation to the university administration to develop better support to minority students and to increase their psychological well-being in these difficult times.

Supervisors: Glena Andrews, PhD

SUPERVISION AND TEACHING EXPERIENCE

Supervisor and Teaching Assistant **Current**
George Fox University, Graduate School of Clinical Psychology
Newberg, Oregon
Clinical Foundations of Treatment 1 & 2

- Provide weekly group supervision to four first year graduate students.
- Provide individual supervision to four first year graduate students.
- Reviewed clinical skill-training videos, and provided feedback.
- Graded professional papers and clinical writing, and provided feedback.
- Worked with students individually and in a group setting to develop foundational therapeutic skills.

Professor: Glena Andrews, PhD

Teaching Assistant **2018**
George Fox University, Psychology Department
Newberg, Oregon
Racial Healing

- Undergraduate course taught to 20 students.
- Assisted professor by facilitating small and large group discussions, covering the following topics: Understanding the Origins of Racism, Examining the Impact of Racism, Examining the Impact of Denial, Unconscious Racial Preferences, Microaggressions, What does it mean to be White?, Ally Building, Understanding Institutional Racism and Defining the Healing Process.

Professor: Winston Seegobin, PsyD

Teaching Assistant, **2018**
George Fox University, Graduate School of Clinical Psychology
Newberg, Oregon
Substance Abuse

- Revised the syllabus to meet accreditation standards.
- Provided support to the professor during the class time.
- Helped the professor plan class interventions to facilitate learning.

Professor: Jory Smith, PsyD

LEADERSHIP

Clinical Advisory Committee, Member **Current**
George Fox University, Doctorate in Clinical Psychology Program
Newberg, Oregon

- Coordinate in finding speakers for Colloquium's and Grand Rounds.
- Consult with DCT on didactic topics and speakers.
- Polling the students for opinions about curriculum issues and other feedback.

Supervisor: Glena Andrews, PhD

Multicultural Leadership, Member **Current**
George Fox University, Doctorate in Clinical Psychology Program
Newberg, Oregon

- Address systemic and societal multicultural issues.
- Find ways to improve the program in how they address adversity.

Supervisor: Winston Seegobin, PsyD

Diversity of Leadership Panel, Panelist **January 2020**
George Fox University, Doctorate in Clinical Psychology Program
Newberg, Oregon

- Discuss how Leadership looks like through various cultural lens.
- Discuss how to be a leader while holding diverse identity markers.

RESEARCH EXPERIENCE

Shame, Resiliency, Trauma-Stress
and Alcohol Related Behaviors in Puerto Rico
George Fox University, Newberg, Oregon
Advisor: Winston Seegobin, PsyD

Post-Traumatic Growth and Resiliency
in Puerto Rican Hurricane Maria Victims
George Fox University, Newberg, Oregon
Advisors: Winston Seegobin, PsyD. and Kathleen Gathercoal PhD.

PRESENTATIONS AND PUBLICATIONS

Journal

Blasini-Méndez, M. (2019). Interpersonal Postcolonial Supervision: Facilitating Conversations of Countertransference. *Training and Education in Professional Psychology*, *13*(3), 233–237.

Poster Presentation

Blasini-Méndez, M., Gathercoal, K., Seegobin, W., & Leytle, M. (2018, August). Post-Traumatic Growth and Resiliency in Puerto Rican Hurricane Maria Victims. Poster presented at annual meeting of the American Psychological Association, San Francisco, CA

PROFESSIONAL TRAINING

Clinical Team

George Fox University, Doctorate in Clinical Psychology Program

- Present 3 Psychodynamic/Interpersonal cases to a group of 4-6 peers each year.
- Collaborated with other group members over case conceptualization of other individuals
- Consulted with clinical team on possible treatment approaches
- Examined multicultural aspects of cases presented to team
- Supported less-advanced students in their conceptualization

Supervisor: Christina Weiss, PsyD ***Current***
Supervisor: Kris Kays, PsyD **2018-2019**
Supervisors: Mary Peterson, PhD and Kyler Shumway, MA **2017-2018**
Supervisor: Rodger Bufford **, PhD** **2016-2017**

Multicultural Training **2017**

Center for Multicultural Training in Psychology, Boston Medical
Boston, Massachusetts

- Received a two-day training on how to address multiculturalism with clients and within psychological, educational and medical systems.

Leadership Training **2017**

George Fox University, Doctorate in Clinical Psychology Program
Newberg, Oregon

- Received 8 hours of leadership training.
- Developed an understanding of different leadership styles and how they coexist within a system.

OTHER PROFESSIONAL TRAINING & WORKSHOPS

Forster, C. (2019). Intercultural Communication
Worthington, E. (2019). Promoting Forgiveness
Bermudez, M. (2019). Working with Immigrants and Mixed-Status People in the US: Practicing Sociocultural Attunement
Marlow, D. (2019). Foundations of Relationships Therapy-The Gottman Model
Safi, D., Millkey, A. (2019). Opportunities in Forensic Psychology
Pengelly, S. (2018). Old Pain in New Brain
McMinn, M., McMinn,L. (2018). Spiritual Formation and the Life of a Psychologist: Looking Closer at Soul-Care
Vogel, M. (2018). Integration and Ekklesia
Taloyo, C. (2018). History and Application of Interpersonal Psychotherapy
Sordal, J. (2018) Telehealth

Gil-Kashiwabara, E. (2017). Using Community Based Participatory Research (CBPR) to Promote Mental Health in American Indian/Alaska Native (AI/AN) Children, Youth and Families
Wharford, P. (2017). Domestic Violence: A Coordinated Community Response
Brown, S. (2017). Native Self Actualization: It's assessment and application in therapy
Bourg, W. (2016). When Divorce Hits the Family: Helping Parents and Children Navigate
Kuhnhausen, B. (2016). Sacredness, Naming and Healing: Lanterns Along the Way

AWARDS

Most Prominent Youth of Puerto Rico **2016**
In the area of Community Leadership
Puerto Rican Youth Commission
in Cooperation with the UNESCO Cultural Center

Dean's List Honor Roll **2012-2015**

Portico Medal for Civism **2014-2015**
University's highest distinction.

Portico Medal for Academics **2015**
University's highest distinction.

PROFESIONAL AFFILIATIONS

National Latina/o Psychological Association **Current**
Division 35 - Society for the Psychology of Women **Current**
Division 13 - Society of Consulting Psychology **Current**
Division 50 - Society of Addiction Psychology **Current**
American Psychological Association **Current**
Puerto Rico Psychological Association **Current**

ASSESSMENT AND SCREENERS

Previously Administered or Completed Competency
16 Personality Factors Questionnaire (16PF)
Counseling Center Assessment of Psych Symptoms (CCAPS)
Millon Clinical Multiaxial Inventory-III (MCMI-III)
Minnesota Multiphasic Personality Inventory-II (MMPI-II)
Minnesota Multiphasic Personality Inventory-II, Restructured Format (MMPI-II-RF)
Mini-Mental State Examination, 2nd Edition (MMSE-II)
Outcome Rating Scale (ORS)
Personality Assessment Inventory (PAI)
Session Rating Scale (SRS)
Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV)
Wechsler Individual Achievement Test, Third Edition (WIAT-III)

Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)

Wechsler Memory Scale (WMS)

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Glena Andrews, PhD.
Director of Clinical Training
George Fox University GSCP. 503-554-2386

Marie-Christine Goodworth, PhD.
George Fox University GSCP. 503-554-2382

Stephanie Shippen, PsyD.
Oregon State University CAPS. 541-737-2131

Winston Seegobin, PsyD.
Director of Diversity
George Fox University GSCP. 503-554-2381