Emotional nonacceptance within the context of traumatic event exposure: The explanatory role of anxiety sensitivity for traumatic stress symptoms and disability among Latinos in a primary care setting

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Objective: Research has found that Latinos (versus non-Latino Whites) evince higher rates of posttraumatic stress symptoms (PTS) and posttraumatic stress disorder (PTSD), yet little attention has been given to intra-individual, emotion-related processes to explicate the higher incidence of these symptoms among Latinos.

Method: Participants included 183 trauma-exposed adult Latinos (88.5% female; Mage = 37.7, SD = 10.7 and 93.4% reported Spanish as their first language) who attended a community-based primary healthcare clinic in Houston. It was hypothesized that anxiety sensitivity would explain the relation between emotional nonacceptance and traumatic stress symptoms, namely re-experiencing, avoidance, and arousal difficulties as well as overall disability. Additionally, it was expected that the observed effects would be evident above and beyond the variance accounted for by number of traumas reported, gender, age, marital status, educational status, years living in the U.S., and negative affectivity.

Results: Consistent with our hypotheses, difficulties accepting negative emotions were associated with increased trauma-related re-experiencing, avoidance, and arousal difficulties. Additionally, anxiety sensitivity was an underlying mechanism in the association between emotional nonacceptance and all but one facet of traumatic stress symptoms (i.e., re-experiencing symptoms) and disability. Alternative models yielded no significant effects, providing greater confidence in the direction of the hypothesized effects.

Conclusion: Findings are discussed in the context of their significance for informing the development of specialized intervention strategies that target anxiety sensitivity for Latinos in primary care with elevated risk for PTS and PTSD by their heightened levels of emotional nonacceptance.

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Census projections estimate that Latinos will represent 28.6% of the U.S. population by 2060 [1], which has resulted in appreciably more research attention to the mental health status and needs of Latinos living in the U.S. [2–6]. These investigations have found differences regarding the prevalence of disorders among Latinos relative to populations with historically better representation in mental health research. For instance, as a group, Latinos in the U.S. evidence lower rates of anxiety and mood disorders than their non-Latino White counterparts [7–9], although given the heterogeneous nature of Latinos, within group differences exist [8]. In contrast, several investigations have found that Latinos evince higher rates of posttraumatic stress symptoms (PTS) and posttraumatic stress disorder (PTSD) than non-Latino Whites [10–14].

Given that PTSD and its symptoms are associated with a host of negative problems, including increased disability [15], anxiety [16], depression [17], substance use [18], and suicidal ideation [19], researchers have begun to focus on the mechanisms that may explicate the higher rates of these symptoms among Latinos. These studies have found that acculturation difficulties; [12,20] discrimination and racism; [21,22] economic and legal integration challenges; [23] exposure to severe political violence and persecution; [24] maladaptive coping style; [21] and poor social support [20,25] are linked to higher rates of PTS and PTSD among Latinos. Yet, little attention has been given to intra-individual, emotion-related processes to explicate the higher incidence of PTS.
among Latinos. This issue is unfortunate, given that PTSD is characterized by emotional and experiential avoidance in which affected individuals struggle with the emotional demands of trauma, particularly the frequent experience of negative affect states [26–29].

One underlying construct of potential relevance to better understanding the increased trauma-related symptoms among Latinos is emotional nonacceptance [30]. Emotional nonacceptance, a subcomponent of broader emotion regulation difficulties, is a relatively stable individual difference construct that includes an unwillingness to accept unwanted emotions, as well as the experience of secondary emotions, such as guilt or anger, in response to a primary emotion [31]. Theoretically, maladaptive reactions toward negative emotional states (which are frequent among individuals with high PTS or PTSD), can maintain or exacerbate such symptoms through fear/avoidance [32]. Consistent with such a perspective, emotional nonacceptance is associated with significantly greater levels of anxiety [29,33–35] and depressive symptoms [36–38]. Likewise, survivors of early-onset interpersonal trauma (vs. non-traumatized controls) reported more difficulties tolerating and regulating negative emotions [39], greater fears of emotional states [28], and higher experiential avoidance (a related, albeit distinct, construct defined as efforts to alter the form or frequency of unwanted internal experiences) [40]. Notably, none of these studies focused on Latinos.

Despite the centrality of emotional nonacceptance to trauma-related psychopathology [28,29,31,41,42], to date, investigations into the mechanisms that may underlie the relation between emotional nonacceptance and trauma-related symptoms are lacking, particularly among Latinos. One candidate may be anxiety sensitivity, defined as the fear of anxiety-related cues due to the belief that these cues signal impending catastrophe [43]. A person with high anxiety sensitivity may perceive an anxiety-related increase in heart rate as a sign of cardiac problems needing prompt medical attention, causing that person to avoid experiences that may lead to those unwanted sensations. A large body of work—on primarily non-Hispanic white samples—suggests that anxiety sensitivity is a risk factor for the acquisition and maintenance of anxiety and depressive psychopathology, including PTSD symptoms [44,45]. Although anxiety sensitivity has not been extensively studied among Latinos, limited evidence suggests it may be related to mental health processes (i.e., anxiety, depression) in a manner largely similar to that reported among non-Hispanic white samples [46–50]. However, to date, no studies with Latino samples have examined the relation of anxiety sensitivity to trauma-related outcomes in particular.

In theory, anxiety sensitivity may explain the relation of emotional nonacceptance to trauma-related symptoms and disability among Latinos. First, a large body of work suggests that anxiety sensitivity is associated with the development, maintenance and severity of PTS and PTSD by increasing arousal, fear and avoidance of interoceptive cues [45,51–53]. Studies have also found that anxiety sensitivity and emotional nonacceptance are interrelated yet serve as independent predictors of PTS symptom severity [28,29,41]. Moreover, openly accepting negative emotions may be considered a sign of weakness or a character deficiency in Latino culture [47,54]. Indeed, among Latino women in particular, self-silencing of negative emotions to maintain harmony in the context of interpersonal relationships is seen as a positive character trait (i.e., marianism) [55]. This culturally sanctioned attitude toward negative emotions may result in apprehension and misunderstanding of interoceptive cues, which, in the context of traumatic exposure, can be related to more severe trauma-related pathology. Specifically, if a Latino individual is unwilling to experience trauma-related negative emotions, such a process could contribute to beliefs about their potential threat and sensitivity toward them, exacerbating the severity of such negative emotional symptoms. Extant research also suggests that severity of disability across work, social, and home/family domains is associated with PTS symptom severity as well as emotion dysregulation among trauma-exposed individuals [56], but no studies to date have examined the role of anxiety sensitivity in these relations. Accordingly, examining the effects of emotional nonacceptance via anxiety sensitivity on traumatic stress and disability among Latinos is an important and clinically-relevant next research step.

Together, the present investigation sought to address whether anxiety sensitivity explained the relation between emotional nonacceptance and traumatic stress symptoms (i.e., re-experiencing, avoidance, arousal, and total PTS symptoms) and severity of disability among trauma-exposed Latinos in a primary care medical setting. Of note, separate tests for each PTS symptom cluster (in addition to total PTS symptoms) were conducted because dimensions of PTS symptoms have shown differential relations with both emotional non-acceptance and anxiety sensitivity [57–59]. From a public health perspective, primary care medical settings represent a strategic location to address mental health disparity among Latinos. Indeed, primary care medical settings are the primary ‘health portal’ for Latinos wherein treatment for health problems in general, and mental health specifically, is sought [60] because it decreases the stigma associated with receiving mental health services [61]. It was hypothesized that anxiety sensitivity would explain the relation between emotional nonacceptance and traumatic stress symptoms, namely re-experiencing, avoidance, and arousal difficulties as well as severity of disability. Additionally, it was expected that the observed effects would be evident above and beyond the variance accounted for by number of traumas reported, gender, age, marital status, educational status, years living in the U.S., and negative affectivity.

1. Method

1.1. Participants

Participants included 183 trauma-exposed adult Latinos (88.5% female; Mage = 37.7, SD = 10.7 and 93.4% reported Spanish as their first language) who attended a community-based primary healthcare clinic in Houston, Texas. Inclusion criteria were as follows: ability to read, write and communicate in Spanish; being between 18 and 64 years old; and endorsing at least one traumatic event on the Posttraumatic Diagnostic Scale [62]. Participants were excluded if there was limited mental competency and/or inability to provide informed, voluntary, written consent or if they endorsed any psychotic-spectrum symptoms on the MINI International Neuropsychiatric Interview [63].

Participants identified a range (see Table 1 for full list) of potentially traumatic stressors for reference on the Post-traumatic Diagnostic Scale (PDS) [62], including natural disaster (43.2%), serious accident/explosion (34.4%), sexual assault (21.3%), non-sexual assault by someone familiar (21.3%), and non-sexual assault by a stranger (18.6%).

A majority (56.3%) identified as Mexican/Mexican American, 29.0% identified as Central American, 5.5% identified as South American, 4.4% of participants identified as American/Born in America, 2.2% identified as Cuban, and 2.7% identified as “Other.” Regarding education, 6.6% of

Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>% (n)</th>
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<tbody>
<tr>
<td>Potentially traumatic event type*</td>
<td></td>
</tr>
<tr>
<td>Natural disaster</td>
<td>43.2% (79)</td>
</tr>
<tr>
<td>Serious accident, fire, explosion</td>
<td>34.4% (63)</td>
</tr>
<tr>
<td>Sexual contact in childhood/adolescent with someone 5 yrs older</td>
<td>21.3% (39)</td>
</tr>
<tr>
<td>Non-sexual assault by someone familiar</td>
<td>20.8% (39)</td>
</tr>
<tr>
<td>Non-sexual assault by a stranger</td>
<td>18.6% (34)</td>
</tr>
<tr>
<td>Sexual assault by someone familiar</td>
<td>15.6% (29)</td>
</tr>
<tr>
<td>Other traumatic event</td>
<td>14.2% (26)</td>
</tr>
<tr>
<td>Sexual assault by a stranger</td>
<td>8.7% (16)</td>
</tr>
<tr>
<td>Prison</td>
<td>6.0% (11)</td>
</tr>
<tr>
<td>Life threatening illness</td>
<td>5.5% (10)</td>
</tr>
<tr>
<td>Torture</td>
<td>2.7% (5)</td>
</tr>
<tr>
<td>Military combat or war zone</td>
<td>2.2% (4)</td>
</tr>
</tbody>
</table>

* As endorsed on the PDS (Poa, 1995).
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